



ABORTION IN CAMBODIA

Care seeking for abortion and family planning services:

Findings from a PEER study, conducted with women in Phnom Penh and Kandal provinces

Dr Joanne Hemmings and **Ben Rolfe**
Reduction in Maternal Mortality Project
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Contact: peer@options.co.uk

Options Consultancy Services Ltd: www.options.co.uk

RMMP: www.rmmp.org.kh

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របាយការណ៍សង្ខេប - REPORT SUMMARY

សារៈសំខាន់ៗ:

ការសិក្សានេះបានធ្វើឡើងក្នុងគោលបំណងស្វែងយល់ទស្សនៈតិរិយាបថ និងអាកប្បកិរិយាបច្ចុប្បន្នទាក់ទង នឹងការរំលូតកូននិងការធ្វើផែនការគ្រួសាររបស់ស្ត្រីនៅតំបន់ទីប្រជុំជនមួយក្នុងទីក្រុងភ្នំពេញនិងភូមិមួយក្នុងខេត្តកណ្តាលនៃប្រទេសកម្ពុជា។ លទ្ធផលរកឃើញពីការសិក្សានេះនិងប្រើប្រាស់សម្រាប់ការបង្កើតគម្រោងកាត់បន្ថយមរណភាពមាតា។ តាមរយៈវិធីសាស្ត្រPEER ស្ត្រីនៅមូលដ្ឋានបានបង្កើតសំណួរដោយខ្លួនឯងផ្ទាល់សម្រាប់សម្ភាសន៍មិត្តភក្តិរបស់ខ្លួននិងផ្តល់មតិកែលម្អលទ្ធផលនេះជូនទៅក្រុមស្រាវជ្រាវ។ ស្ត្រីទាំងនោះបានប្រមូលទិន្នន័យបែបគុណភាពយ៉ាងលឺអិតទាក់ទងនឹងតិរិយាបថចំពោះការរំលូតកូន និងការធ្វើផែនការគ្រួសារនៅក្នុងសង្គមរស់នៅដែលជាសេវាស្ត្រីធ្លាប់ទទួលបាន និងជាកត្តាជះឥទ្ធិពលលើវិធីសាស្ត្រនិងជម្រើសរបស់អ្នកផ្តល់សេវា។

ស្ថានភាពនៃកន្លែងសិក្សាស្រាវជ្រាវ:

ការសិក្សាក្នុងតំបន់ទីប្រជុំជនបានធ្វើឡើងនៅភាគខាងត្បូងនៃទីក្រុងភ្នំពេញ។ ដែលកន្លែងនេះជាកន្លែងស្នាក់នៅរបស់កម្មការនិកាតំបន់ និងអ្នកលក់ដូរតូចតាចជាច្រើននាក់ និងមានទីតាំងស្ថិតនៅជិតតំបន់ឧស្សាហកម្មមូឡានស្រាវ។ តំបន់នេះមានដង់ស៊ីតេប្រជាជនខ្ពស់បង្កហើយស្ថានភាពនៃភាពក្រីក្ររបស់ប្រជាជនក្នុងតំបន់នេះមានលក្ខណៈប្រហាក់ប្រហែលនឹងតំបន់ទីប្រជុំជនផ្សេងទៀតក្នុងទីក្រុងភ្នំពេញ។ ស្ត្រីដែលបានជ្រើសរើសសម្រាប់ការសិក្សានេះអាចចាត់ទុកជាតំណាងឱ្យប្រជាជន នៅក្នុងតំបន់នេះទាំងមូលបើពិនិត្យលើវិបល្លាស្តិក និងការងារដែលគ្មានស្ថេរភាពដោយគ្មានលក្ខខណ្ឌការងារល្អ។

តំបន់សិក្សាក្នុងខេត្តកណ្តាលគឺជាភូមិមួយមានចម្ងាយ៥០គីឡូម៉ែត្រពីទីក្រុងភ្នំពេញ។ ទោះបីភូមិនេះស្ថិតនៅជិតតំបន់គោលដៅប្រឹក្សាទីក្រុងក៏ដោយ ក៏ប្រជាជនក្នុងភូមិធ្វើស្រែចម្ការសម្រាប់ទ្រទ្រង់ជីវភាព ធ្វើស្រែនេសាទនៅតាមបឹងបូរ រកផលិតផលព្រៃឈើ និងការចិញ្ចឹមសត្វ។ អ្នកភូមិខ្លះក៏ធ្វើដំណើរទៅទីក្រុងរកការងារធ្វើផងដែរ។ ស្ត្រីវ័យក្មេងក្នុងភូមិមួយចំនួនបានទៅធ្វើជាកម្មការនិក្នុងរោងចក្រកាត់ដេរសម្លៀកបំពាក់ដែលមានចម្ងាយ ១០ គីឡូម៉ែត្រពីភូមិ។ ប្រជាជនភាគច្រើនប្រកបរបរលក់ដូរខ្នាតតូចផងដែរដូចជាលក់ចំណីអាហារក្នុងផ្សារ សុំឈ្នួលឬកាត់ដេរ។

លទ្ធផលរកឃើញសំខាន់ៗ:

- ស្ត្រីពន្យារការស្វែងរកសេវារំលូតកូនដែលជាញឹកញាប់បណ្តាលមកពីស្ត្រីទាំងនោះព្យាយាមរំលូតកូនដោយខ្លួនឯងដោយប្រើប្រាស់វិធីសាស្ត្រផ្សេងៗដូចជាការលោតហាក់ ការប្រើប្រាស់ឱសថបុណ្យធាតុគ្រាប់ទិញពីឱសថដ្ឋាន។
- នៅពេលដែលស្ត្រីស្វែងរកសេវាកម្មស្ត្រីមិននិយមប្រើសេវាកម្មរដ្ឋសំរាប់សេវារំលូតដោយសុវត្ថិភាពទេ ដោយស្ត្រីមានការភ័យខ្លាចចំពោះបុគ្គលិកដែលមិនទាក់ទងចំពោះពួកគាត់និងភិតភ័យការខ្វះខាតចំពោះការរក្សាការសំងាត់។
- ជារឿយៗស្ត្រីនិយមទៅប្រើប្រាស់សេវារំលូតកូនពីអ្នកផ្តល់សេវាឯកជន និងមិនមានជំនាញដែលស្ត្រីទាំងនោះយល់ឃើញថាជាការផ្តល់សេវា មានភាពពាក់ទាក់រក្សាការសម្ងាត់និងស្នាម។
- ឱសថសំរាប់ធ្វើការរំលូតអាចរកបានយ៉ាងទូលំទូលាយ និងនិយមប្រើប្រាស់ជាទូទៅ។ ប៉ុន្តែគ្មាននរណាម្នាក់ដឹងច្បាស់ថាតើស្ត្រីត្រូវបានផ្តល់ការផ្សព្វផ្សាយអំពីហ្វូត្រីស្តូននិង ប្រូស្តាកាមីស្តូនទឹកដោយសុវត្ថិភាពស្របតាមអនុសាសន៍របស់អង្គការសុខភាពពិភពលោកញឹកញាប់ប៉ុណ្ណោះ (និងក្នុងកម្រិតប៉ុន្មានដូស) ឡើយ។

- ស្ត្រីជ្រើសរើសការរំលូតដោយសារមូលហេតុមួយចំនួនដែលជាទូទៅបំផុត (មិនមែនតាមលំដាប់) : សុខភាពមិនល្អ ការមានផ្ទៃពោះមុនអាពាហ៍ពិពាហ៍ ការមានកូនញឹក ការទទួលខុសត្រូវក្នុងគ្រួសារ និងភាពក្រីក្រ ។
- ការទទួលខុសត្រូវជាច្រើនដែលជាបន្តការបស់ស្ត្រីដែលជាហេតុធ្វើអោយស្ត្រីត្រូវកំណត់នូវការមានគិត
- ស្ត្រីជាច្រើនមានការយល់ដឹងតិចតួចបំផុតអំពីមូលដ្ឋានជីវសាស្ត្រនិងរូបវិទ្យានៃការបន្តពូជ ។
- ទោះបីស្ត្រីភាគច្រើនមានការយល់ដឹងអំពីមធ្យោបាយពន្យារកំណើតទំនើបភាគច្រើនក៏ដោយ ក៏ស្ត្រីទាំងនោះជាញឹកញាប់មានការយល់ដឹងតិចតួចបំផុតអំពីការប្រើប្រាស់និងផលប៉ះពាល់ជាអវិជ្ជមាននៃមធ្យោបាយទាំងនេះ ។
- ពាក្យចោមអារាម និងការភ័យខ្លាចជាច្រើនអំពីផលប៉ះពាល់នៃមធ្យោបាយពន្យារកំណើតគឺជាឧបសគ្គដ៏ធំក្នុងការទទួលយក និងការប្រើប្រាស់ជាមធ្យោបាយពន្យារកំណើតឱ្យបានជាប្រចាំ ។

ធាតុចូលសំខាន់ៗ:

- គុណភាពមិនល្អនៃការផ្តល់សេវាពន្យារកំណើត មិនត្រឹមតែធ្វើឱ្យស្ត្រីស្នាក់ស្នើក្នុងការប្រើប្រាស់សេវាពន្យារកំណើតបែបទំនើបប៉ុណ្ណោះទេ ប៉ុន្តែថែមទាំងបង្កឱ្យមានផលវិបាកយ៉ាងច្រើនទៀតផង ។ ផលវិបាកពិមធ្យោបាយពន្យារកំណើតដែលអាចកើតមាន និងពាក្យចោមអារាមដែលមានលក្ខណៈអវិជ្ជមាន ធ្វើឱ្យស្ត្រីជាច្រើនជ្រើសរើស (ឬងាកទៅប្រើ) វិធីសាស្ត្របុរាណឬធ្វើការរំលូតកូន ។ ការងារជាបន្ទាន់មួយគឺត្រូវផ្តល់សេវាផែនការគ្រួសារដែលមានគុណភាពខ្ពស់រួមបញ្ចូលទាំង ការផ្តល់ប្រឹក្សាដែលមានប្រសិទ្ធភាព និងមានជម្រើសច្រើនយ៉ាង ។ ទាំងនេះនឹងជួយឱ្យ ស្ត្រីស្វែងរកមធ្យោបាយពន្យារកំណើតមួយដែលត្រឹមត្រូវសមស្រប និងប្រើប្រាស់មធ្យោបាយនោះជាប្រចាំ ។
- ការផ្តល់សេវាឱ្យបានប្រសើរជាងមុនត្រូវមានការគាំទ្រពីយុទ្ធសាស្ត្រទំនាក់ទំនងដែលផ្អែកលើភស្តុតាងជាក់ស្តែងនិងមានការរៀបចំបានល្អ ។ យុទ្ធសាស្ត្រទាំងនេះត្រូវបង្កើតឡើងដើម្បីផ្តល់ព័ត៌មាន និងគាំទ្រដល់ការប្រើប្រាស់មធ្យោបាយពន្យារកំណើតជាប្រចាំ និងដើម្បីទប់ស្កាត់ការផ្តល់ព័ត៌មានមិនត្រឹមត្រូវដែលជាមូលហេតុធ្វើឱ្យអត្រាបោះបង់ការប្រើប្រាស់មធ្យោបាយទាំងនេះមានកម្រិតខ្ពស់នាពេលបច្ចុប្បន្ន ។
- ចំពោះស្ត្រីមួយចំនួនដែលមានផ្ទៃពោះដោយមិនចង់បានមធ្យោបាយផ្សព្វផ្សាយព័ត៌មានត្រូវតែផ្តោតទៅលើការស្វែងរកការពិនិត្យការមានផ្ទៃពោះជាបន្ទាន់ និងការទៅទទួលយកការពិគ្រោះយោបល់ជាមួយអ្នកផ្តល់សេវាដែលមានសុវត្ថិភាព និងមានជំនាញ ច្បាស់លាស់ ។
- ដើម្បីទប់ស្កាត់ការស្លាប់បណ្តាលពីការរំលូតកូនដែលគ្មានសុវត្ថិភាព ចាំបាច់ត្រូវរៀបចំឱ្យមានសេវាដែលមានសុវត្ថិភាពផង និងឆ្លើយតបទៅនឹងតម្រូវការរបស់ស្ត្រីផង ។ បច្ចុប្បន្នផ្នែកសាធារណៈកំពុងតែធ្វើឱ្យស្ត្រីបាត់បង់ទំនុកចិត្ត ។ ក្រៅពីសុវត្ថិភាពខាងបច្ចេកទេសផ្នែកសាធារណៈ ចាំបាច់ត្រូវផ្តល់សេវាប្រឹក្សាប្រកបដោយការយកចិត្តទុកដាក់ និងរក្សាការសម្ងាត់ដើម្បីទាក់ទាញស្ត្រីឱ្យចេញពីការប្រើប្រាស់សេវាប្រាជ្ញុការ ។ ស្ត្រីវ័យក្មេងមិនទាន់រៀបការកំពុងប្រឈមនឹងគ្រោះថ្នាក់ជាខ្លាំង ។ ដូច្នេះទាំងសេវាផែនការគ្រួសារនិងសេវារំលូតកូនដោយសុវត្ថិភាពគួរតែរៀបចំឡើងបែបពិសេសដើម្បីបំពេញតម្រូវការរបស់ស្ត្រីវ័យក្មេងទាំងនោះ ។
- ឱសថស្ថានបំបែកការរំលូតកូនគឺជាបច្ចេកទេសបែបវេជ្ជសាស្ត្រដ៏សំខាន់សម្រាប់ទ្រទ្រង់ដល់សុខភាពបន្តពូជរបស់ស្ត្រី ។ ការណែនាំពីការប្រើប្រាស់ឱសថស្ថានបំបែកការរំលូតកូននេះគួរជាអាទិភាពការងារដោយរាប់បញ្ចូលទាំងការផលិតឯកសារត្រឹមត្រូវ និងយន្តការបញ្ជូនសមស្រប ។ ជាពិសេសឱសថការីជាញឹកញាប់ជាមនុស្សដំបូងដែលស្ត្រីត្រូវជួបមុនគេនៅពេលត្រូវការជំនួយ ។
- ការស្រាវជ្រាវបន្ថែមដើម្បីស្វែងយល់ពីការប្រើប្រាស់សេវារំលូតកូនបែបបុរាណនិងទំនើបនាពេលបច្ចុប្បន្ន (ការធ្វើ តែសឱសថសាស្ត្រការសិក្សាអំពីជំនឿរបស់អតិថិជន ។ល ។) ត្រូវធ្វើឡើងជាចាំបាច់ដើម្បីពង្រីកសេវា ។ ការស្រាវជ្រាវបន្ថែមដើម្បីស្វែងយល់ពីការសម្បូរបែប និងការប្រើវិធីធ្វើតែសពិនិត្យផ្ទៃពោះនិងភាពអាចទទួលយកបាននៃមធ្យោបាយពន្យារកំណើតបន្ទាន់ ក៏អាចជួយដល់ការខិតខំប្រឹងប្រែងក្នុងការកាត់បន្ថយការរំលូតកូនដែលគ្មានសុវត្ថិភាពផងដែរ ។

- តំលៃរបស់សេវាកម្មវេជ្ជសាស្ត្រដោយសុវត្ថិភាពគឺបានរាំងស្ទះនៅគ្រប់ផ្នែក ហើយដែលជាសញ្ញាមួយដ៏ធំដែលជំរុញអោយស្ត្រីទៅទទួលសេវាវេជ្ជសាស្ត្រសុវត្ថិភាព។ ភាគច្រើននៃមូលនិធិសមធម៌សុខាភិបាលគឺមិនគាំទ្រសេវាវេជ្ជសាស្ត្រដោយសុវត្ថិភាពដោយផ្អែកតាមគោលនយោបាយជាតិព្រមទាំងច្បាប់ US "MexicoCity" ។ ការបដិសេធសិទ្ធិទទួលបានសុខភាពបន្តពូជមូលដ្ឋានទាំងនេះជាសញ្ញាដែលកំពុងធ្វើអោយស្ត្រីកម្ពុជាជាច្រើនរូបប្រឈមនឹងគ្រោះថ្នាក់ខ្លាំងដល់បាត់បង់ជីវិតនិងពិការភាព។
- អស់រយៈពេលជាង ១០ ឆ្នាំបន្ទាប់ពីការប្រកាសឱ្យប្រើប្រាស់ច្បាប់ស្តីពីការវេជ្ជសាស្ត្រនៅឆ្នាំ ១៩៩៧ សេវាវេជ្ជសាស្ត្រដោយសុវត្ថិភាពនៅតែមិនទាន់ពង្រីកឱ្យដល់ស្ត្រីកម្ពុជាភាគច្រើននៅឡើយដែលមានស្ត្រីចំនួន៨៥% រស់នៅតំបន់ជនបទ។ ក្នុងករណីនេះការងារចាំបាច់គឺត្រូវពង្រីកវិស័យសុខាភិបាលឱ្យបានទូលំទូលាយជាអតិបរមារាប់បញ្ចូលទាំងអ្នកផ្តល់សេវាឯកជនផង ដើម្បីកាត់បន្ថយការវេជ្ជសាស្ត្រដែលគ្មានសុវត្ថិភាពទាំងតាមរយៈ ការធ្វើផែនការគ្រួសារ និងការផ្តល់សេវាដោយយកចិត្តទុកដាក់ជាពិសេសលើសមធម៌និងឱកាសទទួលសេវាតាមរយៈការផ្តល់ហិរញ្ញវត្ថុដើម្បីបំពេញតម្រូវការរបស់ស្ត្រី។

BACKGROUND

This study was conducted to learn about current perceptions, attitudes and behaviours relating to abortion and family planning among women in an inner city area of Phnom Penh and a village in Kandal Province, Cambodia. Findings will inform the development of a maternal mortality reduction project. Using the PEER method, local women developed their own research questions, interviewed their friends, and fed back findings to the research team. They collected detailed qualitative data on attitudes to abortion and family planning, the social context in which women experience these services, and factors influencing method and provider choice.

STUDY CONTEXT

The urban study was conducted in an inner city area in southern Phnom Penh. The area is inhabited by many garment factory workers and small scale traders, and located close to a light industrial area. The area has a relatively high population density and level of poverty typical of much of the periphery of central Phnom Penh. The women recruited for the study were broadly typical of the population in the area: of reproductive age, working in insecure employment, with poor labour conditions.

The Kandal study area was a village 50km from Phnom Penh. Despite its proximity to the city's outer urban sprawl, the village relied on subsistence farming: rice farming, fishing in the lake, gathering wild products and keeping livestock. People could also commute to the city for work, and there were clothing factories from 10km away where many young women from the village worked. Most people were also engaged in small-scale commercial activities: selling food in the market, labouring, or sewing.

MAIN FINDINGS

- **Women delay abortion care seeking**, often trying to self-induce an abortion using a variety of methods –jumping, traditional herbs, pills supplied by pharmacists.
- **When they seek care, women prefer not to use Government providers** for safe abortion care, where they often feel intimidated by unsympathetic staff and fear a lack of confidentiality.
- **Women report having to persuade public providers** in order to receive services.
- **The private sector and often unsafe informal providers are preferred**, perceived by women as “friendly, confidential and clean”.
- **Medical abortion is widely available and in common use**. However it is not clear how often, (and in what doses) woman are provided with the WHO recommended combination of mifepristone and a synthetic prostaglandin.
- **Women choose to have an abortion for numerous reasons**, most commonly (not in order): Ill health, pre-marital pregnancy, short birth interval, competing family responsibilities and poverty.
- **The many responsibilities placed on women limit their options** when considering whether to continue with a pregnancy.
- **Many women have a very limited understanding of the basic biology** and physiology of reproduction.
- **Whilst most women are aware of the majority of modern contraceptive methods**, their understanding of their uses and side effects is often very limited.
- **Widespread rumours and fears about the side effects of contraceptives** present a major barrier to uptake and consistent use.

MAIN IMPLICATIONS

- **The poor quality of contraceptive service delivery** not only limits access, but has wider implications. Unexpected side effects, and the resulting negative rumours influence many women to choose (or revert to) traditional methods, or abortion. There is an urgent need for better quality family planning provision, with effective counselling and a greater range of choice. This will enable women to find a method to suit them, and use it consistently.
- **Improved delivery must be supported by evidence based** and well designed communications strategies. These are required to inform and support consistent use, and to counter the widespread misinformation currently contributing to high rates of discontinuation.
- **For those women who unfortunately find themselves with an unwanted pregnancy**, communications need to stress seeking prompt pregnancy testing, and advice from a safe and qualified provider.

- **To prevent deaths from unsafe abortion**, services must be designed to be both safe, and responsive to the voiced needs of women. The government sector is currently failing women, who, in addition to technical safety, require kind and confidential services to encourage them away from the informal sector. Young, unmarried women are put at particularly high risk, both family planning and safe abortion services should be specifically tailored to their needs.
- **Medical abortion is an important technology for woman's reproductive health.** Its introduction should be prioritised, in tandem with the development of appropriate training and referral mechanisms, especially for pharmacists who are often the first point of contact for women seeking help.
- **Further research to understand the current use of traditional and modern abortifacients** (pharmacological tests, mystery client studies etc) to inform scale up of services is required.
- **Additional research to explore the availability and use of pregnancy testing**, and introduction of emergency contraception would also support efforts to reduce unsafe abortion.
- **The cost of safe abortion services are prohibitive in all sectors**, and a very significant proportion of women are unable to afford anything but an unsafe abortion. The majority of health equity fund implementers are unwilling to support access to safe abortion services in accordance with the national policy, due to the US "Mexico City" gag rule. This denial of basic reproductive health rights is putting many Cambodian women at significant increased risk of death or disability.
- **Over 10 years since the introduction of the 1997 abortion law**, safe abortion services continue to be out of reach to the majority of Cambodian women, 85% of whom live in rural areas. An urgent response is required, which should maximise the potential of the entire health sector, including private providers; to reduce unsafe abortion both through family planning and service delivery, with special attention to equity of access through demand side financing.

1. INTRODUCTION



1.1 THE CONTEXT OF REPRODUCTIVE HEALTH IN CAMBODIA

The Khmer Rouge-led genocide of 1975–1979 had a significant impact on Cambodia’s demographic and fertility profile (de Walque, 2004; NIS & ORC Marco, 2001). Following the end of the regime, a baby boom occurred and continued, with the result that 55 percent of the population is under the age of 20 (NIS & ORC Marco, 2001). This has significant implications for reproductive health and maternal mortality in Cambodia (NIS & ORC Marco, 2001). Family planning (FP) services and modern contraceptives were available for the first time in Cambodia in 1991. The first methods available were reversible

methods such as the pill and condoms. Long term methods such as sterilisation (tubal ligation or vasectomy) and IUDs are a relatively new introduction. These services were either supported or operated by international NGOs. Only in 1994, with support from the United Nations Population Fund (UNFPA), the Royal Government of Cambodia (RGC) took the first steps toward implementing its own FP program, which included the introduction of services at health centers, FP education, and training of public health sector staff.

In the same year, the *Maternal and Child Health Plan 1994-1996* was developed, introducing specific objectives for lengthening the interval between births.

To meet these objectives, the MOH approved its first Birth Spacing Policy for Cambodia (MOH, 1995a), which advocated the provision and use of a full range of contraceptive services: “the availability of reversible and affordable contraceptives will be increased so that all couples may have access to them” (MOH, 1995a). The first mass media campaign about family planning was not until 1996². In 1997, the MOH issued its National Policy and Strategies for Safe Motherhood. This policy provides guidelines to integrate all components of safe motherhood into all maternal and child health and FP activities (MOH 1997a). The implementation of all safe motherhood and family planning activities is overseen by the National Reproductive Health Program under the direction of Dr. Tung Rathavy. ■

1.2 CONTRACEPTIVE PREVALENCE AND UNMET NEED

The first recorded contraceptive prevalence in Cambodia was 7 percent in 1995 (MOH 1995b). The latest estimate of Cambodia’s Contraceptive Prevalence Rate (CPR) is available from the Demographic and Health Survey (DHS) 2005. The DHS puts the CPR at 27 percent for modern methods. There are, however, important dif-

ferentials between different sectors of the population. For example, 30.6% of currently married women in urban areas currently use a modern contraceptive compared with 26.5% of married women in rural areas, and women with secondary education or higher are 1.4 times as likely to use contraception than women with no education (31.9% versus 22.2 % of married women currently using a modern method respectively) (CDHS 2005).

Cambodia’s maternal mortality rate³ is 472 per 100,000 live births (CDHS 2005), a figure that has not improved since the 2000 DHS, and is one of the highest in the region. There is broad agreement that a significant number of maternal deaths could be averted by preventing unwanted pregnancies and eliminating unsafe abortion. At present, there is very limited capacity in Cambodia for the public sector to provide safe abortion care (IPAS 2007), despite Cambodia having one of Asia’s most progressive abortion laws, defined in the 1997 Abortion Act⁴. There is also high unmet need for family planning, with the 25% reported in the CDHS 2005⁵ likely to be an underestimate.

This research was undertaken as part of the DFID⁶ funded Reduction in Mater-

² Ministry of Health (undated) Reproductive health in Cambodia: A summary of research findings 1990-1998.

³ Maternal deaths are defined as any death that occurred during pregnancy, childbirth, or within two months after the birth or termination of a pregnancy. This time-specific definition includes all deaths that occurred during the specified period even if the death is due to non pregnancy-related causes.

⁴ The Act allows women to have an elective termination of pregnancy up to 12 weeks of gestation and, for pregnancies greater than 12 weeks, elective termination is permitted in the case of foetal abnormality, risk to the woman’s life, or rape.

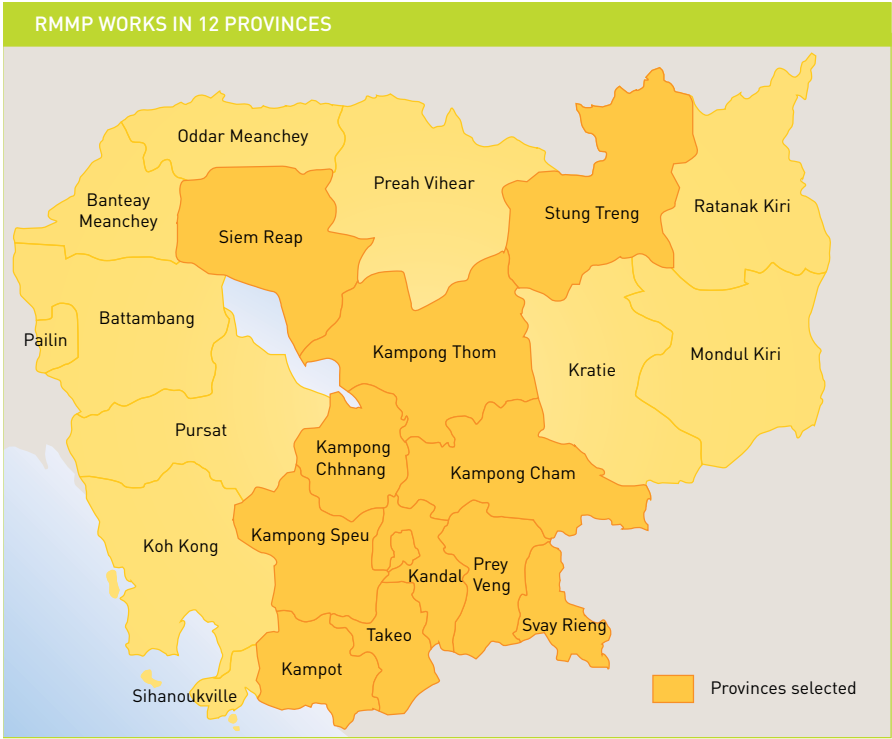
⁵ Women who are currently married and who say either they want no more children or want to wait at least two years before having another child, but are not using contraception, are considered to have an unmet need for family planning (CDHS 2005). The likely unmet need amongst unmarried women is consequently not counted in this figure.

⁶ The UK Department for International Development.

nal Mortality Project (RMMP)⁷, which is working to increase the utilisation of sustainable quality and affordable reproductive and maternal health services by poor women. The project works to improve the capacity of the Ministry of Health to provide, and to increase access to, safe abortion, and longer-term family planning interventions using Manual Vacuum Aspiration (MVA), Voluntary Surgical Contraception (VSC) and Intra Uterine Device (IUD) insertions; in order to reduce maternal mortality in Cambodia. RMMP will work in 12 provinces⁸ principally by:

- Training providers in MVA, VSC and IUD insertion.
- Making minor upgrades to public health facilities to support provision
- Decreasing use of unsafe abortion services through service provision, communications and advocacy activities, with a focus on the poor and excluded.

Activities target the poorest and most vulnerable women, as they are at highest risk of maternal morbidity and mortality and face the greatest barriers to accessing services. ■



⁷ For more information see www.rmmp.org.kh

⁸ Kampong Cham, Phnom Penh, Kandal, Prey Veng, Siem Reap, Takeo, Kampong Speu, Kampong Thom, Kampong Cham, Kampong Chhnang, and Svay Rieng.

1.3 RESEARCH OBJECTIVES

There has been limited research on reproductive health services in Cambodia from the point of view of potential services users (the demand side). This qualitative study explores the current context of abortion and family planning from the perspectives of women themselves, including:

- Perceptions and practices relating to family planning and abortion
- The broader social and economic context in which reproductive health decision making takes place, including gender dynamics and relationships
- Treatment seeking and decision making
- Barriers to access and social exclusion
- Understanding of legal entitlements to services
- Client/provider relationships.

The PEER method was chosen for its capacity to promote the participation and capture the voice of hard to reach populations around sensitive issues. Findings will support design of behaviour change communications and advocacy activities, and will also inform the supply side of the programme. Communications will be developed to inform people of the existence of, and their entitlements to services, and to create demand for these services over unsafe options. Through research dis-

semination, this study will contribute to the wider pool of knowledge on reproductive health issues in Cambodia and significantly progress understanding in a number of key areas. ■

1.4 RESEARCH METHOD: OVERVIEW OF PEER

PEER is a participatory qualitative research method involving ordinary members of the target group. Fifteen women aged 15-35 years from an inner-city area of Phnom Penh, and 15 women of the same age range from a village in Kandal Province were selected to carry out the research. Known as peer researchers, these women took part in a four day participatory training workshop where they developed interviewing skills and designed an interview schedule according to what they felt were the most important issues in their communities. RMMP worked with consultants from the PEER Unit⁹ at Options, together with a local NGO, CHEMS¹⁰, to supervise the workshops and collect data from peer researchers.

After training, peer researchers carried out in-depth interviews with two or three friends in their community on three different topics (resulting in six to nine interviews collected by each peer researcher). Supervisors from the research team met with peer researchers to collect their findings in a series of debriefing sessions, making detailed

⁹ For more information see www.peer-method.com

¹⁰ Cambodia Health Education Media Service www.chems.org.kh

notes of the narrative data that peer researchers had collected. At the end of the data collection period, peer researchers reassembled in their original groups and gave feedback on their experiences, and helped analyse the data. De-briefing notes and the outputs of these workshops form the final dataset, which has been translated into English and analysed by the social scientists from the PEER unit. Further details the PEER method, including selection of peer researchers, are provided in appendix 1.

The PEER method was chosen for the following reasons:

- It generates in-depth, contextual data on a wide range of issues.
- Rather than collecting superficial facts about behaviour and preferences, the method generates a detailed “insider perspective” on the whole context in which decisions are made.
- Existing relationships of trust between peer researchers and their informants mean that findings are more detailed and insightful than if they had been gathered by an outside researcher.
- PEER involves the participation of the target group from the early stages of the programme, building ownership and involvement
- The method is particularly suitable for carrying out research on sensi-

tive topics and is suitable for groups with low literacy

- PEER builds capacity of local implementing partners to carry out research in future
- By participating in PEER, peer researchers become “lay experts” in the research issues, and form a pool of expertise who can be involved in future stages of the programme (e.g. materials and message testing, monitoring service quality).

The PEER method has several advantages over other methods of formative research. Focus group discussions often produce normative statements (which refer to what people should do according to local norms) or reflect dominant voices within the group. Quantitative sample surveys are useful for many purposes but cannot explain the *how* or *why* of social issues. In addition, people are often unable or unwilling to talk about sensitive issues openly in front of focus group moderators or survey interviewers.

In Cambodia, the PEER studies received ethical approval from the National Institute for Public Health National Ethics Committee for Health Research (NECHR) in October 2007. In the UK, the PEER method received ethical approval from the University of Wales Swansea Ethics Committee in July 2007¹¹. ■

¹¹ For more information about the ethics of PEER visit www.peer-method.com/ethics

2. BACKGROUND



REPRODUCTIVE AND MATERNAL HEALTH IN CAMBODIA

This is a brief overview of the context in which the PEER study took place. For detailed background documentation on reproductive health in Cambodia, visit www.rmmp.org.kh.

The total fertility rate (TFR) in Cambodia has declined from 4.0 births per woman in the CDHS 2000 to 3.4 births per woman in CDHS 2005. There are large fertility differentials between urban and rural areas with urban areas having lower TFR: in Kandal the TFR is

3.1, compared with 2.5 in the capital city.

Contraceptive use remains low, though levels are increasing. The percentage of married women using any contraceptive method increased from 18.5% in 2000 to 40% in 2005 (CDHS 2005), however, the percentage using a modern method is substantially lower at 27%. The daily pill is the most commonly used modern method (11%), followed by injectibles (8%). The most common traditional method is withdrawal (8%).

One reason for the low contraception

prevalence rate is discontinuation of use. Recent research on the issue indicates the following:

What leads women discontinuing use of contraception?¹²

- Lack of easily accessible services and counselling leads to intolerance of side effects: drop-out rates reflect supply constraints
- Women saying they are “too busy” reflects limited availability of services (far from women’s homes or short opening hours)
- If contraceptives are discontinued, women rarely switch to another method, even though they mostly planned to use them again
- Two thirds of women did not know when they needed more pills or another injection.
- Lack of knowledge about long term/permanent methods
- Female sterilisation thought to be too expensive, and many misconceptions about its effects
- Side effects that interfere with work are unacceptable to women

The available research indicates that although interest exists in family planning, the needs of women are not met by current services. Many of these findings suggest that current services are not user-friendly; they offer limited reassurance and explanation around health concerns, are difficult to access, and offer limited choice.

Abortion was legalised in Cambodia in 1997 (see box below). However, there is currently a lack of awareness regarding the legality of abortion among the general population and providers, and a lack of provision of safe abortion services (IPAS 2007).

The CDHS 2005 reported that 8% of women of reproductive age had had at least one abortion during their lifetime. Among those who had an induced abortion, 44% had had more than one. There is likely to be considerable under-reporting of abortions as most occur outside the formal health sector and abortion statistics are not currently reported to the Health Information System (HIS)¹³. Additionally,

MAIN POINTS OF CAMBODIA'S 1997 ABORTION LAW

- Women may request abortion on demand for pregnancies up to 12 weeks
- Over 12 weeks they must meet certain criteria including serious health problems with the foetus, danger to mother’s life, or in cases of rape or incest (with woman’s consent and agreement of physicians)
- Abortions may only be performed by authorised secondary midwives, medical doctors or medical assistants, in facilities authorised by the MoH
- Medical personnel must counsel pregnant woman to the possible dangers of abortion, and the importance of “birth spacing” services

¹²RACHA 2000 and Ministry of Health Cambodia Family Planning Survey 2005.

¹³Routine data collection system from government facilities

women are often unwilling to report abortion, particularly if they are unmarried. Further key findings from a recent needs assessment of abortion services in Cambodia are summarised in the box below.

KEY FINDINGS FROM ABORTION SERVICES NEEDS ASSESSMENT (IPAS 2007)

- Only 47% of hospitals, 10% of high-level health centres and 5% of low-level health centres reported availability of abortion services
- Among the facilities that provide safe abortion services, nearly half (42% of hospitals, 44% of health centres) refuse services to adolescents
- 40% of providers from hospitals believe that elective abortion is not permitted by the Ministry of Health.

Gender roles and norms affect many aspects of women's and men's reproductive health: they shape decision making and communication processes, financial and social resources, and be-

haviour such as treatment seeking. A recent summary of gender issues (DFID 2005) described women's status in Cambodia as among the lowest in Asia. Although they contribute disproportionately to the economy, women are disadvantaged in numerous ways: educationally, socially, legally, economically and politically.

The health sector in Cambodia is pluralistic, with many types of provider and treatment: formal and informal, regulated and unregulated, public and private. The first port of call for information and purchasing medicines are pharmacies and drug sellers, especially for poor and young people, for whom private clinics or large hospitals may be inaccessible for a range of reasons.

A recent research summary has described reasons for the lack of trust in the public sector (MoH, undated). In addition to charging user fees which are set by the facility, public providers are also widely reported to charge informal fees, making the total cost of treatment unpredictable. Drugs and services are often not available, and service may be slow unless extra money is paid to get attention (Wilkinson 2003). ■

3. MAIN FINDINGS



The following chapters present key findings from the PEER study. Quotations from the peer researchers are included in italics to illustrate important points. They may have been edited for clarity.

3.1 WHO HAS ABORTIONS, AND WHY?

Understanding and characterising the changing dynamics of sexuality and reproductive health in Cambodia presents major challenges, particularly in terms of quantifying trends where cultural expectations and norms make underreporting of certain behaviours likely. This study attempts to understand the nature and drivers of various behaviours, but makes no attempt to quantify them.

The determinants of abortion are complex, and unplanned pregnancies

were a recurrent and consistent theme in the data, reflecting the low contraceptive prevalence rate and ineffective use of contraception (discussed further in section 4.5.1).

Women reported making decisions based on a range of factors, often strongly related to social and economic issues beyond their immediate control, such as poverty or social pressures. It is likely that socioeconomic changes in Cambodia are impacting significantly on youth sexuality and sexual behaviour, with implications for unplanned pregnancies and unmet need for contraception. ■

■ YOUNG UNMARRIED WOMEN

The PEER data describe clearly the different types of relationships that young women had with men: while some were said to avoid sex before marriage, others had a sweetheart (songsar), or became a mistress to a man, or had sex for money. Factory workers and beer promotion girls were frequently said to be involved in commercial sex work. The overall picture from the PEER data was that young women had a degree of sexual freedom. However, this came with many risks, including damage to the young woman's reputation, contracting an STI, becoming pregnant, and being exposed to risks of rape and violence.

Women had relationships with men for many reasons: they might be trying to find a husband (in which case getting pregnant could be a step towards

“Sex before marriage is good because the man will be responsible and will tell the parents about the relationship...”

securing marriage, though this was a risky strategy), they reported wanting fun, sexual pleasure and romantic love, or relationships that provided economic support. In reality, it was usually a mixture of these factors. Many young women have insecure, low paid employment in garment factories, bars or karaoke clubs (possibly all three), or are involved in small scale trading. Through relationships with men,

women received support ranging from presents (teddy bears, mobile phones) to financial help with the rent.

Sex before marriage is good because the man will be responsible and he will tell the parents about the relationship and when the parents know they have had sex, they will arrange the marriage for them.

Although pre-marital sex is widely socially disapproved of in Cambodia, the PEER data suggest that it is commonplace for unmarried women to be involved in sexual relationships. Women described the enjoyment of sex, and the fact that having sex helped to secure a relationship (women worried they would lose their partner if they did not sleep with him).

Some get a phone number from a friend and ask for love or start a relationship. For the man and woman who know each other from talking on the phone, if they get, along they agree to be songsar (sweethearts) and agree a date, and then after drinks they go to the guest house, because it's cheaper than hotel.

There were many stories in the data about women being coerced into sex through alcohol or drugs, or through persuasion, trickery or force. Risk of rape was a grave concern, and there were many stories about the dangers of coercive sex even in long term relationships.

There are thus both external pressures and internal motivations for women to have sex before marriage. External



factors were often related to poverty, which could lead to women relying on male support. They could also be related to changing social norms and trends, which offer women alternative aspirations for romantic relationships and material possessions. Rural to urban migration is another factor, as it leads to young people living away from the social structures and supervision that may have limited sexual activity in the past, while also increasing young people's need for financial resources.

Without effective contraception, pre-marital sex often leads to unwanted pregnancies with the male partner unwilling to accept any responsibility. "Abandoned" women in this context have limited options. Pre-marital pregnancy led to shame and loss of reputation for the woman and her family, and problems in securing her a good marriage. In this situation a woman's fam-

ily might abandon her or even become violent towards her.

Pre-marital sex was said to be "against tradition" and some said it "angers the ancestors". Women also wanted to save money and establish a stable relationship before they had children. Child-care and the expense of bringing up a child without a husband or family support, made the option of having the child seem unfeasible.

The urban group in particular reported a period of time during late teens where they sought to establish a financial foundation, and future marriage partner; both objectives often involving sexual relationships. However, to see this as purely transactional would be to underestimate an important social, and sometimes pleasure dimension to the interactions. ■



■ MARRIED WOMEN WHO
DO NOT FEEL ABLE TO HAVE A CHILD

According to the latest demographic and health survey, the more living children that women have, and the older women are, the more likely they are to have had at least one abortion (CDHS 2006). This partly reflects increasing exposure to unplanned pregnancy over age. However, reporting biases, particularly the fact that older women are more prepared to report abortions make these data unreliable (the interpretation of surveys is discussed further in section 5.3). There was strong evidence in the PEER data that married women might have abortions at any stage of their childbearing career, for a number of reasons.

The physical experience of pregnancy was seen to be very tiring, difficult and risky. Women recognised that significant short and long term resources

and investments were required for each child. Peer researchers described how in the following circumstances women might choose to abort rather than go through with a pregnancy:

Short birth interval since the last child:

This is thought to make the breast milk sour, and to make the existing child fall ill and lose weight. A short birth interval reflects badly on the mother, who is thought of as ignorant or poor:

When a woman is pregnant and also has a young child, then her young child also has morning sickness. She feels ashamed that other people might criticise her that the distance between the two children is short. In three years one woman had two children, and then her elder daughter got sick, and got thinner and thinner... The short birth space is a reason for having an abortion. It isn't because they don't want a child, it's because they think it will harm their youngest existing child.

When other people know about this [short birth interval], they mock the woman... ‘Why don’t you use birth spacing?’ ■

Mother has health problems:

In many stories, doctors were said to advise women to have abortions for “pregnancy outside the womb”¹⁴ or if the foetus was thought to be dead or deformed. Women might decide to abort if they feared the foetus had been damaged (e.g. if she had been beaten by her husband, or if had already taken an abortifacant which had not resulted in an abortion). Severe morning sickness, being too old, weak or exhausted, and heart complaints were also cited as reasons why women had abortions: their bodies were thought unable to cope with the demands of pregnancy.

In such cases, the decision to abort was difficult, with the whole family discussing whether the

woman should risk having a child. These reports must be understood in the context of the harsh realities of agricultural life and the many simultaneous responsibilities placed on women.

In some cases, the doctors recommend that the lady should have an abortion because her womb is too weak, if we don’t take the baby out it could injure the woman’s health. So the parents try to get money from relatives to pay for it. After she does the abortion, she is better, her health is in better condition.

There was a woman who wanted a baby because she knows her husband loves children. But when pregnant her husband says, as an insult, that she is old and yet is still having another baby. Then she decided to abort although it was 3 months old... She said she didn’t want another baby because whenever she has a baby she argues a lot with the husband, it wastes her time and money and it’s not good for her health because she is old. ■

Marital insecurity:

Stories about domestic abuse appeared frequently in the PEER data and the problem is obviously of tremendous concern to women in both urban and rural communities. There were many stories about troubled marriages in which women felt compelled to abort their pregnancy. These included husbands who beat or neglected

“Whenever she has a baby she argues a lot with the husband, it wastes her time and money and it’s not good for health because she is old...”

their wives, as well as husbands who had other wives or girlfriends, or who simply did not provide for the family. Some women worried that if they got pregnant their husbands would be more likely to have extramarital relationships, and others worried that having more children would lead to arguments at home.

Marital insecurity is closely linked to economic insecurity: divorced or widowed women struggled to make ends

¹⁴ Given the rarity of ectopic pregnancy, this is thought to result from a general lack of understanding about reproductive physiology. There were in fact many references to spurious sounding medical advice in the data, often resulting in recommended abortion.

meet. Women may not want to have a child if it risked contributing to family problems:

When the lady comes back from work, she feels very tired, and sleeps in bed. Her husband kicks her until she gives him money for drink. She is the breadwinner of the family so no one helps her to earn money and the husband is a drunkard, so she decided to do an abortion because there are a lot of problems in the family.

If the husband usually hits her, so she does the abortion secretly, without anyone knowing.

A woman was pregnant and her husband stayed out late. She waits for him, but he is just drunk and always hit and kicked her. She was very sick and decided to abort the child, as she was afraid she would be in danger in future. ■

Poverty and “living standards”:

There are numerous direct and indirect costs associated with having children. Poor women feared not being able to meet these costs. As well as school fees, food, and medical costs, there are opportunity costs in having children: not being able to work during pregnancy or the child’s infancy. Some households were in a situation where

It is difficult for families with many children to feed them, and they don’t have enough money to send them to school or higher education. They don’t have enough time to take care of them as the husband and wife are busy working outside, so they don’t know whether their children go to school, or whether they escape school...so they stop their children from studying and get their children to earn money to support their families.

Anxiety about costs did not only affect the poorest women, even better off women were concerned that an unwanted pregnancy would reduce the living standards of the household. Families aspired to a certain level of material comfort and food security, which could be threatened by the arrival of another child. Women were often the main or sole breadwinners in a household (men might be absent, ill, disabled or simply not as successful at earning money) and thus pregnancy at an inconvenient time could have serious implications for the household income. ■

■ WOMEN WHO HAVE COMPLETED THEIR FAMILY

There was widespread recognition of the benefits of limiting family size.

Having many children in the family was thought to lead to arguments, being too expensive and time consuming.

Women who had reached their desired completed family size might therefore abort future pregnancies. ■

“They [women] don’t like services that are expensive, so they abort on their own if their pregnancy is just early on by taking pills.”

they could ‘only earn enough for each day’ (i.e. could never put anything aside to save) which was a local expression to refer to the poorest families.

■ ADDITIONAL REASONS

Work demands were frequently reported as reasons for ending an unplanned pregnancy. There is high labour force participation of women in low paid, insecure, informal employment and agricultural production. Subsistence farmers may be unable to take time off work if other family members cannot help them. Garment factory workers may take three months maternity leave at highly reduced pay, but if no childcare is available, then women may not be able to continue working.

A factory worker had a baby with her songsar, she asked a friend to buy a Chinese herb to abort. The reason she doesn't want a baby is because she is afraid her parents will criticise her, and won't let her come to work in Phnom Penh again.

A garment worker works right up to delivery, then takes three months off, she will still get money from the factory, they give \$5.50 for powdered milk for the child for 3 months.

Peer researchers reported that women are meant to restrict their activities during pregnancy (avoiding rough roads, hard work etc.) to avoid harming the baby, and because they are thought to be weaker than usual. Miscarriages are often blamed on the carelessness or overwork of women. Yet the work women do in villages is hard: tending fields, herding animals, and carrying loads. In rural areas, the need to keep working is seen as incompatible with

pregnancy and caring for a baby if a woman does not have good health or support from others. A nutritious diet with certain dietary exclusions is also thought to be important during pregnancy, which may be difficult for poor women to achieve. Rather than risking a miscarriage or unhealthy baby, women might choose to abort.

"...she doesn't want a baby is because she is afraid her parents will criticise her, and won't let her come to work in Phnom Penh again."

There was a woman in the village who had two children with no problems. But she decided to abort the third child because her health was bad, and her husband couldn't work much as his health was also bad... She had to work a lot, finding food for the pigs she raised, and driving her moto a lot. She thought that if she kept her baby she wouldn't be able to earn enough to support the baby and her health wasn't good either.

Although some stories described couples making the decision to have an abortion together, women were prepared to have an abortion without telling their husband or family, as long as they had the money.

Women with their own money don't discuss it with their husband just discuss it with their friend, as if they discuss it with their husband he'll want to keep her baby. They rarely discuss it with their parents, as their parents think about karma. Sometimes they have secret abortions without anyone knowing, because they think they'll be criticised for not being able to support their baby.

Her family might also influence whether women aborted or not:

There is a woman in this village whose husband hit her a lot during her pregnancy. She discussed with her relatives whether to keep her baby or abort it. Her relatives and her parents suggested that if you face difficulties, you should abort it, because you have three children already.

When she was five months pregnant she had heart disease... Her husband took her to check with the doctor, who said that if she wanted to keep the baby it was up to her, but she had to take care of her health. She shouldn't work hard and should eat nutritious food. He recommended that if she kept that baby, it would be difficult for her to deliver it... She discussed this with her husband and relatives... They recommended that she should keep it, because they thought about karma: they thought that this baby had life, and if they killed it, it would be a sin. So she decided to keep it. ■

3.2 WHY DON'T WOMEN USE PUBLIC ABORTION SERVICES?

One of the objectives for the PEER studies was to examine “barriers to access” to public abortion services. This

“Her relatives and her parents suggested that if you face difficulties, you should abort it, because you have three children already.”

must be understood in light of our findings that there is little evidence that women want to access public sector abortion services. A clearer way of framing the question is therefore, why do women not use public abortion services, and

what might limit demand for these services in future?

The data indicated that there are many factors that influence women's choice of provider: gestation of pregnancy, financial resources, perceptions of services (confidentiality, cleanliness etc), and recommendations from friends.

Women buy pills from the clinic in the local market. They use pills when the pregnancy is two months; after this they have to abort in the hospital.

They don't like services that are expensive, so they abort on their own if their pregnancy is just early on (e.g. 2 months pregnant), by taking pills.

As pregnancy went on, methods were reported to get more expensive. Access depended on women either having their own funds, or social networks from which to borrow or be given money. For most health problems, women and their families try to mobilise a wide range of sources of support to secure the funds necessary for treatment. However, women seeking abortion are unwilling to visit neighbours and family to borrow or ask for money. The fees reported to be charged for abortions ranged from under \$10 for an abortifacient pill, to

\$20-\$40 for a surgical abortion in the first trimester, to over \$100 for an abortion at the “big hospital” in the second trimester. Poorer women, women who cannot tell their friends or family about the abortion, and women unable to ask



or borrow money are therefore barred from accessing many services.

One scenario that emerged from both rural and urban areas is that women try several methods in sequence, trying to find one that works:

A lady was pregnant and busy with work. She had no money to abort at hospital. She tried to drink some kind of herb, and to run at high speed, and tried to reach high-up objects, but the baby was still there. She did this again, and blood came out, but the baby was still there. Finally she tried to borrow money from people to abort the child. She said that if she kept the baby she couldn't earn money, and she didn't have enough money to raise that baby.

Sometimes women find it hard to decide which way they should abort. If they do it in the clinic they will spend a lot of money. They try to run fast, reach high objects or carry heavy things. After doing so the blood comes out and they feel pain. No matter how hard it is, or even if they might die, they will still try to abort. They chose that way to do the abortion because they don't have enough money to raise the children and they have no choice.

The data indicate that women commonly go through a series of steps attempting to induce an abortion before seeking outside help. This has serious implications as both attempting to self induce, and presenting late, increases risks to women's health. There is urgent need for communications ad-

dressing this issue, informing women of the benefits of promptly seeking a pregnancy test and attention at an appropriate facility if they have an unwanted pregnancy. ■

■ LACK OF DEMAND FOR CURRENT PUBLIC ABORTION SERVICES

Women were unlikely to attend a public health facility if they wanted external help to abort. Local public facilities

They have to say that they can't keep the baby. Because if they don't lie, the doctor won't abort the baby...

in rural areas are rarely appropriately staffed or equipped to conduct abortions [IPAS 2007], which may be why women in Kandal (the rural PEER site) did not even mention the possibility of going to the local facility for an abortion. However, the urban peer researchers did occasionally mention women who visited rural health centres to have abortions so that no one would know about their abortion. Most of the hospitals discussed in the PEER studies were large hospitals in Phnom Penh. The main factors that dissuaded women from going there to abort were:

Poor women felt they were not “for them”:

There was a common view that hospitals were for rich people, who could afford to pay the fees and extra money required to get attention from the doctor and be attended too quickly.

Complicated systems:

Women did not know where to go, or what to do, at big hospitals (e.g. where to register, pay, collect drugs). They said these hospitals required accompaniment by an experienced friend or neighbour, often incompatible with abortion.

Provider attitudes:

Women said that poor people and unmarried women would not be treated kindly at hospital, and might be shouted at and “blamed”. Another common problem was that some providers were unwilling to carry out abortions without

“good reason”:

When they go to abort in large public hospitals in Phnom Penh, they have to lie to the doctor because it's a government hospital. They have to say that they can't keep the baby. Because if they don't lie, the doctor won't abort the baby. Some lie that their husband harms them very much.

They don't like the big hospital or big clinic because they are poor and they get blamed and there is no special care for them.

A woman didn't want to go to a hospital because it's far away and the staff are impolite. They don't pay attention to the customer, and they say the customer is dirty and unhygienic.

Lack of privacy:

Large public hospitals are not designed with confidentiality in mind. One of the strongest issues emerging from the PEER data is that women do not want

to be recognised or seen when seeking an abortion.

Some people rely on legal clinics with modern equipment, but they are afraid people will know them. The mother is afraid it will affect the family reputation and no one will marry her daughter.

Lack of preferred method:

Taking abortifacient pills was a widespread method of attempting abortion, these ranged from traditional herbs to modern pills with various colloquial names. These were not available in hospitals.

Geographical distance:

Women from the more rural group reported prohibitive transport costs to reach hospitals in Phnom Penh. ■

■ **OTHER ABORTION METHODS AND PROVIDERS ARE PREFERRED**

In addition to low demand for public services, numerous competing services and products for abortion exist:

Abortifacients:

Numerous types of pill were available for women seeking medical abortion. Peer researchers were uncertain about their names: the following were mentioned but not consistently: 11-Tiger, the Chinese pill and the French pill. Drugs were usually bought from a pharmacist, but were also bought in the market and from drug sellers. Sometimes friends bought them for women wanting an abortion. Some stories described women taking high doses of

the contraceptive pill to attempt abortion. Women recognised risks associated with these pills, including haemorrhage, incomplete abortion, and weakness and fatigue. It is impossible to tell in how many cases women used the WHO recognised combination of mifepristone and misoprostol, or what regimens are followed.

With existing and proven technology available elsewhere, the current lack of a formally registered, regulated and supported medical abortion drug in Cambodia is a serious concern, putting Cambodian women at unnecessary risk. However, the data do indicate that were an appropriate product to be licensed in Cambodia, women would find it highly acceptable. The unwillingness to seek professional help and advice from higher level providers necessitates strong referral networks with pharmacies.

Medical personnel working informally:

Qualified medical personnel such as midwives, (or unqualified personnel with medical experience) may visit people at home or operate out of small private clinics to conduct surgical abortions.

Small private clinics:

Many different types of private clinic were described. They were often small, and might be located at the back of a pharmacy or in someone's house. They could be staffed by an unqualified person, medical student or paramedical. They are the provider of choice for the

urban group if self induced abortion failed. However they were not mentioned as frequently in the rural data, probably because there were no such clinics in the village (the nearest was 10km away). Known by reputation, they provide a quick, confidential, no-questions-asked service at a cheaper price than public hospitals. Women did not appear to distinguish providers at these clinics by qualifications or competencies: all paramedical staff are referred to as “Doctor”, even though they may not be qualified.

The pharmacist’s wife will have an illegal clinic at the back of the pharmacy.

At the private clinic they don’t ask anything. If a woman goes to abort her baby, then they just do it for her.

The small clinics do respect confidentiality, because there are only two people in the place, the doctor and the girl themselves. Mostly they are professionally trained, they work for big hospitals. People think if they go to hospital, they may spend \$30 for an abortion; at the doctor’s house, they only pay \$10 and the equipment is the same.

Most women like to go to private clinics. They rarely go to big hospitals because the doctor there doesn’t agree to abort them. But if they go to the private hospital and give money to the doctor, the doctor helps them to abort.

Traditional nurse/midwife:

Are said to conduct abdominal massage to induce abortion. Stories about traditional midwives typically described them negatively, suggesting there is

heightened risk awareness about this method of abortion:

Some women go to the traditional midwife to abort, but sometimes women die if she cannot get all the blood and foetus out.

They don’t like the traditional midwife because she aborts by pressing into the abdomen to break the neck in the womb, or penetrates the womb, and this can kill the mother. Sometimes she loses blood but the baby remains in the womb. Because of this the baby becomes spoiled in the womb and causes the mother to die as well.

Traditional herbs/alcohol:

These are bought from the market or from a local person. The PEER data contained numerous references to herbs which make women “hot”, often taken in wine. Heat in the body is thought to induce abortion. These methods form part of the attempts to self-induce abortion that women might try before seeking services at a clinic.

For ladies who are poor, when they want to do abortions, they just take traditional medicines. A lot of blood comes, for nearly the whole month, then the period comes and she also has that for seven days, and then that lady is very exhausted because a lot of blood has been lost.

Some people do abortions by taking hot and strong wine. Sometimes they put a herb (11-Tiger) with chilli and put into wine.

Abortion versus post-abortion Care:

The pattern of abortion seeking as described above means that women will frequently present at a clinic having

already attempted an abortion one or more times. They may thus require post abortion care rather than initiating an abortion for the first time. Post abortion care and abortion care are not distinguished in women's accounts.

■ SUMMARY OF FACTORS AFFECTING CHOICE

Several factors affect women's choice of abortion method and provider:

Financial resources are a key determinant. In stories reported by peer researchers, women raised the money needed for surgical abortion (which are more expensive than self induced or medical abortion methods) through selling land, pawning jewellery, promising their future labour, or spending capital from small businesses. However, some women were unable to borrow money without "security" (e.g. land against which to borrow) or did not want to get into debt.

Women borrow money with interest from others if they want an abortion without telling their husband. They pay it back later. The interest rate for \$25 is \$5 a month. If they can't pay the interest they have to help the owner harvest rice.

The price of abortion should not be seen as a simple barrier to access, but as a determinant of provider and method choice. Women do not necessarily consider going to an expensive hospital; rather, they consider which services are appropriate for them and their financial resources. Socioeconomic status is

also thought to affect quality of care provided in public facilities, as women perceived there to be a lack of respect towards poor women (as discussed in section 4.2.1).

The **quality of service** is also considered. The following quotations describe what women like in abortion services:

Women like to have abortion at safe places, where people know how to console you, and make sure that the place is quiet, and no one can see, and the doctor there must keep the secret. Some don't like to go to the clinic, it's not a suitable place, and people may not look after them if they don't have enough money for them.

A student went to a small clinic because she thought people there would not know her and would keep her secret. She trusts them, it's cheap and they don't need her to register, so people will not know her name. If she aborts in the hospital, she will be ashamed. The place is big, and has a lot of people, and it's not secret. She doesn't want other people to know she is pregnant, and she is afraid people there would know her. Some doctors are not friendly and they always take the money before providing the service, and if the women don't have money, they don't look after them.

They like services that their neighbour used to use, so they know that it won't cause any problems to their health.

They like going to the NGO clinic because the staff pay lots of attention and are polite to the customer. They provide advice about how not to have sex like that in the future and how to take care. And they don't pay much money. Some say that money does not matter if the staff are polite.

They like services that have good equipment, which are cheap, with good and modern equipment, and safe to their health. If they have abortions, and a problem happens, the doctor there takes responsibility.

KEY ASPECTS POSITIVELY INFLUENCING DEMAND

- Staff can be trusted (e.g. recommended by social network)
- Affordable
- Look clean with modern equipment
- Have a set-up that allows confidentiality
- Staff should be polite, skilful, cleanly dressed, and responsible
- Provide advice / consolation / reassurance
- Provide a quick service without asking questions

In summary, safety and other technical aspects of abortion care are not voiced as the primary concern: cost and confidentiality are seen as more critical. Women have little sense of expectation or entitlement to counselling, follow-up, or referral. Many spurious diagnoses by “doctors” are accepted as fact.

The aspects that women do not like about abortion services are often the converse of these. They do not like doctors who only care for them properly when they have money. They do not want doctors to shout at them or judge

them (e.g. for having sex too young). They do not want to wait for a long time to be seen, and do not want to be recognised at the facility.

In terms of women’s preferences around abortion, several aspects of abortion care were not mentioned in the PEER data: including physical pain, pain relief, or distinction between MVA (manual vacuum aspiration) and D&C methods. This is not to say that these might not be potentially important aspects of care. At present women may accept pain management (or lack of it) and type of surgical method used as resting purely in the hands of the provider and therefore it is not seen as worthy of complaint or mention.

The range of qualities both desired and undesired in relation to abortion services suggests that there is low awareness among women of how to evaluate the safety and quality of technical procedures. Rather vague criteria against which to judge risk and safety include recommendations from friends, the “skilfulness” of the doctor (which was not linked to qualifications or any other kind of official verification), and “modernity” of equipment. Women may want modern equipment, but their definition of modern may be very modest. More effective criteria for judging safety need to be made available to women if they are to be encouraged to make use of skilled providers. In Nepal for example safe abortion services are branded. Whilst branding for each clinical service may be confusing to



consumers, there is a need for effective quality assurance combined with communications to support decision making. A quality assurance branding of a minimum reproductive health package may be more appropriate. ■

■ LEGALITY AND RIGHTS TO ABORTION

The abortion law was not mentioned directly in the PEER data, though some women were aware of the illegality of certain clinics and abortifacient drugs. This did not deter women from using these services: abortion law was unimportant in influencing whether and how women chose to have an abortion. Likewise, the concept of entitlement to abortion was absent from the data.

There was no expectation that the poor should be entitled to access to abortion services. If they could not pay, they simply did not expect to receive attention. This was also a realistic expectation of what women expected from providers of other health services. Women expressed frustration with this situation, and appreciated that they should not have to pay additional fees in order to be seen by providers, but they were also fatalistic about the likelihood of the poor receiving a good service.

In summary, lack of knowledge about the legality of abortion does not stop women seeking an abortion. However, lack of knowledge about entitlement to abortion is a barrier to women de-

manding and accessing abortion from qualified providers. Yet simply knowing that they are entitled to abortion services will not be sufficient for women to claim their entitlement unless mechanisms are in place to ensure that providers fulfil their duties to provide services. ■

3.3 WHAT DO WOMEN THINK ABOUT ABORTION?

■ STIGMA

The PEER data were full of pragmatic, everyday accounts of why women had

“ They go in the day or in the morning... If they have an abortion in the morning, they can go to work again at night.”

abortions. Many women discuss abortion as a routine event, indicating a relatively high frequency, and low risk perception.

They go in the day or the morning. If they go at night, the blood may come out more. If they have an abortion in the morning, they can go to work again at night.

Peer researchers sympathetically described difficult situations that women found themselves in, and abortion was seen as a valid response to these circumstances. This widespread understanding indicates that abortion is not highly stigmatised amongst women. There was very little evidence for mor-

al outrage or stigma around abortion from the perspective of peer researchers or their informants. However, women still clearly want to “keep it quiet” if they do have an abortion. There is a lot of gossip about abortion which no one wants to be the focus of. There were a few examples of older members in families saying that it was ‘bad karma’ to abort. However, this did not deter women from having abortions if they felt this was their only choice.

Some still think about karma. Old ladies say that if the woman kills her baby, she will pay in the next life.

Rather than being attached to abortion in itself, stigma was described in relation to other parts of abortion stories: providers chastising women, families becoming

angered and women feeling ashamed. For unmarried women, pre-marital sex was shameful consequently so was any subsequent abortion. For poor women, the fact that they could not afford to bring up another child, rather than the fact that they ended the pregnancy, made them want to keep it a secret as they were ashamed to be so poor. In cases of ill health, or when women were threatened by their husbands, or when women already had several children, abortion had very limited stigma attached to it indeed. They could discuss their decision openly with their family, and could go to a clinic without shame or fear of being scolded by staff. ■

■ RISK PERCEPTION

Women recognised risks associated with traditional abortion methods and to a lesser extent with “modern” abortions, although their risk perceptions differ from biomedical models of risk. They recognised that unsafe or incomplete abortion risked wasting time and money, because you might end up in hospital.

Commonly cited perceptions of the consequences of abortion were

- Womb cancer or thinning womb from repeated abortion
 - Bleeding and complications
 - Weakness, fainting, becoming pale, getting thinner and thinner
 - Fertility problems in future
-

Some people’s wombs are affected by abortion and it can get thinner and thinner, and eventually get cancer. When faced with this they need to see the doctor otherwise they will die. They should go to hospital, but don’t want to go because they can’t afford it. They just drink herbs, if it’s not effective or they don’t recover, they just let it be, or die.

Interestingly, many of these perceived risks are similar to those associated with various methods of contraception (discussed further in section 4.4): both contraceptives and abortion are seen to have negative health consequences.

Particularly in the rural area, there was low risk perception of the specific physical dangers associated with unsafe abortion. Rather than recognising risks

such as morbidity, infertility and death, the main concern seemed to be general weakness following abortion. In addition, risks were thought to increase with repeated abortions, rather than being present in any one procedure. ■

3.4 WOMEN’S PERCEPTIONS AND EXPERIENCES OF FAMILY PLANNING

The PEER findings include insights into both the benefits of having children, and reasons why women want to space and limit births. Having children was seen to make the family happy, keep the husband “faithful and steady”, and motivate children’s parents to work hard. Children could be difficult to care for while they were young, but were a source of support in sickness and old age.

There was widespread recognition of the benefits of limiting family size for social and economic reasons. Peer researchers collected a large amount of data about family planning behaviours and were familiar with a range of methods and their perceived advantages and disadvantages. Various reasons were cited as to why women at different stages of their lives used contraception:

- To ensure a healthy birth interval
- Family complete: no desire for more children
- Delaying the first birth to earn some money before or after marriage
- To avoid pregnancy before marriage

- In the case of condoms: to avoid STIs

The “injection”

was the most popular method. Women liked it because it only needed to be administered once every three months and was thus easy to remember. It was also said to be better for older women (over 30 years old) because it caused

with more negative side effects. When women talked about taking pills, they might not necessarily mean the daily contraceptive pill: other pills are on the market, under names such as Tiger 11 and the Chinese pill, both of which were also named as abortifacient drugs. A variety of pharmaceuticals were sold without women knowing exactly what they were taking.

“When they use pill they become fatter and fatter, and they are afraid that fat will cover their heart and they will die.”

In some instances, women used the pill on an ad hoc basis: for instance, taking it for a few days immediately before

menstruation to become irregular or to stop, which was not desirable for younger women.

expected sexual activity, or taking large doses to try to induce an abortion. It was thought to be better for younger women as it made their periods regular. Becoming fatter was another common side effect: sometimes this was seen in a positive light, indicating good health, whereas in other cases the fat was thought to accumulate around their heart, which was not good for health.

They prefer the injection as it lasts for three months. If they use the pill every day, sometimes they forget about it because they are very busy with work.

Some women when they use the pill, it doesn't work, and they can make her fatigued, thin, and pale, so they decide to use the injection instead. Some women when they use the pill, it can make them fatter and fatter, and her health becomes good.

Her sister uses the injection. Before, she had a womb problem – but after the injection her womb became better.

It is good for their health and effective. After injection, they become fat. Before they were thin.

When they use the pill they become fatter and fatter, and they are afraid that fat will cover their heart and they will die.

Although this was the most popular method, there were still problems reported with its use, including irregular bleeding, and women not feeling themselves.

Contraceptive pills

were mentioned almost as regularly as the injection but were associated

A woman had four children didn't want any more, so she took the pill. Her husband worked far away. She bought a sheet of pills. After taking the sheet

of pills she stopped using it. One day her husband visited her home. Seeing her husband coming she bought more pills and took only two pills. As she was afraid of getting pregnant she took more pills and continued using it every day, but one day her period didn't come... she checked her urine and found out she was pregnant.

Traditional methods

The main methods mentioned were drinking alcohol (home made wine), often with herbs, and the withdrawal method.

They used traditional medicine in the past such as papaya milk with alcohol, but now they have stopped using that medicine because now you can find the pill.

People drink alcohol: they use a kind of fruit (popai) mixed with alcohol. They have to drink a glass of this alcohol three times per day. When they drink it their body feels warm and then they can't be pregnant.

Many of the stories of traditional herbs and wine relate to how things were done in the past. Traditional medicines for contraception appear to play a relatively small role in overall family planning practices and it seems unlikely that the traditional medical sphere would interfere significantly with efforts to promote modern contraceptive methods.

The withdrawal method seems to still have greater relevance: the DHS found

it to be the third most commonly practiced method of avoiding pregnancy (after the contraceptive pill and injection). "Water out of the pot" was a term used covering both the withdrawal method, and douching the vagina after sex to remove semen. These appeared to be very popular methods amongst sexually active young women in the urban area, though "water out of the pot" was often recognised as unreliable.

After having sex, the lady sits there to try to get the bodily fluids out of the vagina and clean it with water, which avoids getting pregnant. The probability of having a baby is just small.

The older generations especially like to take water out of the pot. Now people like to use this method, because when they take the pill or injections, they

"...They have to drink a glass of this alcohol 3 times per day. When they drink it their body feels warm and then they can't be pregnant."

get a lot of flesh around the heart, and if they want to have a baby next time, it's difficult to have, because of all the flesh.

IUD

The IUD was a well known method with numerous negative associations. Rural women saw it as being for rich women, and often did not actually know anyone who had used an IUD. Rumours associated with the IUD included it being uncomfortable for the man having sex, the woman not being able to have sex or work hard, heightened risk of ectopic pregnancy, damage

to the womb, and risk of the IUD becoming embedded in the body:

A woman saw another woman using an IUD who got tired and thinner and also had a pregnancy outside the womb. So she did dare not use it.

With the IUD they can't work easily, and fear that if they use it for a long time it will hurt the womb, only a few people use this.

When they use IUD, people get fatter and fatter so it's difficult to take it out, their flesh covers the IUD.

“People don't like it because it makes the womb smaller, and they may not be able to have children in the future.”

In this village, there are only 2 or 3 people who use IUDs, they use this method because they have relatives working in an organisation (RACH)¹⁵ which provides birth spacing.

The Doctor gave her the option of an IUD in the womb, but she has heard rumours from her neighbours about them, like if you have an IUD in your then you can't get it out again, and it can cause womb cancer. She discussed this with her husband. He understood her feelings and took her to the hospital again. The doctor gave her another choice of having an implant in her arm. She discussed it with her husband, who agreed.

Implants

were only mentioned a few times. On one occasion described as “an IUD but

in the arm”, it was seen to be for rich people.

Compared to other methods of family planning, “tying the womb” (tubal ligation) was not mentioned very frequently. Perceptions were varied. Some said it brought good health, whereas others said that it was linked to cancer. It was widely seen as a method for rich women.

People don't like it because it makes the womb smaller, and they may not be able to have children in the future.

The person who ties their womb has good health: they rarely get sick.

They are afraid that they will become fat and that the fat will cover their heart... most women don't like tying womb, it's a method only used by rich women. They're afraid that they won't be able to work heavily.

Only a very few rich people do tying the womb, because they are afraid of womb cancer. Some women in this village used to tie their womb, some became thinner and thinner, some become fatter and fatter, so they are afraid of it. Some get sick when tying the womb.

The operation is for life. You have to go to the big hospital. It's only for the rich people, it costs \$200-300. For those who pay it's no problem.

Condoms

were mentioned as being used by un-

¹⁵ Reproductive Health Association of Cambodia



married women, and women advocated using them when sex with a husband was risky (e.g. if he had another partner: the risks of HIV and other STIs were widely acknowledged though not necessarily understood in great detail). In contrast to previous studies¹⁶, condom use was not highly stigmatised, and was not strongly linked to commercial sex work. However, many said that condoms were uncomfortable and caused womb thinning.

After her baby miscarried she didn't have sex with her husband as she believed that having sex after miscarriage could cause health problems. During these three months, her husband had sex with another girl outside. After three months, she had sex with her husband, but used condoms, because she was afraid that if she had another pregnancy it would abort again, and her husband could transmit a disease to her.

The method they don't like to use is condoms because using condoms can damage their womb, and

they think that there is virus in the condom.

Vasectomy was only mentioned once in the whole PEER dataset: “the doctor recommended that she tie her womb, or for her husband to have a vasectomy”. A very few peer researchers had heard of vasectomy but did not know what it was.

Emergency contraception was not mentioned in the PEER data. Probing at the peer researcher workshop confirmed that women had no knowledge of this method. ■

3.5 WHAT PREVENTS WOMEN FROM USING FAMILY PLANNING?

■ CAMBODIA AT AN EARLY STAGE OF ADOPTION OF CONTRACEPTIVE USE

Perceptions of family planning and behaviour around contraceptives suggest that Cambodia is still at an “early adoption” stage, characterised by:

¹⁶ Sex Talk –Peer Ethnographic Research with Male Students and Waitresses in Phnom Penh. By David John Wilkinson Gillian Fletcher. PSI 2002.

- **Low levels of knowledge** and education about contraception, especially for young and unmarried women.
- **Inaccessible or poor quality services**, and for long term or permanent methods (IUD and surgical methods). Inconvenient services from public health centres and higher up-front costs for longer term methods meant that buying pills or injections from pharmacies was common. Services were particularly inaccessible for unmarried women.
- Numerous and often inconsistent **stories and rumours** about side effects.
- **Incorrect use of contraceptives** due to lack of knowledge and skills: e.g. cannot remember to take the pill every day.
- **Sub-optimal provision of contraceptives from pharmacies** e.g. not providing full explanations and follow-up, supplying contraceptive pills in packets of ten, poor regulation of pharmaceuticals.
- **Lack of choice:** Difficulties for women in finding a method that “agreed” with their body.

■ DENIAL OF SEXUAL ACTIVITY IN UNMARRIED WOMEN

Unmarried women are not well catered for in family planning services and are able to access very little education about contraception or reproductive health in general.

People don't like single women to know about contraception.

Some don't want to go to the hospital [to get family planning] because they feel shy. If they aren't married, they are afraid that other people will say that they aren't married yet, yet they go to hospital, maybe they are having sex.

The urban data in particular suggest that although many unmarried women do have sex before marriage, they are not prepared for sex when it happens in terms of contraceptive protection. This may be partly because preparing contraception in advance is to admit to yourself and others that you might have sex. This makes the pill and other longer term methods less suitable for these women. and there is a need for targeted services and communications to cater for this group. ■

■ SIDE EFFECTS EXPERIENCED AND FEARED

Side effects have already been discussed in relation to specific contraceptive methods, but it is worth examining the overall impact of the large volume of misconceptions and negative experiences of contraception circulating in the community. Most Cambodian

“People don't like single women to know about contraception.”

These factors combine to contribute to high levels of doubt and suspicion about contraception, a high discontinuation rate, and lowered levels of contraceptive protection if women are not using contraceptives effectively or consistently. ■

women rely on their physical health to work and support themselves and their families. The perceived risk of ill health or weakness might be felt more acutely than the risk of unwanted pregnancy. The way in which women perceive and balance risk, and use this to inform decision making must be addressed. Communications must support women making informed choices around the perceived costs and benefits of using contraception.

COMMON SIDE EFFECTS OF CONTRACEPTIVE METHODS FROM PEER DATA

- Getting hot inside
- Getting fatter and fatter (fear of fat accumulating around heart)
- Getting thinner and thinner
- Irregular bleeding
- Womb thinning and cancer
- Infertility/future difficulties in becoming pregnant

Some women use birth spacing for a long time and later want children, but they can't have them. There was a woman in this village, first she used birth spacing, she earned a lot of money and had a nice house, but then she stopped using birth spacing and now she can't have children.

She didn't use family planning. She used to use birth spacing methods, but it didn't work¹⁷. When she used the pill or injection, she didn't feel well,

she felt tired, became thinner and thinner, and her period flowed heavily. She had no strength to work, and she fainted.

Perceived side effects should not universally be dismissed as purely psychosomatic or neurotic. Family planning services should provide a choice of methods in order to suit couples' needs, as women react to contraceptives in different ways. Some women experience side effects and need to try different brands, methods or dosages. In addition, a poorly regulated pharmaceutical industry, combined with poor usage and dosage delivered through private, unregulated channels might predispose women to side effects. Managing side effects more effectively, by providing greater support, advice, reassurance, and choice of methods, would help tackle the root cause of the rumours. Of course, many feared side effects are clearly misconceptions and should be addressed as such, but these issues should not be rejected as "imaginary", as they are very real to the women concerned.

In summary, there is demand from both women and men to control their fertility, but there are also many obstacles to women achieving effective contraceptive protection: low levels of knowledge; unstructured, unregulated private sector provision; inadequate provision within the public sector; and fear of side effects stemming from mis-

¹⁷ Here, contraception 'not working' does not mean that she became pregnant while using these methods, but that she has tried using them, but felt they were not suitable for her.



conceptions, rumours, and experiences of others. ■

3.6 OTHER REPRODUCTIVE HEALTH ISSUES FOR WOMEN

During the PEER study, women discussed other health problems that affected women like them. These included very common experiences of STIs, vaginal discharge and irregular menstrual periods.

There was an unmarried woman who became thinner and thinner. She didn't dare tell her parents she had discharge. One day her mother asked her "what happened to your health?" She told her mother that she had white fluid flowing out. Her mother didn't have money so she borrowed money from others and took her to the NGO clinic. Now her health became better, but she is still not well yet... The discharge is still flowing... and she became thinner and thinner as her period flowed irregularly.

Her neighbour asked her to send her again, but she said that she didn't have any money.

Unmarried women have a problem with discharge... they get fever and vaginal discharge, but they keep it to themselves and don't tell their mother. They think that it is normal. Eventually they will try a traditional herb to cure it.

When unmarried women have discharge, they dare not go to the doctor, because they are unmarried.

There was a woman with a discharge, but was too afraid to tell anyone, because she thought the family would blame her..

An unmarried woman had irregular periods, and was feeling hot inside, so she asked her mother to take her to hospital. Village women said it was because of her having sex and pregnancy.

The data illustrated several important points about reproductive health issues for Cambodian women. Firstly, among

unmarried women in particular there is reluctance to seek treatment for symptoms such as vaginal discharge. This is partly as discharge may be considered normal, but importantly also because of stigma related to revealing or seeking treatment for reproductive health problems, in case of “blame” or association with pre-marital sex.

The issue of irregular periods may mean that it is harder for women to know whether they may be pregnant or not, another factor that may delay seeking advice or services in the case of an unplanned pregnancy. Further work to explore the availability and use of pregnancy testing would provide important insights into factors affecting delayed treatment seeking.

The problem of unmarried women is that their period does not come because they sit and work for a long time.

Unmarried women say they don't have regular period, and whenever they have it, they feel pain and fever, exhaustion and loss of appetite. ■

3.7 HOW DO TARGET GROUPS RECEIVE INFORMATION?

■ MASS MEDIA

Mass media (radio, TV and printed press) are already delivering content concerning issues such as domestic vi-

olence, gender, human rights, and HIV. Women have learnt to “talk the talk” about these topics, but with limited comprehension of what it all means. During PEER data collection, it was clear when women made superficial statements that they had perhaps heard on television. Women are aware of “gender issues”, but this awareness did not seem to reach beyond agreeing that domestic violence is wrong. They knew of the existence of an issue called “human rights”, but could not elaborate further

“...There was a woman with a discharge, but was too afraid to tell anyone, because she thought the family would blame her..”

on what this meant. There did seem to be interest in programmes about reproductive health, relationships and family planning. However, any communications need to take care not to patronise the audience, who are very accustomed to health messaging. One woman complained that health educators shouldn't tell women what to do when they aren't doing it themselves. There is a need to move towards evidence based Behaviour Change Communications, moving on from outdated assumptions that information or education automatically change behaviour.

Television and radio were highly valued in both urban and rural data. Garment factory workers listen to the radio in during the day at work, and watch TV at weekends. The rural women only watched TV in evening (as their village

only had electricity at night), but said they might be too busy to watch it or might fall asleep in front of the TV. ■

■ INTERPERSONAL CHANNELS

People trust what their friends tell them. Poorer people in particular, lacking access to TV or radio, get their information from gossip and talking to friends. From the length, depth and detail of the PEER datasets, and the sheer amount of information women knew about other people's lives, there is clearly a strong tradition of storytelling and gossiping among friends. Communications that capitalise on the popularity and relevance of testimonials and real life stories are thus likely to be well received.

One finding that emerged clearly from PEER is that although there are strong cultural barriers to talking openly about sex and sexuality, when women are talking to their friends, conversation about very personal issues can flow freely. Employing third person techniques¹⁸

helps, as people do not feel personally exposed or threatened. In terms of target audiences at least, communications need not worry about communicating in an open and honest manner with the target audiences about pregnancy, sexual relationships, family planning, relationships with providers etc. The moral frameworks around these issues are complex, but within female peer networks, these issues are a central feature of day to day discourse.

Rural communities already have administrative and organisational structures in place to deliver messages to their members (see box below for an example from the study village). However, these are not targeted structures: for instance, a village leader might call a meeting about reproductive health, but any member of the household might attend to represent the family (e.g. grandfather, teenage girl). Representation is also likely to be biased towards the richest people in the village, who are also likely to have affiliations to political party. ■

¹⁸ In the form "what do other people say about x" or "have you heard any stories about x".

4. IMPLICATIONS OF PEER FINDINGS



4.1 IMPLICATIONS FOR COMMUNICATIONS

This section examines how the PEER findings impact upon future communications work for the reproductive and sexual health sector. Communications are made up of the messages that the programme wants to deliver, and the channels through which these messages are spread, in order to promote specific behaviour change. ■

■ INCREASING AWARENESS AND ACCESS: KEY ISSUES AND MESSAGES

There is a great need to increase awareness of, and access to, family planning and safe abortion services. This is evidenced by low levels of awareness of entitlements to services, inaccurate risk perceptions, and risky behaviours. Awareness needs to be raised not only among the target groups (women of reproductive age), but also among people who influence them, such as community leaders and men. The oldest woman in the family (mothers and grandmothers) had a lot of influence

in family matters and relationships, and may be key individuals to include. Communications and advocacy activities should recognise the importance of relationships between men and women rather than conceptualising the two genders' needs separately.

Key issues to tackle suggested by the PEER data are as follows:

Women do not seek safe abortion promptly. This delay is caused by trying a variety of different methods first.

Women require greater support to attain reproductive and sexual health.

Women in these communities find themselves in very difficult circumstances due to violent relationships, economic hardship, stigma around issues such as STIs and pre-marital sex, and other social and economic pressures. They may feel compelled to end a pregnancy in secret, or be afraid to seek treatment for suspected infections.

Communications and other interventions must work to tackle the social position of women which underlies these problems, and work towards changing attitudes of men and other people who have an influence on women's health. The Support to Safe Motherhood Programme in Nepal is widely recognised as a leader in the use of demand side empowerment approaches to support safe motherhood¹⁹.

Women do not demand or expect high quality abortion services in the public sector. They do not know about their entitlements nor has there been the opportunity for them to realise their entitlements. Quality of emotional care, cost and confidentiality are at least as important as perceived quality of technical/medical care.

Relationships between providers and clients in the public sector need to be improved, with particular attention to counselling skills, attitudes to poorer clients and eliminating financial malpractice which contributes to low levels of trust in services.

Numerous misconceptions and low levels of knowledge about contraceptive methods need to be addressed. These must include what side effects to expect and what to do, together with improving women's understanding of the basic factors of reproduction and contraception. This lack of understanding contributes to poor uptake and limited effective use of family planning. In particular, longer term and less frequently used methods (IUD, sterilisation) are poorly understood and viewed negatively. Efforts to scale up access must involve coordinated efforts on both the supply side and demand side (eg. communications, financing) to be effective. ■

¹⁹ House of Commons International Development Committee Maternal Health Fifth Report of Session. For more information on SSMP see www.safemotherhood.org.np

■ CHANNELS OF COMMUNICATION

The following communications activities and channels present different opportunities and challenges:

Community based communications:

Can take different forms (eg. meetings, drama) in rural and urban areas and should reflect the target group. Some should be aimed at the primary target audiences (women of reproductive age) whereas others should be aimed at influencing wider community attitudes, especially community leaders. Women's availability to attend such events may be limited by work load and season, as rural women continually stressed how busy they were. Suggested locations for meetings include non-clinical community sites (classrooms, house of women's chief) and in or near work places (venues near factories or markets so that they are convenient for working women to attend). Materials and messages for use in such meetings should be developed and tested in collaboration with members of the target group. Materials should include a suggested topic guide and points for discussion, life-like (or real life) case studies and testimonials, and interactive activities prompting discussion. Meetings are ideal for women to have an opportunity to ask questions: with low levels of general knowledge and many misconceptions about reproductive health, women have a high level

of curiosity and many questions to put to health professionals when they have the chance (as evidenced by experience during Q&A sessions in the peer researchers' workshop). The political and socioeconomic profile of community networks in communities should be considered as they are unlikely to be fully representative of the population, and the most vulnerable members of the target group may be missed by formal activities.

Referral options: Women using family planning or safe abortion services could be provided with a referral card

... Women have a high level of curiosity and many questions to put to health professionals when they have the chance ...

to pass on to friends. Because word of mouth recommendation is highly valued, this is likely to be an effective way of increasing trust. However, it is likely to be a relatively 'slow burner' for safe abortion in particular, as abortion seeking is not a very frequent activity.

Printed materials: leaflets, posters, stickers. These should use simple and authentic language and phrases, and where appropriate include case studies and testimonies from women who have used services. Technical language should be avoided.

Mass Media: the majority of households own a TV and/or radio (see below) so these channels are potentially

an effective way of reaching a large number of people. Although outputs should focus on the key programmatic messages, they should also address other salient themes for women to raise and keep interest. Domestic violence is a hugely important issue for women, as are the difficulties and challenges of making a living, and the resourcefulness that women employ to address these problems. Other issues of concern are alcohol abuse and gambling, husbands working far away from home, and STIs.

MASS MEDIA REACH IN CAMBODIA

63% of urban and 47% of rural households own a radio in Cambodia.

An even greater proportion own a television: 52% in rural areas, rising to 72% in urban areas.

However, this still means that nearly half of households do not have a television.

69% of women in Cambodia are literate, although this is higher in Phnom Penh (87%) and Kandal (79%).

Open days: Once facilities have been refurbished, an effective way of getting the word out to local women is to invite groups of women to visit the new facilities, show and tell them what is available, and give them information to take away for their friends. ■

4.2 IMPLICATIONS FOR SUPPLY SIDE ACTIVITIES

In order for communications activities to be effective, there must be a corresponding increase in the quality, availability and accessibility of family planning and safe abortion services. The supply side needs to be able to fulfil whatever benefits relating to services that have been promised to the target audience. Therefore communications relating to specific improved services must be made locally and only when services are in place. ■

■ ABORTION SERVICES

At present, public facilities are not the main provider of abortion services, and for this to change, the supply side will have to address the following key issues successfully:

→ **Confidentiality:** ensuring women are able to access facilities outside their home area. Ensuring women are not readily identifiable as seeking abortion in public areas of the facility.

→ **Improving access:**

- For vulnerable groups: this may include addressing financial barriers both for fees and associated expenses such as transport (see box below for a summary of Health Equity Funds). Even very small upfront fees can restrict access.
- Providing services outside conventional clinic hours

Summary of current status of Health Equity Funds

Health facilities are encouraged to exempt poor patients from paying user fees. One way of doing this is through Health Equity Funds, which reimburse facilities for poor patients' health care expenses and assist poor patients with indirect costs. They currently cover 1% of the population, 35% of whom are women of reproductive age. There are currently 35 HEFs in operation, with 13 further funds planned for the start of 2008. Problems relating to the use of HEFs for abortion services include confidentiality; women's access to the HEF card; and crucially US funded NGOs controlled by the Mexico City Policy refuse to facilitate access to safe abortion services. Currently the vast majority of HEF implementers fall into this category.

→ Considering

role of private sector:

At present the various private sector players are a very significant provider for women. Expanding access for women necessitates a concentrated and integrated effort to work with the private sector. The inevitable increasing availability of MA makes this particularly urgent.

→ Developing a process for MA:

There is an urgent need to explore service delivery options, and manage the systematic introduction of MA to ensure the benefits of this important reproductive technology are maximised.

→ Improving provider attitudes:

Ensuring that clients receive emotional care and are treated with respect, as well as receiving technically expert care

→ Catering for adolescents:

At present there is a lack of services for young and unmarried people. A model has recently been developed for adolescent friendly reproductive health services in Cambodia [Wilkinson 2003] which provides detailed recommendations for those interested in developing this area. See box below for an example of how the clinics of an NGO in Phnom Penh have responded to their clients' needs.

→ Providing quick, affordable, accessible and confidential pregnancy testing:

If women are to seek a qualified practitioner as soon as possible, they need to be able to have a pregnancy test quickly. It is worth considering how to do this in facilities, without women necessarily having to queue, register etc.

→ Contraceptive counselling and services:

Women using abortion services should be provided with contraceptive advice and supplies if required from the same provider and in the same location. Post abortion contraception counselling and services can help raise the overall contraceptive prevalence rate of an area, as

they are an opportunity for service providers to provide information, advice and services to women.

→ **Emergency contraception:**

Given the findings of the PEER study, particularly the unmet need and widespread use of the withdrawal method, urgent work is required to increase access to emergency contraception.

■ **MEDICAL ABORTION**

PEER data show that use of pharmaceutical abortifacants bought from pharmacies is widespread, such was the frequency and consistency with which they were mentioned. At present internationally approved drugs used to induce abortion are not registered for this purpose in Cambodia. It is not clear what drugs are being supplied, and the frequency and dosage of pills seemed to vary widely, suggesting little consistency in drugs or methods used. Further research is planned by RMMP to investigate these matters; a number of organisations are looking at options

to make MA available to Cambodian women, with work in early stages.

Women would benefit from being able to access recognised and regulated medical abortion services. Issues such as training pharmacists where to refer clients for prescription of drugs, appropriate referral procedures, and securing quality controlled drug supplies need to be considered in detail. All parties need to consider options to work more closely with pharmacists for referral, as they are often the first point of contact for many women. Additionally, public providers should consider making medical abortion widely available at their facilities. There is already great demand for medical abortion in Cambodia, which will continue to be met by unsafe provision without post abortion family planning counselling, unless alternative safer choices are given to women. ■

■ **LONG TERM FAMILY PLANNING**

Many of the implications of PEER findings for developing long term family

AN EXAMPLE OF YOUTH FRIENDLY SERVICES

RHAC clinics in Phnom Penh have separate entrances for adolescents leading into a library, so nobody knows whether they are accessing services or simply visiting the library. Their first point of contact is the librarian, which helps maintain confidentiality. Information in the library is provided on issues of concern to service users. A recent survey showed them to be concerned and interested in drug and alcohol misuse, and the management of sexual violence. Girls wanted to learn how to protect themselves from rape, particularly beer promotion and bar girls.



planning services are similar to those for improving abortion services. Family planning services need to be client-centred, and respond to the needs of women and men who want to access the services. These needs can be summarised as follows:

→ **Confidentiality:**

is required in all services, especially for young and unmarried people. This means addressing the physical layout and organisation of facilities as well as increasing levels of trust.

→ **Improving access:**

as with abortion services above – the financial costs and inconvenient opening hours of services limit access.

→ **Considering the role of the private sector:**

private providers such as pharmacies are a leading source of contraceptives, but women do not always receive adequate counselling, instructions, and follow-up, contributing to ineffective use of contraception and anxiety about side effects.

→ **Improving provider attitudes:**

helping providers to understand and respond to the needs of customers is vital, emotional care and respect are equally important to technical competency for family planning providers.

→ **Catering for adolescents:** tackling the lack of services for young people, including in rural areas, has great potential for reducing the number of unwanted pregnancies and maternal deaths.

→ **Improving perceptions of long term family planning methods:** at present surgical methods of contraception and the IUD are viewed very negatively. Clients at family planning services should be offered a wide range of methods,

...Women talk freely [...] about issues around abortion, [...] but want to keep it a secret when they seek an abortion for themselves...

and providers should be equipped with the skills to explain and reassure women and men about all methods, including the less popular ones.

→ **Reducing financial burden of long term family planning:** one common belief about longer term methods was that they were much more expensive than the injection/contraceptive pill. If longer term methods are to be promoted, the price differentials and financing options will need to be addressed. ■

PEER data allow exploration of how attitudes may affect reporting in surveys on abortion in Cambodia. Eight percent of women are currently estimated to have ever had an abortion. This would seem an underestimate, considering the high frequency with which abortion was discussed by the peer researchers, the nature and content of their stories, and, the fact that many women are likely to be disinclined to admit to abortion. The high level of detailed knowledge about abortion providers and methods, the numerous reasons and situations mentioned described for

why women had abortions, and the matter of fact way in which women talked about abortion, suggest that it is a much more common occurrence. PEER data do not allow a quantitative estimate of prevalence of abortion, but it is worth bearing in mind that survey data may only represent the tip of the iceberg.

Why might women under-report abortion? Although in the third person (i.e. what do other women say about...), women talk freely and comfortably about issues around abortion, PEER data show that many women want to keep it a secret when they seek an abortion for themselves. However, older women who had abortions because they

had had all the children they wanted, or because their health was at risk, were not generally ashamed about having an abortion, as these are more socially acceptable reasons. This may help to explain why in the DHS, the proportion of older women reporting having had one or more abortions is much higher than among young women (of course, one would also expect this figure to be higher among older women due to the fact that they have had longer exposure to risk of abortion too).

Another finding from PEER is that younger women are far more likely to go to private or informal providers for abortions than to public facilities. The most recent data on abortion in Cambodia come from a survey of public facilities, and thus again represent an underestimate of the total number of abortions occurring in the country. In

both rural and urban areas, reported use of public facilities for abortion was very rare. Older women with a socially acceptable reason for having an abortion might be more likely to go to public service providers as they are not as concerned about feeling ashamed or judged.

PEER data also highlight a pattern of attempting abortion by trying to self-induce (through herbs, alcohol, running and jumping), only seeking attention at a hospital or clinic if these attempts fail. For women reporting abortion in a survey, when asked what method they used, they might answer with the final method that resulted in the successful abortion. Surveys may thus underestimate greatly the prevalence of attempts at unsafe abortion using traditional, self-induced, or medical abortion methods. ■

4. IMPLICATIONS FOR ADVOCACY



Advocacy: is a process of working to gain the support of decision makers and people in power. These include services providers, policy makers, and community members. In the case of RMMP, advocacy will aim to build a supportive environment for reducing maternal mortality through the activities of the programme.

5.1 **ADVOCACY** **AT PROVIDER LEVEL**

Any drive to improve safe abortion and family planning services has to ensure that providers (doctors, nurses, midwives and facility staff such as receptionists) recognise women's right to a safe abortion in a government facility, and all women's rights to family planning services. PEER findings will help develop tools for this purpose. Even if providers come from a similar cultural background to their clients, their

professional and social position is very different when they meet in a clinical setting. The provider may think that they have insight into the problems and needs of their clients, when in fact they may know little about the everyday reality of their lives.

Examples of key messages for advocacy work with providers might be:

- **Women are in danger from unsafe providers:** women use unregulated, ineffective and unsafe abortion

methods and providers. If you do not provide them with a service, someone else will.

- **Women's right to choose:** women do not need to justify WHY they want an abortion: if they are required to do so, they will either lie about the reason or go elsewhere. Respect their right to choose.
- **Importance of family planning:** women with unwanted pregnancies have a need for family planning services, which should be offered along with explanations of how the methods work, and reassurances about their safety.
- **Importance of equity of access:** poor women face the greatest dangers with unsafe abortion: help them to avoid this danger by welcoming them to services and treating them with the same respect as any other client.
- **Making services accessible to young people:** young people may be sexually active before marriage, but they should not be treated any differently from married people when they come to access services.
- **Quality of care:** women want quick, polite, affordable, reassuring and confidential services. They do not want to be judged or told off by providers. If they cannot get these qualities from public facilities, they will go elsewhere, where they may receive sub-standard and unsafe services.

- **Accountability:** to improve services, clients need to be able to feedback their experiences of providers, and providers held responsible for responding to this feedback. Explain importance of whatever feedback mechanisms are introduced, such as feedback cards. ■

5.2 **ADVOCACY** **AT HIGHER LEVEL**

The **pragmatic and non-moralistic** tone in which peer researchers talked about abortion is quite different from how

Young people may be sexually active before marriage, but they should not be treated any differently from married people when they come to access services.

abortion is dealt with at a policy level. Abortion is a very sensitive political issue in the national and international arena; it is interesting that Cambodian women are not similarly perturbed by dealing with and discussing the practical and moral issues around abortion. It is very important in terms of advocacy activities to present a realistic picture of abortion in Cambodia. De-stigmatising abortion and other aspects of sex and reproduction is an essential step in improving reproductive health and reducing maternal mortality and morbidity.

Advocacy at government and policy level and above will be important in promoting commitment to access to

safe abortion, and of the right to have an abortion in a government facility, with equitable access for all women. At this level, the following issues will be important to tackle:

- **Financial barriers to access:** services must be affordable. Even if quality of services improves, and knowledge about availability of services increases, financial costs will discourage and prevent women from using public services. This will be a serious barrier to reducing maternal mortality, as the poorest women are at the highest risk, yet will not be using services intended to help them. Urgent work is required to explore pro-poor health financing solutions which include safe abortion in a basic package of services without stigmatising those who use them. All stake-holders, and particularly the donor community have a responsibility to minimise the impact of Mexico City on Equity funds and other pro-poor mechanisms.
- **More structured provision of medical abortion:** as mentioned in

the safety of abortion in Cambodia. As well as developing structures such as drug registration, a supportive environment in terms of attitudes among decision makers and implements will have to be fostered, using the strong arguments for providing regulated medical abortion presented in this report.

- **Provider incentives:** informal payments, long waiting times and poor provider attitudes are all barriers to high quality service provision. Staff must be adequately rewarded for good quality services, training and “sensitisation” will not be effective.
- **Commitment to equity of access:** particularly for young and unmarried people.

5.3 WOMEN'S RIGHT TO ACCESS REPRODUCTIVE HEALTH SERVICES

Advocacy activates should fall under a broad “rights based” framework²⁰. This holds that reducing maternal deaths cannot be accomplished by technical health interventions alone, but requires work to challenge the political and social status quo, including actions within and beyond the health sector.

As PEER data have shown, women's

Health services are often male dominated and struggle to hear the voices of the women they serve.

section 4.2.2, developing safer medical abortion provision presents a huge opportunity for improving

²⁰ For more information see the DFID 'How to' note at <http://www.dfid.gov.uk/pubs/files/maternal-how-to-final.pdf> 13/2/08

health is affected by a number of factors:

- Low levels of knowledge and lack of education
- Gender relations: lack of power and decision making in relationships
- Lack of power in relationships with health care providers
- Lack of money to pay for services

Opportunities should be found to link work around safe abortion and LTFP ac-

cess to other interventions working on gender, empowerment, livelihoods etc. In short, the issue should be addressed from a gendered social development perspective rather than as a purely technical health systems issue.

Health services are often male dominated and struggle to hear the voices of the women they serve. In addition to advocacy, systems of accountability must be developed which put women at the centre of service delivery.²¹ ■

²¹ For more information see DFID Briefing note: Voice and Accountability Matters for Better Education and Health Services 2007 13/2/08

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APPENDIX 1: PEER METHOD IN DETAIL

Selection of Peer Researchers

CHEMS was asked to select 15 peer researchers from both of the study sites according to the following criteria:

- They should be a woman aged 15-35 years
- They should represent typical local women as far as possible
- They should not have been involved in programmatic activities before (e.g. peer education schemes, village health volunteer etc)

The urban location (within Phnom Penh) and rural location (a village in Kandal Province approximately 50km from the centre of Phnom Penh) were selected because RMMP's initial activities are taking place in these areas, and insight into differences between urban and rural communities were required.

Monitoring work involving qualitative operations research will be carried out as RMMP's activities stretch into other provinces. Findings from Kandal and Phnom Penh should not be viewed as representative of the whole country, as there are likely to be many socio-economic differences between Phnom Penh and its immediate surrounds and more remote rural areas. Ongoing dialogue with local communities about their needs will therefore be necessary. However, many structural issues such as financial barriers to access, client/provider relations and the factors that shape decision making around abortion are likely to be important across the country.

Peer Researcher Training Workshop

The peer researcher training workshops were held separately for the urban and rural groups. Informed consent for participation in the study was obtained from all peer researchers, and they were paid a per diem and any expenses incurred. During the four-day workshops, peer researchers:

- Discussed and identified important issues in their community (with an emphasis on women's health)
- Developed their prompts on three different topics, to guide their in-depth interviews, shaped by what they felt to be the most important issues (see below)
 - Practiced asking open-ended questioning, probing, and asking for stories
 - Practiced and were observed asking for consent from their friend to take part
 - Learned about 'third-person interviewing' (using no names, and asking about 'what other people say' rather than personal questions)

- Field tested their interview guide with a friend, fed back to the group and made any necessary adjustments

Peer researchers were provided with pens and notebooks, and were advised that they could write down key words or phrases to help them remember what their friends told them if they wanted. Some peer researchers found this to be a useful practice, whereas others did not have the requisite literacy levels. Experience of PEER in other countries has shown non-literate groups to be highly skilled at remembering the stories they hear when interviewing their friends, and the depth and detail of peer researchers' responses confirmed that this was also the case in Cambodia.

Data Collection

After the training workshop, peer researchers started to carry out in-depth, conversational interviews with two of their friends (rural group) or three of their friends (urban group) on three different topics, using the prompts developed at the workshop to guide the conversation. In the urban group, PEER data were collected from peer researchers by supervisors from CHEMS at regular intervals over a period of around five weeks. At the end of this period, the PEER advisor met up with each peer researcher individually to de-brief them, referring to the notes provided by CHEMS.

The rural PEER study used a more rapid data collection timetable, whereby peer researchers interviewed one friend on one topic every day, and fed back every other day to the PEER advisor and CHEMS supervisor who took detailed notes in English, using an interpreter. All peer researchers successfully remembered detailed information from their friends, some requiring very little prompting from the research team.

Data analysis

Data were analysed in two stages:

By peer researchers: at the end of data collection, peer researchers were brought back together for a workshop to provide feedback on their experiences, discuss their findings, and answer emerging questions from the PEER advisors.

By PEER advisors: Narrative data were entered into Microsoft Word in English, translated from the original data which were in Khmer. Data were read and re-read, and key themes were identified. Data were thematically analysed according to the pre-existing analytical framework (developed according to the objectives of the research). Emerging themes, categories and insights were incorporated into this framework.

PEER researchers feedback on their experience:

What they found difficult:

- First time we thought we couldn't do it
- If we were not clear about the topic, they couldn't answer in detail
- Some of the single peer researchers felt shy to ask and answer some questions (about marriage, reproductive health)
 - Some of our friends felt jealous as we got a lunch allowance
 - A friend rejected the interview saying researchers are too young to talk about sex
 - Some of the interviewees didn't want to talk for a long time
 - Some of our unmarried friends didn't want to talk about sex
 - Some people went off the topic
 - Some people complained about snack provided, that it was too little

What they liked:

- To know about the relationships with men
- To know about health problems and women's problems
- Our friends were friendly
- To get more experiences, share ideas
- That there were incentives but no force
- We are excited, never thought they'd become a researcher
- We learned to express our opinion, and not be shy
- To know more about the women
- We feel proud to have been a researcher
- Before, felt shy to talk about sex, now we dare to face talking about sex
- Dare to talk about everything because we know a lot
- Surprised because I can be a researcher
- Happy to become a researcher, and people are friendly
- We became famous (in the village - met lots of people)

