Abortion in Cambodia

Country Report

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Expanding Access:
Midlevel Provider s in Menstrual Regulation
and Elective Abortion Care
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Abbreviations:

CDHS	Cambodia Demography Health Survey
KAP Survey	Knowledge Attitude and Practice survey
MOH	Ministry of Health
MOP	Ministry of Planning
MMR	Maternal Mortality Rate
NMCHC	National Mother Child Health Center
SESC	Socio-Economic Survey of Cambodia
TBAs	Traditional Births attendents
HC	Health Center

I. Country background

Cambodia, situated in the Mekong Sub-Region, bordered by Thailand in the west and north, Laos in the north, Vietnam in the east and southeast and the Gulf of Thailand in the south-west, is one of the poorest and least developed countries in South East Asia. The total population is over 11 million people, living on an area of 180.000 square kilometers of which more than 40 percent is covered by forest. The capital city, Phnom Penh, lies at the confluence of the Mekong, Tonle Sap and Tonle Bassac Rivers. The country is divided into 24 provinces and 183 districts. Districts vary greatly in total land area and in number of people, the smallest having as few as 3.000 people, the largest more than 150.000.

Cambodia has suffered a long period of war from 1970. During the period of 1975-1979, more than 2 millions people, mostly men and including many medical professionals, lost their lives, leaving a large number of widow women to head their family and raise their children. The health care system was almost totally destroyed in that period. From 1979 and onwards, the health care system has been gradually re-established. In 1991, the signing of the Peace Accords between the fighting parties took place, and in 1993 the first election was organized and a coalition government was formed. However, in July 1997, the armed clashes between the coalition partners put Cambodia into a violent situation. In July 1998 a second election was conducted and followed by the establishment of a new coalition government in December 1998.

II. Reproductive health and fertility

The maternal and child health status in Cambodia is characterized by high rates of maternal and child mortality and morbidity, and high prevalence of sexually transmitted infections (STI) including HIV. In 1996 maternal mortality rate (MMR) was estimated by the sisterhood method at 473 per 100,000 live births. Other estimates are as high as 900 per 100,000 live births (UNICEF). Direct causes of maternal deaths are mainly haemorrhage, eclampsia and complications of unsafe abortion. Underlying medical causes are poor nutrition and anaemia. In addition, morbidity associated with obstetric complications is estimated to affect a large number of women every year.

At current fertility levels, the average urban woman in Cambodia will give birth to 3,1 children and the average rural woman to 4,2 children (CDHS 2000). Knowledge of family planning is high and the desire to space or limit births is also high. However, among married women less than one fourth practice some form of contraception. The most common modern methods among married women are injectables (7,4%) and contraceptive pills (4,5%).

III. Laws and policies

The Cambodian constitution states that women and men have equal rights before national laws. The Cambodian government has signed the Convention on Elimination of Discrimination against Women (CEDAW). A Birth Spacing policy was formulated in 1994 and a Safe Motherhood Policy and Strategy document was adopted in 1997. The Government of Cambodia gives high priority to safe motherhood and views the policy directives as the main approach to the reduction of maternal and peri-natal mortality and morbidity and improvement in women's health. The main focus of the Safe Motherhood Policy is improving maternity care services, including birth spacing, antenatal care, clean labor and delivery, essential obstetric care, treatment of complicated abortion and prevention of STDs including HIV/AIDS. These services are to be provided at all levels of the health care delivery system starting from the family and the community and private sector. It will also aim at behavioral and societal changes at community and service delivery levels in order to improve community participation.

A National Abortion Law was enacted in November 1997. The law has as its goals and objectives to determine the formality and the criteria for abortion. It defines an abortion as the

termination of pregnancy by medical means or by any mean. All pregnant women can ask for an abortion and in all cases, abortion must be requested and accepted by the pregnant woman. Only medical doctors or medical assistants or midwives who have been authorized by the Ministry of Health can perform abortion. Abortion can be performed only in hospitals, health centers, clinics, public or private maternities that have been authorized by the Ministry of Health. All services that have been adopted by the Ministry of Health as an abortion place must have technical capability for urgent management of every complication due to abortion, and means for referral to hospital whenever necessary. Medical doctors or medical assistants or secondary midwives who have the duty to perform an abortion must provide counseling to the pregnant woman about possible dangers that may occur eventually following the abortion and about the importance of birth spacing services. Abortion can be done only for less than 12-week pregnancy. For more than 12-week pregnancy abortion is allowed only if the diagnosis shows that the pregnancy is abnormal, growing unusually or is threatening the woman´s life, or if after birth the child will have a serious incurable disease. In the case of rape, an abortion can be done taking no account the above criteria but must be requested by the woman if she is more than 18 years of age, or by her parents or her tutors if she is less than 18 years of age. All records related to the abortion must be kept confidentially and be available to be given to the woman or to the court if there is a written request.

IV. The abortion situation

Socio-cultural studies from Cambodia have described a number of traditional methods for performing abortions, including abdominal massage, oral herbal medications, and insertion of plant stems into the vagina or cervix (White 1995). These procedures are generally carried out by traditional birth attendants (TBAs) or traditional healers known as 'Kruu Khmer'. Many midwives and other medical staff who provide gynecological services report that performing abortions is a major part of their work in both public and private facilities. These practitioners commonly use curettage, a technique that is less safe than aspiration methods (WHO 1994).

The 1995 KAP survey on fertility and contraception in Cambodia reported that 25% of Cambodian women knew someone who had had an abortion. Five percent of the women reported having had at least one abortion in their lives. The figure was as high as 14% in the capital Phnom Penh. In a study by Ryan et al (1997), almost half of the married women seeking

reproductive health services reported having had at least one abortion, and 30 percent of all women had had more than one abortion. Asking women with abortion where they had the procedure performed, the study found that 60 percent of women attending reproductive health services and 56 percent of sex workers said they went to a private doctor, 27 and 16 percent respectively went to a public clinic or hospital.

Location of last abortion

	Women attending reproductive health services	Sex Workers
Private doctor	60	56
A clinic or hospital	27	16
Home/Brothel	7	24

Source: Ryan and Gorbach 1997.

A study on abortion from 1998 (NMCHC) surveyed 87 women who had come for an induced abortion, and 18 who had come for complications after an induced abortion. One quarter of all elective abortion clients said they were using a contraceptive at the time they got pregnant, mainly the condom and periodic abstinence. The main reason for having an abortion among elective abortion clients was that they were busy with income generation or with their studies (37%). Others reported they had too many children (16%), that their husband died or left (15%) and that they had health worries (12%).

Among women with complications after an induced abortion, the main reason for having had an abortion was that they already had too many children. These women were, on average, older than the first lot. They had been advised by friends or relatives or the providers to have an abortion. The main providers were doctors and midwives. Half had the abortion in their home and the other half went to a private or public hospital. Nine out of 18 were more than three months pregnant at the time of the abortion. The main methods used were curettage and massage/medicines. According to CDHS 2000, the most common place to get an abortion was at private clinics, the second was public health facilities, and the third was in private homes. The

percentage of women who received help for abortion from trained professional was 89% percent among urban women and 80 % among rural women (CDHS 2000).

In the Cambodian Demographic and Health Survey (CDHS 2000) information was collected from women who reported having had at least one abortion in the past five years on the type of procedure used for the last abortion. The most common methods were dilatation and curettage (41 %) and vacuum aspiration (35%). Traditional methods were used by only 9 % of the cases. Older women were more likely to use the dilatation and curettage method (52%) than younger women (31%), while younger women more commonly used the vacuum aspiration methods (47 %) than older women (23 %). Women with no education and rural women were more likely used traditional methods (15% and 10% respectively) than more educated women (7 %) and urban women (6 %).

V. The health system

The new Cambodian Government is committed to improving health care facilities by re-establishing and decentralizing the health care system. The government acknowledges the importance of both public and private health care services and pledges to regulate and improve quality of care in both. The health care system is structured in three main levels:

- Community level: Health Center (nurses, midwives, lab-technician) At community level there are also TBAs, traditional healer or Kruu Khmer, and volunteer health worker. The traditional are not paid by the government.
- Referral Hospital (nurses, midwives, physician, medical assistance)
- National Hospital (nurse, midwives, physician, medical assistance)

There are 929 health centers and 62 referral hospitals in Cambodia, and in the capital Phnom Penh there are 6 main hospitals. Each health center covers from 5000 to 12000 inhabitants.

Reproductive health care services are supposed to be provided at all levels of public health services. The health centers provide birth spacing counseling and distribute pills, condoms, and injection. According to the Safe Motherhood Clinical Management Protocol for Health Center level, midwives and other provider should recognize signs of abortion and prepare the client for

referral to hospital which can provide surgical services if necessary. At referral level midwives are responsible to provide post-abortion care and counseling, evacuate uterus if the fetus is still inside, and provide medical treatment following medical prescription. If bleeding does not stop and shock signs are present, laparotomy should be done.

The health situation in Cambodia is among the worst in the world and the health care system faces immense problems. Quality health care is scarce, and public confidence in the system is low. In 1995 Government per capita spending on health was $2. In 1997 only 5.7 percent of public spending was for health. Limited access to quality health care is worsened by poor living conditions, poor hygiene, large families and food shortages. Illiteracy and poor knowledge of health and hygiene prevent people from copying with illness (UNICEF 1995).

Health care in Cambodia is not free. Expenditure on health is high and for poorer households with little spare cash or saving illness can be catastrophic. The 1997 SESC report that expenditure on health accounted for 5 percent of rural expenditure, and about 10 percent if associated costs (such as transport) were included. Another recent survey found help expenditure to be as high as 20 percent of total household expenditure (MOH 1998). Disaggregated statistics showed no significant gender differentials for treatment of "major illness" in terms of cost per visit. Forty five of health costs were funded by loans from money lenders (MOH 1998).
The first choice for both rural and urban was pharmacist, followed by private doctors and clinics (MOP 1998) The 1996 SESC found that 35 percent of treatment was provided by a parent or relative, with this figure rising to 71 percent in remote provinces. Only 16 percent of treatment was provided by health center staff. The home was perceived as the safest place for health care.

VI. Training of midwives

After completing high school, nurses and midwives receive three years of training to become secondary nurses and secondary midwives. Nurses and midwives are trained together during the first year and separate from the second and third year. In 1995 a new curriculum in Basic Nursing was developed and implemented in training programs.

According to the Safe Motherhood National Policy and Strategy, dated December 1997, post-abortion care shall be included in the Minimum and Complementary Packages of Activity and can be performed by midwives. Also in the Abortion Law of 1997, it is stipulated that abortion below 12 weeks of pregnancy can be done by trained midwives.

However, so far midwives do not receive any formal training to perform abortion during their studies. Some of them who work at the hospitals' Obstetric and Gynecology Departments learn this skill from obstetrician through practice. Although the Directorate of Reproductive Health at the Ministry of Health has developed guidelines for training in safe abortion, these guidelines have not yet been accepted by the Ministry. *Therefore there is no formal training on safe abortion for midlevel providers or any other health staff.*

VII. Professional associations

Cambodian Midwives Association, CMA

During the civil war in Cambodia, we were separated from the rest of the world. Cambodian midwives did not know what midwives developed in their profession. In June 1994, the CMA was established after we got the opportunity to attend the regional ICM conference in Melbourne and in Vancouver 1993. The overall objectives of the CMA are:

- to upgrade midwifery standards in Cambodia;
- to set up national, regional and international networks for midwives at all levels;
- to collaborate with the Ministry of Health and others to improve MCH and contribute to the reduction of maternal mortality and morbidity;
- to advocate for appropriate national policies and legislation for the midwifery profession in Cambodia.

VIII. Problems in providing safe abortion

- Women often come late for abortion. Cambodian women are not used to talk about sex or their own reproductive health problems. If they have an unwanted pregnancy they often try to abort themselves before they go to a health facility;
- Lack of knowledge among women, particularly in rural areas, about their right to safe abortion according to the law;
- Lack of knowledge among health providers in how to perform safe abortion (no formal training);
- Equipment is not appropriate and clean. Some providers abuse dilatation of cervix and curettage, causing trauma for the uterus and reproductive tract problems.
- The abortion law is not implemented (due to lack of supervision of abortion providers and lack of control of private clinics)
- Doctors may be unwilling to provide abortion training to midwives, thereby loosing abortion clients.

IX. Overcoming barriers to midlevel providers in abortion services

- Midwives must receive appropriate training and be licensed to provide safe abortions:
- International organizations can help in providing formal training courses for midwives in safe abortion, as Cambodian doctors are few and may not be willing to train midwives;
- The capacity and resources of the Cambodian Midwives Association must be strengthened to be able to expand its training of midwives in safe pregnancy and abortion care.

Expanding access to safe abortion

- Public information and education must be carried out to inform all Cambodian women of their right to safe abortion;
- Advocacy and information should be carried out among Cambodian community leaders, educators and health professionals on the existing Abortion Law of 1997 and to develop favorable community attitudes towards women's reproductive health and rights including safe abortion services;

- The Ministry of Health must be convinced of the need to implement the Abortion Law and develop its capacity to provide guidance and supervision of licensed abortion providers, public and well as private.

X. References

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