# *Rapid Assessment on Social and Health Impact of COVID-19 Among Returning Migrant Workers in Cambodia*

November 2020

# FUNDING

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## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| ANC | Antenatal care |
| CDHS | Cambodia Demographics and Health Survey |
| COVID-19 | Coronavirus Disease 2019 |
| ILO | International Labour Organization |
| IOM | International Organization for Migration |
| IRL | Indochina Research (Cambodia) Co., Ltd |
| IEC | Information Education and Communication |
| IUD | Intrauterine device |
| MCH | Maternal and Child Health |
| MoH | Ministry of Health |
| NGO | Non-governmental organization |
| PHD | Provincial Health Department |
| PNC | Postnatal care |
| QC | Quality controls |
| RGC | Royal Government of Cambodia |
| RMW | Returning Migrant Workers |
| SH/KI | Stakeholder/Key informant |
| UN | United Nations |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| WASH | Water, Sanitation and Hygiene |
| WHO | World Health Organization |

## FOREWORD

Migration is an increasingly important economic lifeline and a factor driving social mobility for families in Cambodia. Over the last fifteen years, internal and international migration has been one of the most significant transformational changes in Cambodian society and the trend is set to continue. Migration offers opportunities and poses challenges for migrants and their families, especially children. As a powerful driver of sustainable development migration helps fill labour market gaps, promotes cultural exchange and skills transfer, and ensures that businesses can flourish. In the countries of origin, migrants' income, sent in the form of remittances constitutes a critical lifeline for millions of individual households, helping families raise their living standards above subsistence and vulnerability levels although some of them have experienced challenging and dangerous situation and exploitation in the destination countries. Families left behind tend to use this income to satisfy basic needs, such as food, access to medical care and/or to repay debt.

As Thailand began to curb COVID-19 by reducing its economic activities and closing its borders, more than 120,000 Cambodian migrant workers have crossed the border from Thailand to Cambodia since March 2020. The mass return of migrants has led to socio-economic repercussions on their families and communities. A big proportion of non-poor households, who sit just above the poverty line, constitute the main group of migrants looking for better livelihood opportunities in neighboring countries. Their return to Cambodia with no jobs means their family and host communities can easily slide back to poverty, particularly in the context of the projected contracting economy.

Migrant workers' access to social protection is fraught with challenges and shortcomings. Legislative barriers limiting migrant workers' access to social security benefits are compounded by the fact that social security systems cover only part of the labour force. A worker's specific immigration status, including when a person is an undocumented migrant worker, may make them ineligible for accessing benefits. Factors such as nationality, residence or documentation requirements, being employed in the informal economy, or other administrative barriers may also prevent migrant workers from being covered by social security systems of either the host or the home country.

The *Rapid Assessment on the Social and Health Impact of COVID-19 Among the Returning Migrant Workers* led by UNFPA on behalf of the UN team and funded by MPTF, UNFPA, IOM, UNICEF, UNWOMEN, UNAIDS and the Government of Japan and conducted in collaboration with the National Committee on Counter Trafficking in Persons (NCCT) and relevant ministries, aimed to produce evidence to identify and formulate new policies and strategies to effectively respond to the impact of COVID-19 on the returning migrants in Cambodia. We hope that the findings and recommendations from this assessment will help inform stakeholders to respond to the challenge of building back better through developing concrete short-term, immediate and long-term action plans to support migrants, their families and children

We would like to take this opportunity to thank the Indochina Research team and all the people who contributed to this study. Finally, we would like to express our sincere thanks to MPTF, UNFPA, IOM, UNICEF, UNWOMEN and UNAIDS for providing technical and financial support for the successful completion of this research.

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The *Rapid Assessment on Social and Health Impact of COVID-19 Among Returning Migrant Workers* was led and managed by UNFPA in close collaboration with the National Committee on Counter Trafficking in Persons (NCCT) and in consultation and technical and financial support from IOM, UNICEF, UN Women and UNAIDS.

The assessment has been concluded through a collaborative inter-agency process and involved many partners and stakeholders at national and provincial levels as well as local non-governmental organizations. This publication would not have been possible without their committed collaboration and valuable contributions.

Firstly, UNFPA Cambodia would like to express our sincere gratitude and appreciation to H.E. Mrs. Chou Bun Eng, Secretary of State, Ministry of Interior and permanent NCCT Vice Chair for her strong leadership and support on behalf of the Royal Government of Cambodia. The NCCT team played and continues to play a crucial coordinating role among key stakeholders at the national and sub-national levels to support the returning migrants.

The study was conducted by Indochina Research Co., Ltd. (IRL). UNFPA is grateful to Dr. Thor Rasoka, research Advisor and Ms. Hong Sineath, research manager of IRL and other field data collectors for their assistance in carrying out this study.

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Finally, UNFPA wishes to recognize the invaluable contribution made by the returning migrants themselves and other key stakeholders who voluntarily spent their time, participated in the study, and provided insightful information for this assessment.

We hope that this report is useful and provides tangible evidence for policy makers, implementing partners and relevant organizations to develop relevant policy responses to support the returning migrants and their families.

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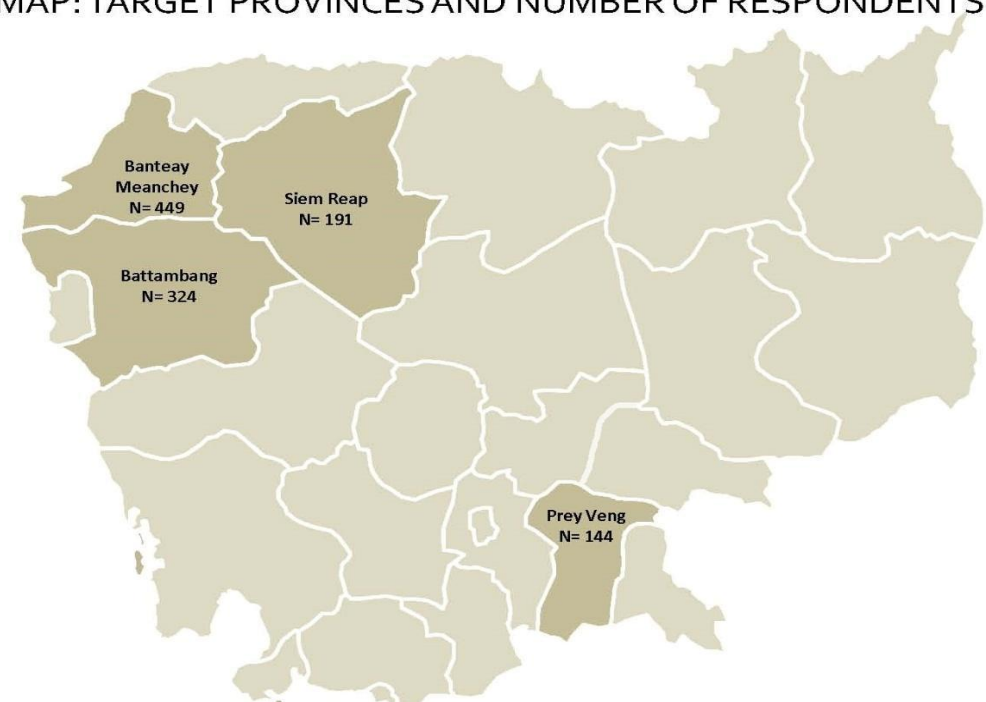
## EXECUTIVE SUMMARY

On March 23, 2020, Thailand declared the closure of its borders with neighbouring countries because of the COVID-19 pandemic. Since then, approximately 115,000 Cambodian migrant workers have returned to Cambodia. This situation has created a humanitarian emergency and a health threat by potential spread of the coronavirus. There are also concerns about the situation of the returning migrant workers (RMW) and their families amidst the COVID-19 pandemic. It is assumed that they are facing multiple challenges to meet their basic social and health needs since they are back at their home communities.

The IOM, UNAIDS, UNFPA, UNICEF and UNWOMEN commissioned this Rapid Assessment to better understand the impact of COVID-19 pandemic among the RMW, including their current living condition, their social and health needs, their access to, and utilization of maternal and child health services such as sexual and reproductive health, child protection issues etc.

The information and recommendations generated by the research would support the Royal Government of Cambodia to develop evidence-based medium and long-term policies/strategies to effectively support the RMW and their families.

This assessment is undertaken in August 2020 using quantitative and qualitative methods. The data collection is conducted via telephone calls. Sample size of the quantitative survey is 1,108 RMW in four provinces: Banteay Meanchey (BMC), Battambang (BTB), Prey Veng (PV), and Siem Reap (SR). Meanwhile, the qualitative survey is done with 56 stakeholders/key informants (in Phnom Penh and the four target provinces).



The quantitative survey sample includes 54.5% women and 45.5% men. The mean age of the survey population is 33.2 years (33.0 years for women, 33.4 years for men). By age group, the largest number of both women and men respondents is 25-34 years old (43.7%), followed by 35-45 years old (30.3%). The survey sample includes people presenting a factor of vulnerability: pregnant women (6.4%), people with disability (2.4%), people living with HIV (1.0%), and adolescents 15-17 years old (0.6%).

## KEY FINDINGS

### Social and Financial Situation

1. Nearly all RMW in the survey have reintegrated their community of origin (94.1%). Housing is not an issue for them as 99.1% either returned in their own houses or are hosted at no charge by parents or relatives.
2. The median value of monthly household total income *(including salary, remittance, and all other incomes)* is 150 US$ (150 US$ for men, 127 US$ for women), but nearly one out of three RMW households have no income at all *(no significant difference between men and women)*. Also, more than half of RMW (58.0%) currently have no source of earning with women (66.4%) being more affected than men (48.0%). Moreover, divorced (83.3%) and widowed (61.1%) are more affected than married (57.1%), and single (56.8%) individuals.
3. More than half (55.7%) of respondents currently have debts: 30.5% have debts with a bank or microfinance institution, 9.8% with a moneylender and 20.9% with relatives/friends/neighbours. More women are in debt (60.8%) than men (49.6%). The median amount of loans is 1,500 US$ (men at 1,295 US$, women at 1,500 US$) while the median amount of monthly loan payment is 96 US$ (men at 75 US$, women at 100 US$).
4. RMW take loans mainly for buying foods (32.6%) and for health care (25.0%).
5. Women are more likely than men to have no money (27.3% versus 21.4%) or no financial autonomy for four weeks or less (31.5% versus 24.6%) while men are more likely than women to have financial autonomy for one month or more (41.5% versus 28.0%).
6. The most frequent concerns of RMW are insufficient income (81.8%), followed by unemployment (69.4%), and COVID-19 infection (39.9%).
7. The IDPoor Card is owned by 25.3% of the respondents: 7.5% Type 1 (Very Poor), 12.5% Type 2 (Moderately Poor) and 5.2% who do not know which type. The percentages of IDPoor cardholders in the survey per province are consistent with the percentages in the general population of the four provinces. Only Banteay Meanchey and Prey Veng have rates of IDPoor Type 2, which are lower in the survey than in the population.
8. One in five RMW has benefited from the government's Cash Transfer Programme for Poor and Vulnerable Households. Getting the cash support is linked to having the IDPoor card with 65.2% of cardholders receiving the cash support versus 4.7% of those not having the card. Moreover, getting cash support is not associated to the level of household income or having no source of earnings. The results suggest that the coverage of RMW by the cash transfer programme is still low and the targeting of the most-needy RMW could improve through increasing the IDPoor identification/registration.
9. Overall, the RMW have received little external support so far: 8.6% have received free distribution of food/rice, 9.7% free health care, 3.3% livelihood support (seeds, animals etc), 3.3% psychosocial counselling, 4.0% identity registration and 1.2% legal service. The support comes mainly from the government institutions, in a lesser extent from NGOs and civil society organizations (CSO) and very little from private companies.

10. Only 4.9% of all RMW, men and women alike, have sought any support. Prey Veng has the lowest rate at 0.7% while Battambang has the highest rate at 7.7%. Meanwhile, Banteay Meanchey has 3.6% and Siem Reap has 6.3%. The main recourse for assistance is the village chief (63.0%) followed by the commune council (22.2%). Only 7.4% have contacted a local NGO or social organization. None of the RMW has approached the district or provincial authorities for assistance. The results indicate that the more distant the services are from the beneficiaries, the fewer people use them.

## Health and Nutrition Situation

11. Insufficient food is a relatively frequent problem that affects one out of five RMW and families (21.0%). The situation is worse in Siem Reap with one out of three respondents saying they are not able to eat enough every day (29.8%) while the problem is relatively minimal in Prey Veng (5.6%). More than half of those who do not have enough food has no other solution than to reduce their food intake (64.3%). This means a risk of malnutrition for the children and other vulnerable groups like pregnant women etc.
12. For 22.8% of RMW, their physical health has become worse since their return from Thailand. One out of three RMW or family member has been sick, and this is more frequent among women. A little more than half of those being sick (59.8%) go to the health centre or referral hospital, and 38.6% go to private clinics. Also, 52.3% of them declare having constraints to obtaining any form of health care with the main bottleneck being lack of money and distance/lack of transport, with urban residents having more financial constraints (84.6%) than rural residents (47.7%). And this is happening as the fears of COVID-19 is a minor constraint in seeking health care services (8.5%).
13. The mental health has become worse for 40.9% of RMW. Among these individuals, 42.6% has sought any help, 55.9% has talked to family or friends, and 0.7% has consulted a social worker or a health staff. This indicates that the existing mental health and counselling services are not sufficiently promoted.
14. Less than five percent of RMW and families present a physical or intellectual disability. Similarly, chronic diseases, tuberculosis and HIV/AIDS are rare (1.7% or less for tuberculosis, 1.0% or less for HIV/AIDS). This is probably because people who have a disability or pre-existing health conditions are less likely to go on migration and find work in Thailand. Only 36.9% of the patients who need treatment for their existing health condition are able to get medicines. Meanwhile, the public health sector is the place of treatment for four out of five patients. The main constraints for this are the lack of money (40.0%) and the distance/lack of transport (12.8%) with the fear of COVID-19 very low at 5.6%. The results suggest that people with existing health conditions have difficulties in accessing health services.
15. Overall, the maternal and child health situation of the RMW and families is good. The utilization rate is high of immunization services for children aged up to one year at (84.4%) and antenatal care by pregnant women at (94.4%). Among those who get ANC, 97.0% go to the public health facilities, and only 3.0% go to private clinics.

16. All pregnant women in the survey plan to deliver in a public or private health facility. Though awareness about postnatal care (PNC) is insufficient with only 12.7% of pregnant women capable to follow the recommended number of four visits within the first six weeks after birth.
17. Among married RMW, 55.2% are currently using a modern contraceptive method (CDHS 2014: 36%). Daily pill is the most frequently used method with 38.0% (CDHS 2014: 18%).
18. Three in four RMW households (77.7%) get drinking water from an improved water source. Although 52.6% of RMW boil their water (CDHS 2014: 55%) and 27.5% use a water filter (CDHS 2014: 17%), still 30.7% report not having any water treatment before drinking or use non-appropriate water treatment methods (CDHS: 31%).
19. Three in four RMW households (76.9%) have an improved and personal (not shared) toilet facility (urban 78.4%, rural 76.9%). These rates are higher than in the CDHS 2014 (total 46%, urban 83.2%, rural 39.7%). But still 9.6% of RMW households in the rural areas have no toilet facility at all.

## Situation of Children and Vulnerable Groups

20. Even though schools accept migrant children upon their return with presentation of a birth certificate, many RMW have difficulties to put them to school because either they never attended school, or they have been in the Thai educational system. On the other hand, children who do not migrate with their parents are generally schooled, however livelihood challenges and financial constraints are important limiting factors for RMW to keep their children up to the completion of secondary school.
21. The SH/KI from the commune and village levels are not aware of any case of domestic violence or child abuse inside the RMW families during the pandemic. Moreover, respondents aged 15-17 years have not reported any abuse or violence outside the household *(questions about domestic violence inside the household are not allowed to be asked by telephone)*. Yet, their number (N=7) is too small to allow any significant conclusion.
22. One priority of the Rapid Assessment is to look at the specific situation of the vulnerable groups. One in ten respondents presents a factor of vulnerability *(pregnant woman, adolescent, person with disability, and people living with HIV)*. The vulnerable groups do not have more constraints to access health care and do not face more discrimination.

## COVID-19 Prevention

23. Most RMW, men and women alike, have received interventions related to COVID-19 from the Cambodian authorities at the border points of entry: temperature check (78.7%), face mask/hand gel (67.1%), and health information on COVID-19 prevention (79.7%).
24. All RMW are requested to do the two-week quarantine, either in a quarantine facility (38.4%) or at home (69.2%). However, only 74.5% have completed the two-week quarantine *(88.3% among those who are advised home-based quarantine and 86.8% among those who are advised facility-based quarantine)*. The compliance rate of the quarantine is higher in Prey

Veng (87.5%) than in the other three provinces, Battambang (76.9%), Siem Reap (70.7%), and Banteay Meanchey (70.4%).

25. Nearly all RMW (96.3%) have received information about COVID-19 since they returned from Thailand. But few have done the preventive measures regularly: wearing of face mask (76.3%), washing of hands with soap or using sanitizer (84.8%) and keeping a safe distance (75.9%).
26. RMW have preference for social media like Facebook (78.1%) and television (51.6%) over the traditional IEC methods like newspapers (0.5%) or posters (4.5%).
27. The discrimination against RMW is notable with 19.0% declaring that they have experienced discrimination inside their community.

### Government, Development Partners, and NGO/CSO's Assistance

The collaboration with UN agencies and NGO has been critical to the success of interventions, such as the COVID-19 screening structures at the border and quarantine facilities.

There is a consensus among SH/KI at the central level that the collaboration between line ministries and partners, UN agencies, NGO/CSO is good, and similarly the collaboration between NGOs and UN agencies (IOM, ILO, UN Women).

However, some SH/KI claim that the coordination between NGO/CSO and the government authorities at the local level could be improved as the current situation sometimes led to overlapping interventions or created gaps with lack of data sharing.

SH/KI has advised for more collaboration, less competition and a more participatory approach to improve the efficiency of support to RMW. They also recommend the development of human resources at the local level and the development of a long-term policy at the national level.

# CONCLUSIONS AND RECOMMENDATIONS

The Rapid Assessment shows that the COVID-19 pandemic has significant social and health impacts on the RMW.

One-fifth of the respondents declare that their physical health has worsen since their return and two-fifths claim that their mental health has deteriorated. Although a majority of RMW have access to medical care, still half of them declare having financial constraints especially in the context of health care being the second most frequent reason for taking loans behind buying foods. Moreover, people with chronic medical conditions have faced challenges. Meanwhile, the utilization of MCH and reproductive services is satisfactory except for the postnatal care.

At least one-fourth of the respondents are in a critical situation in terms of daily subsistence because they have no work, no income, not enough food, and often are pressured by debts. For this scenario, women are more affected than men.

The survey data suggests that RMW have so far received little external support. The assistance provided by the government institutions, local authorities, development partners, and NGO/CSO has brought some emergency reliefs (and hence, not sustainable) and insufficient in terms of scope.

With the above findings and based on the analysis of both quantitative data and qualitative information of the Rapid Assessment, IRL suggests some recommendations for future interventions and policies to assist the RMW in both short and long term:

## At National Level

1. The government should develop guidelines for supporting the RMW (*it could be an integral part to the general policy on migrants/migration)* and a specific budget should be allocated for future interventions. The policy making process should be widely participatory, involving local authorities, NGO/CSO/private sector and in consultation with migrant workers, considering their opinions, concerns, and aspirations. In this way, a 360-degree perspective and context can be obtained that could help produce plans and execution points that would mitigate the effect of the pandemic.
2. Interventions in the long-term should favour the re-integration of RMW in the workforce. This could include facilitating access to job market, vocational training, small business support and encouraging farming and facilitation of land access (with temporary concession, for instance).
3. For the RMW who prefer to go back to migration, this should be done in a safe and orderly manner. The future policy should strive to facilitate and lower the cost of administrative procedures (passport, recruitment companies, etc.), that creates an enabling environment for migrants to enjoy safe, orderly, and regular migration.
4. It would be helpful, if the government could negotiate with banks and microfinance institutions to delay debt payments during the pandemic with no or minimal interests.

## At Sub-national Level

5. The commune councils should provide the IDPoor card to all RMW households who meet the criteria of eligibility and submit their names to the RGC's cash support program.
6. Because the limitation of resources would not allow to provide the same support to all the RMW and families, there should be a prioritization process (if this is not being done already), based on clear criteria. This is to identify who are the most in need among the RMW and therefore get the assistance first, for instance female heads of household, persons with a vulnerability, or households with no income.
7. The RMW registration system should include a short questionnaire for the local authorities to systematically collect essential information about the living condition and basic needs of the RMW. This information should be regularly updated, for instance every month, because the living conditions may change. This data should be aggregated by the provincial working group for sharing with all the stakeholders as needed. The updated information could be used to complement the IDPoor card in aiding the RMW.
8. The RMW relief assistance from the government should preferably be managed and implemented by the local authorities (commune councils and village chiefs) because they are nearer to the RMW and it is them who are the preferred recourse of the RMW.
9. The commune councils should be given more resources and skills to monitor and help the RMW. The provincial and district authorities should provide the resources and supervision to the commune councils.
10. NGO/CSO should always collaborate with the commune councils and village authorities when they provide any assistance to the RMW. They should also inform and share their information with the Provincial Working Group for RMW on a regular basis.
11. The access to essential health services for RMW, and particularly for the people with vulnerabilities or chronic health conditions should be improved with a coordinated approach with initial aims of addressing bottlenecks of accessing the services *(such as financial barriers and/or lack of transportation)*.
12. With the stresses that families are facing amid the COVID-19 pandemic, government authorities should ensure that violence against women (VAW) and violence against children (VAC) referral mechanisms are in place and active, as when people are stressed, the risks for the abuses rise also.

# 1. INTRODUCTION

When Thailand declared on March 23, 2020 the closure of its borders with neighbouring countries because of the COVID-19 pandemic, many migrant workers hastily returned to their country of origin (Cambodia) without preparedness. It is assumed that those RMW and their families are now facing multiple challenges to meet their basic social and health needs since they are back in their home communities.

This Rapid Assessment is commissioned by IOM, UNAIDS, UNFPA, UNICEF, UNWOMEN, and WHO, with the guidance from relevant government line ministries such as the Ministry of Interior, Ministry of Labour and Vocational Training, Ministry of Health (MoH) and Ministry of Women's Affairs, Ministry of Social Affairs, Veterans and Youth and Rehabilitation, to obtain a better understanding of the characteristics and vulnerabilities of the RMW, their social and health conditions, the impact on their physical and mental health, their access to and utilization of essential health services including sexual and reproductive health, and the child protection issues.

The information generated by the research would support the RGC in developing evidence-based medium and long-term policies, and strategies to effectively respond to the impact of COVID-19 among the RMW and their families.

## 1.1. Context of the Research

On December 31, 2019, China officially reported the first cluster of pneumonia cases caused by COVID-19. Within six weeks, international travellers quickly spread the new disease to other countries on all continents. WHO declared on March 11, 2020 the situation as a global pandemic[1].

In many countries, the disease quickly overwhelmed the national health system. High numbers of symptomatic cases overloaded the hospitals. The most vulnerable patients, mainly the elderly and people with health pre-conditions, developed serious complications that require intensive care and ventilation assistance; and ultimately, a significant number died. Health professionals and frontline workers also paid a heavy price to the disease.

The outbreak has raised huge concerns worldwide. Many governments are taking drastic measures to combat the spread of the virus, such as business interruption and city (or country) lockdown that have heavily disrupted the economies, with serious impacts on the economic and social situations of citizens and families.

While the whole population of every country is affected by the health and socio-economic crisis, one socio-professional category: the foreign migrant workers are among those who suffer the

[1] Coronavirus disease 2019 (COVID-19) Situation Report – 51, WHO, March 11, 2020

most because they are already in a more vulnerable position with lower income and less access to the social safety nets[2].

In recent years, hundreds of thousands of Khmer men and women go abroad to find better job opportunities or search for higher income. Among countries that attract Khmer migrant workers, Thailand comes as the number one destination. In 2018, the Thai government registers 391,000 migrant workers coming from Cambodia who seek income-generating activities in key economic sectors such as agriculture, construction, fishing, and manufacturing. An IOM study in 2019 estimates that every year, around 460 million US Dollars are sent back home by the migrant workers, contributing to the economy of Cambodia[3].

The COVID-19 pandemic has disrupted labour migration throughout the Southeast Asia region and globally. The virus reached Thailand on January 13, 2020 and the first local transmission was reported eighteen days later. As the number of cases increased rapidly in mid-March with over a hundred cases per day, the government of Thailand ordered public venues and businesses to close in Bangkok and several other provinces. The country was placed in a state of emergency, with many parts of the nation in a lockdown. Thailand declared on March 23, 2020 the closure of its borders with neighbouring countries[4]. From March to June 2020, approximately 115,000 Cambodian migrant workers have returned home, crossing the border amidst the COVID-19 pandemic thus creating a humanitarian emergency and a potential health threat with the importation of the coronavirus.

At the time of the return of migrant workers, Cambodia was already affected by COVID-19. After the first case was confirmed on January 27, 2020, the situation was rather calm until the second week of March with only seven registered cases. Then, the number of cases quickly climbed in the second half of March to reach 109 cumulative cases[5]. Therefore, there was great concern that RMW may bring with them the coronavirus and spread it to their communities across the country. To deal with the influx of RMW, the RGC has set up COVID-19 screening structures at the main border crossings, with the support from the UN agencies and development partners. The RMW were checked for COVID-19 symptoms and were provided emergency assistance. Some were put in quarantine facilities while others were given instruction to implement a 14-days quarantine at home with the oversight by the local authorities. Fortunately, Cambodia has seen very few new cases in April and May, and up to November 2020, most imported cases.

There are also concerns about the situation of the RMW and their families amid the COVID-19 pandemic. The UN warns that women and children will likely face increasing threats to their safety and well-being – including malnutrition, lack of health care, mistreatment, gender-based

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[2] Experiences of ASEAN migrant workers during COVID-19. ILO brief, June 3, 2020

[3] Assessing potential changes in the migration patterns of Cambodian migrants and their impacts on Thailand and Cambodia. ARCM/IOM, 2019

[4] COVID-19: Impact on migrant worker and country response in Thailand, ILO, update July 3, 2020

[5] Cambodia Coronavirus Disease 2019 (COVID-19) Situation Report #1, WHO/MOH, July 6, 2020

violence that are more likely to occur while families are confined at home experiencing intense stress and anxiety.[6].

### 1.2. Purpose of the Research

This Rapid Assessment aims to collect quantitative and qualitative data and, the analysis and interpretation can generate insights that will be useful for the RGC and development partners to better understand the living conditions of the RMW during the COVID-19 pandemic, their constraints to stay physically and mentally healthy as well as their needs for social and health services.

Moreover, the analysis and interpretation of the study will help the researchers to formulate evidence-based recommendations to inform policies and strategies that could help improve the social and health conditions of RMW in the era of COVID-19 pandemic.

The research has two objectives, as follows:

1. Assess the impact of COVID-19 among RMW by focusing on key demographics, social and health characteristics including impact on their physical and mental health; vulnerability to gender-based violence; access to and utilization of SRH, child protection and social services; youth and adolescent health services.
2. Make concrete recommendations for possible program interventions and policy in the short-term and long-term for RMW at household level and host communities related to their social and health conditions, and related social services.

Based on the assessment objectives, the following research questions are formulated by the researchers to develop the quantitative survey questionnaire and the qualitative research interview guides:

1. How are the living and working conditions of RMW in Cambodia?
2. What are the reasons for return of RMW? What assistance do they receive at the border?
3. Do RMW implement properly COVID-19 quarantine and preventive measures?
4. What are the living conditions of RMW and families in Cambodia *(finances, physical/mental health, nutrition, water, and sanitation)?*
5. What are RMW's social and health needs, challenges, and concerns?
6. Have RMW received or sought any assistance? From whom?
7. Do RMW families have proper access to medical care and MCH services *(immunization, ANC, safe delivery, PNC, family planning)*?
8. What is the situation of the vulnerable RMW *(adolescents, pregnant women, people living with chronic disease, HIV/AIDS, or disability)*?
9. Do RMW suffer any social discrimination or violence during the COVID-19 pandemic?

[6] Policy brief: the impact of COVID-19 on children. UN, April 15, 2020

10. What are the interventions of government institutions and NGO/CSO/private sector in support to RMW amidst the COVID-19 pandemic?
11. Do the interventions and existing services effectively help RMW?
12. What recommendations could be done for the long-term support for RMW?

# 2. METHODOLOGY

The Rapid Assessment is conducted from August 04 – 15, 2020 for quantitative fieldwork and August 12 - September 16, 2020 for qualitative phase. The research covers four provinces: Banteay Meanchey, Battambang, Siem Reap, Prey Veng (with quantitative and qualitative interviews), and the capital city: Phnom Penh (with qualitative interviews).

Because it is not possible to conduct face-to-face interviews during the COVID-19 epidemic, IRL researchers use telephone calls as a data collection method.

## 2.1. Sample Design

The total number of RMW from Thailand (from the four provinces) is approximately 85,796 *(45% of which are women)*. The sample size is calculated with a confidence level of 95% and ±3 margin of error using the standard sampling formula:

$$\text{Sample Size} = {}^{[z^2 * p(1-p)] / e^2} / {}_{1 + [z^2 * p(1-p)] / e^2 * N]}$$

*N*=population size, *e*=margin of error, *z*= z-score (1.96 for 95% confidence level), *p*= standard of deviation

The quantitative study requires a total sample size of 1,054 respondents. Table 1 shows the breakdown of the sample size based on the proportion of migrant workers from Thailand of the four target provinces.

Table 1: Sample Size of Quantitative Survey by Provinces

| Provinces | % | Sample Size |
|---|---|---|
| Banteay Meanchey | 40 | 427 |
| Battambang | 27 | 283 |
| Siem Reap | 17 | 178 |
| Prey Veng | 16 | 166 |
| **Total** | **100** | **1,054** |

The specific respondent criteria for the quantitative leg are as follows:

- Male and female adult migrants (26-60 years old, 55% of male and 45% of female)
- Youth 18-25 years old

The study also included a vulnerable group with:

- Pregnant women
- Children 15-17 years old
- People with disability: problem of vision, hearing, walking, or climbing, remembering, or concentrating, self-care and communicating (CDHS 2014)
- People living with HIV

## 2.2. Instruments for Data Collection

The study uses a survey questionnaire for quantitative data collection which includes eight modules: 1) Screener and Demographic Information; 2) Respondent's background; 3) Respondent's situation in Thailand; 4) Respondent's living conditions after the return in Cambodia; 5) Health and social impact of COVID-19 on the respondent; 6) Women of reproductive age; 7) Child protection; and 8) Water and sanitation.

The design of the survey questionnaire is based on the research questions. The survey questionnaire is developed in English by IRL with support from UNFPA, IOM, UN Women, UNICEF and UNAIDS. The questionnaire is translated into Khmer language and is pre-tested during the training. Data is collected using the survey questionnaire in Khmer that interviewers read on the phone to the respondents.

The interview is conducted by recording the responses directly to the Android tablet, where the structured questionnaire is scripted on the SurveyToGo software. This allowed for automation of data entry with logic checks to reduce human error, having a timestamp showing when the interview is conducted as well as saving voice recording for additional quality control.

Meanwhile, for the qualitative research, the interviews of stakeholders/key informants are done with a semi-structured questionnaire specific to each category of respondents. However, some questions are common to all.

## 2.3. Training of Interviewers

Before the fieldwork, IRL provides all interviewers with a three days briefing session during which they learned about the survey objectives, the data collection techniques using Android tablets with the survey questionnaires, interview protocols, ethical standards, confidentiality, data privacy, and data security measures. The last day is used for mock-up sessions, where interviewers practiced live interviews using the provided questionnaire.

Only interviewers who demonstrate satisfactory performance, measured as the successful execution of all protocols during the training/mock-up are selected to take part in the fieldwork. All staff are thoroughly briefed about the ethical considerations inherent to this study.

In addition, the briefing and training are done to ensure that the fieldwork team understands how it is important to get quality data for the study, which are explained below. Also, this step is done to get feedback about the questionnaire for revision, if necessary.

The IRL internal team (supervisors, scripters, quality controllers, data management personnel) also participate in the training to be familiar with the research instruments and their implementation.

Prevention measures against coronavirus transmission are applied during the training and the interviews sessions in order to protect the safety of the staff such as wearing of face masks, washing of hands with sanitizer and ensuring proper physical distancing.

### 2.4. Pilot Test

After the training, a pilot test is conducted in IRL office in Phnom Penh to ensure that questions are clear and understandable and that the survey length is reasonable. The pilot test uses the questionnaires with 23 respondents contacted by phone, altering phrasing to ensure that questions are clear and understandable.

Following the pilot test, IRL revises some terminologies in Khmer questionnaire to make the questions more understandable to the respondents and capture the required information. The final questionnaires are approved by UNFPA before starting the fieldwork.

### 2.5. Data collection and data processing

#### a) Survey Results

The total number of respondents interviewed in the quantitative study is 1,108 as per the required sample size. Table 2 shows the sample size completed (versus required sample size) per category of respondents and per province. The number of women is higher than planned and higher than the number of men since some men have returned to Thailand to work or work in Cambodia but far from their houses. Meanwhile, the number of respondents in vulnerable groups is less than the plan as it is a challenge to find them because only a few vulnerable people migrated abroad to work.

During the data processing, open-ended responses are coded using a code framework to sort and organize the data. All encoded survey cases are checked by IRL Data Management Head prior to data table processing. Moreover, all processed data tables are checked for consistency by the Client Management Team of IRL.

Table 2: Survey Sample Size

| | Total | | Women | | Men | | Vulnerable Groups | |
|---|---|---|---|---|---|---|---|---|
| | *Required* | Achieved | *Required* | Achieved | *Required* | Achieved | *Required* | Achieved |
| **Total** | ***1,054*** | **1,108** | ***528*** | **604** | ***527*** | **504** | ***200*** | **116** |
| Banteay Meanchey | *427* | 449 | *214* | 249 | *214* | 200 | | 46 |
| Battambang | *283* | 324 | *142* | 185 | *141* | 139 | | 37 |
| Prey Veng | *166* | 144 | *83* | 67 | *83* | 77 | | 15 |
| Siem Reap | *178* | 191 | *89* | 103 | *89* | 88 | | 18 |

For the qualitative study, out of 61 planned SH/KI, 56 completed the study, and five declined. The survey sample is composed of the following:

- Four representatives of line ministries (Ministry of Woman Affairs, Ministry of Social Affairs, Ministry of Labour and Vocational Training, and National Committee for Counter Trafficking)
- Seven officers of UN agencies at central and provincial levels (UNICEF, IOM, UNAIDS)
- Nine representatives of NGO/CSO: Reproductive Health Association of Cambodia (RHAC), Center for Alliance of Labour and Human Right (CENTRAL), Legal Support for Children and Women (LSCW), Caritas, Catholic Reliefs Service (CRS), Damnak Teuk, Association of Cambodian Recruitment Agencies (ACRA), Cambodian Labour Confederation (CLC)
- Eight representatives of provincial authorities or departments
- Eightrepresentatives of Commune Councils Chief/CCWC
- Four chiefs of health centres
- Eight Village Health Support Group (VHSG)
- Eight village chiefs

### b) Quality Controls

Quality control (QC) measures are implemented across stages of the survey to ensure that high quality standards are met. Each team of data collectors has one QC person who is responsible for observing the fieldwork from the beginning until the end. Two QC staff conduct office-based quality checks across fieldwork teams such as phone call-back checking and listening to the audio records of the actual interviews.

The accuracy of survey data collection is further checked with the following measures

- During the day to day data collection, Field Supervisors and QC Team conduct 100% observations of the interviews in order to ensure correct administration, implementation, and completion of the survey in accordance with the agreed protocols
- After the first day of fieldwork, Field Supervisors, and QC Team met to reflect and discuss the key issues observed on-field and advised the team about improvement areas for the succeeding fieldwork days

## 2.6. Data Analysis

The collected quantitative data are organized and analysed, using SPSS software and Excel to calculate the variables/indicators. For all variables, data are disaggregated by province, locality, and socio-demographic characteristics such as gender, age groups and marital status. For nominal values, mean and median are calculated when needed.

The Pearson's chi-square test or the Fisher exact test (when sample sizes are small) are performed to test the association of variables, with statistical significance at $p<0.05$ for gender, locality, and province. The p-value is used to find the difference between the variables i.e. statistically

significant. When relevant, cross-tabulations are done to find associations between some variables.

Meanwhile, the qualitative study is conducted with interviews in Khmer using a specific semi-structured questionnaire for each category of SH/KI. The contents of the conversations are transcribed in verbatim format.

The qualitative analysis is done using text-based data from the transcripts using these approaches: coding the information, classifying the data in categories, grouping by themes, identifying significant patterns and relationships, and interpreting the meanings of the data. The whole analysis process is done manually. The analysis looks for similarities and differences in the experiences and thoughts of the respondents.

Comparison of qualitative study findings with the results of the quantitative survey are done, and when relevant, with reviewed publications. Noteworthy quotations (or verbatim) from the transcripts are translated and inserted in the analysis to highlight important findings.

## 2.7. Ethical Considerations

At the start of each interview, the data collector does a self-introduction. The respondent is informed about the purpose and nature of the research, and the information would be recorded. Respondents are informed of their right to withdraw from the study and about data confidentiality. Hence, verbal informed consent is obtained from each respondent before conducting the interview.

Moreover, when respondents are under 18 years old, they are asked for their informed consent as well as that of (one of their) parents or guardians before they can participate in the study.

Likewise, respondents are also informed about the availability of the 24-hour helpline (1280) in case they need any help.

Lastly, IRL ensures that the gender of the interviewers is the same as that of the respondents for the quantitative survey.

The survey report and its annexes do not include any individual respondent information and present the results for sub-groups of the main population (e.g. gender, wealth groups, age groups, etc.), so it is not possible to identify individual respondent by examining the survey results. This ensures the anonymity and confidentiality of the respondents and their answer including the HIV status.

IRL also adhered to the following guidelines of UNFPA:

- UNFPA's UNEG Reporting Standards/Code of Conduct

- UNFPA's Ethics in Interviewing Children[7] and UNFPA's Guideline Notes on Training Enumerators to Work with Children
- UN Convention on the Rights of the Child

## 2.8. Limitations of the Study

Because of the COVID-19 epidemic, the primary data collection is conducted through telephone interviews to avoid face-to-face interactions. Naturally, technical challenges come up such as the telephone call quality is not stable and hence, the interview is interrupted as interviewers and respondents do not understand each other. Therefore, this might weaken the quality of the data.

Likewise, the average interview length is 45 minutes, longer than expected and what is stated in the Terms of Reference and Technical Proposal of IRL. Possible respondent fatigue might create an issue about the quality of collected information.

Other limitation is the potential response and recall biases because most collected data in the survey are self-reported by the respondents, who may over-report or under-report their experiences.

Moreover, one respondent has to answer more than one module/questionnaire depending on his/her eligibility per survey module/questionnaire.

Those factors may also have some form of effect on the accuracy of the responses.

[7]https://childethics.com/library/ethical-considerations-for-evidence-generation-involving-children-on-the-COVID-19-pandemic/

# 3. FINDINGS OF QUANTITATIVE SURVEY

## 3.1. Sample distribution

The Quantitative Survey is done in four provinces: Banteay Meanchey, Battambang, Prey Veng and Siem Reap. 1,108 respondents is the sample size of the quantitative survey with the following provincial breakdown: 40.5% (N=449) in Banteay Meanchey, 29.2% (N=324) in Battambang, 13.0% (N=144) in Prey Veng, and 17.2% (N=191) in Siem Reap. The distribution by provinces is not proportionate to the provincial population sizes of RMW.

## 3.2. Socio-demographic Characteristics of Respondents

Among the total survey population, 54.5% (N=604) are women and 45.5% (N=504) are men. Almost all respondents are ethnic Khmer (99.7%) while the remaining 0.3% are ethnic Cham. Table 3 contains the socio-demographic characteristics of the respondents.

Table 3: Socio-demographic Characteristics of Respondents

| | Total | | Gender | | | | Residence | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Male | | Female | | Urban | | Rural | |
| | N | % | N | % | N | % | N | % | N | % |
| *Base: Total respondents* | *1108* | *100%* | *504* | *100%* | *604* | *100%* | *56* | *100%* | *1052* | *100%* |
| **Gender** | | | | | | | | | | |
| Male | 504 | 45.5% | | | | | 25 | 44.6% | 479 | 45.5% |
| Female | 604 | 54.5% | | | | | 31 | 55.4% | 573 | 54.5% |
| **Age** | | | | | | | | | | |
| 15-17 years | 7 | 0.6% | 4 | 0.8% | 3 | 0.5% | 1 | 1.8% | 6 | 0.6% |
| 18-24 years | 165 | 14.9% | 77 | 15.3% | 88 | 14.6% | 1 | 1.8% | 164 | 15.6% |
| 25-34 years | 484 | 43.7% | 210 | 41.7% | 274 | 45.4% | 28 | 50.0% | 456 | 43.3% |
| 35-45 years | 336 | 30.3% | 156 | 31.0% | 180 | 29.8% | 16 | 28.6% | 320 | 30.4% |
| 46-60 years | 116 | 10.5% | 57 | 11.3% | 59 | 9.8% | 10 | 17.9% | 106 | 10.1% |
| **Marital Status** | | | | | | | | | | |
| Married/ Living together | 867 | 78.2% | 378 | 75.0% | 489 | 81.0% | 50 | 89.3% | 817 | 77.7% |
| Divorced/Separated | 36 | 3.2% | 6 | 1.2% | 30 | 5.0% | 2 | 3.6% | 34 | 3.2% |
| Widowed | 36 | 3.2% | 12 | 2.4% | 24 | 4.0% | 0 | 0.0% | 36 | 3.4% |
| Single | 169 | 15.3% | 108 | 21.4% | 61 | 10.1% | 4 | 7.1% | 165 | 15.7% |
| **Number of Children** | | | | | | | | | | |
| 1 | 313 | 28.2% | 132 | 26.2% | 181 | 30.0% | 19 | 33.9% | 294 | 27.9% |
| 2 | 320 | 28.9% | 136 | 27.0% | 184 | 30.5% | 16 | 28.6% | 304 | 28.9% |
| 3 | 124 | 11.2% | 50 | 9.9% | 74 | 12.3% | 6 | 10.7% | 118 | 11.2% |
| 4 | 47 | 4.2% | 18 | 3.6% | 29 | 4.8% | 6 | 10.7% | 41 | 3.9% |
| 5 to 7 | 23 | 2.1% | 10 | 2.0% | 13 | 2.2% | 0 | 0.0% | 23 | 2.2% |
| **Education Level** | | | | | | | | | | |
| Primary School | 617 | 55.7% | 281 | 55.8% | 336 | 55.6% | 30 | 53.6% | 587 | 55.8% |
| Lower Secondary School | 282 | 25.5% | 129 | 25.6% | 153 | 25.3% | 16 | 28.6% | 266 | 25.3% |
| Upper Secondary School | 69 | 6.2% | 39 | 7.7% | 30 | 5.0% | 5 | 8.9% | 64 | 6.1% |
| Graduate / Equivalent | 4 | 0.4% | 3 | 0.6% | 1 | 0.2% | 0 | 0.0% | 4 | 0.4% |
| No formal education but can read and write | 4 | 0.4% | 2 | 0.4% | 2 | 0.3% | 0 | 0.0% | 4 | 0.4% |
| Never attended school | 129 | 11.6% | 49 | 9.7% | 80 | 13.2% | 5 | 8.9% | 124 | 11.8% |

The survey sample is mainly composed of respondents from the rural areas 94.9% (N=1,052) versus 5.1% (N=56) from the urban areas.

The mean age of the survey population is 33.2 years (33.0 years for women, 33.4 years for men). By age group, the largest number of both women and men respondents is aged 25-34 years old (43.7%), followed by 35-45 years old (30.3%), 18-24 years old (14.9%), and 46-60 years old (10.5%). Only 0.6% (N= 7) is aged 15-17 years old. Ninety percent of women respondents are aged 15-45 years old.

Majority of respondents are married or living with a partner (78.2%, N=867). The single persons represent 15.3% (N=169) of the survey population, the divorced represent 3.2% (N=36), and the widowed represent 3.2% (N=36). There are more widowed and divorced in the women group than in the men group, more single in the men group than in the women group with a statistically significant difference at $p<0.05$. Among all respondents, 74.6% declare having one or more children.

The level of education is similar for both genders with 55.8% (N=281) of men and 55.6% (N=336) of women having primary education, 25.6% (N=129) of men and 25.3% of women having lower secondary education and 7.7% (N=39) of men and 5% (N=30) having upper secondary education. Only very few, 0.6% (N=3) of men and 0.2% (N=1) of women are at graduate level. On the other hand, 10.1% (N=51) of men and 13.5% (N=82) of women never attended school or with no formal education.

The IDPoor Card is held by 25.3% (N=280) of the total survey sample [Table 4]. There is no significant difference (at $p<0.05$) in card ownership between men (23.4%) and women (26.8%), and between urban residents (23.2%) and rural residents (25.4%). The percentages of card holders by province are Banteay Meanchey (18.0%), Battambang (37.7%), Prey Veng (15.3%), and Siem Reap (28.8%). The cardholder rate is highest in Battambang and lowest in Prey Veng with a difference that is statistically significant at $p<0.05$.

Regarding the category of equity card, 7.5% (N=83) of the respondents have IDPoor Card type 1 (very poor), 12.5% (N=139) have IDPoor Card type 2 (moderately poor), and 5.2% (N=58) do not know which type they have. There is no significant difference (at $p<0.05$) in ownership of Card type 1 between men (6.7%) and women (8.1%), and no significant difference (at $p<0.05$) in ownership of Card type 2 between men (11.5%) and women (13.4%).

Meanwhile, the government's cash assistance for COVID-19 pandemic, called the Cash Transfer Program for Poor and Vulnerable Households, is received by 19.9% (N=221) of the respondents. There is no significant difference (at $p<0.05$) in access to cash assistance between men (19.0%) and women (20.7%), and between urban residents (17.9%) and rural residents (20.1%). The access rates to cash assistance by province are Banteay Meanchey (12.0%), Battambang (30.6%), Prey Veng (21.5%), and Siem Reap (19.4%). The access to cash assistance rate is the highest in

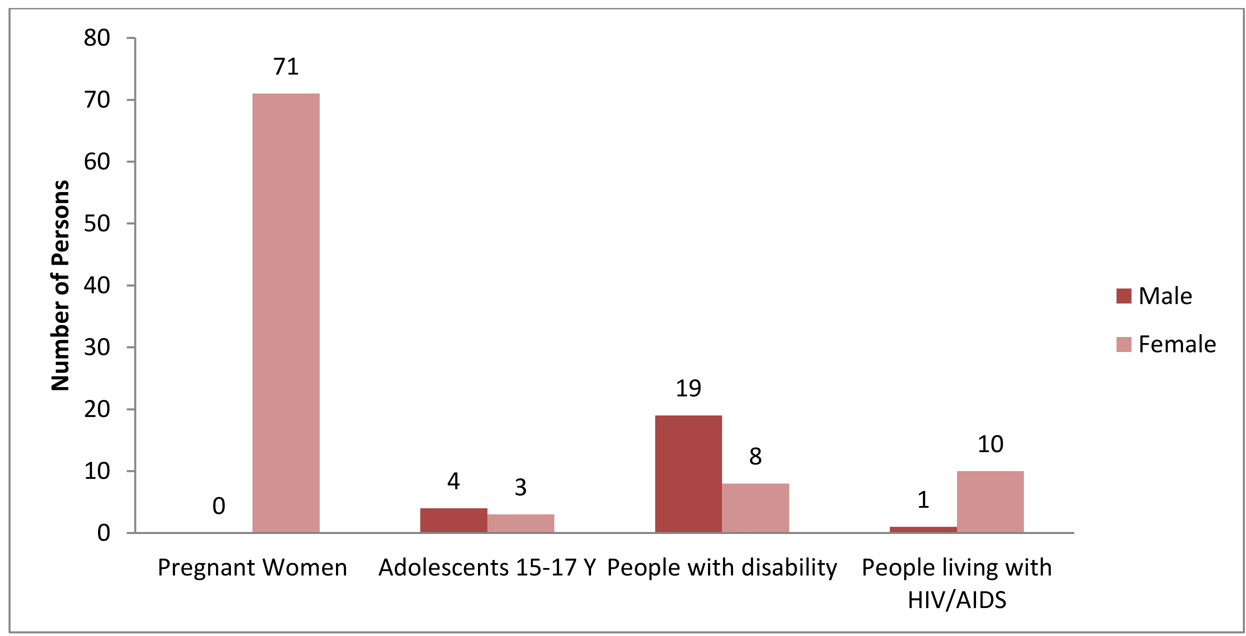
Battambang and lowest in Banteay Meanchey with a difference that is statistically significant at $p<0.05$.

Table 4: IDPoor Cardholders and COVID-19 Cash Assistance

| | Total | Gender | | Residence | | Province | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Male | Female | Urban | Rural | BMC | BTB | PV | SR |
| *Base: Total respondents* | *N=1108* | *N=504* | *N=604* | *N=56* | *N=1052* | *N=449* | *N=324* | *N=144* | *N=191* |
| **ID Poor Card Ownership** | | | | | | | | | |
| Yes | 25.3% | 23.4% | 26.8% | 23.2% | 25.4% | 18.0% | 37.7% | 15.3% | 28.8% |
| No | 74.1% | 75.4% | 73.0% | 76.8% | 74.0% | 81.3% | 62.3% | 84.0% | 69.6% |
| Don't know | 0.6% | 1.2% | 0.2% | 0.0% | 0.7% | 0.7% | 0.0% | 0.7% | 1.6% |
| **ID Poor Card Type** | | | | | | | | | |
| Type 1 | 7.5% | 6.7% | 8.1% | 10.7% | 7.3% | 5.3% | 9.9% | 6.9% | 8.9% |
| Type 2 | 12.5% | 11.5% | 13.4% | 10.7% | 12.6% | 8.5% | 19.8% | 5.6% | 15.2% |
| Don't know | 5.2% | 5.2% | 5.3% | 1.8% | 5.4% | 4.2% | 8.0% | 2.8% | 4.7% |
| **Cash Assistance COVID-19** | | | | | | | | | |
| Yes | 19.9% | 19.0% | 20.7% | 17.9% | 20.1% | 12.0% | 30.6% | 21.5% | 19.4% |
| No | 79.7% | 80.4% | 79.1% | 82.1% | 79.6% | 87.5% | 69.1% | 77.8% | 80.6% |
| Don't know | 0.4% | 0.6% | 0.2% | 0.0% | 0.4% | 0.4% | 0.3% | 0.7% | 0.0% |

Among the total survey population, 10.5% present a factor of vulnerability (N=116): pregnant women (6.4%, N=71), adolescents 15-17 years old (0.6%, N=7), people with disability (2.4%, N=27), and people living with HIV (1.0%, N=11). The graph in Figure 1 shows the distribution of vulnerability factors by gender.

Figure 1: Factors of Vulnerability (By Gender)
*Base: Those with Vulnerabilities (N-116)*



### 3.3. Migrants' situation in Thailand

#### 3.3.1. Occupations and Incomes

All respondents are asked what type of work they have been doing in Thailand and how much is their monthly incomes/salary.

Occupations: In the survey sample, the three most frequent occupations of migrant workers in Thailand are construction worker (40.4%), factory/manufacturing worker (17.4%) and farm worker (15.6%). Altogether, those three sectors of work account for almost three quarters of the total respondents [Table 5]. For those three occupations, there is no statistically significant difference between the male group and the female group (at $p<0.05$).

Incomes in Thailand: The mean (average) monthly salary in the survey sample is 9,310 Baht/ 294 US$ *(10,069 Baht/ 318 US$ for men, 8,671 Baht/ 274 US$ for women)* and the median monthly salary is 9,000 Baht/ 285 US$ *(10,000 Baht/ 316 US$ for men, 9,000 Baht/ 285 US$ for women)*. The proportion of those who earned a monthly salary higher than 10,000 Baht/ 316 US$ is 35.9% in the male group versus 15.9% in the female group which has a the difference that is statistically significant (p-value is <0.05).

Table 5: Occupation of Migrant Workers in Thailand

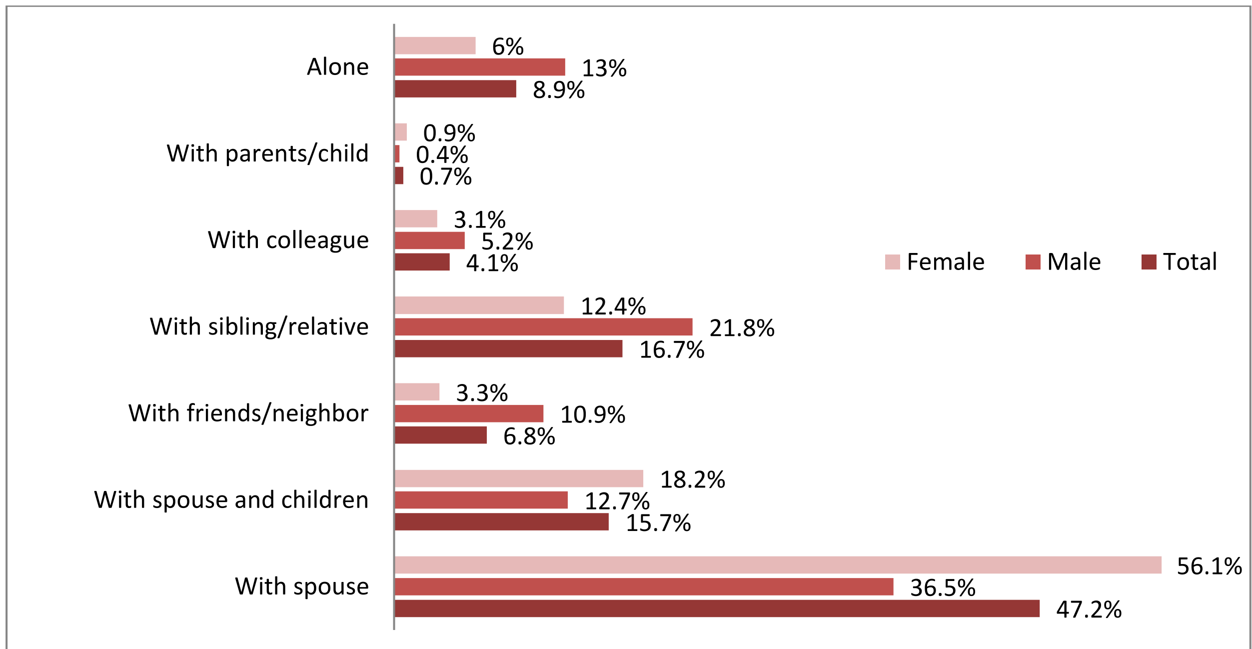
| | | Gender | | Age Group | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Total** | **Male** | **Female** | **15-17** | **18-24** | **25-34** | **35-45** | **46-60** |
| *Base: Total respondents* | *N=1108* | *N=504* | *N=604* | *N=7* | *N=165* | *N=484* | *N=336* | *N=116* |
| Construction worker | 40.4% | 40.7% | 40.2% | 28.6% | 40.6% | 39.5% | 40.8% | 44.0% |
| Factory/manufacturing worker | 17.4% | 18.1% | 16.9% | 0.0% | 17.0% | 20.5% | 16.1% | 10.3% |
| Farm worker | 15.6% | 14.5% | 16.6% | 57.1% | 12.7% | 12.6% | 17.6% | 24.1% |
| Hotel/restaurants | 6.7% | 6.3% | 7.0% | 0.0% | 8.5% | 8.1% | 6.0% | 0.9% |
| Seller for other employer | 8.0% | 6.9% | 8.9% | 0.0% | 11.5% | 9.5% | 6.0% | 3.4% |
| Fisherman | 4.1% | 6.9% | 1.7% | 0.0% | 3.0% | 3.3% | 5.7% | 4.3% |
| Housemaid/cook | 3.0% | 1.8% | 4.0% | 0.0% | 1.8% | 3.3% | 2.1% | 6.0% |
| Entertainment Worker | 0.2% | 0.4% | 0.0% | 0.0% | 0.6% | 0.2% | 0.0% | 0.0% |
| Others | 4.6% | 4.4% | 4.7% | 14.3% | 4.3% | 3.0% | 5.9% | 6.9% |

### 3.3.2. Length of Stay and Living Conditions

The average length of stay is 16.2 months *(16.2 months for men, 16.1 months for women)* and the median length is 9.5 months *(8.0 months for men, 10.0 months for women)*. Over three quarters (77.0%) have resided one to twelve months in Thailand, 12.5% have stayed 13 to 24 months, and 10.5% have stayed 25 months or more. There is no statistically significant difference between the male group and the female group (at $p<0.05$).

More than half of the survey population migrate to Thailand with their family: 47.2% goes with spouse/partner and 15.7% goes with spouse and children.

Figure 2: Accompany During Migration (By Gender)
*Base: Total Respondents (N=1,108), Males (N=504), Females (N=604)*



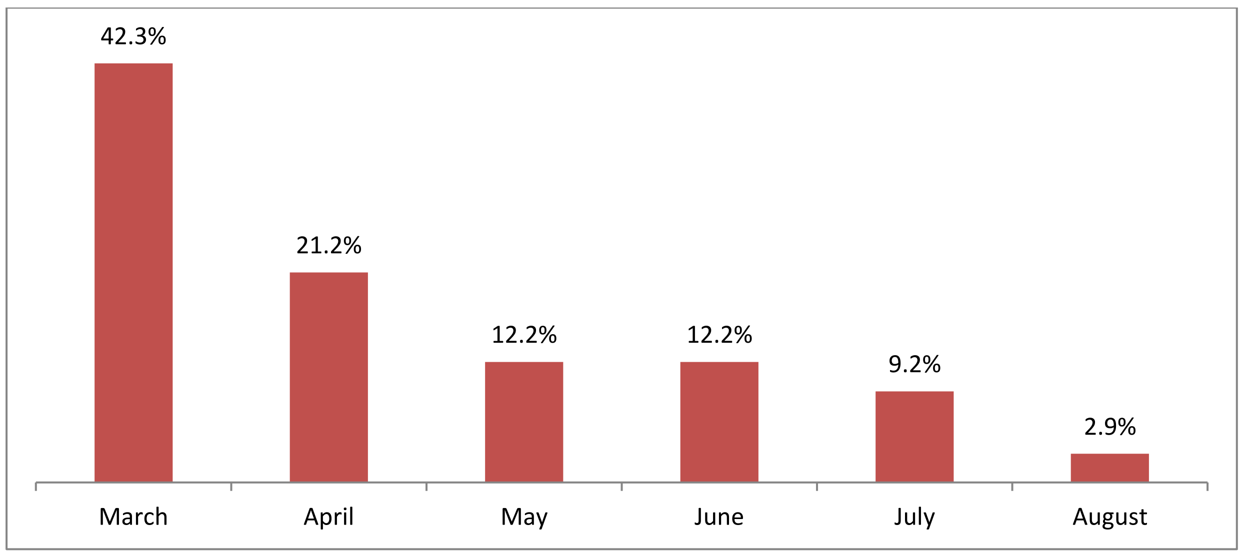

Employment abuses or exploitation:
A large majority of respondents (81.1%, N=899) claim that they never experienced any abuse or exploitation while in Thailand, 14.7% (N=162) report some sort of problems, and 4.2% (N=47) does not want to answer.

Among the reported problems, withholding of wage is the most frequent (7.6%), followed by false promises/deception (4.4%), excessive working hours (3.7%), withholding identity/travel documents (1.9%) and psychological abuse (1.5%). There is no report of sexual abuse. The proportion of respondents who claim they never experienced any abuse or exploitation is higher in the women group (84.6%) than in the men group (77.0%), with a statistically significant difference (p-value is <0.05). Among the seven respondents aged 15-17 years, only one reports an abuse (which is withholding the wage).

## 3.4. Return to Cambodia Amid the Pandemic

Most of the survey population (63.5%) return to Cambodia in March and April 2020. The trend is continuously down from March to August 2020. Figure 3 shows the proportions of respondents returning from Thailand by month from March to August 2020.

Figure 3: Return of Respondents to Cambodia Over Time (By Month)
*Base: Total Respondents (N=1,108)*




### 3.4.1. Reason for Return to Cambodia

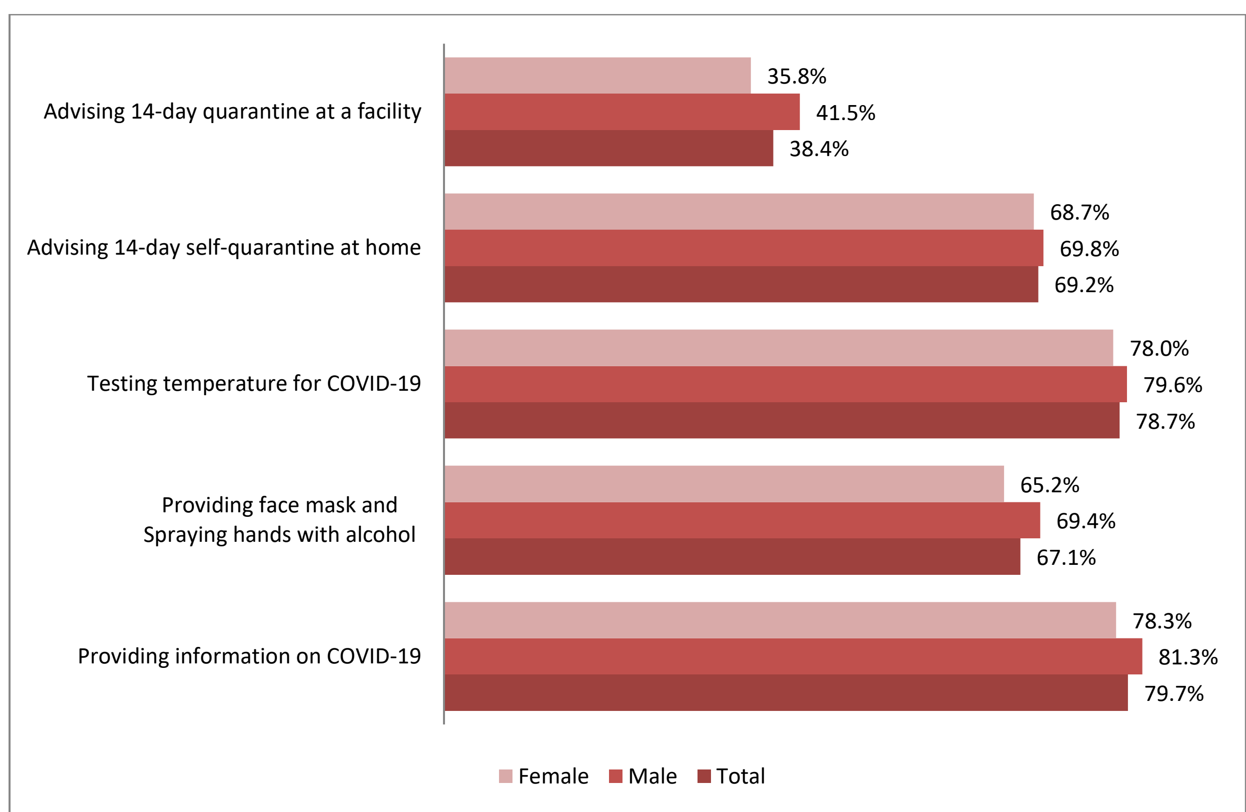
Among the reasons for the respondents to return to Cambodia, the fear of COVID-19 ranks first with 51.7%, followed by personal/family reason with 47.0%, loss of job/closure of workplace with 27.8% and end of the legal working permit with 7.1%. The reasons are similar between men and women sub-groups.

### 3.4.2. COVID-19 Assistance at the Border

The survey respondents are asked whether, in their return trip, if they receive any intervention related to COVID-19 from the Cambodian authorities at the border.

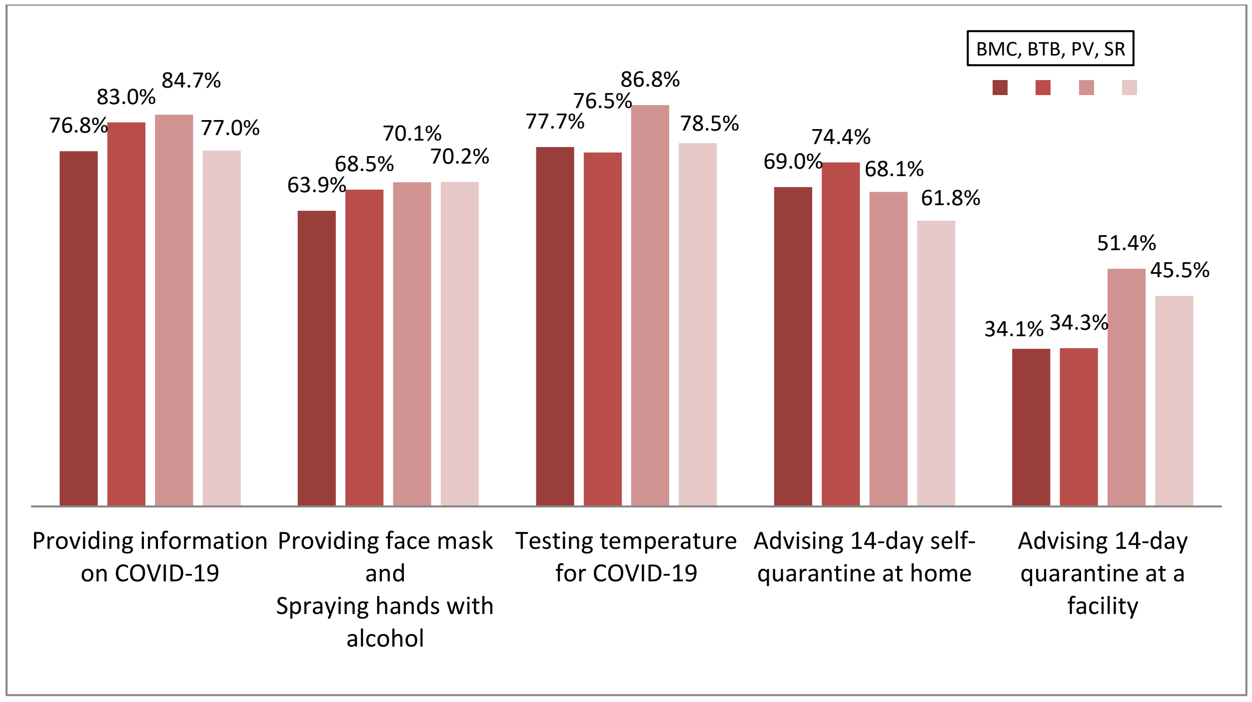
More than three out of four respondents (79.7%) are provided with health information about COVID-19 prevention, 67.1% receive face masks and alcohol hand-spray, 78.7% get temperature check, 69.2% are advised to do a 14 days-self-quarantine at home, and 38.4% claim that they received advice to do quarantine at a facility. There is no significant difference (at $p<0.05$) between men and women for these interventions. [Figure 4]

Figure 4: Assistance at the Border for COVID-19 (By Gender)
*Base: Total Respondents (N=1,108) ; Males (N=504), Females (N=604)*




When comparing the COVID-19 related interventions received at the border in the four survey provinces, there is no significant difference (at $p<0.05$) between the provincial groups of respondents for these interventions. [Figure 5]

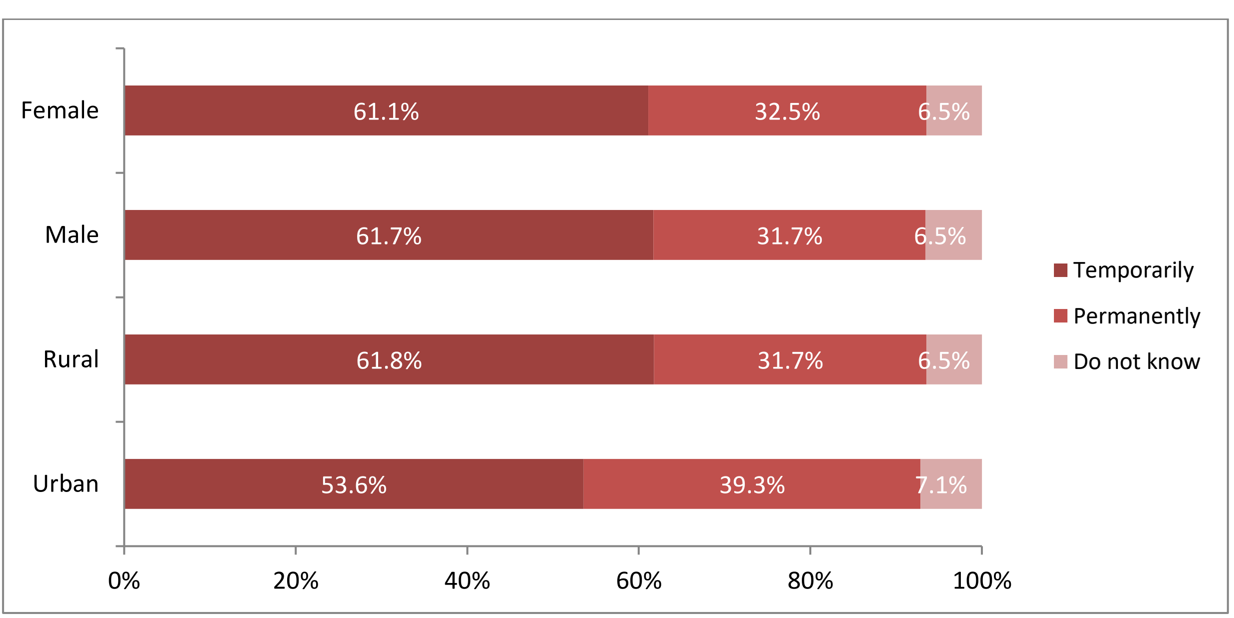
Figure 5: Assistance at the Border for COVID-19 (By Provinces)
*Base: BMC (N-449), BTB (N=324), PV (N=144), SR (N=191)*




### 3.4.3. Re-migration Plan

Among all respondents, 61.4% say they plan to migrate again in the future *(when the borders will re-open)*, 32.1% claim they plan to stay permanently in Cambodia, and 6.5% say they don't know yet. There is no significant difference in the intention to re-emigrate and the choice of destination country between men and women, and no difference between the urban residents and rural residents (at $p<0.05$). Figure 6 shows the distribution of the expected length of stay in Cambodia by gender and by locality.

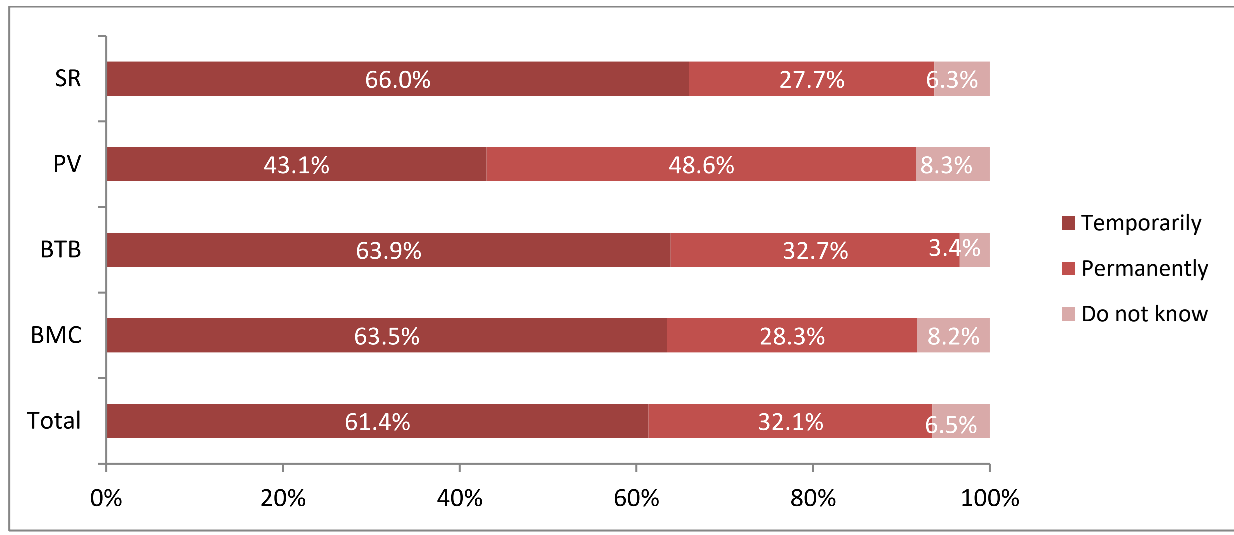
Figure 6: Expected Length of Stay in Cambodia (By Gender, By Locality)
*Base: Males (N=504), Females (N=604) ; Urban (N=56), Rural (N=1,052)*



The proportion of respondents who plan to migrate again is significantly lower (p-value is <0.05) in Prey Veng (43.1%) than in the three provinces near the border with Thailand: Banteay Meanchey (63.5%), Battambang (63.9%), and Siem Reap (66,0%). [Figure 7]

Figure 7: Expected Length of Stay in Cambodia (By Provinces)

*Base: Total Respondents (N=1,108) ; BMC (N-449), BTB (N=324), PV (N=144), SR (N=191)*




Thailand is the country of destination for 91.4% of respondents who plan to migrate again.

Among the respondents who have children and claim that they plan to migrate again to Thailand (N=508), only about one fifth (19.7%) say they will bring their children with them to the destination country. The others think that they will leave the children with their spouse (19.1%) or with the grandparents (53.9%).

## 3.5. Living Conditions back in Cambodia

The survey asks questions to all respondents to assess the social and health problems and challenges faced by the RMW and their families.

### 3.5.1. Relocation and Housing condition

Almost all survey respondents (94.1%) come back to their village of origin and are currently living with their family in the same village as before they migrated to Thailand.

Less than half of respondents (46.4%) are living in their own house, 47.5% stay with their parents/family, 5.0% are hosted at no charge by relatives, 0.6% are paying rent, and 0.5% are living in a temporary shelter. There is no significant difference in the housing condition between men and women, and no significant difference between and rural residents (at p<0.05).

### 3.5.2. Financial situation

Incomes in Cambodia: The survey asks RMW what is the current total monthly income of their household *(including salaries, remittances, and all other incomes)*. The mean value of monthly household income is 164 US$ *(169 US$ for men, 159 US$ for women)*, the median value of monthly household income is 150 US$ *(150 US$ for men, 127 US$ for women)* [Table 6]. Those who declare that their household has no income at all represent 29.6% (N=328) of all respondents, 29.4% (N=148) of the men group, 29.8% (N=180) of the women group, 30.4% (N=17) of the urban group, and 29.6% (N=311) of the rural group. In the provinces, they represent 33.2% (N=149) in Banteay Meanchey, 25.3% (N=82) in Battambang, 31.3% (N=45) in Prey Veng, and 27.2% (N=52) in Siem Reap. There is no significant difference (at p<0.05) between men and women groups, between urban and rural groups, and among the four provinces. Those who declare having less than 100 US$ of monthly household income represent 9.8% of the survey sample, and those who have between 100-500 US$ of monthly household income represent 54.1% of the survey sample.

Table 6: Incomes in Cambodia

*Base: Total Respondents (N=1,108) ; Males (N=504), Females (N=604)*

| | TOTAL | | | Gender | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Men | | | Women | | |
| | N | Mean | Median | N | Mean | Median | N | Mean | Median |
| Total monthly income in Cambodia of respondents' household *(in US$, including all types of incomes)* | 1, 076 | 164 | 150 | 490 | 169 | 150 | 586 | 159 | 127 |
| Monthly earnings in Cambodia of respondents *(in US$, not including loan/cash support)* | 413 | 170 | 150 | 243 | 184 | 150 | 170 | 149 | 118 |

More than half of the respondents (58.0%, N=643) say they currently have no source of earnings in Cambodia, while 21.9% (N=243) do daily labour, 5.6% (N=62) have a small business, 13.8% (N=153) do farming, 2.4% (N=27) get cash support from family or friends, and 1.9% (N=21) obtain cash support from the RGC. In the men group, 48.0% (N=242) have no source of earnings versus 66.4% (N=410) in the women group, with a difference statistically significant (p-value is <0.05). When considering the marital status, the proportion of those who have no source of earnings is higher among Divorced (83.3%) and Widowed (61.1%) than among Married (57.1%) and Single (56.8%) with a statistically significant difference (p-value is <0.05). There is no significant difference, though between age groups (p-value is 0.15), nor among the four provinces (p-value is 0.06).

Among the N=413 respondents who declare having currently a source of earnings in Cambodia *(not including loan, remittance or other cash support)*, the average income is 170 US$ per month *(184 US$ for men, 149 US$ for women)* and the median income is 150 US$ per month (*150 US$ for men, 118 US$ for women)*.

Loan (purpose of loan, amount of loan, monthly payment): About half (55.7%) of the respondents currently have loan debts: 30.5% have debts with a bank or microfinance institution, 9.8% have debts with a money lender and 20.9% get their debts with relatives/friends/neighbours.

The proportion of respondents having debts is highest in Siem Reap (63.9%), followed by Battambang (59.3%), Banteay Meanchey (55.2%), and Prey Veng (38.2%). The difference among provinces is statistically significant (p-value is <0.05).

Meanwhile, the proportion of respondents having debts among women (60.8%) is higher than among men (49.6%) with the difference statistically significant (p-value is <0.05). Albeit, the difference between the proportion of respondents having debts among urban residents (62.5%) and rural residents (55.3%) is not statistically significant (p-value is 0.29).

For N=617 respondents who have loans, the average amount of loans is 2,786 US$ *(2,505 US$ for men, 2,972 US$ for women)* and the median amount of loans is 1,500 US$ *(1,295 US$ for men, 1,500 US$ for women)* [Table 7]. Nearly one out of four indebted respondents (24.3%) take out a loan up to 500 US$, 19.9% have a loan between 520-1,000 US$ and 7.3% take a loan between 1,120-1,500 US$. For reimbursement of their loans, respondents have to pay on average 122 US$ per month *(men at 106 US$, women at 132 US$)*. The median amount of monthly loan payment is 96 US$ *(men at 75 US$, women at 100 US$)*. The difference between men and women is statistically significant (p-value is <0.05).

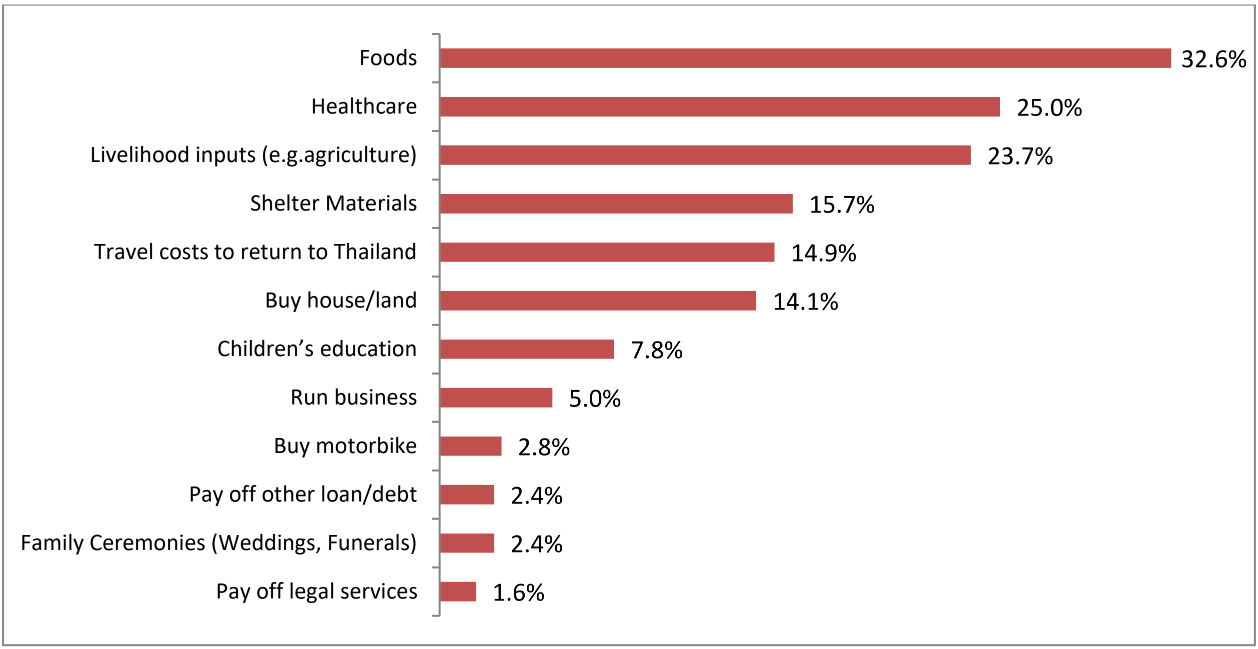
Table 7: Loans and Loan Payment

*Base: Those with Loans and Loan Payments*

| | TOTAL | | | Gender | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Men | | | Women | | |
| | N | Mean | Median | N | Mean | Median | N | Mean | Median |
| Monthly loans payment (in US$) | 457 | 122 | 96 | 179 | 106 | 75 | 278 | 132 | 100 |
| Total amount of loans (in US$) | 606 | 2,786 | 1,500 | 242 | 2,505 | 1,295 | 364 | 2,973 | 1,500 |

Returnees take loans mainly for buying food (32.6%), for health care (25.0%), for investing in livelihood such as agriculture (seeds, animals, etc.), for buying shelter materials (15.7%), for travel costs to return to Thailand (14.9%), to buy house/land (14.1%) and for children's education (7.8%). Figure 8 shows the main reasons for taking a loan by frequency.

Figure 8: Purpose of Loan (By Frequency)
*Base: Those with Loans (N=606)*




<u>Financial autonomy for daily subsistence:</u> When respondents are asked with the question: "Starting from today, how long are your finances for daily subsistence likely to last?", 24.6% say they currently have no money, 15.9% claim their finances will last 1-2 weeks, 12.5% say 3-4 weeks, 21.2% state 1-2 months, 12.9% declare 3 months or more, and 12.9% say they don't know. Table 8 shows the results by provinces, gender, and locality .

Women are more likely than men to have no money or financial autonomy for four weeks or less, while men are more likely than women to have financial autonomy for one month or more (significant at $p<0.05$). On the other hand, there is no difference that is statistically significant between the urban and rural residents (p-value is 0.17), and among the four provinces (p-value is 0.22).

Table 8: Financial Autonomy for Daily Subsistence

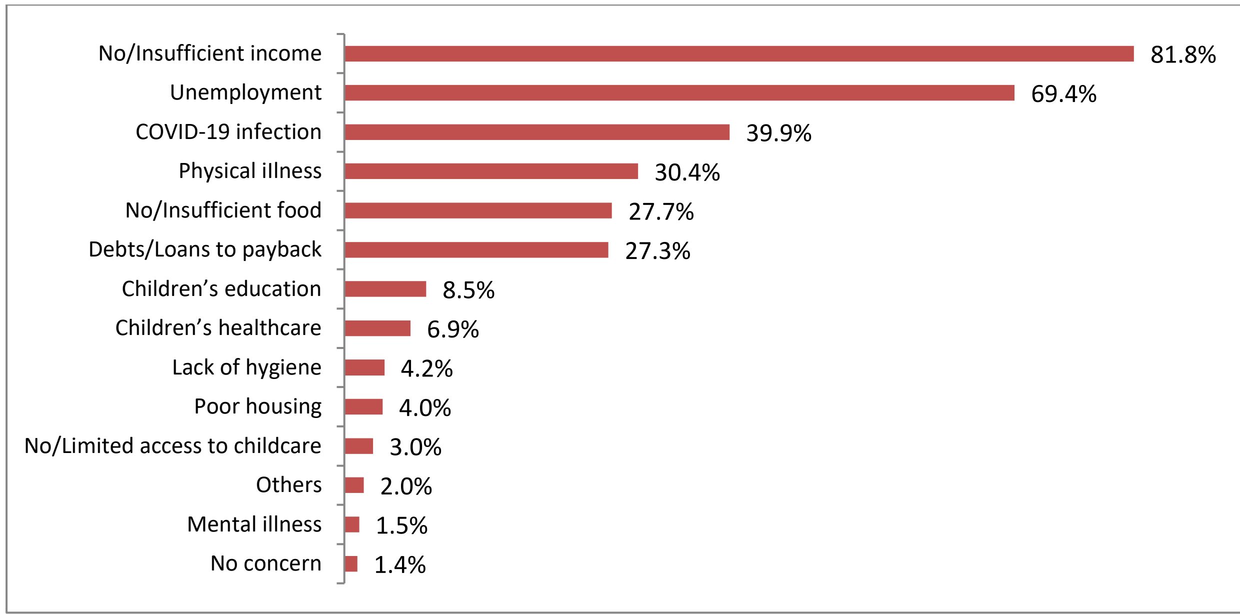
| | Total | Provinces | | | | Locality | | Gender | |
|---|---|---|---|---|---|---|---|---|---|
| | | BMC | BTB | PV | SR | Urban | Rural | Male | Female |
| *Base: Total Respondents* | *N=1,108* | *N=449* | *N=324* | *N=144* | *N=191* | *N=56* | *N=1,052* | *N=504* | *N=604* |
| No money | 24.6% | 25.8% | 21.9% | 25.0% | 26.2% | 28.6% | 24.4% | 21.4% | 27.3% |
| 1-2 weeks | 15.9% | 15.1% | 18.5% | 11.8% | 16.2% | 17.9% | 15.8% | 15.3% | 16.4% |
| 3-4 weeks | 12.5% | 13.1% | 11.7% | 11.1% | 13.1% | 8.9% | 12.6% | 9.3% | 15.1% |
| 1-2 months | 21.2% | 18.7% | 25.9% | 25.0% | 16.2% | 10.7% | 21.8% | 26.2% | 17.1% |
| 3 months or more | 12.9% | 13.4% | 11.4% | 17.4% | 11.0% | 19.6% | 12.5% | 15.3% | 10.9% |
| Don't know | 12.9% | 13.8% | 10.5% | 9.7% | 17.3% | 14.3% | 12.8% | 12.5% | 13.2% |

### 3.5.3. Concerns and Supports

The respondents are asked what are the main concerns that they and their family currently have (one or more answers are possible).

The top six concerns are the insufficient incomes *(81.8% of total respondents, 80.2% of men, 83.1% of women)* followed by unemployment *(69.4% of total respondents, 68.7% of men, 70.0% of women)*, COVID-19 infection *(39.9% of total respondents, 43.5% of men, 36.9% of women)*, physical illness *(30.4% of total respondents, 29.6% of men, 31.1% of women)*, no/insufficient food *(27.7% of total respondents, 26.0% of men, 29.1% of women)* and debts/loan reimbursement *(27.3% of total respondents, 23.6% of men, 30.5% of women)*. No/insufficient children's education (8.5%) and no/insufficient children's health care (6.9%) rank seventh and eighth, respectively. Figure 9 shows the concerns of returnees by frequency.

Figure 9: Current Concerns of Returnees and Families (Frequency)
*Base: Total Respondents (N=1,108)*




Only 4.9% (N=54) of the respondents have ever sought any support. There is no significant difference (at $p<0.05$) between men (4.4%) and women (5.3%) so does between urban residents (8.9%) and rural residents (4.7%) (at $p<0.05$). Among the four provinces, the rate is lower in Prey Veng (0.7%), Banteay Meanchey (3.6%) and Siem Reap (6.3%), and highest in Battambang (7.7%). The differences are statistically significant ($p <0.05$).

Of those who seek assistance, 63.0% (N=34) address the village chief at 22.2% (N=12), the commune council at 20.4% (N=11), the neighbours/other villagers at 7.4% (N= 4) and a local NGO or social organization. One person has a recourse to the health staff while none of the respondents go to the district or provincial authorities for assistance.

Supports received: Among all the respondents, 8.6% (N=95) receive support for food/rice, 9.7% (N=108) for health care, 3.3% (N=37) for livelihood support, 3.3% (N=37) for psychosocial counselling, 4.0% (N=44) for identity card registration and 1.2% for legal service (N=13) etc. Table 9 shows all the types of support that are receive by the RMW.

Table 9: Supports Received by Returnees

| | Total | Locality | | Gender | | Provinces | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Urban | Rural | Male | Female | BMC | BTB | PV | SR |
| *Base: Total Respondents* | *N=1108* | *N=56* | *N=1052* | *N=504* | *N=604* | *N=449* | *N=324* | *N=144* | *N=191* |
| | % | % | % | % | % | % | % | % | % |
| Food / Rice | 8.6% | 12.5% | 8.4% | 8.3% | 8.8% | 6.7% | 11.7% | 6.9% | 8.9% |
| Drinking Water | 2.5% | 3.6% | 2.5% | 2.2% | 2.8% | 1.8% | 2.8% | 4.9% | 2.1% |
| Housing | 1.5% | 0.0% | 1.6% | 2.4% | 0.8% | 0.9% | 0.6% | 2.8% | 3.7% |
| Health Care | 9.7% | 12.5% | 9.6% | 10.7% | 8.9% | 11.1% | 7.1% | 11.8% | 9.4% |
| Livelihood support | 3.3% | 8.9% | 3.0% | 3.2% | 3.5% | 5.8% | 3.1% | 0.0% | 0.5% |
| Employment | 0.1% | 0.0% | 0.1% | 0.0% | 0.2% | 0.0% | 0.3% | 0.0% | 0.0% |
| Registration (Nat ID) | 4.0% | 8.9% | 3.7% | 4.6% | 3.5% | 5.1% | 2.2% | 2.8% | 5.2% |
| Legal Services (e.g. violence case) | 1.2% | 0.0% | 1.2% | 1.4% | 1.0% | 1.1% | 1.5% | 0.7% | 1.0% |
| Psycho-social Counselling | 3.3% | 5.4% | 3.2% | 3.6% | 3.1% | 5.1% | 2.8% | 2.1% | 1.0% |

For those respondents who have received support, it is mainly from the government institutions: food/rice (63.2%), health care (94.4%), livelihood support (62.2%), housing (88.2%), drinking water (75.9%), legal service (92.3%), psycho-social counselling (70.3%, and registration (81.8%). Meanwhile, NGOs provide some assistance especially for food/rice (27.4%) and livelihood support (35.1%) while the support from private recruitment agencies are registration (18.2%), psycho-social counselling (18.9%), food/rice (8.4%), drinking water (6.9%), and housing (5.9%). [Table 10]

Table 10: Sources of Supports
*Base: Per Source of Support*

| | Total | Government | UN/NGO | Private recruitment agency | Health Center | Don't Know |
|---|---|---|---|---|---|---|
| Food/Rice (N=95) | 100% | 63.2% | 27.4% | 8.4% | 0.0% | 3.2% |
| Drinking Water (N=29) | 100% | 75.9% | 13.8% | 6.9% | 0.0% | 3.4% |
| Housing (N=17) | 100% | 88.2% | 5.9% | 5.9% | 0.0% | 0.0% |
| Health Care (N=108) | 100% | 94.4% | 2.8% | 0.0% | 1.9% | 0.9% |
| Livelihood Support (N=37) | 100% | 62.2% | 35.1% | 0.0% | 0.0% | 2.7% |
| Employment (N=1) | 100% | 0.0% | 100.0% | 0.0% | 0.0% | 0.0% |
| Registration (N=44) | 100% | 81.8% | 0.0% | 18.2% | 0.0% | 0.0% |
| Legal Service (N=13) | 100% | 92.3% | 15.4% | 0.0% | 0.0% | 0.0% |
| Counselling (N=37) | 100% | 70.3% | 13.5% | 18.9% | 0.0% | 0.0% |

### 3.5.4. Engagement in housework (in Thailand and Cambodia)

The survey also asks the respondents about their involvement in the housework when they were in Thailand and currently since they are back in Cambodia.

During their stay in Thailand, respondents are involved in house cleaning *(70.0% partially, 15.2% fully)*, food cooking *(65.9% partially, 18.0% fully)*, health care of the family *(47.9% partially, 9.0% fully)*, collecting water *(41.6% partially, 5.2% fully)*, and child care *(16.5% partially, 3.2% fully)*. Table 9 presents the detailed results of the level of engagement in the housework in Thailand by locality and by gender. The table shows that women are more engaged than men in all five housework activities with a difference that is statistically significant (at $p<0.05$). There is no significant difference (at $p<0.05$) between urban and rural residents for the five tasks, though.

When they returned to Cambodia, respondents are involved in house cleaning *(69.6% partially, 18.4% fully)*, food cooking *(60.1% partially, 20.3% fully)*, health care of the family *(55.6% partially, 13.1% fully)*, collecting water *(52.7% partially, 8.6% fully)*, and child care *(45.4% partially, 20.7% fully)*. Table 11 shows the detailed results of the level of engagement in the housework in Cambodia. The below data shows that, again women are more engaged than men in all five housework activities with a difference that is statistically significant (at $p<0.05$). Meanwhile, there is a significant difference (at $p<0.05$) between urban and rural residents for cleaning the house.

Table 11: Level of Engagement in the Housework in Thailand and in Cambodia
Base: Per Engagement in Housework

| | | In Thailand | | | | | In Cambodia | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | Residence | | Gender | | Total | Residence | | Gender | |
| | | | Urban | Rural | Male | Female | | Urban | Rural | Male | Female |
| *Base: Total Respondents* | | *N= 1,108* | *N= 56* | *N= 1,052* | *N= 504* | *N= 604* | *N= 1,108* | *N= 56* | *N= 1,052* | *N= 504* | *N= 604* |
| **Childcare** | N/A | 23.1% | 19.6% | 23.3% | 24.0% | 22.4% | 9.7% | 8.9% | 9.7% | 10.1% | 9.3% |
| | Totally | 3.2% | 3.6% | 3.2% | 0.8% | 5.3% | 20.7% | 19.6% | 20.7% | 6.9% | 32.1% |
| | Partially | 16.5% | 19.6% | 16.3% | 15.7% | 17.2% | 45.4% | 42.9% | 45.5% | 51.6% | 40.2% |
| | None | 57.1% | 57.1% | 57.1% | 59.5% | 55.1% | 24.3% | 28.6% | 24.0% | 31.3% | 18.4% |
| **Collect water** | N/A | 3.0% | 0.0% | 3.1% | 4.6% | 1.7% | 0.8% | 0.0% | 0.9% | 1.6% | 0.2% |
| | Totally | 5.2% | 7.1% | 5.1% | 4.8% | 5.6% | 8.6% | 14.3% | 8.3% | 6.7% | 10.1% |
| | Partially | 41.6% | 30.4% | 42.2% | 44.6% | 39.1% | 52.7% | 39.3% | 53.4% | 62.1% | 44.9% |
| | None | 50.2% | 62.5% | 49.5% | 46.0% | 53.6% | 37.9% | 46.4% | 37.5% | 29.6% | 44.9% |
| **Housework/ Cleaning** | N/A | 0.9% | 0.0% | 1.0% | 1.6% | 0.3% | 0.5% | 0.0% | 0.5% | 1.0% | 0.0% |
| | Totally | 15.2% | 25.0% | 14.6% | 8.3% | 20.9% | 18.4% | 25.0% | 18.1% | 6.7% | 28.1% |
| | Partially | 70.0% | 57.1% | 70.7% | 68.7% | 71.2% | 69.6% | 53.6% | 70.4% | 73.0% | 66.7% |
| | None | 13.9% | 17.9% | 13.7% | 21.4% | 7.6% | 11.6% | 21.4% | 11.0% | 19.2% | 5.1% |
| **Cook food** | N/A | 0.9% | 0.0% | 1.0% | 1.6% | 0.3% | 0.6% | 0.0% | 0.7% | 1.4% | 0.0% |
| | Totally | 18.0% | 19.6% | 17.9% | 9.1% | 25.3% | 20.3% | 25.0% | 20.1% | 6.7% | 31.6% |
| | Partially | 65.9% | 66.1% | 65.9% | 65.1% | 66.6% | 60.1% | 50.0% | 60.6% | 57.3% | 62.4% |
| | None | 15.3% | 14.3% | 15.3% | 24.2% | 7.8% | 19.0% | 25.0% | 18.6% | 34.5% | 6.0% |
| **Health care of family** | N/A | 3.0% | 5.4% | 2.9% | 2.6% | 3.3% | 0.5% | 0.0% | 0.5% | 0.8% | 0.2% |
| | Totally | 9.0% | 12.5% | 8.8% | 5.0% | 12.4% | 13.1% | 23.2% | 12.5% | 4.8% | 20.0% |
| | Partially | 47.9% | 42.9% | 48.2% | 48.4% | 47.5% | 55.6% | 44.6% | 56.2% | 58.9% | 52.8% |
| | None | 40.1% | 39.3% | 40.1% | 44.0% | 36.8% | 30.9% | 32.1% | 30.8% | 35.5% | 27.0% |

The survey asks the respondents how much time they spent on housework activities when they were in Thailand and in Cambodia. The average time spent by male and female respondents is higher in Cambodia than in Thailand for all activities *(child care, house cleaning, food cooking, collecting water, family health care)* while the median time is the same for all activities except for the water collection, which is higher within the men group *(one hour in Cambodia versus 0.5 hour in Thailand)*, and the median time for child care is higher in the women group *(three hours in Cambodia versus two hours in Thailand)*. Table 12 shows the detailed results of time spent on the housework in Thailand and Cambodia.

Table 12: Time (hours) Spent on the Housework in Thailand and in Cambodia
*Base: Total Respondents (N=1,108) ; Males (N=504), Females (N=604)*

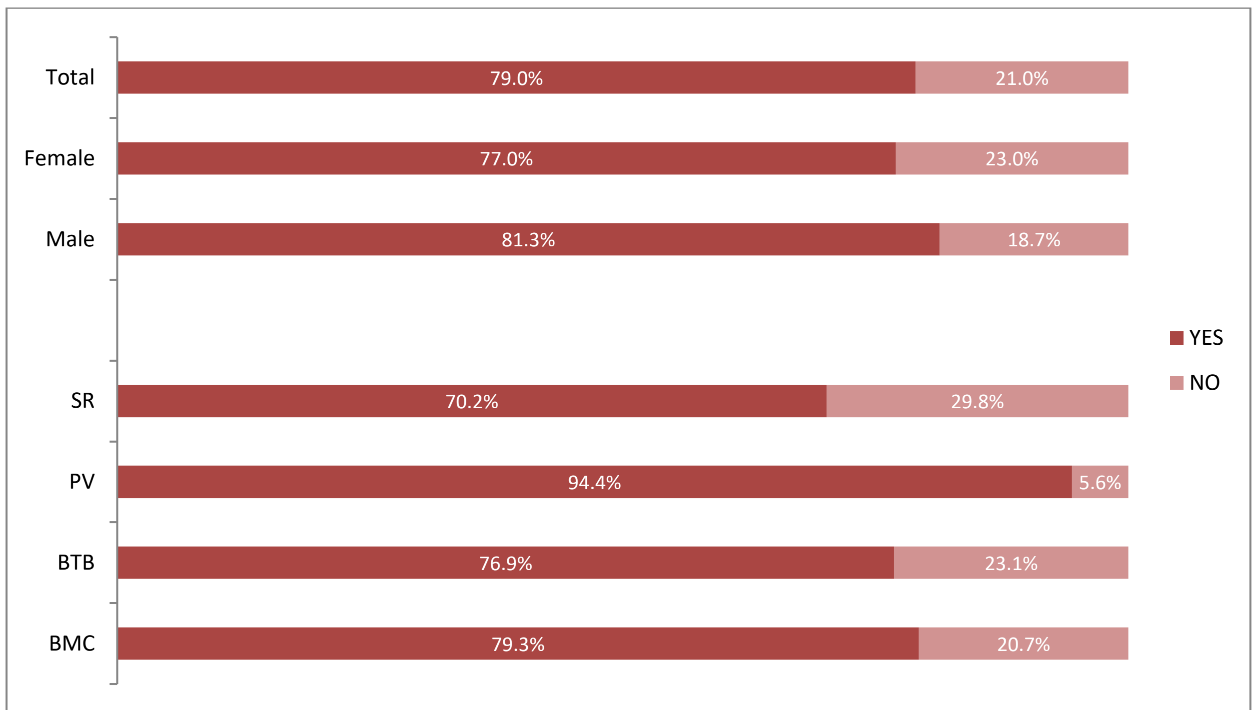
| | Total | | | | Male | | | | Female | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | In Thailand | | In Cambodia | | In Thailand | | In Cambodia | | In Thailand | | In Cambodia | |
| | Mean | Median | Mean | Median | Mean | Median | Mean | Median | Mean | Median | Mean | Median |
| Childcare | 2.50 | 2.00 | 2.76 | 2.00 | 1.92 | 2.00 | 2.23 | 2.00 | 2.85 | 2.00 | 3.11 | 3.00 |
| Collecting water | 0.67 | 0.50 | 0.81 | 1.00 | 0.70 | 0.50 | 0.87 | 1.00 | 0.63 | 0.50 | 0.75 | 0.50 |
| Housework / cleaning | 0.98 | 1.00 | 1.30 | 1.00 | 0.98 | 1.00 | 1.21 | 1.00 | 0.98 | 1.00 | 1.36 | 1.00 |
| Cook food | 1.07 | 1.00 | 1.31 | 1.00 | 1.03 | 1.00 | 1.23 | 1.00 | 1.09 | 1.00 | 1.36 | 1.00 |
| Health care of family | 1.28 | 1.00 | 1.68 | 1.00 | 1.32 | 1.00 | 1.83 | 1.00 | 1.24 | 1.00 | 1.57 | 1.00 |

## 3.6. Health and Social Impact of COVID-19

### 3.6.1. Nutritional Situation

When asked: "Since returning from Thailand, have you and your family been able to eat enough every day?", 79.0% (N=875) answered "Yes" and 21.0% (N=233) answered "No" [Figure 10]. There is no significant difference (at $p<0.05$) between men and women. By provinces, Prey Veng had the highest percentage of respondents who said they were able to eat enough every day, as compared to Banteay Meanchey, Battambang, and Siem Reap (difference statistically significant at $p<0.05$).

Figure 10: Respondents Having Sufficient Daily Foods (By Gender, Province)
*Base: Total Respondents (N=1,108) ; Males (N=504), Females (N=604) ; BMC (N-449), BTB (N=324), PV (N=144), SR (N=191)*



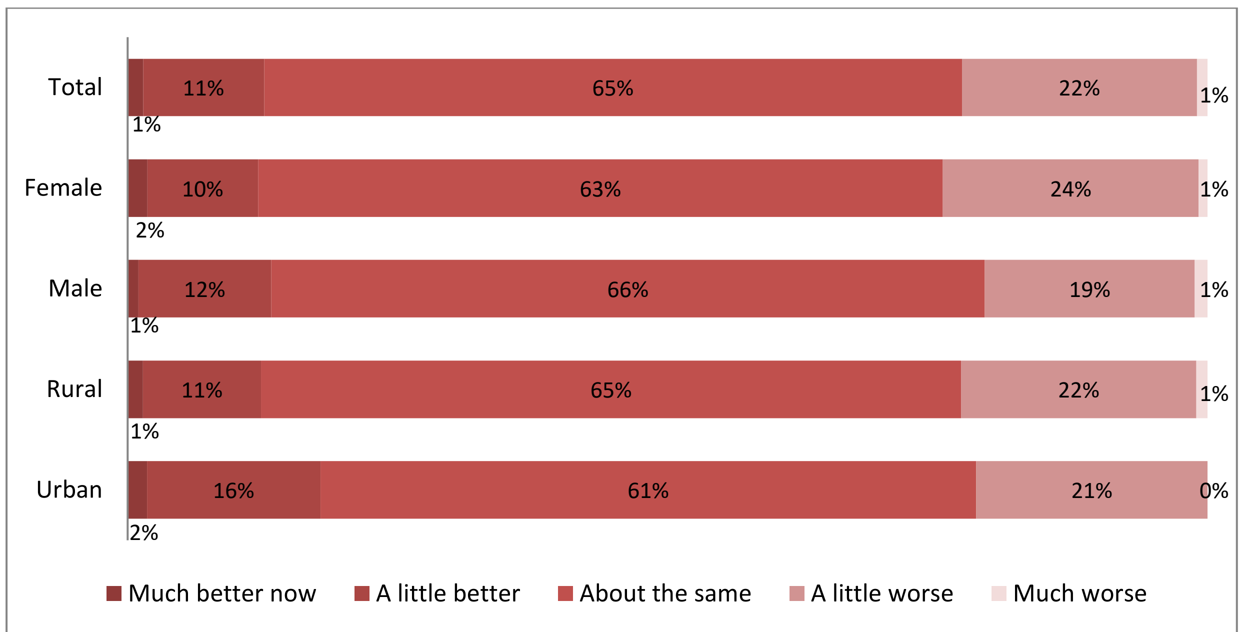

Among the 233 respondents who did not have enough daily food, 44.6% have asked support from relatives and 13.7% have asked support from friends. But 12.4% did nothing and 51.9% have reduced their amount of eating.

### 3.6.2. Family Health Situation

When asked to compare their current physical health (at the time of the survey) with how it was in Thailand, 64.6% (N=716) of the respondents claim that it is about the same, 21.8% (N=241) a little worse, 11.2% (N=124) a little better, 1.4% (N=16) much better and 1.0% (N=11) much worse [Figure 11]. There is no significant difference (at $p<0.05$) in the responses between men and women and between urban and rural residents.

Figure 11: Changes in Physical Health Status (By Gender, Locality)

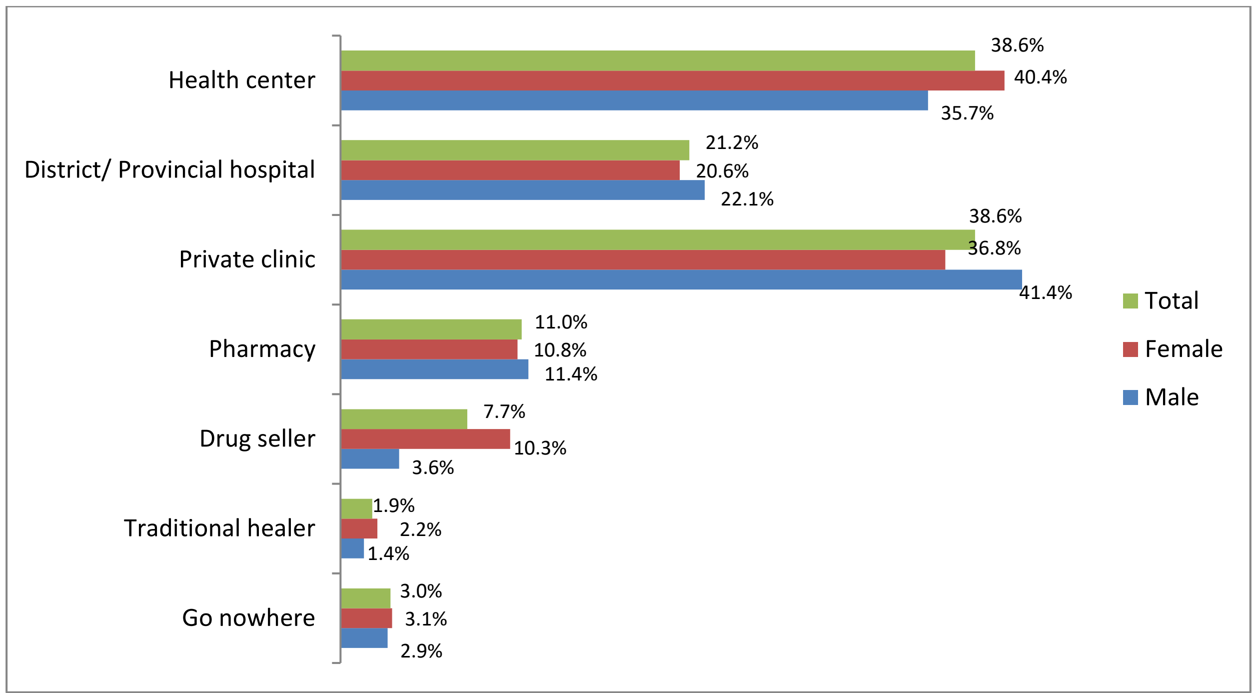
*Base: Total Respondents (N=1,108) ; Males (N=504), Females (N=604) ; Urban (N-56), Rural (N=1,052*




Since their return from Thailand, 32.8% (N=363) of respondents (or a family member) have been sick and needed medical care. The occurrence of sickness is higher among female respondents (36.9%) than among male respondents (27.8%) with the difference that is statistically significant at $p<0.05$. Although, there is no significant difference at $p<0.05$ between urban residents (23.2%) and rural residents (33.3%).

Among the N=363 respondents who have been sick, 38.6% (N=140) say they go to the health centre, 38.6% (N=140) to the private clinic, 21.2% (N=77) to the district or provincial hospital, 11.0% (N=40) to the pharmacy, 7.7% (N=28) to the drug seller, 1.9% (N=7) to the traditional healer, and 3.0% (N=11) did not go anywhere. Figure 12 shows the places of medical consultation distributed by gender. There is no significant difference at $p<0.05$ between men and women, and between urban and rural residents. Moreover, there is no significant difference at $p<0.05$ among the four provinces.

Figure 12: Places of Medical Consultation (By Gender)
*Base: Total Respondents (N=1,108); Males (N=504), Females (N=604)*




49.0% of the respondents who have been sick indicate the lack of money, 16.8% the distance or lack of transport, 8.5% the fear of COVID-19 and 3.3% the discrimination as the constraints in getting medical care. On the other hand, 47.7% claim that they have no constraint in getting medical care. There is no significant difference at $p<0.05$ between men and women. The proportion of respondents who mention lack of money as a barrier is significantly higher for urban residents (84.6%) than rural residents (47.7%) at $p<0.05$ while the proportion of respondents who have no constraint is significantly lower for urban residents (15.4%) than rural residents (48.9%) at $p<0.05$.

Meanwhile, a few of the respondents claim that they, their spouse, or their children have pre-existing health conditions: 2.3% have a physical disability, 0.5% have an intellectual disability, 0.9% have tuberculosis, and 1.0% have HIV/AIDS [Table 13]. There is no significant difference at $p<0.05$ between men and women, and among the four provinces.

Table 13: Existing health conditions of Respondents

| | Total | | Gender | | | | Province | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Male | | Female | | BMC | | BTB | | PV | | SR | |
| | N | % | N= | % | N | % | N | % | N | % | N | % | N | % |
| *Base: Total Respondents* | *1108* | | *504* | | *604* | | *449* | | *324* | | *144* | | *191* | |
| Physical disability | 25 | 2.3% | 18 | 3.6% | 7 | 1.2% | 7 | 1.6% | 13 | 4.0% | 3 | 2.1% | 2 | 1.0% |
| Intellectual disability | 5 | 0.5% | 4 | 0.8% | 1 | 0.2% | 0 | 0.0% | 3 | 0.9% | 1 | 0.7% | 1 | 0.5% |
| Mental illness | 0 | 0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Tuberculosis | 10 | 0.9% | 3 | 0.6% | 7 | 1.2% | 1 | 0.2% | 9 | 2.8% | 0 | 0.0% | 0 | 0.0% |
| HIV / AIDS | 11 | 1.0% | 1 | 0.2% | 10 | 1.7% | 6 | 1.3% | 4 | 1.2% | 0 | 0.0% | 1 | 0.5% |

Regarding the spouses or partners of the respondents, 2.8% have a physical disability, 2.5% have an intellectual disability, 1.6% have a mental illness, 1.7% have tuberculosis, and 0.7% have HIV/AIDS [Table 14]. There is no significant difference at $p<0.05$ between the responses from the male and female groups, and among the four provinces.

Table 14: Existing Health Conditions of Respondents' Spouses or Partners

| | Total | | Gender | | | | Province | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Male | | Female | | BMC | | BTB | | PV | | SR | |
| Base: Those with Spouses or Partners | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| | 867 | | 378 | | 489 | | 354 | | 242 | | 116 | | 155 | |
| Physical disability | 24 | 2.8% | 7 | 1.9% | 17 | 3.5% | 8 | 2.3% | 11 | 4.5% | 0 | 0.0% | 5 | 3.2% |
| Intellectual disability | 22 | 2.5% | 14 | 3.7% | 8 | 1.6% | 6 | 1.7% | 12 | 5.0% | 2 | 1.7% | 2 | 1.3% |
| Mental illness | 14 | 1.6% | 5 | 1.3% | 9 | 1.8% | 3 | 0.8% | 6 | 2.5% | 0 | 0.0% | 5 | 3.2% |
| Tuberculosis | 15 | 1.7% | 6 | 1.6% | 9 | 1.8% | 2 | 0.6% | 10 | 4.1% | 0 | 0.0% | 3 | 1.9% |
| HIV / AIDS | 6 | 0.7% | 2 | 0.5% | 4 | 0.8% | 1 | 0.3% | 4 | 1.7% | 0 | 0.0% | 1 | 0.6% |

Among the children of all the respondents, 1.6% have a physical disability, 4,2% have an intellectual disability, 1.1 have a mental illness, 1.2% have tuberculosis, and 0.4% have HIV/AIDS [Table 15]. Also, there is no significant difference at $p<0.05$ between the responses from the male and female groups, and among the four provinces.

Table 15: Existing Health Conditions of Respondents' Children

| | Total | | Gender of Respondents | | | | Province | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Male | | Female | | BMC | | BTB | | PV | | SR | |
| Base: Those with Children | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| | 182 | | 76 | | 106 | | 78 | | 53 | | 26 | | 25 | |
| Physical disability | 13 | 1.6% | 5 | 1.4% | 8 | 1.7% | 2 | 0.6% | 9 | 3.7% | 0 | 0.0% | 2 | 1.4% |
| Intellectual disability | 35 | 4.2% | 11 | 3.2% | 24 | 5.0% | 11 | 3.3% | 15 | 6.1% | 3 | 2.9% | 6 | 4.1% |
| Mental illness | 9 | 1.1% | 4 | 1.2% | 5 | 1.0% | 2 | 0.6% | 4 | 1.6% | 0 | 0.0% | 3 | 2.1% |
| Tuberculosis | 10 | 1.2% | 1 | 0.3% | 9 | 1.9% | 2 | 0.6% | 6 | 2.4% | 0 | 0.0% | 2 | 1.4% |
| HIV / AIDS | 3 | 0.4% | 1 | 0.3% | 2 | 0.4% | 0 | 0.0% | 3 | 1.2% | 0 | 0.0% | 0 | 0.0% |

Among N=233 respondents who respond that they (or a member of their family) have existing health conditions, 83.7% (N=195) claim that they needed treatment for their illness. Among these people, only 36.9% (N=72) are able to get medicines. There is no significant difference (at $p<0.05$) in the access to medicines between men (34.1%) and women (29.1%), and between urban (36.4%) and rural residents (30.6%). When comparing the four provinces, the rate of access to medicines is lower in Siem Reap (16.3%) and Prey Veng (21.7%) than in Banteay Meanchey (37.2%) and Battambang (36.0%), but there is no significant difference (at $p<0.05$).

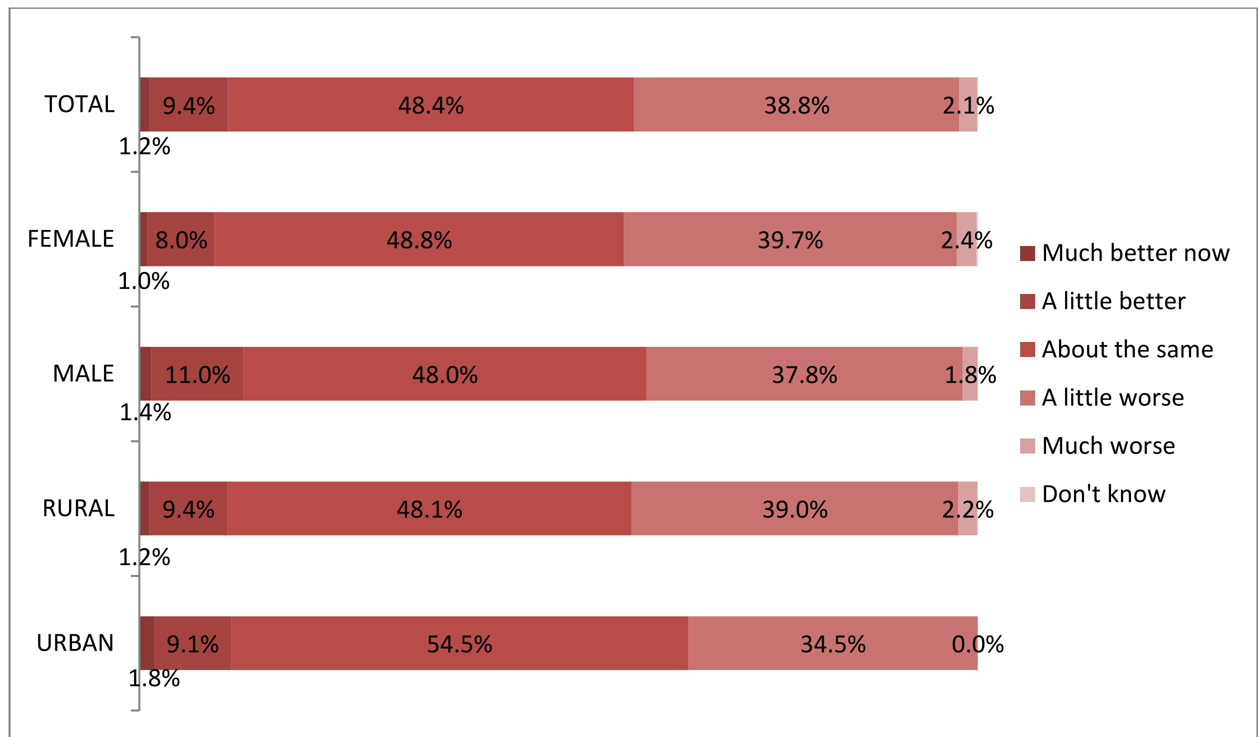
Those who are able to treat their chronic health conditions (N=72) get their treatments from the health centre (58.3%), from the district or provincial hospital (22.2%), from the private clinic (20.8%), from the pharmacy (4.2%), and the traditional healer (1.4%). There is no significant difference (at $p<0.05$) in the choice of health services between men and women, and between urban and rural residents.

When asked if they have constraints to get their treatment, 56.4% of the N=195 respondents who need treatment for their health illness claim that they have no barrier *(45.9% of men versus 62.8% of women)*. Yet, 40.0% quote the lack of money as the constraint *(50.0% of men versus 33.9% of women)*, 12.8% the distance/lack of transport *(21.6% of men versus 7.4% of women)*, and 5.6% the fear of COVID-19 *(12.2% of men versus 1.7% of women)*. The presence of constraints is similar among those who have been able to get their medicines and among those who cannot (respectively, at 56.9% and 56.1%).

Among N=1,088 respondents who are asked how is their mental health now as compared to when they were in Thailand, 48.4% (N=527) sat that it is about the same, 38.8% (N=422) a little worse, 9.4% (N=102) a little better, 1.2% (N=13) much better and 2.1% (N=23) much worse [Figure 13]. There is no significant difference at $p<0.05$ in the responses between the male and female groups, and between the urban and rural groups.

Table 16: Change in mental health after the return (by gender, residence)

*Base: Total Respondents (N1,108); Males (N=504), Females (N=604) ; Urban (N=56), Rural (N=1,052)*




When asked "How do you cope with your mental distress?", 42.6% of all respondents say that they do nothing, 51.4% talk with a family member, 4.5% talk with a close friend, 0.2% get counselling with a social worker and 0.5% consult a health centre or referral hospital. In the group of men, 47.0% are passive about it, 47.2% talk with a family member and 4.4% talk with a close friend while among women, 38.9% do nothing, 54.8% converse with a family member add 4.6% talk with a close friend.

### 3.6.3. Situation Related to COVID-19 Prevention

Among all respondents, 96.3% have received information about COVID-19 since they returned from Thailand (96.4% of men versus 96.2% of women; 98.2% of urban residents versus 96.2% of rural residents).

The top five favourite sources of information on COVID-19 are Facebook (78.1%), Television (51.6%), Relative/friend/colleague (30.2%), Government officials at the border (19.9%), and YouTube (14.2%). Table 16 shows the distribution of favourite sources of information on COVID-19 by locality and by gender. There is no significant difference (at $p<0.05$) in the preferred sources of information on COVID-19 between men and women, and between urban and rural residents.

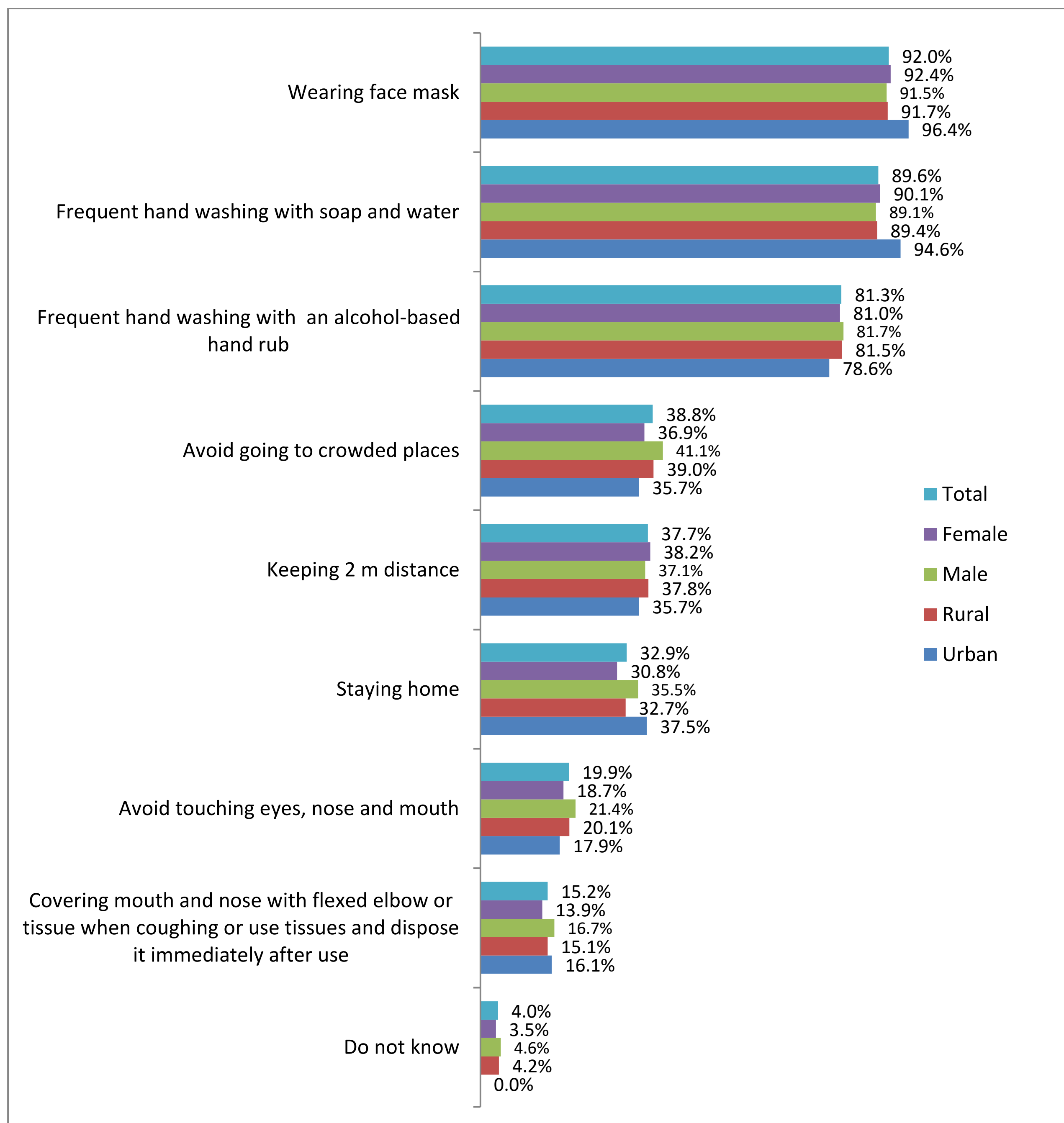
Table 17: Favourite sources of information on COVID-19

| | Total | | Locality | | | | Gender | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Urban | | Rural | | Male | | Female | |
| | N | % | N | % | N | % | N | % | N | % |
| *Base: Total Respondents who Receive COVID-19 Information* | *1,101* | *>100%* | *55* | *>100%* | *1,046* | *>100%* | *503* | *>100%* | *598* | *>100%* |
| Facebook | 860 | 78.1% | 46 | 83.6% | 814 | 77.8% | 424 | 84.3% | 436 | 72.9% |
| TV ads | 568 | 51.6% | 27 | 49.1% | 541 | 51.7% | 251 | 49.9% | 317 | 53.0% |
| Relative / friend / colleague | 332 | 30.2% | 16 | 29.1% | 316 | 30.2% | 126 | 25.0% | 206 | 34.4% |
| Government officials at the borders | 219 | 19.9% | 8 | 14.5% | 211 | 20.2% | 91 | 18.1% | 128 | 21.4% |
| YouTube | 156 | 14.2% | 8 | 14.5% | 148 | 14.1% | 92 | 18.3% | 64 | 10.7% |
| Radio | 128 | 11.6% | 8 | 14.5% | 120 | 11.5% | 58 | 11.5% | 70 | 11.7% |
| Ministry of Health website | 113 | 10.3% | 4 | 7.3% | 109 | 10.4% | 40 | 8.0% | 73 | 12.2% |
| Leaflets / brochures / flyers | 63 | 5.7% | 4 | 7.3% | 59 | 5.6% | 24 | 4.8% | 39 | 6.5% |
| Web ads (i.e. banners, pop-up ads) | 56 | 5.1% | 3 | 5.5% | 53 | 5.1% | 33 | 6.6% | 23 | 3.8% |
| Posters / streamers | 49 | 4.5% | 0 | 0.0% | 49 | 4.7% | 21 | 4.2% | 28 | 4.7% |
| Twitter | 38 | 3.5% | 3 | 5.5% | 35 | 3.3% | 25 | 5.0% | 13 | 2.2% |
| Mobile phone (SMS) | 23 | 2.1% | 2 | 3.6% | 21 | 2.0% | 14 | 2.8% | 9 | 1.5% |
| Tuktuk / motorcycle / taxi ads | 14 | 1.3% | 2 | 3.6% | 12 | 1.1% | 4 | 0.8% | 10 | 1.7% |
| Village Chief | 14 | 1.3% | 1 | 1.8% | 13 | 1.2% | 7 | 1.4% | 7 | 1.2% |
| Billboards | 9 | 0.8% | 0 | 0.0% | 9 | 0.9% | 6 | 1.2% | 3 | 0.5% |
| Newspaper / Magazines | 5 | 0.5% | 0 | 0.0% | 5 | 0.5% | 2 | 0.4% | 3 | 0.5% |
| Bus / Airport Station Ads | 1 | 0.1% | 0 | 0.0% | 1 | 0.1% | 0 | 0.0% | 1 | 0.2% |
| NGO | 1 | 0.1% | 0 | 0.0% | 1 | 0.1% | 0 | 0.0% | 1 | 0.2% |
| Village Leader | 1 | 0.1% | 1 | 1.8% | 0 | 0.0% | 0 | 0.0% | 1 | 0.2% |
| Others | 19 | 1.7% | 1 | 1.8% | 18 | 1.7% | 8 | 1.6% | 11 | 1.8% |
| Do not like watching/listening to information | 2 | 0.2% | 0 | 0.0% | 2 | 0.2% | 1 | 0.2% | 1 | 0.2% |

Among the respondents, the proportion of those who know the main elements of COVID-19 prevention and social distancing is : wearing face mask (92.0%), washing hands with soap (89.6%), washing hand with alcohol (81.3%), avoiding crowded places (38.8%), and keeping distance of two meters (37.7%). Figure 14 shows the level of knowledge of COVID-19 preventive measures with distribution by gender and by locality with no significant difference (at $p<0.05$) between men and women and between urban and rural residents.

Figure 13: Knowledge of COVID-19 Preventive Measures (By Gender and Locality)

*Base: Total Respondents (N=1,108) ; Males (N=504), Females (N=604) ; Urban (N=56), Rural (N=1,052)*



All respondents are asked how often in their everyday life they perform actions that prevent the COVID-19 transmission. For washing hands with soap for at least 40 seconds or with hands sanitizer, 84.8% of respondents say frequently, 14.1% occasionally, and 1.1% never. For wearing a face mask, 76.3% claim frequently, 20.3% occasionally, and 3.4% never. Meanwhile, for avoiding crowded places, 76.0% percent declare it to be done frequently, 18.2% occasionally, and 5.8% never. For covering the mouth with a tissue when coughing/sneezing and disposing it quickly into the bin, 67.1% say that they do this frequently, 20.8% occasionally, and 12.2% never [Table 17].

Results for all the above actions are not significantly different (at $p<0.05$) between men and women, and between urban and rural residents, except for "sneezing/coughing into elbow" where there is a significant difference (p-value is 0.048) between urban (71.4% frequently) and rural residents (57.2% frequently).

Table 18: Frequency of Preventive Actions Against COVID-19 Transmission (By Gender and Locality)

| | | Total | Residence | | Gender | |
|---|---|---|---|---|---|---|
| | | | Urban | Rural | Male | Female |
| | | N=1108 | N=56 | N=1052 | N=504 | N=604 |
| | | % | % | % | % | % |
| Handwashing with soap and water for at least 40 seconds or using alcohol-based sanitizer | Never | 1.1% | 0.0% | 1.1% | 1.8% | 0.5% |
| | Sometimes | 14.1% | 10.7% | 14.3% | 16.1% | 12.4% |
| | Frequently | 84.8% | 89.3% | 84.6% | 82.1% | 87.1% |
| Covering mouth when coughing/sneezing with a tissue and disposing into bin quickly | Never | 12.2% | 17.9% | 11.9% | 13.7% | 10.9% |
| | Sometimes | 20.8% | 17.9% | 20.9% | 21.0% | 20.5% |
| | Frequently | 67.1% | 64.3% | 67.2% | 65.3% | 68.5% |
| Sneezing/coughing into elbow | Never | 18.4% | 17.9% | 18.4% | 18.8% | 18.0% |
| | Sometimes | 23.6% | 10.7% | 24.3% | 23.6% | 23.7% |
| | Frequently | 57.9% | 71.4% | 57.2% | 57.5% | 58.3% |
| Avoiding crowded places | Never | 5.8% | 7.1% | 5.7% | 5.8% | 5.8% |
| | Sometimes | 18.2% | 16.1% | 18.3% | 18.5% | 18.0% |
| | Frequently | 76.0% | 76.8% | 76.0% | 75.8% | 76.2% |
| Keeping a safe distance from others | Never | 4.4% | 3.6% | 4.5% | 4.4% | 4.5% |
| | Sometimes | 19.7% | 19.6% | 19.7% | 20.6% | 18.9% |
| | Frequently | 75.9% | 76.8% | 75.9% | 75.0% | 76.7% |
| Wearing a mask | Never | 3.4% | 0.0% | 3.6% | 4.0% | 3.0% |
| | Sometimes | 20.3% | 17.9% | 20.4% | 21.2% | 19.5% |
| | Frequently | 76.3% | 82.1% | 76.0% | 74.8% | 77.5% |

**Reasons for not taking action:**

Among respondents who never wash their hands or do it occasionally (N=168), a large majority (73.2%) say that they forgot about it, 17.3% because there is no available soap , 4.2% because no clean water is available, and 10.7% does not believe that it is important or necessary.

Among the respondents who never wear a face mask or carry this out occasionally (N=263), a large majority (70.7%) claim that they forgot about the activity, 32.3% does not believe it is important or necessary, and 4.9% say that masks are difficult to find or expensive.

<u>COVID-19 Quarantine</u>:

Among all survey respondents, 74.5% (N=826) claim that they do the two-weeks quarantine for COVID-19 *(88.3% are advised the home-based quarantine and 86.8% are told to do facility-based quarantine)*. The compliance rate is higher in Prey Veng (87.5%) than in the three other provinces, Battambang (76.9%), Siem Reap (70.7%), and Banteay Meanchey (70.4%), with a statistically significant difference (p-value is 0.0002). Conversely, the compliance rates in urban areas (82.1%) and rural areas (74.1%) are not significantly different (at $p<0.05$), so does among the men group (76.2%) and women group (73.2%) (at $p<0.05$).

Among the N=826 respondents who do the quarantine, 81.1%say that they have a separate room to stay isolated from the rest of the household during the quarantine. And this is higher in Prey Veng (87.3%) and Siem Reap (86.7%) than in Banteay Meanchey (77.8%) and Battambang (79.1%) with a p-value equal to 0.033, albeit there is no marked difference between men and women, and between urban and rural (at $p<0.05$).

To the question: "Since you returned from Thailand, and after you completed the two-weeks quarantine, have you and your family experienced any discrimination in your community?", a large majority of the respondents (81.0%) say that they do not suffer any discrimination, 17.6% declare having been discriminated by neighbours/friends, 2.1% by parents/relatives, and 1.0% by the village authorities. The discriminations as reported by the respondents include: "Don't want to talk to us" by 89.2%, "Don't look at us" by 38.9%, "Don't engage our services or buy our products" by 7.0%, "Don't want to provide us services" by 4.5%, and "Don't allow their children to talk or play with our children" by 3.8%.

### 3.6.4. Situation Related to Maternal and Child Health

In the survey population, among N=165 respondents who have at least one child aged one year or less, 84.4% say that their children receive vaccines. The rate is 89.0% in Banteay Meanchey, 82.9% in Battambang, 86.7% in Prey Veng, and 68.2% in Siem Reap with no significant difference (at $p<0.05$) among the provinces, between male respondents (82.6%) and female respondents (85.7%), and between urban (100%) and rural residents (83.8%).

Meanwhile, out of the N=695 women in the survey population, 11.7% (N=71) are pregnant at the time of the study. Among those pregnant women, 21.1% (N=15) are aged 18-24 years, 66.2% (N=47) are aged 25-34 years, and 12.7% (N=9) are aged 35-45 years. Among them, sixty-seven pregnant respondents (94.4%) declare getting antenatal care (ANC) with is no significant difference (at $p<0.05$) in the ANC rates among the provinces: Banteay Meanchey (93.3%), Battambang (100%), Prey Veng (100%), Siem Reap (83.3%), and even between urban (100%) and rural residents (94.1%). ANC visits take place for most pregnant women (89.6%) at the health centre while for the rest, 4.5% at the outreach session in the village, 3.0% at the district or provincial hospital, and 3.0% at the private clinic.

Among the pregnant women, 28.2% (20/71) declare they have constraints in accessing the ANC services. There is no significant difference (at $p<0.05$) among the provinces: Banteay Meanchey (13/30=43.3%), Battambang (3/17=17.6%), Prey Veng (2/12=16.7%), Siem Reap (2/12=16.7%), and between urban (0/3=0.0%) and rural residents (20/48=29.4%) with Fisher exact test statistics value=0.55. Among the 20 pregnant women who have constraints in accessing the ANC services, fourteen women (19.7%) say that the barrier is the lack of money while for five women (7.0%) is about the distance or lack of transport and lastly, for two women (2.8%) is the fear of COVID-19.

When the N=71 pregnant women are asked "Where do you plan to deliver your baby?", 73.2% (N=52) claim that it would be at the health centre, 18.3% (N=13) at the district or provincial hospital, and 7.0% (N=5) at the private clinic. No woman said she wants to deliver at home.

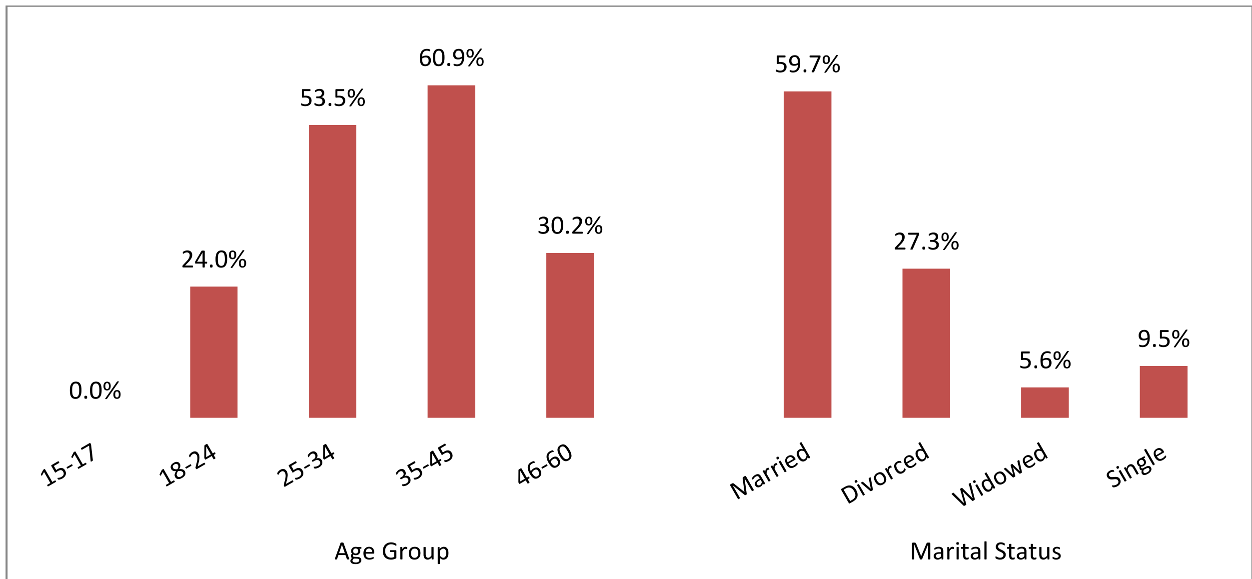
To the question: "Do you know how many post-partum check-ups should a mother attend with her baby for the first six weeks after birth?", 43.7% say zero, 9.9% claim one, 12.7% exclaim two, 21.1% assume three, and 12.7% mention four or more.

Meanwhile, a question about family planning is asked to all respondents (including men) except pregnant women: "Are you currently using any method to delay or prevent getting pregnant?". Men are expected to answer if they or their spouse is using a contraceptive method.

Nearly half of the respondents (48.6%) say that they are currently using a contraceptive method with no significant difference (at $p<0.05$) on the contraceptive use rate reported by men (46.0%) and women (51.0%), as well as by urban residents (54.7%) and rural residents (48.3%) (at $p<0.05$).

Figure 15 shows the utilization rates by age groups and by marital status. The utilization rates are highest in the age group 35-46 years (60.9%) and among the married respondents (59.7%).

Figure 14: Contraceptive Utilization (By Age, Marital Status)
*Base: By Age and By Marital Status*




Regarding the contraceptive methods currently used by the respondents or their partners, the modern methods are used by 46.5% and the traditional methods by 7.3% [Table 16]. The total is higher than one hundred percent because some respondents declare multiple contraceptive methods with the daily pill as the most frequently used method (30.9%).

Table 19: Contraceptive Methods Currently Used by Respondents (By Province, Locality, Married)

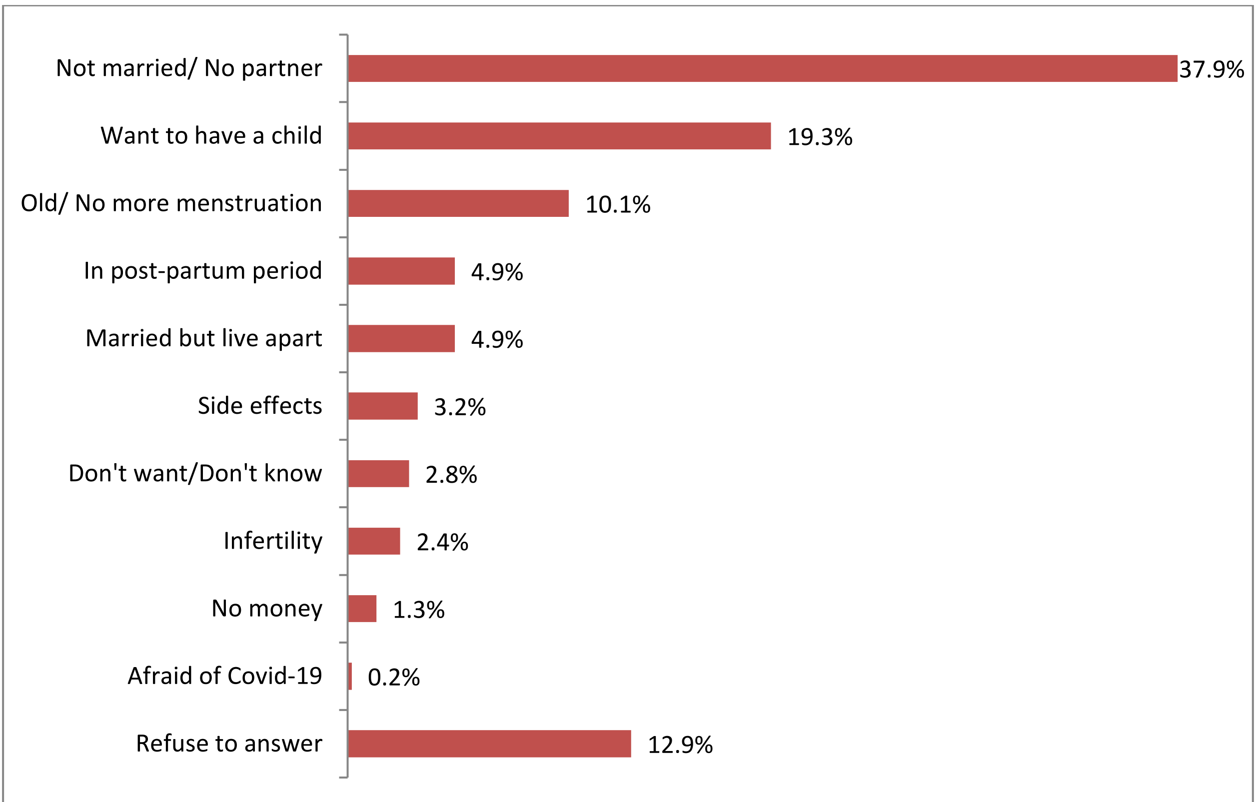
| | Total | BMC | BTB | PV | SR | Urban | Rural | Married |
|---|---|---|---|---|---|---|---|---|
| | N=1,037 | 419 | 307 | 132 | 179 | 53 | 984 | 799 |
| | % | % | % | % | % | % | % | % |
| Female sterilization | 1.3% | 0.7% | 1.3% | 3.0% | 1.1% | 0.0% | 1.3% | 1.6% |
| Male sterilization | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| IUD | 1.7% | 1.4% | 2.9% | 1.5% | 0.6% | 0.0% | 1.8% | 2.0% |
| Injectables | 6.0% | 5.7% | 6.2% | 6.8% | 5.6% | 9.4% | 5.8% | 7.0% |
| Implants | 2.3% | 3.1% | 2.0% | 2.3% | 1.1% | 9.4% | 1.9% | 2.8% |
| Daily Pill | 30.9% | 28.6% | 30.0% | 32.6% | 36.3% | 30.2% | 30.9% | 38.0% |
| Monthly method (Chinese pill) | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| Emergency contraceptive pill | 0.1% | 0.0% | 0.0% | 0.8% | 0.0% | 0.0% | 0.1% | 0.1% |
| Male condom | 4.2% | 3.6% | 5.2% | 3.8% | 4.5% | 0.0% | 4.5% | 3.6% |
| Female condom | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| Lactational amenorrhea method | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| Calendar/Rhythm method | 0.3% | 0.2% | 0.0% | 0.8% | 0.6% | 1.9% | 0.2% | 0.4% |
| Withdrawal | 7.0% | 6.0% | 10.1% | 9.8% | 2.2% | 5.7% | 7.1% | 9.1% |
| Other modern method | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| Other traditional method | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |

When asked: "Where do you get the information about the method that you are currently using?", 62.3% of respondents say from the health centre or public hospital, 20.2% from a pharmacy or private clinic, 7.9% from a drug seller, 4.4% from NGO, and 3.2% from other sources.

Only 8.5% (N=43) of contraceptive users claim that they have constraints to get their contraceptive method. Among them, 56.8% (N=25) report the lack of money, 31.8% (N=14) the distance or lack of transport and 15.9% (N=7) the fear of COVID-19 as the key constraints.

To those who do not use any contraceptive method, the survey asks what is the reason. About one out of three women (37.9%) say because they currently have no partner, 19.3% claim because they want to have a child, 10.1% because they are old or have no more menstruation, 4.9% said because they are still in the post-partum period, 4.9% claim because they lived far from their spouse, 3.2% elaborate because they suffer from the side effects of contraceptives, 2.4% say because they are already infertile, and 1.3% claim because they have no money. Figure 16 shows the frequency of reasons for not using contraception.

Figure 15: Reasons for Not Using Contraception (Frequency)
*Base: Those who are Not Using Contraception*




### 3.6.5. Situation related to Water and Sanitation

Sources of Drinking Water:

The source of water is an indicator of whether the water is suitable for drinking. Based on the categorization proposed by the WHO/UNICEF Joint Monitoring Program for Water Supply and Sanitation, the water sources suitable for drinking called "improved source" are piped water supply into the dwelling, piped water to a yard/plot, public tap/standpipe, tube well/borehole, protected dug well, protected spring, bottled water, and rainwater. The water sources which are non-suitable for drinking called "non-improved source" are unprotected dug well, unprotected spring, cart with a small tank/drum, water tanker-truck, and surface water. Table 19 shows the distribution of improved sources and non-improved sources of drinking water.

Among all respondents, rainwater is the first ranked household source of water (39.6%), followed by tube well (17.9%), cart with small tank (15.3%), bottled water (12.6%), surface water (12.1%), protected well 10.8%, and piped into dwelling 7.3%. There is no statistically significant difference (at $p<0.05$) in the distribution of water sources between men and women respondents. In the meantime, the use of rainwater is significantly higher (at $p<0.05$) for rural respondents (40.2%) than for urban respondents (28.6%).

Rainwater is the first ranked source of water in Banteay Meanchey (49.0%) and Battambang (50.3%) but only at third place in Prey Veng (13.2%) and Siem Reap (19.4%) where predominated

the tube well (34.7% in Prey Veng , 31.4% in Siem reap) and the protected well (23.6% in Prey Veng, 26.2% in Siem Reap) are more population water source options. Meanwhile, piped water into the dwelling is low for both urban respondents (8.9%) and rural respondents (7.2%).

Table 20: Household Sources of Drinking Water

| | Total | Province | | | | Locality | | Gender | |
|---|---|---|---|---|---|---|---|---|---|
| | | BMC | BTB | PV | SR | Urban | Rural | Male | Female |
| Base: Total Respondents | N=1,108 | N=449 | N=324 | N=144 | N=191 | N=56 | N=1,052 | N=504 | N=604 |
| **Improved Source** | | | | | | | | | |
| Piped into dwelling | 7.3% | 8.5% | 7.7% | 7.6% | 3.7% | 8.9% | 7.2% | 6.5% | 7.9% |
| Piped to yard / plot | 0.7% | 0.7% | 0.9% | 0.7% | 0.5% | 1.8% | 0.7% | 0.6% | 0.8% |
| Piped to neighbour | 0.5% | 0.4% | 0.9% | 0.0% | 0.0% | 0.0% | 0.5% | 0.2% | 0.7% |
| Public tap / standpipe | 1.4% | 1.3% | 1.5% | 0.0% | 2.1% | 3.6% | 1.2% | 1.0% | 1.7% |
| Tube well / borehole | 17.9% | 10.9% | 12.0% | 34.7% | 31.4% | 25.0% | 17.5% | 21.6% | 14.7% |
| Protected well | 10.8% | 3.8% | 5.9% | 23.6% | 26.2% | 17.9% | 10.5% | 10.1% | 11.4% |
| Protected spring | 0.6% | 0.0% | 0.6% | 2.8% | 0.5% | 0.0% | 0.7% | 0.8% | 0.5% |
| Rainwater | 39.6% | 49.0% | 50.3% | 13.2% | 19.4% | 28.6% | 40.2% | 39.9% | 39.4% |
| Bottled water | 12.6% | 14.3% | 13.9% | 13.2% | 6.3% | 8.9% | 12.8% | 14.3% | 11.3% |
| Pure water 20 Litre | 2.4% | 4.7% | 0.9% | 2.1% | 0.0% | 1.8% | 2.5% | 2.8% | 2.2% |
| **Non-improved Source** | | | | | | | | | |
| Unprotected well | 4.5% | 1.6% | 4.6% | 5.6% | 10.5% | 1.8% | 4.7% | 3.6% | 5.3% |
| Unprotected spring | 0.3% | 0.2% | 0.3% | 0.7% | 0.0% | 0.0% | 0.3% | 0.2% | 0.3% |
| Tanker-truck | 11.1% | 11.4% | 13.0% | 9.7% | 8.4% | 19.6% | 10.6% | 11.5% | 10.8% |
| Cart with small tank | 15.3% | 18.5% | 15.4% | 11.8% | 10.5% | 17.9% | 15.2% | 16.7% | 14.2% |
| Surface water (river, dam, lake, pond, stream, canal, irrigation channel) | 12.1% | 14.0% | 17.6% | 2.8% | 5.2% | 5.4% | 12.5% | 14.1% | 10.4% |

Treatment of Drinking Water:

Household water treatment before drinking can have a significant impact on the quality of the water. Appropriate methods to efficiently remove or kill pathogens are boiling the water, adding bleach or chlorine to the water, filtering the water (with a ceramic filter, sand, etc.), and solar disinfection of the water. Conversely, inappropriate treatments of drinking water are letting the water stand and settle or straining the water through a cloth. Table 20 shows the distribution of respondents using appropriate water treatments versus non-appropriate treatments.

Among all respondents, 52.6% boil their water before drinking, 27.5% use a water filter, 3.8% let the water settle or strain through a cloth, 1.2% add chlorine, and 0.1% use solar disinfection. There is no difference that is statistically significant (at $p<0.05$) in the distribution of water treatment methods between men and women, and between urban and rural residents. By province, Siem Reap has a higher rate of water filter use (46.6%) and a lower rate of water boiling (33.0%) than the three other provinces. On the other hand, about one out of four respondents

(26.9%) do not treat their water before drinking and this situation is similar between provinces, urban and rural and between male and female respondents.

Table 21: Household Water Treatment Methods

| | Total | Province | | | | Locality | | Gender | |
|---|---|---|---|---|---|---|---|---|---|
| | | BMC | BTB | PV | SR | Urban | Rural | Male | Female |
| *Base: Total Respondents* | *N=1,108* | *N=449* | *N=324* | *N=144* | *N=191* | *N=56* | *N=1,052* | *N=504* | *N=604* |
| **Appropriate Methods** | | | | | | | | | |
| Boil | 46.8% | 47.9% | 51.5% | 51.4% | 33.0% | 42.9% | 47.1% | 44.6% | 48.7% |
| Boil with Bark | 5.8% | 5.6% | 7.4% | 4.9% | 4.2% | 3.6% | 5.9% | 6.9% | 4.8% |
| Add Bleach / Chlorine | 1.2% | 1.1% | 1.2% | 0.7% | 1.6% | 1.8% | 1.1% | 1.0% | 1.3% |
| Use Water Filter (Ceramic, Sand, Composite, Etc.)… | 27.5% | 25.2% | 18.8% | 29.2% | 46.6% | 28.6% | 27.5% | 26.8% | 28.1% |
| Solar Disinfection | 0.1% | 0.2% | 0.0% | 0.0% | 0.0% | 1.8% | 0.0% | 0.0% | 0.2% |
| **Non-appropriate Methods** | | | | | | | | | |
| Strain It Through a Cloth | 0.4% | 0.2% | 0.9% | 0.0% | 0.0% | 0.0% | 0.4% | 0.0% | 0.7% |
| Let It Stand and Settle | 3.4% | 2.2% | 4.3% | 4.9% | 3.7% | 3.6% | 3.4% | 5.4% | 1.8% |
| Do nothing | 26.9% | 29.8% | 25.3% | 24.3% | 24.6% | 26.8% | 26.9% | 29.0% | 25.2% |
| **Don't Know** | 0.8% | 0.4% | 1.5% | 0.7% | 0.5% | 1.8% | 0.8% | 1.0% | 0.7% |

## Toilet Facility:

A toilet is classified as improved/hygienic if the type of toilet effectively separates human waste from human contact, and if it is used only by household members *(is not shared by other households)*. Those are toilets that pour-flush into a piped sewer system, septic tank, or pit latrine with a slab. Among all the interviewed returnees, 87.6% declare having an improved toilet facility. However, only 76.9% do not share the toilet with other households. There is no statistically significant difference (at $p<0.05$) between men and women, between urban and rural areas, nor among provinces. (Table 21).

Table 22: Household Sanitation Facilities

| | Total | Province | | | | Locality | | Gender | |
|---|---|---|---|---|---|---|---|---|---|
| | | BMC | BTB | PV | SR | Urban | Rural | Male | Female |
| *Base: Total Respondents* | *N=1,108* | *N=449* | *N=324* | *N=144* | *N=191* | *N=56* | *N=1,052* | *N=504* | *N=604* |
| **Improved facility** | **87.6%** | **89.8%** | **87.0%** | **91.0%** | **81.2%** | **87.5%** | **87.6%** | **87.3%** | **87.9%** |
| Flush to septic tank | 37.8% | 39.2% | 37.7% | 38.9% | 34.0% | 44.6% | 37.5% | 36.1% | 39.2% |
| Flush to septic hole/store | 49.0% | 50.3% | 47.5% | 51.4% | 46.6% | 41.1% | 49.4% | 51.0% | 47.4% |
| Hole with toilet bowl | 0.8% | 0.2% | 1.9% | 0.7% | 0.5% | 1.8% | 0.8% | 0.2% | 1.3% |
| **Non-improved facility** | **12.4%** | **10.2%** | **13.0%** | **9.0%** | **18.8%** | **12.5%** | **12.4%** | **12.7%** | **12.1%** |
| Hole without toilet bowl | 0.1% | 0.2% | 0.0% | 0.0% | 0.0% | 0.0% | 0.1% | 0.2% | 0.0% |
| Pond/Lake/River | 0.3% | 0.0% | 0.3% | 0.0% | 1.0% | 0.0% | 0.3% | 0.6% | 0.0% |
| Flush to another place than septic hole/store | 2.4% | 1.6% | 4.3% | 2.1% | 1.6% | 3.6% | 2.4% | 1.2% | 3.5% |
| Do not use toilet | 9.6% | 8.5% | 8.3% | 6.9% | 16.2% | 8.9% | 9.6% | 10.7% | 8.6% |
| Shared toilet | 23.1% | 20.0% | 24.9% | 23.1% | 27.5% | 21.6% | 23.1% | 23.3% | 22.8% |
| Not shared toilet | 76.9% | 80.0% | 75.1% | 76.9% | 72.5% | 78.4% | 76.9% | 76.7% | 77.2% |

### 3.6.6. Situation related to Child Protection

In many countries, reports of child abuse have surged since the schools are closed to prevent the spread of the COVID-19. The survey asks questions about violence against children and child labour to seven respondents aged 15-17 years (four boys and three girls. All are single).

When asked: "Do you or one or more of your siblings (aged under 18 years) suffer from any kind of violence (physical, mental/emotional, sexual abuse) outside of your home?", all the seven respondents answer "No". The question about domestic violence (inside of the household) is not asked because of its sensitivity.

To the question: "Is any member aged under 18 years of your household working to bring money or foods to help the family?", three respondents say "Yes", for themselves - composed of two boys and one girl.

## 3.7. Highlights of Quantitative Results

The most meaningful results of the quantitative survey are summarized as below.

Needs and challenges faced by RMW: 1/3 have currently no income, 1/2 have no earning, 1/2 have debts, 1/3 have debts with bank/microfinance institution, 1/4 have no money, 1/5 have not enough food, 1/3 have fallen sick and need medical care and 1/5 have been discriminated.

Assistance provided to RMW: 1/5 receive government cash support, 1/10 receive food, 1/30 receive support for livelihood, 1/30 get psychological support, 1/20 seek support (less than 1/100 in Prey Veng) and none goes to district or province officials for support.

Family health situation: For 1/5 of the respondents, the current physical health is worse than when in Thailand *(no significant difference between men and women)*, and for 2/5 of the respondents, the current mental health is worse than when in Thailand *(no significant difference between men and women)*. Since their return from Thailand, 1/3 of the respondents (or a family member) have been sick and needed medical care *(women are more affected than men)*. Among the respondents who have been sick, 1/2 have no barriers in getting medical care, while 1/2 face financial constraints *(no significant difference between men and women).*

Utilization of MCH services by RMW: 8/10 bring their child to vaccination, 9/10 pregnant women go to ANC, all pregnant women are planning to deliver in a health facility, 1/8 know the correct number of PNC visits, 1/2 use a modern contraception method and almost 7/8 do not know the proper number of postnatal visits.

Water and sanitation situation of RMW: 3/4 use an improved source of water, 3/4 has proper water treatment before drinking and 3/4 has an improved toilet facility.

COVID-19 prevention: 3/4 RMW fully comply with quarantine process, 3/4 regularly wear a face mask, 8/10 regularly wash their hands with soap and 3/4 regularly avoid any crowded place.

# 4. FINDINGS OF QUALITATIVE SURVEY

## 4.1. Sample of stakeholders/key informants

Out of 61 planned stakeholders/key informants (SH/KI), 56 have completed the interview, and five have declined. The survey sample is composed of four representatives of line ministries (Ministry of Woman Affairs, Ministry of Social Affairs, Ministry of Labour and Vocational Training, and National Committee for Counter Trafficking), six officers of UN agencies at central and provincial levels (UNICEF, IOM, UNAIDS), eight representatives of NGO/CSO: Reproductive Health Association of Cambodia (RHAC), Center for Alliance of Labour and Human Right (CENTRAL), Legal Support for Children and Women (LSCW), Caritas, Catholic Reliefs Service (CRS), Damnak Teuk, Association of Cambodian Recruitment Agencies (ACRA), Cambodian Labour Confederation (CLC), seven representatives of provincial authorities or departments, nine representatives of Commune councils chief/CCWC, four chiefs of health centres, eight Village Health Support Group (VHSG), and ten village chiefs.

## 4.2. Viewpoints of stakeholders/key informants

### 4.2.1. Impact of COVID-19 pandemic on RMW

Most of SH/KI from government institutions, development partners, NGO/CSO and local authorities have similar views about the needs and challenges of RMW. When they are asked what they know or believe are the needs of RMW and families amid the COVID-19 pandemic, SH/KI most frequently respond the following: money for daily subsistence, COVID-19 prevention, psychological support, food, job and access to health care.

SH/KI also brings up the challenges faced by the RMW, which are unemployment, the stress linked to loan reimbursement *(some RMW are heavily in debt because they have contracted a big loan to build a house or pay for expensive health care)*, the uncertainty of the future, the lack of land for farming, and few RMW households have been so far interviewed by the commune council for the IDPoor registration.

Meanwhile, some of the SH/KI from the government institutions as well as from the partner organizations put strong emphasis on the COVID-19 prevention. They are worried that many RMW do not comply with COVID-19 quarantine protocols at home or in the facilities. The commune councils also report that villagers are more receptive to the information on social media and television than to their health education interventions in the field.

SH/KI from the government institutions and NGO/CSO mention the increased risks of domestic violence during the COVID-19 pandemic. SH/KI from the commune and village levels report verbal disputes among some couples. However, commune councils claim that they have not seen an increase of domestic violence in their communes during the pandemic.

Regarding the long-term needs of RMW, many SH/KI mention two things that would be helpful to the RMW : to have vocational training and have a support for loan payment to the microcredit institutions.

The NGOs/CSOs get information on RMW in two possible ways: directly from the community or the RMW during field visits and through information sharing from other organizations or local authorities. The knowledge is often focused and limited to their specific field of interventions. SH/KI at the commune and village levels say their knowledge about the needs and challenges of RMW come directly from their fieldwork.

One issue raised by SH/KI is that many RMW want to go back to Thailand before the re-opening of the border. Those who tried to go back to Thailand illegally are easy prey for exploitation by the brokers. Eventually, these people are arrested by Thai authorities. Among the RMW in Battambang and Banteay Meanchey, some take the risk because they have no money for daily subsistence.

### 4.2.2. Assistance to RMW and Existing Services

In general, SH/KI claim that the government institutions and NGO/CSO are actively providing support to RMW. One KI from the civil society declare: *"We see that NGOs and government institutions are very busy in providing assistance. And the help we see is related to emergency relief"*.

The response of the government institutions and development partners, and NGO/CSO to the issue of RMW has two main objectives: providing the emergency relief assistance to RMW and families, and preventing the dissemination of COVID-19. Based on the type of their organization or institution, the SH/KI seem to give more focus to one or another.

The RGC has set up structures at the borders which are open 24 hours to receive RMW and provide basic assistance like food, screening for COVID-19, quarantine in institutional facility if showing symptoms and transportation to their province of origin. NGOs and UN agencies are actively collaborating, giving prevention equipment, food etc.

In theory there is a clear protocol: when RMW arrive at the border crossing, they are received by a working group which do the screening for COVID-19 and provide immediate assistance. If they are not put in quarantine at the border, they are transported to their province of origin. They are supported by the local authorities who monitor their home-quarantine and provide assistance, as necessary e.g. if they need food during the quarantine. For the easy follow-up of the RMW, the authorities provide them with a "yellow card" that they must show to the village chief to be allowed to stay in the village.

At the border RMW could also benefit from various assistance from NGOs: transport cost, and foods. In the village, the Cambodian Red Cross distributes relief packages containing rice, noodle, sardines, fish sauce and soap.

The government's intervention with most frequent mentions by SH/KI is the Cash Transfer Program for the Poor and Vulnerable Households, as operationalized in June 2020 in all 25 provinces and municipalities to assist the most affected and vulnerable households with temporary cash assistance during the COVID-19 pandemic.

In the first round, about 560,000 households *(covering approximately 2.3 million people)* are eligible with their IDPoor card. The cash support varies from 100,000 to 300,000 Riel per month, based on the type of IDPoor card (category 1 or category 2) and additional criteria *(large family, family with elderly, people with disability, HIV patient, pregnant women and children under five).*

In addition, the program also features the "On Demand ID Poor" component, allowing those who recently fall into poverty, including because of the COVID-19, to apply for financial assessment via their commune councils, village chief or a local NGO representative to determine eligibility for cash transfer without having to wait for the regular three-year poverty listing circle.

The RMW may receive the cash support if they have the IDPoor card. However there is no official data as how many of RMW have received the cash support as mentioned by one SH/KI: *"What I notice is that for the cash transfer program, the government is referring to the [IDPoor] first category and second category. It has its criteria. Do RMW have the IDPoor cards, do they have enough documents to be eligible to receive those benefits? This is something for consideration. I do not know how many workers have benefited so far. And we see recently, the government and the United Nations launching a program to help people. But we do not know if out of the nearly 150,000 workers who have returned, all or only some have benefited from the program*".

Besides this, the support that the government institutions can provide to the RMW are already existing interventions such as legal aid and assistance to women victims of violence. All ministries are involved with each ministry implementing its core responsibility e.g. MOWA focusing on gender based violence, the Ministry of Agriculture giving training on farming skills, and the MoH providing health education on COVID-19 etc.

Regarding NGOs/CSOs, some are already working with migrant workers issues long before the pandemic and some are working in specific fields like health, HIV/AIDS, or children and women rights. Some of them provide legal aids locally in their target areas or legal counselling more widely through a hotline. Those organizations have added to their regular interventions, activities for the COVID-19 prevention and/or emergency relief for the RMW. In fact, some organizations are acting as facilitators (referral system) who guide RMW to specific support or service providers, according to their needs. Some do cash support locally and in a smaller scale.

Meanwhile, the support from recruitment companies are limited to job prospects, advice on COVID-19, and some counselling on stress management. One KI from NGO/SKO declares: *“But if you look at the private partners, we see that in the past, the private partners have played a small role in supporting the returning workers. This is an issue. Private partners cannot do anything besides providing employment opportunities for workers"*.

SH/KI at the local level underline that support from family and relatives is often an important factor to get the RMW out of the critical situation.

The provincial authorities, meanwhile, have a system in place for legal support and counselling, and in providing safe shelter for victims of gender violence. The Anti-Human Trafficking Committee can act at the commune level. SH/KI at the local level confirm that there is government support (provincial Working Groups for RMW) to RMW with food, but only few RMW have received it.

In the meantime, the commune councils give support to RMW in making the family book and on IDPoor registration. With the village chiefs, the commune council also do the Social Service Mapping. On a case by case basis, the commune council can use the commune social funds to support RMW with some commune councils having collaboration with pagodas to collect assistance in kind for the RMW who are in need.

Meanwhile, the health centres are working normally during the COVI-10 pandemic, with increased measures for COVID-19 prevention *(distancing, washing hands with alcohol or soap, and wearing facemask)*. The attendance has dropped slightly in the early months of the pandemic, mainly for the general consultation. There is no interruption on outreach service in the village and the attendance by villagers is as usual. The RMW families take their children for vaccination and use other services like the other villagers. Health centres' chiefs have seen few RMW coming to the health centre for treatment of chronic disease like tuberculosis or HIV/AIDS. The health centres also continue to provide sexual and reproductive health, even at the quarantine facility, if needed. One KI says, *"I remember, there was one woman who was pregnant almost in full-term. So we [health centre staff] went to check her at the quarantine facility because she was not allowed to come out of the health centre".* Moreover, the health centre collaborates with the commune council and the police in the supervision of the quarantine.

In the medium term, trainings are available for RMW who want to get new skills - *"Currently, we see that the agricultural sector has great potential, so those who returned can work in the agricultural sector, and our Ministry also provides scholarships for those who want to attend short training courses in accordance with their situation. This is implemented by the provincial departments in all provinces".*

### 4.2.3. Collaboration and Coordination of Assistance

At the national level, the main institution involved in the issue of RMW is the National Committee for Counter Trafficking (NCCT) and the Ministry of Labour and Vocational Training.

Overall, SH/KI find that the collaboration among the ministries is good. For example, the cash transfer program is a collaboration between the Ministry of Planning and the commune councils who are responsible for providing the IDPoor card, and the Ministry of Finances and the Ministry of Social Affairs who pay the beneficiaries using the phone payment technology (via Wing). Moreover, "*there is a Migrant Resource Center in each province to provide advice and guide the RMW to find a job or a business*".

SH/KI at the central level are generally satisfied with the ongoing collaboration between line ministries and partners (UN agencies, NGO/CSO). SH/KI say there is a good collaboration between government institutions and NGO/CSO at the national level, with the set-up of working groups, etc.

At the sub-national level, the collaboration with provincial authorities, commune councils and provincial departments is also generally good. One SH/KI from CSO say *"For the collaboration, in general, we work well. We always have meetings to share information, for example, among civil society organizations, we have formed a working group to discuss the issue. We work with the Department of Labour and Vocational Training. We work with the commune also to provide assistance to our people in the community"*. On the other hand, some SH/KI complain that the collaboration could be improved.

Similarly, SH/KI mention that there is good collaboration between NGOs and UN agencies (IOM, ILO, UN Women). Many NGOs are using IEC documents from MOH/WHO to do health education on COVID-19.

Regarding the coordination, some SH/KI say that it could be enhanced at the sub-national level. There are examples of lack of collaboration/coordination that lead to overlaps: *"Like some organizations, they have funds to do the interventions. However, the districts just know that they go to the field but do not know what they are doing. Therefore, regarding the identification of target areas, everyone should go to the same place."*

Meanwhile, the collaboration between the government institutions and UN agencies is good. It covers many aspects of the interventions from data collection to activities implementation. *"We have identified their needs through our development partners, the ILO and IOM. They studied the needs and challenges of returning workers by conducting field research and gather information from local authorities. Moreover, we get information by visiting RMW in their communities".*

The information is not always shared though, between the authorities and the partners, NGO/CSO. Some SH/KI note that there is no information available about the prevalence of IDPoor card holders among the migrant population: *"We do not have data on how many returning migrant families get coverage from the identification of poor families. We do not have information on that."*

On the other hand, there are SH/KI who claim that the collaboration has improved with government institutions being more responsive to NGO requests, and there is more presence of NGOs in different committees and working groups.

For a better collaboration and coordination of support , SH/KI call for the creation of a platform where in particular, organizations that work on providing vocational and agriculture training can work together.

#### 4.2.4. Challenges for the Assistance

The first challenge is to obtain accurate and relevant information on the RMW, especially about their living conditions and their needs. When the RMW arrive at the border, they are interviewed by the authorities. However, the information collected are not always accurate as what one SH/KI shares *"The main problem is that some RMW don not cooperate with us. For example, when we interviewed and asked about their problems, they did not answer frankly, making it difficult for us to get information from them"*. And despite the screening structures put in place at the border, some RMW are missed because they do not come through the official border gates.

In the community, the government has setup a bottom-up data collection system to obtain statistics on the RMW starting from the village chiefs, then goes up to the commune councils, the district offices, and ends at the Provincial Working Group on RMW. But most of the times, this system only collects the number and names of RMW, but not the information about their living condition or needs.

Meanwhile, the NGO/CSO get the information on RMW in two possible ways: directly from the community or the RMW during field visits and through information sharing from other organizations or local authorities. The knowledge is often focused and limited to their specific field of interventions. SH/KI at the commune and village levels say that their knowledge about the needs and challenges of RMW come directly from their field work.

Several SH/KI recognize that information sharing is insufficient, and the knowledge of the situation is incomplete. One SH/KI clearly states *"We need to search for more data. Those who get the information keep it for themselves. Well, now we are thinking about organizing the data to flow to each other [organization]."*

Secondly, the lack of specificity in the targeting of beneficiaries may also be an obstacle for reaching the RMW. One KI from the NGO/CSO exclaims *"And another thing you notice is that the cash transfer program that the government is doing, refer to the [IDPoor] first category, the second category, as criteria. Do returning workers have relevant documents to be eligible to receive those benefits? This is something we must consider. I do not know how many workers have benefited so far. And we see recently, the Royal Government and the United Nations have launched a program to help people. But I think we do not know if, out of the nearly 150,000 workers who have returned, all have benefited from the program fully or partially"*.

During the COVID-19 pandemic, the activities of government institutions, development partners, and NGO/CSO have been disrupted by the obligation for social distancing as well as by the concern to protect their staff. Some NGO/CSO have strongly reduced or even interrupted their field interventions. Hence, many SH/KI mention the overload of work for government institutions at all levels and this is associated with the limited human resource.

For some NGOs and CSOs, the main challenge is the limited budget. Support from NGOs are often located in one or two provinces, and thus, limited in scope.

Moreover, some SH/KI emphasize the lack of specific policy for RMW and that the approach to the issue of RMW is not enough participatory to design a common policy (among the stakeholders). The interventions are mainly concentrated in three provinces, namely BMC, BTB and SR, where there are the biggest number of RMW. The other provinces have lesser support.

Another challenge is the sustainability of the support. For instance, the cash support program for poor families is planned at the beginning for three months. The Government has decided in September to extend it for three more months.

Likewise, there is instability of among RMW as many of them want to migrate again as soon as they can. They are not very interested by the long-term support like trainings.

Lastly, the supports provided to RMW, has created jealousies from the other villagers.

### 4.2.5. Suggestions Made by SH/KI

SH/KI have made some suggestions in improving the assistance to the RMW in the future. They are presented here as a collected data, but they are not yet the recommendations of this study, even though some are taken into consideration for the development of the study recommendations.

- Maintain close and regular collaboration between government and NGO/CSO
- There should be more collaboration and less competition between the organizations who involved in the assistance to RMW
- There should be more participatory approach including the consultation of RMW about their needs
- Private companies should be more involved in supporting RMW in the long-term, especially to help them have a safe migration
- Private companies should reduce the transaction cost of the re-migration.
- RGC should have better cooperation with the Thai government in the future.
- RGC should help suspend loan reimbursement.
- There should be a long-term policy for aiding the RMW (and their families)
- Additional suggested actions: Favour human resource development with skills improvement, introduce farming skills, have temporary land concession for farming, give loans and reduce spending on migration and re-migration. One SH/KI says *"The government could make social concessions to them [RMW] so that they can use the land, and train them in agricultural skills. Give them a loan"*.

## 5. DISCUSSION (ANALYSIS OF FINDINGS)

This Rapid Assessment seeks to answer key questions about the impact of COVID-19 pandemic on the social and health situation of RMW. For this section, the study will highlight and discuss the most significant results from the quantitative and qualitative studies based on the two research objectives and the research questions.

**Objective 1:** Assess the impact of COVID-19 on returning migrants by focusing on key demographics, social and health characteristics including impact on their physical and mental health; vulnerability to gender-based violence; access to and utilization of health and SRH services, child protection and social services; youth and adolescent health services.

The COVID-19 pandemic has sparked fears and job losses among the Khmer migrant workers in Thailand, prompting some of them to return hastily to Cambodia. Back in their community of origin, they are likely to face financial, social, and personal challenges to meeting their basic needs in nutrition, health, and children's education, etc. Other negative effects of the counter-migration may arise, such as unemployment, indebtedness, domestic violence, mental distress, and discrimination, that contribute to making their re-integration extra difficult. However, some repatriated migrant workers are able to receive support from government institutions, CSOs, or the local community.

The survey sample is predominantly composed of rural residents (94.9%). Moreover, women are slightly over-represented in the survey (54.5%), in comparison with the national population (51.5% women[8]). Three out of four respondents are aged 25 to 45 years while most respondents are married (78.2%) and have one child or more (74.6%). Meanwhile, men and women have similar education profile while one out of two respondents has achieved at least primary education (55.8%), one out of three has achieved secondary education (31.7%), and one out of ten has no education/never attended school (12.3%). The rate of men having no education in this survey (10.3%) is similar to the rate of men having no education in the CDHS 2014 (10.4%) while the rate of women having no education in this survey (13.5%) is lower than the rate of women having no education in the CDHS 2014 (18.9%).

The survey does not check the economic status of the households but asks if they have the IDPoor card which is provided by the RGC to households that meet the criteria of poverty. The card allows access to free health care in the public health facilities and is used to target beneficiaries for assistance programs such as the government's cash support. The percentages of IDPoor cardholders in the survey samples per province are consistent with the percentages in the general population of the four target provinces[9]. There is no significant difference (at $p<0.05$) between the results in the survey samples per province and the provincial populations, except the rate of

[8] General Population Census of the Kingdom of Cambodia 2019. NIS/MOP, June 2019

[9] https://www.idpoor.gov.kh

IDPoor cardholders level 2 which is significantly lower in the survey sample than in the general population in Banteay Meanchey and Prey Veng. [Table 22]

Table 23: Percentage of IDPoor in the Survey Sample and General Population (By Provinces)

| | BMC | | BTB | | PV | | SR | |
|---|---|---|---|---|---|---|---|---|
| | General Population | Survey Sample | General Population | Survey Sample | General Population | Survey Sample | General Population | Survey Sample |
| Poor Level 1 (very poor) | 6.2% | 5.3% | 8.1% | 9.9% | 9.3% | 6.9% | 5.9% | 8.9% |
| Poor Level 2 (moderately poor) | 12.1% | 8.5% | 18.2% | 19.8% | 15.0% | 5.6% | 11.4% | 15.2% |
| Don't Know | | 4.2% | | 8.0% | | 2.8% | | 4.7% |

In the survey sample, the possession of IDPoor card is not consistent with the level of income. There is no significant difference between the proportions of cardholders who earn 100 US$ or less per month and those who earn over 100 US$ per month. This may be explained by the fact that the IDPoor eligibility is not based only on the income but more on the household assets.

There are concerns that migrant workers may be victims of human trafficking or exploitation in host countries (Thailand, specifically for this research), especially the illegal workers or among those who do not know about their labour rights.

In the survey sample, the main occupations of migrant workers in Thailand are construction workers (40.4%), factory/manufacturing workers (17.4%), farm workers (15.6%), sellers (8%), hotel/restaurant workers (6.7%), and fishermen (4.1%). These results are consistent with the findings of the ARCM/IOM study in 2019[10] which found the following: construction workers (30%), general labour workers (19%), industrial production workers (11%), manufacturing workers (7%), fishery worker (8%), and agriculture/animal husbandry workers (5%).

The median monthly earnings are around the minimum wage in Thailand, higher for men (10,000 Baht) than for women (9,000 Baht).

Only one in four respondents have remained more than a year in Thailand, one out of two with the spouse, and one in ten with spouse and children. Majority of the respondents (81.1%) say that they never experienced any abuse or exploitation in Thailand. The answers of RMW seem to suggest that their situation in Thailand is overall fair without any serious issue but they could also result from the fact that migrant workers are generally not open to talk about this sensitive issue.

The main motivations for repatriation, primarily subjective and personal, are the fear of COVID-19 (51.7%) or family reasons (47.0%). The loss of job (27.8%) comes far behind in third place. Three out of five RMW, men and women alike, plan to go back to Thailand when the borders will re-open. One in five migrant workers will bring their children with them. There are fewer candidates for re-migration in Prey Veng than in the three other provinces. An IOM survey in June

[10] Assessing potential changes in the migration patterns of Cambodian migrants and their impacts on Thailand and Cambodia. ARCM/IOM, 2019

2020 on N=242 returning migrants[11] has found that 71% of respondents expressed the desire to re-migrate, all of them back to Thailand.

Almost all RMW in the survey have re-integrated into their community of origin, with very few going to a new place. On their way back to home, they receive (at the border gates) some interventions related to COVID-19 from the Cambodian authorities. Most of them, men and women alike, are provided with health information about COVID-19 prevention (79.7%), face mask (67.1%), and had their temperature tested (78.7%). All RMW are requested to do a 14 days-quarantine at home or in a quarantine facility. These results indicate that the RGC has taken screening measures to prevent the spread of the disease. However, there are still people who are missed by the intervention.

### *Living conditions and Assistance*

Housing is not a problem as 99.1% of the respondents stay in their own house or are hosted free-of-charge by parents or relatives.

In the survey, 29.6% of the respondents report to currently have no income, 9.8% with less than 100 US$ per month, and 54.1% from 100 to 500 US$ per month. These data are consistent with the results of the IOM survey in June 2020 on N=242 returning migrants from Thailand which has found that 39% of respondents who reported to have no income at the moment, 12% with less than 100 US$, and 39% between 100 and 500 US$. Meanwhile, more than half of the respondents (58.0%) have currently no source of earnings in Cambodia with women being more affected than men, and divorced or widowed more negatively impacted than married or single. For those who have a source of earning, the median income is 150 US$ per month *(150 US$ for men, 117 US$ for women).*

To add to the challenge, about half of the RMW (55.7%) have debts, 30.5% with a bank or microfinance institution and 20.9% with relatives/friends, 9.8% with money lenders. Women are more affected than men. People take loans mainly for foods, health care, and investment in livelihood. The average amount of debts is 2,786 US$ *(2,505 US$ for men, 2,972 US$ for women)* and the median amount of debts is 1,500 US$ per month *(1,295 US$ for men, 1,500 US$ for women)*. In fact, the situation of RMW is not unique nor the worst, considering that the Cambodian population hold the world's highest average amount of microfinance institution loans, with a total of US$3,804 per capita[12].

People have to pay on the average 122 US$ per month for their loan *(men 106 US$, women 132 US$)*. Therefore, the financial autonomy of the RMW households is fragile. One out of four respondents say they have no money for daily subsistence, and less than half of respondents

[11] Cambodia Returning Migrants Survey, IOM Displacement Tracking Matrix, 2020

[12] https://www.hrw.org/news/2020/07/14/cambodia-micro-loan-borrowers-face-COVID-19-crisis

(46.6%) could say that they have money for at least three weeks (from the day of the interview). Women are more likely than men to have no money or a shorter span of financial autonomy for daily subsistence.

Consequently, the main current concerns expressed by RMW are insufficient incomes (81.8%), unemployment (69.4%), and COVID-19 infection (39.9%).

**Case story 1: Srey Poeuv***

Srey Poeuv is from Thmor Kol district, Battambang. She is 23 years old and the youngest of four siblings. Both of her parents are HIV positive. She recently came back from Thailand and now stays with her parents, one brother, and one nephew. She told us her story:

*"I left school in grade five at thirteen years old when my father fell seriously ill. My parents have HIV/AIDS. We borrowed money from a money lender to pay for his treatment. We had no job, no food! So at sixteen years, I decided to go to Thailand to find work. I had been working in Thailand for seven years. I worked as a waitress in restaurants in Bangkok.*

*Since I came back from Thailand because of COVID-19, I have no work. I just stay home and doing nothing. My older sister, who is still in Thailand, sends us some money but not regularly, and only about one hundred thousand or two hundred thousand Riel per month. Life is quite difficult for us now.*

*Every day, I am hoping that the border will re-open again so that I can go back to work! If only I could find a job here, I would prefer to stay and take care of my parents. And if I have money, I wish to run a small grocery shop at home. But I don't have any money."*

* The name has been changed to preserve anonymity

In response to the economic impact of the COVID-19 pandemic, the RGC has conducted a cash distribution campaign to support the poorest families in 25 provinces of Cambodia, including the four target provinces of the survey.

One out of five RMW has benefited from the programme. Getting the cash support is linked to having the IDPoor card, as 65.2% of cardholders receive the cash support versus 4.7% of those who do not have the card. However, the survey has shown that getting cash support is not associated with the level of household income or having no source of income. There is no significant difference between the proportions of cash support recipients who have a monthly income of 100 US$ or less (19.6%), and those who have a monthly income of over 100 US$ (20.2%). Surprisingly, the proportion of cash support recipients among those who have a source of earning is significantly higher than those who have no source of earning (25.6% versus 16.6%). These results suggest that the coverage of RMW by the cash support program is still low and that the targeting of the most-needy should be improved.

Besides the government's cash support program, some other assistance such as distribution of food/rice, livelihood support, psycho-social counselling and legal service, have been received but by very few beneficiaries (1.2% - 8.6%). Those assistance come mainly from government institutions and to a lesser extent, from NGOs and CSOs. The support from private recruitment agencies is not significant and mostly, for psycho-social counselling and administrative procedures. These results indicate that on the overall, the RMW have so far received little external support.

Meanwhile, only 54 out of all the 1,108 respondents say they have asked for support. They first seek help inside their village with the village chief (63.0%) and other villagers (20.4%), then with the commune council (22.2%). Very few (7.4%) request support from an NGO or a social organization. None of the respondents has addressed the district or provincial authorities for assistance. These results indicate that RMW seek assistance mainly with the local authorities and that the further the services are from the beneficiaries, the less they are used.

### *Imbalance of gender labour division in the household*

There are concerns that after they returned from Thailand, female RMW are more affected than their male peers and are in a disadvantaged position in the household, as well as inside the community. The survey checks if the women's housework load has changed in Cambodia as compared to Thailand, and if there is a significant imbalance in the share of housework between men and women. The results show that women are more engaged than men in the housework both in Thailand and Cambodia. And while the median time for most housework activities remains the same, the median time spent by women every day in child- care is higher in Cambodia (three hours) than in Thailand (two hours). The explanation for this could be that some women who have left their children behind, are now reunited with their children and have more time to take care of them.

### *Family health and nutrition*

Insufficient food is a relatively frequent problem that affects one out of five RMW and families (21.0%). The situation is worse in Siem Reap with one out of three respondents saying they are not able to eat enough every day (29.8%), while the problem is almost non-existent in Prey Veng (5.6%). More than half of those who do not have enough food have no other solutions than to reduce their food intake (64.3%). This means a risk of malnutrition for RMW' children.

In general, RMW estimate that their physical health remains the same since they are back in Cambodia. Only one in five respondents thinks that it has become a little worse. On the other hand, one in ten respondents thinks that their physical health has become better. However, one out of three RMW or family member has been sick, more frequently a woman. A little more than half of them (59.8%) go to the health centre or referral hospital, and 38.6% go to the private clinic. Also, 52.3% of them declare having constraints to get health care services with the main constraints being lack of money and the distance/lack of transport. There are proportionally more

people having financial constraints to get medical care among urban residents (84.6%), nearly twice as much as among rural residents (47.7%). The fear of COVID-19 is a minor constraint though.

People are more affected by their mental health as nearly half of them say that it gets worse since they are back in Cambodia (40.9%). Many of them have not sought any help (42.6%), others talk to family or friends (55.9%), and very few consult a social worker or a health staff (0.7%). This may indicate a lack of services around mental health or RMW are shy to discuss their mental health issues or fear.

Meanwhile, the prevalence of physical or intellectual disability is rather low among the RMW and their families at less than five percent. Similarly, chronic diseases, tuberculosis and HIV/AIDS are rare *(1.7% or less for tuberculosis, 1.0% or less for HIV/AIDS)*. This is because people who have pre-existing health conditions are less likely to go on migration and find work in Thailand. The survey results show that it is difficult for the patients who need treatment for their chronic disease (N=195), as only 30.9% of them are able to get medicines. The situation is not significantly different in the four provinces, and between men and women. The public health sector is the place of treatment for four out of five patients. The main constraints are the lack of money for 40.0% and the distance/lack of transport for 12.8% while the fear of COVID-19 is only 5.6%.

In summary, RMW and their families are more affected by their mental health (although moderately) than their physical health. In most cases, they can get support but with more difficulties for people with existing health conditions.

### *Maternal and child health*

Universal immunization of children against six vaccine-preventable diseases *(tuberculosis, diphtheria, whooping cough, tetanus, polio, and measles)* is crucial to reducing infant and child mortality. In the CDHS 2014, the rates of vaccination are 95.9% for BCG at birth, 81.9 % for the 3rd dose of tetravalent vaccine at 3 months, and 70.3% for measles at nine months. The survey asks if RMW use vaccination services for their children aged one year or less, but it does not specify the types of vaccine they received. Therefore, it informs about the utilization rate of immunization services but not on the coverage rate of specific vaccines. The utilization rate of immunization services is 84.4% among the survey respondents. This result shows that RMW are using the vaccination services for their children.

Meanwhile, the health care that a mother receives during pregnancy and at the time of delivery is important for the survival and well-being of both the mother and the child. Antenatal care (ANC) from a trained provider is vital in monitoring the pregnancy and reducing morbidity risk for the mother and child during pregnancy and delivery. CDHS 2014 showed that 95% of women received ANC from trained personnel (doctors, nurses, and midwives) at least once. In the survey sample, 94.4% of pregnant women declare getting ANC. Among those who get ANC, 97.0% go to the public health facilities and only 3.0% in the private clinic. Yet, one out of four pregnant women

declares having constraints in accessing the ANC services, with the main reasons being the lack of money and long distance/lack of transport. The fear of COVID-19 is a constraint but for only 2 women (2.8%).

All the pregnant women in the survey (100%) plan to deliver at the health centre/referral hospital or private clinic. Delivering the baby in a health facility with a skilled midwife is the safest option, whilst delivering at home with a traditional birth attendant is at high risk of maternal mortality. In the CDHS 2014, four in five births (83%) are delivered in a health facility.

In the survey, the awareness about postnatal care (PNC) is low with only one in ten pregnant women (12.7%) able to give the recommended number of four PNC visits for the mother and the newborn within the first six weeks after birth. The lack of care in this period may result in death or disability affecting women and newborns, as well as a missed opportunity to promote healthy behaviours such as access to family planning in the early postnatal period, which is important to avoid poorly spaced pregnancies[13].

The level of the current use of contraceptive methods is an indicator frequently used to assess the success of the family planning program. The survey shows relatively high rates for the current use of contraceptive methods. Among the survey respondents (excluding pregnant women), 48.6% are currently using a contraceptive method for family planning (38.5% in the CDHS 2014), and 46.5% are using a modern method (26.6% in the CDHS 2014). In the survey, 59.7% of married respondents are currently using a contraceptive method (56% in CDHS 2014), and 55.2% are using a modern method (39% in CDHS 2014). The daily pill is the most used method among married respondents (38.0% in the survey, 18% in CDHS 2014). The public health sector is the biggest provider of contraceptive methods (62.3%). Few users have constraints to get their contraceptive method (8.5%). For the women who are not using contraceptive methods, it is more because they do not need it than because they suffered from side effects of contraceptives.

These results on child vaccination, ANC, delivery and family planning suggest that overall, the maternal and child health situation of the RMW and families in the survey sample is fair, and the fear of COVID-19 transmission is not an obstacle for RMW to use MCH services at the health facilities. Nevertheless, female RMW need more information about PNC.

[13] "Ministry of Health, Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality 2016-2020, May 2016

### *Water and Sanitation*

The water sources likely to be of suitable quality for drinking are listed under “improved source”: piped water supply into the dwelling, piped water to a yard/plot, a public tap/standpipe, a tube well/borehole, a protected dug well, a protected spring, bottled water, and rainwater. In the survey, the proportion of households consuming drinking water from an improved source is high (77.7%). For comparison, in the CDHS 2014, the percentage of households getting drinking water from an improved source are 64.5% in the dry season and 83.3% in the rainy season.

The efficient methods for water treatment before drinking are water boiling, adding chlorine, using water filter, and solar disinfection. Although 52.6% of the respondents report boiling their water before drinking and 27.5% using a water filter, still 26.9% of the respondents report no treatment before drinking, and 3.8% are using non-appropriate treatment methods.

Among all respondents, 76.9% declare having an improved and not shared toilet facility. The rate is 78.4% in the urban areas, and 76.9% in the rural areas. These figures are higher than those of the CDHS 2014 where 46% of all households have an improved/not shared facility *(83.2% in urban areas, 39.7% in rural areas)*. However, in the survey, still 9.6% of households in the rural areas have no toilet facility.

These results show similarity between the water and sanitation situation of RMW households and the situation in the general population.

### *COVID-19 Prevention*

The level of awareness about COVID-19 in the survey sample is high with 96.3% of the respondents having received information about COVID-19 since they returned from Thailand.

With regards to the source of information, both male and female RMW have a clear preference for popular electronic social media like Facebook, YouTube, or the television. Traditional IEC (information/education/communication) supports like magazine, newspaper, posters, billboards leaflets, village chiefs, village volunteers, etc. get very low ratings. Yet, one out of five RMW have appreciated getting COVID-19 information from government officials at the border, and one out of three from relatives/friends/colleagues.

There is not always consistency between the knowledge of COVID-19 transmission preventive measures and their actual implementation. For instance, "wearing a face mask" is known by 92.0% of respondents but only 76.3% do it regularly and "washing hands with soap" is known by 89.6% and executed regularly by 84.8% of respondents. On the other hand, while only 38.8% of respondents know "avoiding crowded places" as a preventive measure, 76.0% declare doing it regularly.

The compliance to the home-based COVID-19 quarantine is not high (74.5%), and differ in the four survey provinces with Prey Veng having a higher rate than Battambang, Siem Reap, and Banteay Meanchey.

Only one in five respondents declares having been discriminated in their community, mainly by the people surrounding them: neighbours, friends, and relatives. The discriminations are: "Don't want to talk to us" in 89.2% of cases, "Don't look at us" in 38.9%, "Don't engage our services or buy our products" in 7.0%, "Don't want to provide us services" in 4.5% and "Don't allow their children to talk or play with our children" in 3.8%.

These results suggest that the COVID-19 quarantine has not been correctly completed by all RMW. The implementation of preventive measures against coronavirus transmission is not regular despite a rather high level of awareness. The discrimination against RMW is rather limited in scope.

### *Child protection and child education*

There were only seven respondents to the questions on child abuse. There is no reporting of any kind of violence suffered outside the household. Half of the respondents who are aged 15-17 years old are working to bring money home. However, the survey sample is too small to allow any significant analysis of the situation and draw a valid conclusion. According to the UN global study: *"A third of the global population is on COVID-19 lockdown, and school closures have impacted more than 1.5 billion children. Movement restrictions, loss of income, isolation, overcrowding and high levels of stress and anxiety are increasing the likelihood that children experience and observe physical, psychological and sexual abuse at home - particularly those children already living in violent or dysfunctional family situations".* [14]

There are concerns that RMW's children are disadvantaged for access to school as compared to other children in their community. According to the key informants (village chiefs), schools are open for enrolment of children who went to Thailand with their parents and came back, as long as they provide a birth certificate or a recommendation letter from the village chief. But for the moment, school activities are interrupted because of the COVID-19 pandemic. In general, there are constraints for RMW to put their children in school upon their return because either the children have never attended school or have been in the Thai education system. Children who do not migrate with their parents and remain in the village with the grandparents, are generally schooled like other children in the village. However, livelihood challenges and financial constraints are important limiting factors for RMW to keep their children up to the completion of secondary school.

[14] "https://violenceagainstchildren.un.org/news/violence-against-children-hidden-crisis-COVID-19-pandemic

**Case story 2: A mother wishing her children to study**

The respondent is 37 years old, from Mongkol Borei district in Banteay Meanchey, married with two children. Her seventeen years old son and fifteen years old daughter are studying in secondary school. Since she and her husband returned from Thailand because of the COVID-19 pandemic, the family lives with the grandparents, one of whom has a physical disability. She shared her story:

*"We migrated to Thailand six years ago because we had not much to eat, and we needed money for our children's studies. A friend gave us the name of a broker who took us to Thailand on foot through the forests and canals.*

*There, people we worked with asked us if we want to get the legal document to stay and work in Thailand. In fact, they cheated us and took 20,000 Baht, which we borrowed from the landlord. So, we worked just to pay back our debts. Later, we obtained the legal documents, but it added up 6,750 Baht more to our debts. With my monthly salary of 5,000 Baht and my husband's salary of 7,000 Baht, it took us several months to slowly recover our debts because we had to send money back for our children's education and food. We also came home often to visit my sick parents and my sick mother-in-law, who has now died. We spent a lot, each time we came back to Cambodia. It was hard to make any savings.*

*Now, since we are back in Cambodia, I stay at home and we live day-by-day on my husband's daily labour which is not regular. He carries rice bags, sprays chemical fertilizer in the rice fields, or works in construction. We have a lot of shortage for the children's education. We stay in my parent's house. It is small, and we are living with my parents, my second and fourth siblings' families (spouses and children), all in one room.*

*I want to go back to Thailand if I have money to do a new passport. I want to get a job with a higher salary in the meantime. I would like to sell fried potato to get some money for my children's education. I asked my children to look for a job to earn some money to build our own house, but they do not want to stop their studies until they finish high school. I do not think I can support them further as now they enter Grades 10 to 12 and they will need to study at the district town.*

*If I could ask for support, I wish my children have enough support until they finish high school."*

### *Vulnerable Group*

One priority of the Rapid Assessment is to look at the specific situation of the vulnerable group. One out of ten respondents in the survey presents a factor of vulnerability: pregnant woman, adolescent, person with disability, and person living with HIV.

When relevant, cross-tabulations are done to verify if the vulnerable group is disadvantaged compared to other. The statistical test shows that the vulnerable group is not more discriminated than the group without vulnerability and the vulnerable group does not have more constraints to access health care than the group without vulnerability.

**Objective 2:** Make concrete recommendations for possible program interventions and policy in the short-term and long-term for returning migrants at household level and host communities related to their social and health conditions, and related social services.

The government, as well as development partners and NGO/CSOs are taken aback by the emergency situation of the RMW. Therefore, it is assumed that the urgent mitigation measures from those institutions in response to the RMW's problems might suffer from a lack of cooperation, coordination, integration, relevance and effectiveness, and also are lacking strategy for supporting the RMW in the long term.

### *RMW's Needs and Supports*

The knowledge of health and social needs of RMW and families is not widespread among the stakeholders/key informants (SH/KI). Few representatives of government institutions or NGO/CSO have a comprehensive vision of the issues while others see only some aspects directly related to their specific field of action. Meanwhile, there is a recognition of the RMW's main issues by the RGC, development partners, and NGO/CSO, which are unemployment, lack of income, debts, lack of food, psychological support, and prevention of domestic violence & child abuse.

There seems to be some discrepancies between the viewpoint of SH/KI and the results of the quantitative survey about the prioritization of the needs of the RMW. COVID-19 prevention and the quarantine are among the most highlighted topic by the SH/KI while it comes only at the third place in the list of concerns of RMW in the quantitative survey. There are more concerns about the COVID-19 transmission and the correct implementation of quarantine among the SH/KI than among the RMW.

It is well recognized by all SH/KI that the government made significant efforts to receive the RMW at the border, providing support, screening for COVID-19, helping people to return to their province, trying to ensure the continuity of care (yellow card for follow-up).

The other significant action of the government is the cash support programme, although it is not specifically designed for the RMW but for the poor households in general.

The confidence expressed by SH/KI that any time RMW has a need they could refer to the services is not consistent with the answers of RMWs showing low rate of RMW having received supports. All the supportive structures are in place, and many services are available. But the support received by RMW and families remain limited. The question is why people are not looking for support. Like more than half of those who do not have enough food say that they do not do anything. What is needed is the effective connection between the persons who need support and the services. This could be improved with better information provided at the border and then in the village.

SH/KI at the local level confirm the results of quantitative survey that RMW are using MCH and sexual and reproductive health services and that RMW are not discriminated by the health staff. On the other hand, the good availability of various supports and services at the district and provincial levels as mentioned by SH/KI is not consistent with the answers of RMW in the quantitative survey which show that almost none of them have used those services.

Meanwhile the occurrence of COVID-19 pandemic has changed the way government institutions and partner organizations, NGO/CSO institutions operate in the field. NGO/CSO use more internet, social media platform (Facebook) to communicate with the public.

Some SH/KI report that is difficult to implement long-term supportive actions such as vocational training because many RMW want to migrate again as soon as possible.

### *Collaboration and Coordination of Assistance*

The collaboration with UN agencies and NGO has been critical to the success of interventions, such as the COVID-19 screening structures at the borders and quarantine facility.

There is a consensus among SH/KI at the central level that the collaboration between line ministries and partners, UN agencies, NGO/CSO is good, and similarly, the collaboration between NGOs and UN agencies (IOM, ILO, UN Women) is good.

At the sub-national level, the collaboration with provincial authorities, commune councils and provincial departments is generally good. On the other hand, there are SH/KI who complain that the coordination between government authorities and NGO/CSO at the sub-national level and in the field could be improved. This situation leads sometimes to the overlapping of interventions or resulting in gaps in case of lack of data sharing.

For some SH/KI, the collaboration has improved with the government institutions being more responsive to NGO requests, and there is more presence of NGOs in different committees and working groups.

To improve the efficiency of the support to RMW, SH/KI advise for more collaboration, less competition, and a more participatory approach. They also recommend the development of human resource at the local level and the development of a long-term policy at the national level.

# 6. CONCLUSIONS

The Rapid Assessment shows that the COVID-19 pandemic has significant social and health impacts on the RMW. One-fifth of the respondents to the survey declare that their physical health has deteriorated since their return, and two-fifths that their mental health has become worse.

Although a majority of RMW have access to medical care, still half of them declare having faced financial constraints, and health care is the second reason for taking loans (25.0%) after buying foods (32.6%). People with chronic conditions have faced challenges to get their treatment. Meanwhile the utilization of MCH and reproductive services is overall, satisfactory except for the postnatal care.

At least one-fourth of the RMW are in a critical situation in terms of daily subsistence because they have no work, no income, do not have enough food, and often, are pressured by debts. In general, women are more affected than men.

The survey data suggests that RMW have so far received little external support. The assistance provided by the government institutions, local authorities, development partners, and NGO/CSO has brought some emergency reliefs but is not sustained and sufficient in scope. The available resources are insufficient to support all the RMW who are in need. Moreover, these limited supports may not effectively reach the neediest or the most vulnerable among the RMW, as the study's data has shown that the use of IDPoor card for the selection of beneficiaries is not enough inclusive in the context of RMW emergency.

Despite the problem of unemployment and the lack of income, which create tension and stress in the RMW households, the SH/KI at the commune and village levels do not report any case of domestic violence or child abuse inside the RMW families, and the respondents aged from 17 to 24 years did not report any victim of violence outside the households *(however, because it is generally difficult to obtain this confidential information through a phone interview and because the number of respondents aged 17-24 years is small, it is not possible to make any valid conclusion).*

According to the SH/KI, the sense of solidarity among the villagers prevails the discrimination inside the community.

# 7. RECOMMENDATIONS

Based on the analysis of quantitative data and qualitative information of the Rapid Assessment, IRL would suggest some recommendations for future interventions and policies to assist the RMW in the short and long-terms.

## At National Level

1. The government should develop guidelines for supporting the RMW (*it could be an integral part to the general policy on migrants/migration)* and a specific budget should be allocated for future interventions. The policy making process should be widely participatory, involving local authorities, NGO/CSO/private sector and in consultation with migrant workers, considering their opinions, concerns, and aspirations. In this way, a 360-degree perspective and context can be obtained that could help produce plans and execution points that would mitigate the effect of the pandemic.
2. Interventions in the long-term should favour the re-integration of RMW in the workforce. This could include facilitating access to job market, vocational training, small business support and encouraging farming and facilitation of land access (with temporary concession, for instance).
3. For the RMW who prefer to go back to migration, this should be done in a safe and orderly manner. The future policy should strive to facilitate and lower the cost of administrative procedures (passport, recruitment companies, etc.), that creates an enabling environment for migrants to enjoy safe, orderly, and regular migration.
4. It would be helpful, if the government could negotiate with banks and microfinance institutions to delay debt payments during the pandemic with no or minimal interests.

## At Sub-national Level

5. The commune councils should provide the IDPoor card to all RMW households who meet the criteria of eligibility and submit their names to the RGC's cash support program.
6. Because the limitation of resources would not allow to provide the same support to all the RMW and families, there should be a prioritization process (if this is not being done already), based on clear criteria. This is to identify who are the most in need among the RMW and therefore get the assistance first, for instance female heads of household, persons with a vulnerability, or households with no income.
7. The RMW registration system should include a short questionnaire for the local authorities to systematically collect essential information about the living condition and basic needs of the RMW. This information should be regularly updated, for instance every month, because the living conditions may change. This data should be aggregated by the provincial working group for sharing with all the stakeholders as needed. The updated information could be used to complement the IDPoor card in aiding the RMW.

8. The RMW relief assistance from the government should preferably be managed and implemented by the local authorities (commune councils and village chiefs) because they are nearer to the RMW and it is them who are the preferred recourse of the RMW.
9. The commune councils should be given more resources and skills to monitor and help the RMW. The provincial and district authorities should provide the resources and supervision to the commune councils.
10. NGO/CSO should always collaborate with the commune councils and village authorities when they provide any assistance to the RMW. They should also inform and share their information with the Provincial Working Group for RMW on a regular basis.
11. The access to essential health services for RMW, and particularly for the people with vulnerabilities or chronic health conditions should be improved with a coordinated approach with initial aims of addressing bottlenecks of accessing the services *(such as financial barriers and/or lack of transportation)*.
12. With the stresses that families are facing amid the COVID-19 pandemic, government authorities should ensure that violence against women (VAW) and violence against children (VAC) referral mechanisms are in place and active, as when people are stressed, the risks for the abuses rise also.

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