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Threads of a Common Cloth: Access to Safe Abortion and Human Rights in Cambodia

by

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Spring 2003

**Threads of a Common Cloth: Access to Safe Abortion and Human Rights in Cambodia**

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**Felicia Chiara Lester**

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## List of Acronyms

ASPs	Abortion Service Providers
BS	Birth Spacing
CARE	CARE International
CRC	Convention on the Rights of the Child
CDHS	Cambodian Demographic and Health Survey
CEDAW	Convention on the Elimination of all Forms of Discrimination
CWC	Cambodian Women's Clinic
D&C	Dilation and Curettage
DoH	Department of Health
EC	European Commission
EVA	Electrical Vacuum Aspiration
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social, and Cultural Rights
KC	Kompong Chhnang
MA	Medical Assistant
MoH	Ministry of Health
MSI	Marie Stopes International
MVA	Manual Vacuum Aspiration
MW	Midwife
MWVA	Ministry of Women's and Veterans' Affairs
NGO	Non-Governmental Organization
NMCHC	National Maternal and Child Health Center
NRHP	National Reproductive Health Program
PRAKAS	Operational Guidelines
RGC	Royal Government of Cambodia
RH	Reproductive Health
RHAC	Reproductive Health Association of Cambodia
RUPP	Royal University of Phnom Penh
TBA	Traditional Birth Attendant
UC	University of California
UDHR	United Declaration of Human Rights
UNFPA	United Nations Population Fund
UNHCHR	United Nations High Commissioner on Human Rights
UNICEF	United Nations Children's Fund
\$US	United States Dollars
WHO	World Health Organization



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#### Takeo

Ms. Sek Sokhom – field supervisor and trainer, RHAC  
Mr. Vong Samrang – local informant, Takeo-RHAC  
Ms. Mariden – interviewer, RUPP  
Ms. Hou Sophallika – supervisor, MWVA  
Ms. Dok Saren – interviewer, MWVA  
Ms. Ung Khemara – interviewer, MWVA  
Ms. Kuthea – interviewer, MWVA

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Ms. Chea Vanny – interviewer, Pursat DoH  
Ms. Khroach Vanthy, Pursat DoH  
Ms. Chan Bolen – interviewer, CARE Pursat

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## **Introduction**

To speak of human rights in Cambodia invokes images of skulls piled high at the killing fields, black and white photos of children turned soldiers on the wall of Tuol Sleng, and a myriad of horrors that led to the death of nearly a quarter of the population of this small country during the course of the Khmer Rouge regime. The population pyramid in Cambodia seems narrow where the 24-26 year old age group should be prominent – a narrowing that represents those children who were never born or who died shortly after birth due to the harsh policies that the Khmer Rouge implemented when they occupied Phnom Penh in 1975. The atrocities committed by the Khmer Rouge regime and the civil strife that characterized the country between 1979 and 1998, strongly influence Cambodian society today. Given this recent history, issues of human rights take on special significance. Today in Cambodia human rights are central to the discourse of foreign assistance. Discussion revolves around political violence associated with commune elections, the denial of food and services to families who don't vote for the dominant party, land mines, child trafficking and prostitution, the plight of street children, rights of garment factory workers, domestic violence, land rights, and prison conditions. These problems are the mainstream of human rights discourse in a country fraught with challenges to civil and political rights.

Human Rights in Cambodia operate in a context in which economic development has been hampered by political instability, an ineffectual judiciary, corruption, and social unrest. These structural barriers to development also make human rights more of a theoretical aspiration than a reality for most Cambodians. A glaring example of this problem is the fact that after perpetrating one of the worst genocides in history, not a

single leader of the Khmer Rouge movement has ever been brought before a court of law to answer for those crimes. In the year leading up to the first “free” commune elections in February of 2002, 4 opposition candidates were killed and 2 were injured. The UN High Commissioner on Human Rights concluded that 3 of these killings were politically motivated, but the local police said that they were all results of personal disputes.<sup>1</sup> During this time, there were 82 threats and acts of violence directed at opposition candidates. Despite hundreds of millions of dollars in donor aid annually, Cambodia remains one of the poorest countries in the world, with an average annual income of \$258 per capita.<sup>2</sup> The majority of Cambodians have little or no education, with only 7% of men and 4% of women having completed primary school. Life expectancy is also low in Cambodia at 59.5 for women and 54.8 for men, placing it 13<sup>th</sup> among 15 Asian nations with only Myanmar and Laos ranking lower.

Despite a 1993 Constitutional decree to accord equal rights to women, Cambodian women continue to experience severe gender discrimination. Twenty-five of married women reported being victims of domestic violence in their lifetime in the 2000 CDHS, but a smaller study found that 56% of women surveyed experience domestic violence. Police routinely ignore domestic violence, which is considered a private matter. Rape is also a widespread crime that often goes largely unpunished, with victims sometimes encouraged to allow their family to collect a small compensation for not taking the case to court.<sup>3</sup> Cambodia has an estimated 30,000 to 50,000 sex workers, 50% of whom are trafficked or forced into the business, but the sex industry is often supported and

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<sup>1</sup> ADHOC (Cambodia Human Rights and Development Association). [www.bigpond.com.kh/users/adhoc/women/Women.htm](http://www.bigpond.com.kh/users/adhoc/women/Women.htm) (last visited 2003).

<sup>2</sup> ADHOC. 2003.

<sup>3</sup> Beaufils, Laure. Population Matters. Laure Beufils. UNFPA 2000.

protected by members of the military, police, or other government officials.<sup>4,5</sup> One women's group estimates that 80% of Cambodia's brothels are protected by police officers or soldiers, and some report that government officials are sometimes silent partners in these establishments.<sup>6,7</sup> Women in sex work face violence from brothel owners and clients and are often forced to have unprotected sex. This puts them at high risk for contracting HIV, which is now widespread in Cambodia. Trafficking and prostitution are significant problems in Cambodia, and demonstrate the low status afforded women's rights. Rural poverty and widespread police, judicial, and governmental corruption, create a situation where trafficking flourishes, and will continue to do so until those problems are addressed.

Maternal mortality remains a major public health problem. According to UNFPA statistics, the maternal mortality rate is approximately 500/100,000, which translates into 2,000 deaths annually from pregnancy-related causes. Estimates of morbidity indicate that for each death, 100 women experience obstetrical complications that cause suffering and disability.<sup>8</sup> Based on this estimate, in Cambodia approximately 200,000 women have serious health problems due to inadequate reproductive health care each year.

Reproductive health experts in Cambodia believe that a significant portion of this morbidity and mortality results from unsafe abortion.<sup>9</sup> In 1999 the Special Representative to the UN High Commissioner on Human Rights drew attention to the need to

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<sup>4</sup> Unmacht, E. Women's Rights Often Come Last in Cambodian Sex Trade. Asian Human Rights Commission. 2002. <http://cambodia.ahrchk.net/mainfile.php/news200211/503/> (last visited 2003).

<sup>5</sup> Human Rights Watch World Report 2002: Asia: Cambodia. [www.hrw.org/wr2k2/asia3.html](http://www.hrw.org/wr2k2/asia3.html) (last visited 2003).

<sup>6</sup> Charmichael, Robert. Manging Editor of the Phnom Penh Post. Personal Communication. 2002.

<sup>7</sup> Unmacht. 2003.

<sup>8</sup> Beaufils. 2000.

<sup>9</sup> Beaufils. 2000.

immediately address the high number of maternal deaths in Cambodia.<sup>10</sup> The problems associated with reproductive health are compounded by the vast unmet need for family planning services, which means that Cambodian women find themselves pregnant more often than they would like. More than eight out of ten Cambodian women still lack access to effective contraceptive services.<sup>11</sup>

Maternal mortality and unsafe abortion in Cambodia are conceptualized squarely within the realm of public health. Awareness of the devastating health effects of unsafe abortion led to the legalization of abortion in 1997. The legislation cited family welfare as the guiding principle behind liberalizing the law, but a rights-based discourse around establishing access to safe abortion and reducing maternal mortality was absent. The law required the Ministry of Health to establish guidelines for abortion services, which, as of the Summer of 2002, had not yet been signed. The lack of guidelines has meant that, for all intents and purposes, there is no abortion law, and therefore most women lack access to safe abortion just as they did before the new legislation.

Human rights organizations in Cambodia and around the world have been largely silent on the issue of abortion. In countries with appalling human rights records on the most basic civil and political rights, some people simply don't see unsafe abortion as a human rights issue and access to safe abortion is absent from the discourse. However, in terms of highlighting reproductive rights within the context of human rights in Cambodia, in 1999 the Special Representative to the UNHCHR reported:

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<sup>10</sup> UN. Situation of Human Rights in Cambodia. Report of the Secretary General. Fifty-fourth session. Agenda item 116 (b). September, 1999.

<sup>11</sup> Beaufils. 2000.

Despite an increase in the number of couples using contraception and the adoption of an abortion law and efforts to improve treatment and prevention of sexually transmitted diseases and safe motherhood services, Cambodians still have limited access to information and services which would enable them to exercise their reproductive rights.<sup>12</sup>

This represents a step in the right direction, as reproductive rights were included in the report. However, subsequent reports by the same body did not refer to reproductive rights.

I contend that access to safe abortion brings to light some of the most central issues of human rights, and in order to attempt to establish even the most “basic” civil and political rights, one must look at the most basic right to control one’s body, one’s fertility, and as such, one’s destiny. Specific human rights within the broad purview of civil, political, economic, social, and cultural rights are intimately connected - they all influence each other and, ultimately, the ability of individuals to realize their full human potential. Cambodia’s failure to implement the 1997 abortion law violates internationally and nationally protected human rights. As the case of Cambodia demonstrates, even where abortions are ostensibly legal, lack of access to safe procedures is a profound injustice perpetuated by the power structure and the low status of women. Low-income and rural women are disproportionately affected by the lack of guidelines and are more likely to resort to unsafe abortion procedures due to the lack of public availability of safe services.

In Section I of this paper I shift the focus away from Cambodia in order to explore the theoretical underpinnings for looking at abortion through a human rights lens. In Section II, I explore the impact of abortion legislation on the availability of safe services. In Section III of this paper I present the results of a qualitative and quantitative study on

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<sup>12</sup> UN. 1999.



the state of abortion in Cambodia. To conclude, I discuss how the Cambodian situation illustrates the limitations of liberal abortion law alone in a country where other obstacles remain in place and where women lack access to a broader base of human rights.

## Section I - Access to Abortion in the Context of Human Rights: Current Framework and Future Directions

### Introduction

It has long been established that unsafe abortion poses a significant health risk to women. In fact, it is estimated that 55,000 unsafe abortions take place per day, and 200 women die daily from these procedures.<sup>13</sup> When a catastrophe occurs and 200 people die in a single event, it attracts the attention of the media and people everywhere. But death from unsafe abortion is largely an invisible tragedy that, like many silent tragedies, takes place predominantly in the developing world.<sup>14</sup> From a medical standpoint, however, abortion is an extremely safe procedure, carrying less than a one percent complication rate when performed with appropriate technology in the first trimester of.<sup>15</sup> From this perspective, unsafe abortion is an entirely preventable public health problem that desperately needs to be addressed.

However, abortion is not only an issue of public health concern. From a rights perspective, the vast morbidity and mortality associated with unsafe abortion is a case of grave injustice in which “individuals with hopes and aspirations are condemned to die horrible deaths in the prime of their lives”, simply because they attempt to control their own fertility.<sup>16</sup> Within the context of women’s rights, access to abortion is

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<sup>13</sup> Uprety, Aruna. *Abortion Laws in Nepal*.

[www.hsph.harvard.edu/Organizations/healthnet/Sasia/repro/aruna.html](http://www.hsph.harvard.edu/Organizations/healthnet/Sasia/repro/aruna.html) (last visited 2002).

<sup>14</sup> According to the WHO, the most frequent complications of unsafe abortion are incomplete abortion, sepsis, hemorrhage and intra-abdominal injuries, such as puncturing or tearing of the uterus. Long-term health problems caused by unsafe abortion include chronic pelvic pain, pelvic inflammatory disease, tubal blockage and secondary infertility. Other possible consequences of unsafe abortion are ectopic pregnancy, fistula, and an increased risk of spontaneous abortion or premature delivery in subsequent pregnancies. Such problems can limit women's productivity inside and outside the home, constrain their ability to care for children and adversely affect their sexual and reproductive lives. Uprety. 2002.

<sup>15</sup> Yamin, Alicia and D. Maine. Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations. *Human Rights Quarterly*. 12(3). pp 563-607. 1999.

<sup>16</sup> Yamin and Maine. 1999.

conceptualized by many as essential to the realization of the full enjoyment of human rights. If a woman is unable to exercise control over her own body and destiny, she will be unable to take part in a full range of civil, political, economic, and social rights.

On the other hand, abortion is seen by some as a violation of the right to life of the unborn. Framed against the concept that life begins at conception, and the vision of the fetus as a full human being with all of the rights entitled to it as such, a woman's right to abortion is in direct opposition to the right of the fetus to life.

Situating the right to safe abortion squarely and firmly within international human rights discourse is not a simple matter, as it calls into question the very nature and scope of human rights. While contemporary human rights documents recognize the broad category of reproductive rights, they don't explicitly condemn or sanction abortion, and the issue remains hotly debated in the international arena. However, I assert that the lack of access to safe abortion is more than a public health problem – it is a violation of various human rights doctrines set forth in international charters and conference platforms.

I begin by establishing the basis set forth in human rights documents for treating access to safe abortion as a human right. In order to do this, I invoke the right to life, liberty, and security; non-discrimination on the basis of gender; the right to health, scientific progress, information, and education; and the right to privacy. I then illustrate how these issues play out in Cambodia. I go on to explore the way in which the rights of the unborn are conceptualized within human rights documents and examine the role of religion in the abortion debate. Finally, I address the implications of my conclusions, and make recommendations for future directions in this field.

## **Human Rights, Women's Rights and Reproductive Rights**

Human rights documents include the Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which together are considered the "International Bill of Rights."<sup>17</sup> Other legally binding instruments include the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC). Human rights documents that have emerged from UN Conferences are the Vienna Platform, the Cairo Programme, and Beijing Platform, which, though not legally-binding, provide a strong basis for advocacy. Over the last few decades, rights discourse has come to include both first and second-generation rights, which represent negative rights ("freedom from") and positive rights ("right to"), respectively. When signatory states ratify a charter, they agree to observe the fundamental freedoms and human rights spelled out in the document.<sup>18</sup> Such documents often not only prohibit states from actively infringing on rights, but also require them to provide the means to secure positive rights.

The original Universal Declaration of Human Rights of 1948 did not explicitly define "fundamental freedoms and human rights," but since then many human rights documents have explained the scope of many of these rights to include reproductive rights. For example, CEDAW includes the following declaration of non-discrimination based on gender:

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<sup>17</sup> Mann, J. et al. Health and Human Rights. *Health and Human Rights*. 1(8). 1994.

<sup>18</sup> It is noteworthy that many states, including the United States, have yet to sign or ratify a number of human rights charters. Of those listed, the US has still not ratified the ICESCR, the CEDAW, or the CRC. Office of the United Nations High Commissioner for Human Rights (UNHCHR). Status of Ratifications of the Principal International Human Rights Treaties. December, 2002.

Article 16.1.e: States Parties shall take all appropriate measures to eliminate discrimination against women... and in particular shall ensure, on a basis of equality of men and women . . . The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.<sup>19</sup>

Interestingly, human rights doctrines have very little to say explicitly regarding abortion, perhaps due in part to the polarity of the debate and the need to draft international charters that will be endorsed by a broad range of signatories. However, both the Cairo Platform and the Beijing Programme call on governments to recognize unsafe abortion and urge government action to improve abortion-related services.<sup>20</sup> This represents progress in that it establishes a rights-based discourse around abortion in non-legally binding conference documents. But a universal right to safe abortion has yet to be outlined.

In 1992, a proposal to alter national laws and guarantee all women equal access to abortion was put forth to the European Commission on Human rights, which oversees interpretations of human rights documents among European states. Although a majority of European countries voted 74-56 in favor of the proposal, it fell short of the required 2/3 majority. Opposition from Poland, Ireland, Germany claimed national rules reflect cultural and religious values that must be respected. However, the Commission has made decisions that apply to countries where abortion is illegal that establish the right to information regarding legal abortion services, and the right to travel outside the country to access legal abortion.<sup>21</sup> The same commission has fallen short of establishing whether the right to life extends to the unborn, and it has rejected the claim that the right to

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<sup>19</sup> UNFPA. The State of World Population 2000. Chapter 6: Women's Rights are Human Rights. [www.unfpa.org/swp/2000/english/ch06.html](http://www.unfpa.org/swp/2000/english/ch06.html) (last visited 2002).

<sup>20</sup> WHO. Considerations for formulating reproductive health laws. [www.who.int/reproductive-health/publications](http://www.who.int/reproductive-health/publications) (last visited 2002).

<sup>21</sup> Lawless, J.M. Fertility, Bodies and Politics: The Irish Case. [www.hsph.harvard.edu/Organizations/healthnet/reprorights/docs/murphy/html](http://www.hsph.harvard.edu/Organizations/healthnet/reprorights/docs/murphy/html) (last visited 2002).

respect for privacy requires states to permit a woman to terminate a first-trimester pregnancy upon request.<sup>22</sup>

Given this ambiguity, there is ample room for advocates of both abortion rights and fetal rights to invoke human rights norms to support their position. In the section that follows, I will explore the basis for advocating for abortion rights within the context of existing human rights doctrines, as well as the concept of including the unborn in the rights discourse.

### **Is there a Right to Safe Abortion?**

Each year, 75 million women have unwanted pregnancies. Each of these women has her own familial relationships, hopes for the future, economic concerns, and health needs. These and other factors will influence her decision to carry a pregnancy to term or to seek an abortion. Given the complexity of the decision, the only person equipped to make it is the pregnant woman herself.... Governments should respect a woman's right to make decisions regarding her reproductive life ...[and] she must have access to the facilities and care that will enable her to terminate her pregnancy safely.<sup>23</sup>

The reproductive rights field has laid claim to the right to safe abortion based on a number of provisions contained in international human rights documents, including: the right to life, liberty and security of person; the right to freedom from discrimination based on gender; the right to health, scientific progress, and information and education; and the right to privacy. The full recognition of these rights often requires governments to not only refrain from impinging on rights, but also to allow the observance of positive rights by providing access to appropriate services.

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<sup>22</sup> Green Paper on Abortion. <http://www.irlgov.ie/taoiseach/publication/greenpaper/chapter3.htm#7> (last visited 2002).

<sup>23</sup> Center for Reproductive Law and Policy (CRLP-1). Safe and Legal Abortion is a Woman's Human Right. 2000 [www.crlp.org](http://www.crlp.org) (last visited 2002).

***Right to life, liberty, and security of person***

*UDHR Art. 3; ICCPR Art. 6.1, 9.1; CRC Art 6.1, 6.2; Cairo Prin.1 Para. 7.3, 7.17, 8.34; Beijing Par. 96, 106, 108.*

***⌘ Right to life***

Because we know that approximately 500,000 women die each year from pregnancy-related causes, and an estimated 80,000 to 200,000 of them from unsafe abortion, by limiting women's access to safe abortion procedures through restrictive laws or by the denial of services, states infringe on a woman's right to life.<sup>24</sup> When governments systematically refuse to recognize the horrific contribution that unsafe abortion makes to maternal mortality, it is plausible to invoke the right to life as a means of obliging the state to take action to limit mortality associated with unsafe abortion. Both the Cairo Programme and the Beijing Platform call on governments to recognize unsafe abortion as a leading cause of maternal death and a major public health concern.<sup>25</sup> In fact, one case involving a maternal death was brought to the European Commission of Human Rights, and though it was dismissed for technical reasons, the Commission emphasized that Article 2 of the European Convention for Human Rights, which states that "everyone's life shall be protected by law," is interpreted to require states to take action to limit unintentional loss of life, not just to protect from intentional killing.<sup>26</sup>

A Bolivian doctor who advocates for access to safe abortion asserts, "not to recognize abortion and consider legalizing it is to devalue human life as less important

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<sup>24</sup> Cook, Rebecca J., and Mahmoud F. Fathalla. *Advancing Reproductive Rights Beyond Cairo and Beijing. Studies in Family Planning* 22(3): 115-121. 1996.

<sup>25</sup> Cook and Fathalla. 1996.

<sup>26</sup> WHO. 2002.

that certain concepts and prejudices.”<sup>27</sup> This statement points to the reality of the impact of unsafe abortion on women’s lives - women are dying from these procedures, and by ignoring it, governments negate the right to life of women who choose to avoid motherhood or who make decisions that are not sanctioned by the political power structure.

### *⌘ The right to liberty and security of person*

When women face punitive laws against abortion, they not only risk their lives by seeking out clandestine services, they also face criminal charges. The Beijing Platform’s call for governments to recognize women’s liberty included the charge to review punitive laws for illegal abortion, which threaten these fundamental rights by subjecting women to imprisonment and physical harm. Nepal, Poland, and Chile have all been asked by the Committee to revoke laws that impose criminal penalties on women who undergo abortion, and lead to unsafe abortion practices.<sup>28</sup> In Canada, the Supreme Court found criminal abortion provisions to be unconstitutional based on a violation of women’s security and liberty.<sup>29</sup> In France, Austria, and Italy, the Human Rights Commission found that liberal abortion laws are consistent with the right to liberty.<sup>30</sup> However, forced or coercive abortion, family planning, or sterilization are in opposition to liberty and security, and are therefore in violation of human rights. Based on this principle,

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<sup>27</sup> Rance, S. Safe Motherhood, Unsafe Abortion: A Reflection on the Impact of Discourse. *Reproductive Health Matters*. No. 9. pp10-19. 1997.

<sup>28</sup> UNFPA. 2000.

<sup>29</sup> Pine, Rachael, N, Law, Sylvia A. Principals Governing Reproductive Freedom. *The Lawyers*. 8(10). pp 13-15. 1993.

<sup>30</sup> UNFPA. 2000.



informed, free choice is essential to the success of reproductive health programs and is the basis for the quality of care framework put forth in the Cairo Programme.<sup>31</sup>

The right to freedom from torture is akin to the right to security and liberty, and in this context, theoretically protects women from forced pregnancy, which can occur when a woman is raped and denied an abortion.<sup>32</sup> The right to bodily integrity is similarly related, not only to protect the individual from coercive or forced means of limiting her fertility, but also to ensure that each individual has the right to the possession and control of her own person, including freedom from laws that force unwanted pregnancy.<sup>33</sup>

The right to freedom from involuntary servitude has also been invoked in this context. "That control by which the personal service of one (person) is disposed of or coerced for another's benefits" constitutes involuntary servitude.<sup>34</sup> Specifically, if a woman is forced to carry an unwanted pregnancy to term, either due to restrictive laws or lack of services, she is essentially forced to serve her fetus. Forcing women to be mothers or "giving fetuses the legal right to the continued use of their mothers' bodies" violates the right to be free from involuntary servitude.<sup>35</sup>

***Freedom from discrimination based on gender***

*UDHR, Art. 2; ICCPR, Art. 2.1, 3; ICESCR, Art 2.2; CEDAW, Art1, 3; Vienna, Para 18; Cairo, Princ. 1,4; Beijing, Par. 214*

All of the documents listed above ensure equity and freedom from discrimination based on gender, and recent progress has been made to promote adherence to this freedom. In March 2000, the Human Rights Committee issued a new General Comment

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<sup>31</sup> Bruce, J., and A. Jain. A Reproductive Health Approach to Objectives and Assessment of Family Planning Programs. In Sen, G., Germain, A. and L. Chen (eds): *Population Policies Reconsidered: Health, Empowerment and Rights*. Boston, MA: Harvard University Press. pp 193-210. 1994.

<sup>32</sup> Beijing Platform. 1995. [www.un.org/womenwatch/daw/beijing/platform/plat1.htm](http://www.un.org/womenwatch/daw/beijing/platform/plat1.htm) (last visited 2002).

<sup>33</sup> Pine. 1993.

<sup>34</sup> Pine. 1993.

<sup>35</sup> Pine. 1993.

that explicitly spelled out Article 2.1 and 3 of the ICCPR. It states that, “gender equality applies to the enjoyment of all rights – civil, cultural, economic, political, and social – and is not merely a right to non-discrimination; affirmative action is required.”<sup>36</sup> From the Beijing Platform:

The neglect of women’s reproductive rights severely limits their opportunities in public and private life, including opportunities for education and economic and political empowerment. The ability of women to control their own fertility forms an important basis for the enjoyment of other rights.<sup>37</sup>

Moreover, in 1999 the Optional Protocol to CEDAW was signed by 33 countries.

This is a legal instrument that will allow complaints of human rights violations based on gender to be submitted to the Committee on the Elimination of Discrimination against Women.<sup>38</sup>

Women cannot be free and equal to enjoy the spectrum of human rights until they have the right to control their fertility, which must include access to safe abortion. Even if all women were able to use contraceptive methods that they chose, methods sometimes fail and women will find themselves with unwanted pregnancies, which they may choose to terminate. Therefore, negating a woman’s right to abortion constitutes discrimination on the basis of gender, as men do not face similar health risks or restrictions on their opportunity to participate fully in all aspects of civil, political, economic, social, and cultural activities.<sup>39</sup> Fundamentally, denying women the right to abortion is about exercising control over women and denying women’s capacity to make moral decisions, which violates the principle of non-discrimination.<sup>40</sup> As one theorist put it, “when states restrict access to abortion, it is not the biological differences between men and women,

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<sup>36</sup> UNFPA. 2000.

<sup>37</sup> Beijing. 1995.

<sup>38</sup> UNFPA. 2000.

<sup>39</sup> CRLP-1. 2000.

<sup>40</sup> Hubbard, R. The Politics of Fetal/Maternal Conflict.

[www.hsph.edu/Organizations/healthnet/gender/docs/hubbard.html](http://www.hsph.edu/Organizations/healthnet/gender/docs/hubbard.html) (last visited 2002).

but the state itself that perpetuates gender inequality.”<sup>41</sup> Governments continue to focus on women’s role as mothers, and neglect their right to participate equally in society.

Even if other human rights are theoretically secured equally for women, without access to the means to control their fertility, women do not have the means to determine their future and will never be able to fully realize these rights in practice. Thus, abortion and reproductive rights must be universally and explicitly realized if we are to be truly equal in rights and practice.

***Right to Health, Scientific Progress, and Information and Education***  
*ICESCR 10.2, 12.1, 12.2; CEDAW 10, 11.2, 11.3, 12.1, 14.2; CC 24.1, 24.2; Vienna Para 41; Cairo Prin 8, Para. 7.45; Beijing Par 89, 92, 267*

### ***⌘ Right to Health***

The ICESCR was the first international human rights document to ensure the right to the “highest attainable standard of health.” The WHO defines “health” as a “state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity.”<sup>42</sup> The Beijing Platform goes much further to state:

Art. 97 ... women are subject to particular health risks due to inadequate responsiveness and lack of services to meet health needs related to sexuality and reproduction. Unsafe abortions threaten the lives of a large number of women, representing a grave public health problem as it is primarily the poorest and youngest who take the highest risk. Most of these deaths, health problems, and injuries are preventable through improved access to adequate health-care services, including safe and effective family planning methods and emergency obstetric care, recognizing the right of women and men to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services...<sup>43</sup>

These documents call for governments to work toward improving the health of people in their country, which in turn implies that states must recognize causes of significant mortality and morbidity in order to provide appropriate services. As discussed

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<sup>41</sup> Pine. 1993.

<sup>42</sup> WHO. 2002.

<sup>43</sup> Beijing. 1995.

above, abortion is a significant cause of ill health and death. In order to ensure the right to health comprehensively, states should strike restrictive abortion laws that lead to the practice of unsafe abortions. They should also collect data on abortion that can be applied to create programs that address the health consequences of unsafe abortion by providing high-quality services and access to family planning.

Along these lines, the Human Rights Committee has called on Peru to review laws and improve access to all health services, including safe abortion and emergency medical attention for complications that result from abortion. Similarly, it has asked Ecuador to help adolescents facing unwanted pregnancy to access health care and education. The committee has also voiced concern about Poland's strict abortion laws, high numbers of unsafe abortion, limited access to contraceptives, and lack of sex education in schools.<sup>44</sup>

First-hand experience throughout the world indicates that often women who arrive at hospitals with vaginal bleeding are mistrusted and not given appropriate medical attention.<sup>45</sup> In South Africa, a visiting medical student noted that women who came in with vaginal bleeding were treated with disrespect and medical attention was often delayed.<sup>46</sup> When asked how it is determined whether a woman's bleeding is the result of an induced or spontaneous abortion, the director of a woman's hospital in Bolivia stated, "that's a difficult question to answer, because right from the start, we mistrust the woman."<sup>47</sup> This mistreatment and denial of appropriate medical care, regardless of the cause of the injury, violates the right to health.

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<sup>44</sup> UNFPA. 2000.

<sup>45</sup> Rance. 1997.

<sup>46</sup> Gabriel-Cox, Katie. Personal Communication. 2002.

<sup>47</sup> Rance. 1997.

In Nepal, though illegal, abortion is sometimes provided in public hospitals. However, it is not provided consistently and not necessarily upon the request of the woman. This kind of inconsistency violates the right to equal access to health care.<sup>48</sup> In Bolivia, a similar scenario in which the problem of unsafe abortion is ignored within the official safe motherhood effort masks the reality of unsafe abortion and denies the need for care. Some health professionals have even suggested not discussing the issue publicly so as to be able to continue to provide care secretly.<sup>49</sup> These instances not only limit women's access to adequate health care, but also represent discriminatory medical practices in which some women receive care and some do not.

#### *⌘ Right to benefit from scientific progress*

From a technical point of view, abortion doesn't have to be fatal, or even particularly dangerous.<sup>50</sup> When it is carried out in hygienic conditions and with appropriate methods, it is a highly safe procedure.<sup>51</sup> This is becoming all the more true as recent scientific and technologic advances now include medical abortion and emergency contraception. Women who live in areas where abortion is illegal or inaccessible and contraception, including emergency contraception, is not available cannot benefit from these advances, which should, according to human rights doctrines, be universally available. Because they cannot access these quality services, they suffer the health consequences of dangerous methods. Moreover, there is a stark discrepancy in the quality and nature of services between rural and urban areas and socio-economic strata within nations, as well as between them.

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<sup>48</sup> Uprety. 2002.

<sup>49</sup> Rance. 1997.

<sup>50</sup> Rance. Ibid.

<sup>51</sup> WHO. 2002.

### *⌘ Right to information and education*

Access to information and education about health issues is conceptualized as part of the right to access to health care and services. In fact, Ireland was recently found to be in violation of the individual right to receive and impart information when the government tried to prevent circulation of information about abortion legally obtained in Britain.<sup>52</sup> The United States' "global gag rule" forbids non-governmental organizations receiving money from USAID to provide information regarding abortion services to clients. This policy has been challenged on the grounds of violating the right to seek and impart information, and it was revoked under the Clinton administration, but George W. Bush has reinstated it as part of US foreign policy.<sup>53</sup>

### *Right to Privacy*

*ICCPR Art. 17.1; CRC Art 16.1, 16.2; Cairo Para 7.45; Beijing Par 106, 107*

The right to privacy regarding decisions that people make about their own bodies, especially as it relates to reproductive capacity, ensures women's confidential and autonomous choice in reproductive matters.<sup>54</sup> On this basis, abortion is grounded on claims of personal privacy within which governments may not coerce choice or restrain liberty. The claim to the autonomous choice of women has been upheld by the European commission in cases in which a woman's partner has attempted to veto her decision.<sup>55</sup> Additionally, national laws that allow abortion on the grounds of privacy, such as the US law under *Roe v. Wade*, have been approved under international human rights

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<sup>52</sup> Lawless. 2002.

<sup>53</sup> CRLP-1. 2000.

<sup>54</sup> Pine. 1993.

<sup>55</sup> Lawless. 2002.

doctrines.<sup>56</sup> Despite this rights-based framework for federal law, *Roe v. Wade* has been undermined by court decisions and state mandates that allow such restrictions as parental notification and waiting periods, and have denied public funding for abortions.<sup>57</sup>

### **Summary of the Right to Abortion**

Because human rights are inextricably linked in both theory and practice, the denial of women's access to abortion puts human rights, as well as health, in jeopardy. As demonstrated by these provisions, international documents provide a strong basis for the right to abortion on many grounds. Moreover, when the right to abortion has been central to cases brought before human rights commissions, the documents have by and large been used to support access to safe abortion. In order to illustrate this discussion, I will explore access to safe abortion and human rights in Cambodia.

### **Religious Discourse and the Right of the Fetus to Life**

The claim to the right to life of the fetus changes the debate entirely. Some countries explicitly recognize the right to life of the unborn. For example, a 1983 amendment to the Irish Constitution states:

The state acknowledges the right to life of the unborn and, with due regard to the right to life of the mother, guarantees in its laws to respect, and as far as practicable, by its laws to defend and vindicate that right.<sup>58</sup>

In Ireland in 1992, Case X involved a 14-year-old rape victim who became pregnant and who, with her parents' support, attempted to obtain a legal abortion in England. The abortion was forbidden by the court on the basis of the amendment above. This case

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<sup>56</sup> Cook and Fathalla. 1996.

<sup>57</sup> NARAL. *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 10<sup>th</sup> Edition. 2001.

<sup>58</sup> Lawless. 2002.

caused a public outcry in Ireland, during which much of the populace who had voted in favor of the amendment, found themselves advocating for the girl's right to obtain an abortion. When the girl became suicidal as a result of the forced pregnancy, the case was again brought before the court by the girl's parents, and the previous ruling was overturned by a vote of 4-1 on the grounds that the life of the mother is equally important as the life of the fetus.<sup>59</sup>

On the international scene, the case prompted the European Commission on Human Rights to address the issue of the right to life of the unborn. Though the Commission did not explicitly state whether or not the right to life extends to the unborn, it did state that if that right does extend to the unborn, it is not an absolute right, and must be considered in relation to the right to life of the pregnant woman. It found that such an absolute right would be contrary to the spirit and purpose of the Convention.

If [the right to life] were held to cover the foetus and its protection were, in the absence of any express limitation, seen as absolute, an abortion would have to be considered as prohibited even where the continuance of the pregnancy would involve a serious risk to the life of the pregnant woman. This would mean that the 'unborn life' of the foetus would be regarded as being of a higher value than the life of the pregnant woman....<sup>60</sup>

As this case demonstrates, there is not a provision in the international rights doctrines that extends rights of any kind to the unborn. Additionally, this statement provides that any right of the fetus to life should not be regarded as more important than the life of the pregnant woman. However, it falls short of explaining what constitutes enough of a "serious risk to the life of the pregnant woman" to permit an abortion, *if*, and this is an "if" not granted by any international rights doctrine, the right to life extends to the fetus.

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<sup>59</sup> Lawless. 2002.

<sup>60</sup> Green Paper. 2002.



Interestingly, the most comprehensive criticism of Ireland's abortion laws comes from a Catholic Organization – Catholics for a Free Choice. A summary of their position is contained in the following statement:

... even in a country that is predominantly Catholic, laws governing abortion need not adhere to the Catholic hierarchy's narrowly defined position. The reasons cited were threefold. First, Catholic teaching and tradition, which stress the importance of conscience, leave room for a more nuanced position on abortion than that currently taken by the hierarchy. The Catholic church has acknowledged that it does not know when a fetus becomes a person and has not declared its teaching on abortion infallible. Second, many Catholics themselves do not support the church's position on abortion and their opinion, not the hierarchy's, should shape public policy. And finally, the Irish system has instituted a separation between church and state that makes it inappropriate for church doctrine to substitute as public policy.<sup>61</sup>

This statement supports the notion that regulations of abortion based on religious doctrines, specifically Catholic doctrines, should not dictate public policy or law. Freedom of religion preempts any legislation based on religious tenets espoused by the religious hierarchy.<sup>62</sup> Figureheads of the church invoke religious doctrines that are subject to interpretation and are by no means monolithic. There is much debate as to when life begins and how to legislate on "moral decisions" within religions, as well as outside of them.

Along these lines, citizens and members of the world's religions are not singular in their stance on the right to life of the fetus. In Tunisia, for example, first trimester abortion was legalized with the blessing of the Tunisian Islamic scholars.<sup>63</sup> Similarly, Turkey, as well as some predominantly Islamic former Soviet republics have liberal abortion laws.<sup>64</sup> In fact, Islamic scholars have differing views about when "ensoulment"

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<sup>61</sup> Catholics for a Free Choice. *Abortion in Good Faith: Reforming Irish Law*. 1999. [www.cath4choice.org/international/irish%20paper/abortioningoodfaith1199.htm](http://www.cath4choice.org/international/irish%20paper/abortioningoodfaith1199.htm) (last visited 2003).

<sup>62</sup> Catholics for a Free Choice. 1999.

<sup>63</sup> Freedman, L, and S. Isaacs. Human Rights and Reproductive Choice. *Studies in Family Planning*. 24(1). pp 18-30. 1993.

<sup>64</sup> Center for Reproductive Law and Policy (CRLP-2). Religious Voices Worldwide Support Choice. [www.crlp.org](http://www.crlp.org) (last visited 2002).

of the fetus occurs, and therefore differing opinions on when, and under what circumstances, abortion is permitted by Islamic law.<sup>65</sup> Further, in Islam, as in all religions, there is great diversity, ambiguous texts, contradictions and reform movements, as well as fundamentalist strands.<sup>66</sup> One study of Islam found that clerics who actually have contact with followers are more open to believe that economic hardship is a legitimate justification for abortion than those who engage solely in religious study.<sup>67</sup> All of these factors contribute to the current reality and the future possibility for Islamic nations to support access to safe abortion.

Within religions there is debate about when in the gestational period “personhood” or “ensoulment” occurs. There is also considerable support for the idea that, regardless of this philosophical debate, the question of whether or not to have an abortion should be an issue of personal choice, subject to the individual’s own conscience and moral decision-making strategy, rather than government dictates.<sup>68</sup> One thing is certain, women everywhere, of every religious faith, choose to have abortions, often under very dangerous conditions. In fact, one study found that Catholics in the US undergo abortions at a rate 29% higher than Protestant women.<sup>69</sup> Laws espousing a single view of when life begins and an endorsement of a religious tenet of some, may violate freedom of religion and non-discrimination by “preempting personal decisions of conscience” and failing to recognize women as capable of moral decision-making.<sup>70</sup> Fetal rights

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<sup>65</sup> CRLP-2. 2002.

<sup>66</sup> Obermeyer, C. A Cross-Cultural Perspective on Reproductive Rights. *Human Rights Quarterly*. 17(2). pp 366-381. 1995.

<sup>67</sup> CRLP-2. 2002.

<sup>68</sup> CRLP-2. 2002.

<sup>69</sup> CRLP-1. 2002.

<sup>70</sup> Pine. 1993.

proponents would argue that these same rationalizations were used to justify slavery and undermine the rights of people with disabilities and mental retardation.<sup>71</sup>

However, other arguments against extending rights to the unborn state simply that the fetus has no medical and legal rights as long as it is in the woman's body. According to Ruth Hubbard, "as long as you must manipulate the woman to get to the fetus, she is the only one with the right to make decisions about the pregnancy. Once it's outside, its well-being doesn't impact her physical autonomy."<sup>72</sup> In a case regarding maternal substance use in 1996, Canada's supreme court ruled that nobody has the right to interfere with a woman's pregnancy against her will, even if her behavior threatens the fetus. The majority opinion stated that, "the only law recognized is that of the born person. Any right or interest the fetus may have remains inchoate and incomplete until the birth of the child." Moreover, "the most sacred sphere of personal liberty – the right of every person to live and move in freedom... A pregnant woman and her unborn child are one... to make orders to protect fetuses would radically impinge on the fundamental liberties of the mother – both as to lifestyle choices and as to where she chooses to live..."<sup>73</sup> The majority opinion clearly supports the claim that only a born person, in this case the pregnant woman alone, can lay claim to human rights.

### **Access to Safe Abortion and Human Rights in Cambodia**

In Cambodia, approximately 2,000 women die each year from pregnancy-related causes and an additional 200,000 suffer lifelong disability.<sup>74</sup> Though exact numbers for

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<sup>71</sup> Flemming, J and Warwick, N. Submission to the Northern Ireland Human Rights Commission on Abortion and the Proposed Bill of Rights. 2000.

<sup>72</sup> Hubbard. 2002.

<sup>73</sup> Robinson, B.A. 1997. Balancing the rights of the woman and her fetus. [www.religioustolerance.org/abo\\_feta.htm](http://www.religioustolerance.org/abo_feta.htm) (last visited 2002).

<sup>74</sup> Beaufils. 2000.

abortion-related morality are unavailable, WHO estimates from a 1997 report an abortion-specific maternal mortality ratio of approximately 130/100,000 live births, which would represent over 25% of the maternal mortality ratio estimated in 1996 by the sisterhood method of 437/100,000.<sup>75,76</sup> Though the law to liberalize abortion has been passed, the lack of guidelines and therefore lack of availability of public services has led the UNFPA to believe that these figures are likely unchanged and unsafe abortion still represents a significant threat to the right to life of Cambodian women. Cambodia has ratified the ICESCR, ICCPR, CEDAW, and CRC.<sup>77</sup>

In Cambodia, women face many obstacles to security and liberty, including domestic violence, rape, trafficking, prostitution, and lack of access to reproductive health services including family planning and abortion. These factors all limit the extent to which a Cambodian woman has full possession and control over her own person – the basic tenet of security, liberty, freedom from slavery, and bodily integrity. In Cambodia, more than 80% of women have an unmet need for contraception; furthermore, though abortion was legalized in 1997, the law has not been implemented because the Ministry of Health has not issued the guidelines required by the legislature. This limits equitable access to abortion in the public sector, which is where all women, regardless of their economic situation, should be able to have safe abortions.<sup>78</sup> Due to the lack of provision of these services, Cambodian women are often faced with unwanted pregnancy and lack of the means to control their own fertility, person, and future.

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<sup>75</sup> WHO. *Unsafe Abortion: Global and Regional Estimates*. WHO 1997 & World Abortion Policies, UN.

<sup>76</sup> Sprechmann, Sophia, Soeung, Sann Chan, Kerr, Helen, Long, Chun, and Meakea, Mey. *Estimating the Magnitude of Maternal Mortality in Cambodia: An Application of the Sisterhood Method*. NMCHC. 1996.

<sup>77</sup> UNHCHR. 2002.

<sup>78</sup> Beaufile. 2000.

Though women with financial means can access quality services, women who are poor and marginalized, such as sex workers, have fewer options when faced with an unwanted pregnancy. It is estimated that more than half Cambodia's 30-50,000 sex workers have been trafficked or forced into this work.<sup>79</sup> Sex workers who become pregnant are often forced by the brothel owner to obtain abortions from certain providers. They therefore do not have the choice of whether or not to have an abortion, or freedom to choose a safe provider. This situation leads to the perpetuation of forced servitude and undermines their bodily integrity by subjecting them to the services of abortion providers chosen by the brothel owner. The public provision of services could help allay the situation by ensuring access to a range of providers and offering counseling that would focus on free choice so that women can decide for themselves whether to have an abortion or to carry a pregnancy to term.

In Cambodia, Article 35 of the Constitution guarantees the equality of men and women in political, social, economic, and cultural arenas.<sup>80</sup> Cambodia is also a signatory to the CEDAW, and has the internationally recognized obligation to eliminate discrimination against women in order to ensure the equal enjoyment of rights. Article 36 of Cambodia's constitution states that women and men must receive equal pay for equal work, however, while 67% of all manufacturing workers are female, women in this industry are paid 30% less than men in the same industry.<sup>81</sup> Though women constitute 52% of the workforce, they hold only 13% of the managerial positions. Moreover, while over one quarter of households are female-headed, these households report the smallest landholdings.

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<sup>79</sup> Unmacht. 2002.

<sup>80</sup> ADHOC. 2002.

<sup>81</sup> ADHOC. 2002.

There are few women in positions of decision-making authority; there are only two female ministers out of a total of 28 and the national assembly has only 10 women, compared to 112 men.<sup>82</sup> Of the 110 judges in Cambodia, just 8 are women, and there are no female prosecutors among the 40. In effect, though women form the majority of the population, they have little control over the creation of the law and policy that govern Cambodia's people.

Though education is seen as the key to empowerment for women, girls have much higher drop-out rates and lower enrollment rates than do boys because when family resources are short, it is girls who are kept at home to care for siblings and to work, while boys are allowed to pursue their education. As a result, just 51% of women are somewhat literate, compared to 85% of men.<sup>83</sup>

Domestic violence and rape continue to be widespread and largely unpunished crimes, which are major problems indicated by the High Commissioner's report on the situation of human rights in Cambodia.<sup>84</sup> Sexual double standards make it such that a girl who has sex before marriage is like "leftover food," but the same is not true for men.<sup>85</sup> A young woman who engages in pre-marital sex at the urging of a boyfriend who promises marriage, faces grave consequences. If the boyfriend subsequently refuses to marry her, she is left with a sullied reputation and is often not considered for future marriage. Girls in this situation may be more easily coerced into prostitution.<sup>86</sup>

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<sup>82</sup> Beaufils. 2000.

<sup>83</sup> Hammarburg, Thomas. Report on Human Rights in Cambodia. [http://members.aol.com/cambodia/un\\_rep3-3.htm](http://members.aol.com/cambodia/un_rep3-3.htm) (last visited 2003).

<sup>84</sup> UNHCR. 2002.

<sup>85</sup> Beaufils. 2000.

<sup>86</sup> Beaufils. 2000.

Prostitution and trafficking of girls and women are on the rise in Cambodia, with family members as well as strangers implicated in this exploitation.<sup>87</sup>

Access to health services, including reproductive health services, is limited for a significant portion of the population, which contributes to Cambodia's high maternal mortality rate. Due to limited access to health services, such as contraceptive methods and reproductive health services, 80% of Cambodian women have unmet need for contraception. They therefore risk the health complications of unplanned pregnancy.

In Cambodia, access to abortion services is severely limited by the lack of guidelines despite the ostensible legality of the procedure. Though abortion was legalized in 1997, the lack of guidelines has translated into the lack of provision of abortion services in the public sector, forcing women to use private facilities, which for poor women means accessing services from untrained TBAs. The high unmet need for contraception indicates a significant lack of access to appropriate health services, and implies a high demand for abortion services. This lack of services is felt disproportionately by rural women who often live far from health facilities. Over 84% of Cambodian women deliver their babies without trained personnel, relying instead on services from TBAs or delivering with no assistance whatsoever.<sup>88</sup> Access to affordable, good quality health care is extremely limited for most of the population. According to the Special Representative to the UNHCHR, the amount of money spent on health care is disproportionate to the income of most households: in 1996, households with incomes of

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<sup>87</sup> Unmacht. 2002.

<sup>88</sup> ADHOC. 2002.

less than \$15 per month spent 28% of their incomes on health care and 45% of households had to borrow money to pay for in-patient care.<sup>89</sup>

Moreover, due in large part to the lack of adequate salaries and training, health care workers have been known to deny care to people who are unable to pay, channel clients to their private clinics, and extort money from patients.<sup>90</sup> The problem of low salaries is a serious structural obstacle to the right to health in Cambodia. This situation consistently undermines the quality of services provided in the public sector and entices workers to deny services at the public clinics only to offer them to clients in their own private “clinics” so that they can supplement their public income. This diverts revenues from the public sector and jeopardizes the availability of public health services by limiting the service delivery points and potentially driving up the cost, which pushes poor people to access services from less well-regarded practitioners who charge lower fees. Though this issue is of great concern, it was not selected as a health care sector priority for 2003-2007 by the Health Sector Review Board.<sup>91</sup>

In terms of the right to benefit from scientific progress, in Cambodia the WHO-sanctioned method for first trimester abortion, Manual Vacuum Aspiration, is only available at two clinics in the capital city of Phnom Penh, while 84% of the population lives in rural areas with only limited access to distant, as well as inappropriate, abortion services.<sup>92</sup>

In Cambodia, it is generally accepted that the Buddhist religion is uncompromising in its respect for life, a view that carries over to the abortion debate. It is thought that

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<sup>89</sup> UN. 1999.

<sup>90</sup> UN. 1999.

<sup>91</sup> ADHOC. 2002.

<sup>92</sup> Beaufils. 2000.



having an abortion is killing an unborn baby, and if you have an abortion, you will receive bad karma.<sup>93</sup> However, Buddhism in Cambodia also recognizes the economic pressures on families and women, and there are many sympathetic monks who understand the difficult position women with unwanted pregnancies find themselves in. Though a person may receive bad karma for having an abortion, this bad karma must be weighed against the reality of carrying an unwanted pregnancy to term and having a child. It is just one factor to be considered in this decision.

The lack of equal access to education, positions of power, land, and income for Cambodian women undermines their ability to limit the perpetuation of the widespread violence, rape, trafficking, prostitution, and lack of access to necessary reproductive health services that they experience. In turn, the persistence of violence against women and lack of the means to control their fertility and destiny prevent Cambodian women from accessing educational, economic, and career opportunities. This represents a vicious cycle of gender discrimination in which the inability to realize each of these rights in turn makes it more difficult to exercise each of the other rights, thus illustrating the indivisibility of civil, political, economic, social, and cultural rights. The lack of access to safe abortion services in Cambodia undermines the ability of Cambodian women to control their fertility, their destiny, and therefore, their ability to participate fully in the wide range of human rights that they are ostensibly guaranteed.

### **Conclusion**

The interconnectedness of rights implies that a woman has the right to control her own body, fertility, and therefore destiny, if she is to be empowered and able to fully enjoy her civil, political, economic, social, and cultural rights. It is perhaps this very

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<sup>93</sup> Green, Caroline. Abortion in Cambodia stigma and controversy. *Phnom Penh Post*. August, 16 2002.

notion that makes the issue of the right to abortion so controversial. If it is true that it is necessary to have access to safe abortion in order for women to be full citizens, then it follows that people who do not believe women should, or are capable of, exercising a full range of freedoms are opposed to the right to abortion. As stated by Rachael Pine, “abortion is the fulcrum of a much broader ideological struggle in which the very meanings of family, the state, motherhood, and young women’s sexuality are contested.”<sup>94</sup> Opposition thus stems from the desire to keep women in their traditional role as mothers and wives, essentially “barefoot and pregnant.”

In Cambodia women’s roles are defined very differently than those of men. There is a clear sexual double standard: traditionally “good” women are only valued as virginal, pure girls or mothers whose role is to care only for the well-being of her family. This double standard extends into the political and civil sphere where Cambodia still lacks significant representation of women in positions of decision-making authority in the government, the judiciary, or management. Though this view is changing somewhat in Cambodia with the work of the Ministry of Women’s Affairs, the UNFPA, and numerous NGOs, there is still much work to be done to improve the status of women. If one looks at safe abortion within the context of the low status of women and the perpetuation of traditional gender roles, it is not surprising that the MoH is dragging its feet to pass the guidelines and there doesn’t seem to be much political pressure to make them move more quickly.

Just as the full realization of women’s human rights is dependent on her ability to control her fertility, so are her reproductive rights and health influenced by access to, and

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<sup>94</sup> Pine. 1993.

control over, social resources.<sup>95</sup> This was recognized in 1994 by the International Federation of Obstetrics and Gynecology, which stated that there is a need for state action to correct injustice to women, recognizing that health is compromised by infringements on human rights, not just lack of medical knowledge.<sup>96</sup> For instance, a woman's education level strongly influences her reproductive health, use of family planning, and child survival.<sup>97</sup> This indicates the need for reproductive health advocates to not only call for narrow provisions relating to health, but also universal education, and the removal of barriers to girls education and the opportunity to enjoy a free and open future. Legal literacy and legal service programs to help women understand their rights and use courts to advocate for their rights also have a central role in the effort to improve reproductive health and attain access to safe abortion. These advances, however, depend on an effectual judiciary, which is absent in countries like Cambodia.

Theoretical rights are meaningless if there are no means to exercise those rights due to constraints of poverty, political turmoil, gender inequality, or cultural norms that infringe on the full enjoyment of rights.<sup>98</sup> This is strikingly obvious in Cambodia where the population as a whole suffers from governmental corruption, economic inequality and judicial ineffectiveness. As one document states, "The failure to implement legislative measures to curb corruption by state and government officials violates the people's fundamental economic, social and cultural rights and counteracts efforts to secure social justice and genuine poverty reduction."<sup>99</sup> Women are disproportionately affected by this

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<sup>95</sup> Uprety. 2002.

<sup>96</sup> Cook and Fathalla. 1997.

<sup>97</sup> Yamin and Maine. 1999.

<sup>98</sup> Freedman, L. and D. Maine. Facing Facts: The Role of Epidemiology in Reproductive Rights Advocacy. *The American University Law Review*. Vol.44. pp 1085-1092. 1995.

<sup>99</sup> ADHOC. 2002.

reality due to their low literacy rates, lack of representation in positions of power, low wages, and their susceptibility to trafficking, violence, and rape. However, participation in civil society is on the rise and each day women are becoming more involved, creating organizations to empower themselves, and advocating for social change in Cambodia.

According to Pine, “there must be a move to ensure reproductive choice within the socio-economic context in which real choices are made.”<sup>100</sup> This points to a need to address the constraints and coercions that impede the right to freely decide about whether to have children and highlights issues such as sex-selective abortion. These issues extend far beyond the legality of abortion, and are deeply rooted in the economic, cultural, and social realities of individuals throughout the world – individuals to whom the rights discussed thus far theoretically apply equally. Health programs and policy in a vacuum can do little to address these fundamental factors that structurally limit an individual’s or community’s ability to fully exercise their rights, including the right to control their fertility. Therefore, comprehensive, multidisciplinary strategies that involve the local community and aim for empowerment are the only means to fully address the implicit and explicit violation of rights that I have described.

### **Future Directions**

Situating the right to abortion firmly in the human rights discourse is a major step forward in addressing the depth and breadth of unsafe abortion. Further, it establishes the basis for widespread advocacy. Human rights documents can and should be used to hold governments accountable for violations of reproductive rights. These include direct action on the part of the state, such as coercive sterilization, as well as inaction to meet the minimum core obligations to human rights, which includes neglecting to address

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<sup>100</sup> Pine. 1993.

significant causes of mortality and morbidity, such as unsafe abortion. Therefore, both state action and inaction that are contrary to the right to essential health services and the means to protect one's reproductive health should be sanctioned by the UN Human Rights Commission. Moreover, violations relating to structural discrimination that disadvantage women in the aggregate, such as broad discrepancies in access to health services, must be addressed.

It has been suggested that reproductive rights impact assessments be created to help governments determine their programs of action with regards to meeting reproductive health needs.<sup>101</sup> Tools that help governmental and non-governmental organizations incorporate rights-based aspects to their work represent an important bridge between establishing a theoretical basis for reproductive rights, including abortion, and taking the steps to incorporate these norms into practice. A model of this sort was discussed by Sofia Gruskin, of the François-Xavier Bagnoud Center for Health and Human Rights at Harvard University, as it relates to her work with the government of Mozambique. The model includes the following steps:<sup>102</sup>

1. The development of a rights framework.
2. The incorporation of this framework into the language of political statements.
3. A review of state laws as written and as carried out.
4. The collection of data that reflects the reality of reproductive health and rights.
5. The creation of new programs and re-allocation of resources.

The issue of unsafe abortion can be explicitly incorporated into this model and used for the practical goal of helping governments improve their response to this pressing need.

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<sup>101</sup> Yamin and Maine. 1999.

<sup>102</sup> Gruskin, Sophia. Personal Communication. 2002.

In the international arena there remains considerable work to be done in the effort to ensure access to safe abortion. The steps outlined above indicate ways to move forward in the promotion of reproductive and abortion rights and health, given the current laws and documents that govern abortion today. However, we must also continue to advocate for access to safe abortion as a universal human right. There is a strong basis for doing so in current human rights documents, but an explicit provision for the access to safe abortion and reproductive self-determination is necessary.<sup>103</sup> Not to do so is to continue to deny women the opportunity to fully experience human rights in their entirety.

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<sup>103</sup> Abrams, P. Reservations About Women: Population Policy and Reproductive Rights. *Cornell International Law Journal*. 1996.

## Section II: Abortion, Human Rights, and Domestic Law

Laws on abortion vary widely from country to country, but even in places where laws are not restrictive, the application of the law depends largely on the wording of the law, associated requirements to implement the law, political will, and a proactive public health care system. Both the Cairo Platform and the Beijing Programme call on governments to recognize unsafe abortion and urge government action to liberalize abortion laws and improve abortion-related services. As stated in the ICPD+5 Review of Progress in 1999:

Paragraph 63(iii)... in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health.<sup>104</sup>

Even in countries where the right to safe abortion has been recognized legally, access to such services is often limited. Cambodia is one such country. Though abortion was legalized there in 1997, the guidelines needed to begin the process of making the law a reality have not been issued and the services are therefore not available in public clinics. This brings into question the issue of legislating abortion law, as often the way the law is conceptualized and worded has significant implications for how the law is implemented and whether it is implemented at all. For instance, in the UK, the wording of the abortion law contained special regulations that only permitted inpatient procedures, which took over a quarter of a century to change.<sup>105</sup> A similar situation occurred in India, where the 1972 abortion law is still not a reality for most rural Indians. Though the procedure has

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<sup>104</sup> *ICPD+5 Review of Progress*. New York, 1999.

<sup>105</sup> Potts, Malcolm. Personal Communication. 2002.

been legal for decades, more unsafe than safe abortions still take place and a reported 10 out of every 11 abortions are performed outside of the public health system.<sup>106</sup>

Belgium, on the other hand, requires that facilities offer appropriate counseling and information about the support a woman can receive if she chooses to carry the pregnancy to term, and only stipulates that abortions be performed under “good medical conditions.”<sup>107</sup> While in many countries laws constrain provision by only allowing physicians to perform abortions, in Botswana and Cameroon, registered or qualified “medical practitioners” may do so. In Bangladesh, “family welfare personnel” are allowed to perform menstrual regulations.<sup>108</sup> These seemingly small differences in the law can have a profound impact on how the law is implemented and how women’s lives are affected.

However, factors beyond the wording of the law itself are instrumental in the application of the law. Medical barriers are not uncommon where doctors have the ultimate decision-making authority about whether a woman may receive an abortion. This is the case in the UK, though liberal interpretation of the law seems to make abortion veritably available upon request. Physician and community opposition to abortion in certain areas of the United States, Germany, and Poland significantly limit access to abortion. Additional restrictions on abortion, such as stipulations about the type of facility or provider that can offer the services, gestational age, waiting periods, third-party authorizations, mandatory counseling, and registration of the procedure have been

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<sup>106</sup> Anderson, David. Abortion, Women’s Health and Fertility. International Union for the Scientific Study of Population. 1998. [www.iussp.org/Publications\\_on\\_site/PRP/prp15.htm](http://www.iussp.org/Publications_on_site/PRP/prp15.htm) (last visited 2003).

<sup>107</sup> Rahman, A. et al. A Global Review of Laws on Induced Abortion, 1985-1997. *International Family Planning Perspectives*. 24(2). pp 56-64. 1998.

<sup>108</sup> Rahman. 1998.



justified on claims of concern about the safety of the services.<sup>109</sup> The cost of abortion services and lack of public funding can also limit access to services, even where they are legal. This reality is best summarized below:

Because laws are subject to widely varying interpretations by governmental authorities and by medical personnel and because enforcement is uneven or (sometimes) nonexistent, the literal wording of laws paints an imperfect picture of their impact on medical practice and on the actual availability of legal abortion services. Moreover, the attitudes of the medical community and inadequacies in the country's healthcare system may limit abortion availability even where services would be legally permissible.<sup>110</sup>

In Cambodia, because the guidelines that are required by the 1997 abortion law have not been implemented, abortion services are not available readily in the public sector. The reasons that the guidelines haven't been signed and applied are thus far unclear. The ramifications of this are also not known, though it is thought by many reproductive health professionals in Cambodia and the local UNFPA office that, because there has been no training of health care providers in the procedure, nor regulated provision of abortion services, the safety of abortion has not improved since the law passed.

The situation in Cambodia highlights the indivisibility and interconnectedness of human rights. Basic civil and political rights; economic, social, and cultural rights, including gender equality and access to safe abortion, are threads of a common cloth. The strength of the fabric depends on the integrity of each individual strand, as reproductive rights and human rights are woven together. Forces that threaten access to safe abortion, as well as those that threaten more widely recognized human rights, work to unravel this fragile cloth and the full enjoyment of life.

Based in part on the steps outlined previously by Gruskin, and considering the earlier discussion of abortion and human rights, the Cambodian context provides fertile ground

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<sup>109</sup> Rahman. 1998.

<sup>110</sup> Rahman. 1998.

on which to review how the abortion law is written and carried out, as well as collect data that reflects the reality of abortion services within the larger purview of human rights. This research can then be used for the creation of programs, considering the context of the status of women and human rights discussed in the previous section, to address the needs yet to be met by the abortion law.

In Section III, I explore the context of abortion in Cambodia by employing qualitative and quantitative research methodology.

### **Section III - Abortion in Cambodia: A Qualitative and Quantitative Study of the Current Situation in Cambodia**

#### **Background**

##### **Introduction**

While unsafe abortions pose a significant health risk to women throughout the world, unsafe abortions occur in much greater numbers in certain parts of the world. Half of the world's unsafe abortions take place in Asia (10,000,000), with nearly one third (6,500,000) in Southeast Asia alone. In Asia, more women die from unsafe abortion than in any other region of the world, and an estimated 12% of all maternal mortality is thought to be caused by unsafe abortion, with an estimated 38,000 women dying per year from these procedures.<sup>111</sup> Morbidity and mortality associated with unsafe abortion is a critical public health concern worldwide, as it is an entirely preventable problem due to the low health risk of safe abortions. As I have argued, however, abortion can, and should, also be conceptualized within the human rights framework. Reproductive rights, which enable a person to control her own body, fertility, and therefore destiny, are intimately linked with a person's capacity to take part in a full range of civil, political, and economic rights.

##### **Cambodian Context**

In Cambodia a liberal abortion law was passed by the National Assembly in 1997. The law permits abortion on demand for pregnancies up to 12 weeks; for pregnancies over 12 weeks abortion is permitted if the woman's life is in danger, if the child would have an incurable disease (including HIV/AIDS), or if the pregnancy is a result of rape

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<sup>111</sup> Ipas. *Unsafe Abortion in the ESCAP Region*. [www.ipas.org](http://www.ipas.org) (last visited 2002).

(or incest). For a later term abortion (over 12 weeks), a woman's decision to abort must be approved by a group of 2 to 3 physicians.<sup>112</sup> Abortions can be performed by any health professional and health facility authorized by the MoH.<sup>113</sup> However the guidelines necessary to implement the law, known as "PRAKAS," have not yet been issued. This represents a situation in which a "liberal" abortion law has been passed, but, due to the wording and stipulations of the law, which require MoH action, it has not been implemented.

As is the case in most countries, abortion is not a topic that is openly discussed in Cambodia, nor are statistics on the topic easily gathered. The CDHS approximated a 5% prevalence of abortion among all women, but CDHS abortion statistics are thought to demonstrate significant underreporting, in part because of the difficulty of collecting reliable data on this sensitive issue from women in large-scale household surveys.<sup>114</sup> The CDHS also found that among women ages 45-49, the oldest age group of women surveyed and therefore those who most closely represent a lifetime prevalence, 8.7% reported ever having had at least one abortion.<sup>115</sup> Preliminary data from a study of 91 indirect sex workers (in this case, "beer girls")<sup>116</sup> indicate an abortion prevalence of 56%, with a median number of 2 abortions among the 51 beer girls who had ever had an abortion. Of the 81 beer girls who had ever been pregnant (88% of the total), the abortion prevalence was 63%.<sup>117</sup> Though data on abortion specific mortality has not

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<sup>112</sup> See Appendix: Cambodia Abortion Law. 1997.

<sup>113</sup> UNFPA. Country Population Assessment Report. Cambodia.

<sup>114</sup> UNFPA. *Cambodian Demographic and Health Survey (CDHS), 2000*. Chapter 6, page 67. 2001.

<sup>115</sup> UNFPA. *CDHS, 2000*. Chapter 6, page 68. 2001.

<sup>116</sup> Indirect sex workers are girls working in the sex industry indirectly, such as via entertainment, drinking and eating establishments, but who do not operate in brothels. "Beer girls" specifically refers to women and girls who work in this capacity, officially as beer promoters in eating and drinking establishments.

<sup>117</sup> Kim, Andrea. Unpublished study from UCSF and NCHADS collaborative work on beer girls in Battambang. Personal communication. 2002.

been collected recently, WHO estimates from a 1997 report an abortion-specific maternal mortality ratio of approximately 130/100,000 live births, which would represent over 25% of the maternal mortality ratio estimated at 437/100,000 in 1996.<sup>118,119</sup>

### **Rationale**

Although the MoH has made maternal and child health a “high priority”, and the strategic plan for safe motherhood includes abortion care, very little information has been collected to create effective programs to address this stated priority in the area of abortion.<sup>120</sup> Therefore, there is a pressing need for accurate information about the current state of induced abortion, including a profile of service provision, in order to aid in the MoH effort to address this issue and attract funding for this agenda.

Because an estimated 84% of Cambodians live in rural areas, and there is a high unmet need for contraceptives and more limited access to health services in these areas, it is especially important to look at abortion in rural areas. However, recent unpublished research indicates that among over 2,000 women surveyed, those who have had abortions have received only 5.5% of services from TBAs, with the majority receiving services from other “private sources.”<sup>121</sup> For this reason, the Cambodian office of the UNFPA in Cambodia wanted to survey public and private Abortion Service Providers (ASPs), at the district and commune/village level to obtain an overview of abortion to assist in the creation of a reality-based and effective MoH Safe Abortion Program.

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<sup>118</sup> *Unsafe Abortion: Global and Regional Estimates*. WHO 1997 & World Abortion Policies, UN.

<sup>119</sup> Sprechmann, et al. 1996.

<sup>120</sup> *Cambodian Safe Motherhood National Strategy*. Section 1.C.1.24. 1997.

<sup>121</sup> Long, Dr. Chhun. Unpublished study from the National Reproductive Health Program. Personal communication. 2002.

## Objectives

The general objective of this study was to bring the situation of abortion to the attention of donors, policymakers, and program planners by providing information on the experience and effects of current abortion policies, with the ultimate goal of reducing maternal morbidity and mortality associated with unsafe abortion. This study did not aim to achieve a country-wide representative sample. Instead, a few sites were selected to provide some indication of the situation in regard to abortion - thus, the results should not be considered “generalizable”, but rather “indicative.” The research team gathered information from providers in two provinces as well as key informants in Phnom Penh in order to provide a broad overview of the way abortion issues are conceptualized in Cambodia, and to provide an indication of the reality of the practice of abortion in the study areas.

The study’s specific objectives were to:

1. indicate the demand for abortion services.
2. identify the demographic characteristics of women seeking abortion.
3. understand the health consequences of unsafe abortion.
4. profile ASPs at the district and commune level, including their level of training, income earned through the provision of abortion-related services, and whether they practice in the public or private sector.
5. elucidate the nature of abortion-related care, including methods used to induce abortion, the location of service provision, the cost and quality of services, and the prevalence of post-abortion birth spacing counseling and provision of birth spacing methods.
6. identify how providers and clients understand the legal status of abortion.
7. understand how policy makers, programmers, donors, and providers envision the future of abortion care.

## **Study Design**

The data collection period of this study had two phases and incorporated both qualitative and quantitative methods. Phase One was a survey of Abortion Service Providers, and Phase Two consisted of a series of key informant interviews.

### ***Phase One:***

#### **Survey of ASPs**

A survey of 75 abortion service providers was implemented in two provinces, Takeo and Pursat, in order to collect quantitative data on the areas of interest identified above.

#### ***Design and Study Population***

This arm of the study consisted of a retrospective, cross-sectional survey of ASPs practicing on the district, commune and village level in the provinces of Takeo and Pursat. For the purposes of this study, doctors, nurses, midwives, TBAs and medical assistants were surveyed.

#### ***Methodology***

#### **Research Team**

This study represented a collaboration between personnel from the UNFPA, MoH, MWVA, RHAC, and CARE, as well as a student from the RUPP. Personnel who work with each of these organizations were involved in various aspects of the design, training, and implementation of the survey.

The research team in Takeo consisted of the author, along with a supervisor from MWVA and three interviewers from MWVA. Additionally, a supervisor from RHAC worked part time on the project and a student from RUPP was an interviewer for the study. A staff member of RHAC in Takeo who is familiar with practitioners involved in

reproductive health services in the area acted as the local informant for the purpose of identifying providers.

The research team in Pursat consisted of the author, one CARE supervisor from Kompong Chhnang, one CARE midwife from Kompong Chhnang, one CARE midwife from Pursat, and two DoH midwives who work with CARE in Pursat.

### Survey Instrument

The questionnaire was drafted based in part on WHO guidelines for conducting research on unsafe abortion, as well as on other reproductive health surveys used in Cambodia.<sup>122</sup> This draft was circulated to local personnel in each of the collaborating organizations with experience in the field as well as other consultants. The primary translation into Khmer was done by MWVA staff, with revisions made by staff from the UNFPA, MoH, and RHAC. The instrument was further modified after training and field-testing. It was then back-translated to check for accuracy.<sup>123</sup>

### Training and Field-testing

The author and the RHAC-associated field supervisor worked together to design a one-day training course for surveyors, which took place the weekend before fieldwork. The training was conducted by Dr. Chhun Long of the NRHP and the RHAC field supervisor. Emphasis was placed on building rapport with the respondent, following the survey instrument correctly, and recording data accurately. Additionally, the training included the theory and practice of abortion research, collecting data in an unbiased manner, and problem solving. The day after the training, field-testing took place in Kandal province with Kandal MWVA staff acting as local informants for the purpose of

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<sup>122</sup> WHO. *Studying Unsafe Abortion: a practical guide for programme managers*. 1995

<sup>123</sup> The survey instrument is included in the Appendix in both English and Khmer.



mapping and identifying providers. The field-testing allowed for cross-checking of the translation of questions and establishing the appropriate question order, as well as determining the length of the interview. We also checked the validity and reliability of questions and made appropriate modifications.

### Sampling

Takeo and Pursat were chosen to be the study areas primarily for convenience. Takeo was chosen because the field supervisor had to be there for other professional obligations during the time that this study was scheduled to take place. Pursat was chosen because the CARE team and field supervisor in that area were available at the time the study was scheduled to take place. Random sampling of study areas was not implemented and therefore the data cannot be generalized, but rather should be thought of as indicative. This method is similar to the sampling method used in the Safe Motherhood Situation Analysis of 1997.<sup>124</sup> The ways in which these two provinces are similar and different from other areas in Cambodia should be considered when interpreting the data, and I discuss this in the limitations section.

Because there is no registry of ASPs, we employed convenience sampling and identified abortion providers in each province with the assistance of a local informant with familiarity with reproductive health service providers in the area. We attempted to interview all known ASPs identified by the local informant. If a provider was unavailable, we attempted to reach the provider at a later time. However, we were unable to reach five identified ASPs because they were away for training or due to personal obligations. We also used snowball sampling, as we asked practitioners surveyed if they

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<sup>124</sup> *Safe Motherhood Situation Analysis based on Qualitative Data*. Royal Kingdom of Cambodia, MOH. 1997

knew of other abortion providers in the area and we attempted to interview practitioners identified in this way, as well as those identified by the local informants.

### Data Collection

Data was collected from June 17 through June 21, 2002 in Takeo, and from June 24 through June 28, 2002 in Pursat. Interviewers visited the ASPs in their place of work or their home, which were often one and the same. Interviewers explained the purpose of the study and asked for verbal informed consent.<sup>125</sup> Upon consent, interviewers conducted a structured interview with both open and closed-ended questions. Respondents were each compensated two US dollars for their time in Takeo, and given a sarong of approximately equal value in Pursat.<sup>126</sup> Data collectors recorded any problems that arose in the field, and the survey team met each day for supervision and to check the quality of data collection.

### Data Analysis

UNFPA staff transferred and translated the responses to the questionnaires into an Excel file. The author theme-coded open-ended answers and entered all responses into SPSS 11.0. The author conducted descriptive analysis using SPSS 11.0, under the supervision of Nicholas Jewell, Professor of Biostatistics at the UC Berkeley School of Public Health.

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<sup>125</sup> Verbal, as opposed to written, informed consent was obtained for purposes of maintaining confidentiality and building trust.

<sup>126</sup> Respondents were given a sarong as opposed to cash in Pursat per the request of a local NGO that expressed concern over setting a precedent of giving cash for participation in research.

## **Findings**

### **Service Delivery**

#### ***Providers***

As indicated in Table 1, of the 75 practitioners interviewed, 6 were doctors, 4 were nurses, 48 were midwives, 14 were TBAs, and 3 were medical assistants. The majority of abortion providers in our sample are MWs and TBAs, with services also provided by doctors, medical assistants, and nurses.

**Table 1: Profession of ASPs Surveyed**

Profession	Frequency (number)	Percent
<b>Doctor</b>	6	8%
<b>Nurse</b>	4	5%
<b>Midwife</b>	48	64%
<b>TBA</b>	14	19%
<b>Medical Assistant</b>	3	4%
<b>Total</b>	75	100%

#### ***Training***

Though providers were not asked specifically about their training in abortion techniques, data on their professional training was gathered. All of the physicians surveyed have attended medical school. Eighty-five percent of midwives have received some technical training and 100% of nurses and medical assistants have received some technical training. However, only 14% of TBAs have received some technical training, with 72% learning from “a ghost”<sup>127</sup>, being self-taught, or apprenticing with a midwife or another TBA, and 14% were trained as health workers at refugee camps during the Khmer Rouge regime.

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<sup>127</sup> A TBA told us that learning from “a ghost” involves being visited by a spirit who comes to you in a vision and tells you how to perform an abortion.

## *Methods*

Of the 75 providers interviewed, 51 providers, 68% of the sample, reported providing first trimester abortion services. Of those, the main methods used to induce abortion in the first trimester are manual vacuum aspiration, dilation and curettage, electrical vacuum aspiration, Cytotec<sup>®</sup> (misoprostol), and deep massage.<sup>128,129,130</sup>

Data presented in Table 2 illustrates that the provision of different methods varies by profession. Midwives and doctors are most likely to use MVA, with approximately 50% of those interviewed from each profession reporting the use of that method. Approximately 33% of medical assistants, 25% of nurses, and 20% of TBAs use MVA. D&C is most likely to be used by nurses, with 75% reporting the use of curettage, while 66% of doctors surveyed use D&C. Half of TBAs surveyed use D&C, and one third of midwives and medical assistants use it. Electrical vacuum aspiration is used by nurses and medical assistants, and a small minority of midwives. Cytotec<sup>®</sup> is used by only one doctor. Massage is practiced by five TBAs.

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<sup>128</sup> Abortion can be performed safely using aspiration, surgical, or medical methods. Within these categories, a variety of techniques and agents can be used, depending on the training and skills of the staff and the equipment and pharmaceutical agents available. Vacuum aspiration methods for abortion include manual, electric or pedal and hand pump aspiration. Surgical methods for abortion are sharp curettage (also known as dilatation and curettage or D&C), and dilatation and evacuation (D&E). Many international and national authorities consider vacuum aspiration an essential service for uterine evacuation; vacuum aspiration is generally preferred over D&C because it is associated with fewer complications. Medical methods for abortion include administering pharmaceutical agents, such as misoprostol (Cytotec<sup>®</sup>). Ipas. [http://www.ipas.org/english/womens\\_health/abortion/](http://www.ipas.org/english/womens_health/abortion/) (last visited 2003).

<sup>129</sup> Based on key informant interviews, and as described by some of the TBAs surveyed, deep massage is described as a method practiced by traditional healers which involves lifting the uterus and applying deep pressure repetitively, sometimes over the course of days, until bleeding ensues.

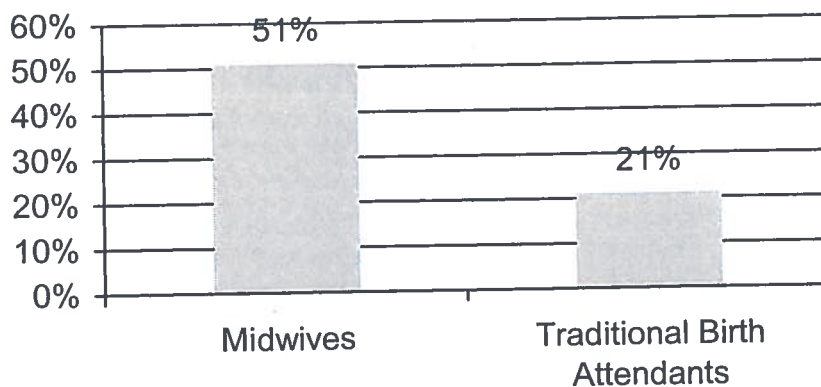
<sup>130</sup> Oxytocin is a hormone that is used to induce labor by promoting uterine contractions, but it can also be used as an abortifacient, though with debatable success depending on the dose and stage of pregnancy when it is used, generally thought to be relatively ineffective in the first trimester in part because it does not soften the cervix. Baird, D. 2000. Mode of Action of Medical Methods of Abortion. *Journal of the American Medical Women's Association*. Vol. 55, No.3. supplement. pp 121-126

**Table 2: Methods used for First Trimester Abortions by Profession<sup>131</sup>**

	MVA	D&C	EVA	Massage	Cytotec <sup>®</sup>	Oxytocin
<b>Doctor (n=6)</b>	50%	66%	0	0	16%	0
<b>Nurse (n=4)</b>	25%	75%	50%	0	0	0
<b>MW(n=48)</b>	51%	33%	4%	0	0	0
<b>TBA (n=14)</b>	21%	50%	0	36%	0	2%
<b>MA(n=3)</b>	33%	33%	33%	0	0	7%
<b>TOTAL</b>	44%	41%	7%	7%	1%	3%

As depicted in Figure 1, when we compared midwives and TBAs on the provision of WHO-recommended vacuum aspiration techniques, we found that 51% of midwives use these methods, while only 21% of TBAs do, which is a statistically significant difference.

**Figure 1: Percentage of Provider Performing Vacuum Aspiration (p=.04)**



<sup>131</sup> Note that figures don't add to 100% as providers may use more than one procedure to induce abortion in their practice.

Second trimester abortions are provided by 19 of the 75 providers, representing 25% of the survey population. As indicated in Table 3, the methods used vary by provider. MVA is provided by 3 midwives and 2 TBAs; D&C is used by 1 doctor, 4 midwives, and 4 TBAs; “Covac”<sup>132</sup> is used by 1 doctor, 1 nurse, 4 midwives, and 1 TBA; One TBA inserts an object into the cervix to induce second trimester abortion, and deep massage and the administration of oxytocin are used by 1 TBA.

**Table 3: Methods used for Second Trimester Abortions by Profession**

	MVA	D&C	Insert object	Massage	Oxytocin	Covac	C-Sxn
<b>Doctor (n=2)</b>	0	1	0	0	0	1	1
<b>Nurse (n=1)</b>	0	0	0	0	0	1	0
<b>MW (n=9)</b>	3	4	0	0	0	4	1
<b>TBA (n=7)</b>	<sup>2</sup>	4	1	1	1	1	0
<b>MA (n=0)</b>	0	0	0	0	0	0	0
<b>TOTAL (n=19)</b>	5	9	1	1	1	7	2

Only 5 of the 75 practitioners interviewed offer third trimester services, which represents 7% of the study population. “Covac” is reportedly used by five practitioners for third trimester abortions, including one nurse, three midwives, and one TBA.

<sup>132</sup> According to providers, “Covac” is a method that reportedly involves inserting a condom filled with oxytocin and saline into the uterus to induce the expulsion of uterine contents.

### Cost

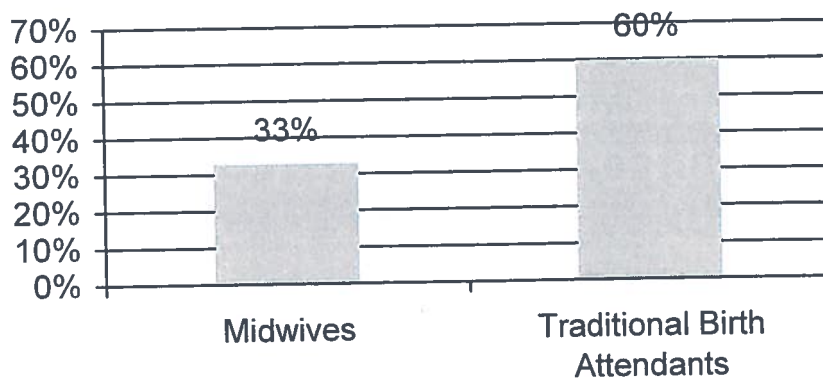
The cost of abortion-related services was also shown to vary by the type of provider. Table 4 indicates that the least expensive services are available from TBAs, with higher fees charged by doctors, nurses, and midwives.

**Table 4: Average Cost of Services in US Dollars by Profession (standard deviation in parenthesis)**

Provider	Average cost of first trimester, \$US	Average cost of second trimester, \$US	Average cost of third trimester, \$US	Average cost of complications, \$US
<b>Doctor</b>	16 (5.2)	75 (-)	-	16 (3.6)
<b>Nurse</b>	21 (4)	120 (-)	120 (-)	-
<b>Midwife</b>	15 (9.4)	76 (35)	35 (-)	22 (24)
<b>TBA</b>	10 (7.1)	33 (29)	75 (71)	-
<b>MedicalAsst</b>	16 (4)	-	-	-
<b>All</b>	15 (8.6)	64 (39)	76 (54)	19 (16)

Figure 2 depicts the cost of services provided by TBAs vs. those provided by MWs. We found that 60% of TBAs offer services for \$10 or less, while only 33% of midwives offer services at this cost.<sup>133</sup> However, this difference did not reach statistical significance.

**Figure 2: Percentage of Providers offering services for \$10 or less (p=.09)**



<sup>133</sup> \$10 was used as the cutoff for less expensive services because key informants indicated that is a relatively reasonable fee for many women.

### ***Public vs. Private Provision of Services***

Of the 61 non-TBA practitioners, 89% (N=54) practice in both public and private sectors, and 52% (N=28) provide abortion services in their private clinics and *not* in the public sector.<sup>134</sup> Their average monthly public-sector income is \$27 and average private-sector income is \$122. In aggregate, these providers saw approximately 4,780 women for abortion-related care in the past twelve months. If these services had been provided in the public sector at an average cost of \$10, this would represent a gross annual revenue of approximately \$47,800.

### ***Post-abortion birth spacing services***

One hundred percent of nurses and medical assistants report the provision of birth spacing counseling and services after providing abortion services. Eighty-three percent of doctors report this activity, as do 76% of midwives. However, only 41% of TBAs report offering such services.

### **Demand and Demographics**

Though data gathered from ASPs in Pursat and Takeo cannot be used to estimate a prevalence of abortion in the survey areas,<sup>135</sup> the gross figures of the number of women seeking care provide insight into the demand for such services, as well as some key demographic information of women seeking services, the complications that arise from induced abortion, and whether women die of unsafe abortion in the communities

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<sup>134</sup> TBAs are not included in these results because only one TBA practiced in both the public and private sector.

<sup>135</sup> There is no registry of abortion providers in the study areas, therefore we do not know the overall population of providers from which our sample was drawn, nor the proportion of women of reproductive age in the sample areas that they serve, and can therefore not estimate the prevalence of abortion in the sample areas.



surveyed. As shown in Table 5, within the past 12 months, the 75 providers surveyed report that a total of 5514 women sought services for unwanted pregnancy, 3052 sought services because they missed a period and wanted services to bring it on, and 1429 asked for services for complications that the practitioner suspected to be due to an induced abortion.<sup>136</sup> The total number of women of reproductive age in these two provinces is estimated to be 306,217.<sup>137</sup>

**Table 5: Estimated Number of Women Seeking Abortion-related Service in Past 12 Months in Takeo and Pursat<sup>138</sup>**

	Unwanted Pregnancy (# women seeking care in past 12 months)	Missed Period (# women seeking care in past 12 months)	Complications (# women seeking care in past 12 months)	Total (# women seeking any abortion-related care in past 12 months)
<b>All Providers(n=75)</b>	5514	3052	1429	9997
<b>Mean per provider</b>	74	41	19	134
<b>Range</b>	0-600	0-306	0-250	
<b>Midwives (n=48)</b>	3133	1770	872	5785
<b>Mean per midwife</b>	65	37	18	120
<b>Range for midwives</b>	3-600	0-300	0-250	
<b>TBAs (n=14)</b>	1046	664	258	1968
<b>Mean per TBA</b>	75	47	18	140
<b>Range for TBAs</b>	0-402	0-306	0-60	

<sup>136</sup> According to the WHO, the most frequent complications of unsafe abortion are incomplete abortion, sepsis, hemorrhage and intra-abdominal injuries, such as puncturing or tearing of the uterus. Uprety, 2002.

<sup>137</sup> The total number of women of reproductive age (15-49) in Takeo and Pursat was taken from projections of the 2001 Census. *General Population Census of Cambodia, 1998*. National Institute of Statistics, Ministry of Planning. Phnom Penh, Cambodia. Funded by the UNFPA. July, 2000.

<sup>138</sup> Note that only figures for the subpopulations of midwives and TBAs are included in this table, as they represent the vast majority of providers surveyed.

As shown in Table 6, of those interviewed, 69 of the 75 providers, representing 92% of the sample, state that their clients are mostly from rural areas. Thirty-five percent have some urban clients and 97% have some rural clients. The age of the clients ranges from 12-55, and the number of children that clients have ranges from 0-16. Ninety-five percent see some married women, and 56% see some single women, with 89% stating that they see mostly married women. Only 7% of providers report never seeing the same woman for multiple abortion services, while 72% say that this sometimes occurs and 17% state that this occurs often, for a total of 89% reporting the provision of multiple abortions to the same woman.

**Table 6: Demographics of Women Seeking Care**

	Mostly rural	Some urban	Some Rural	Age range	Number of children	Sometimes multiple	Often multiple	Some complications
<b>All providers (n=75)</b>	92%	35%	97%	12-55	0-16	72%	17%	89%

### **Health Consequences**

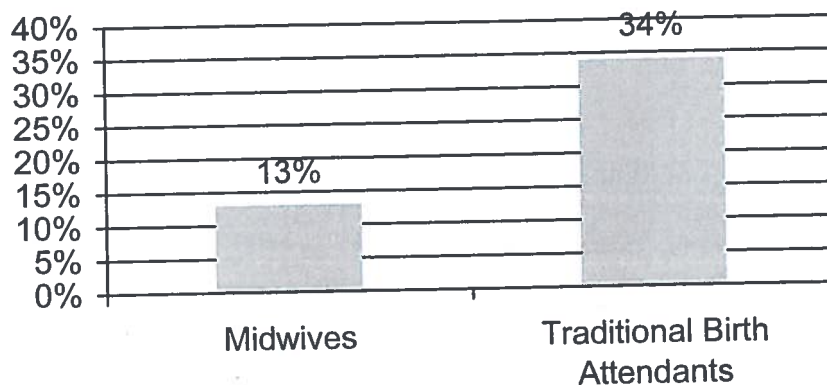
Only 11% of providers report that they have never seen a woman for care of abortion-related complications. As shown in Table 7, 25% of providers state that they know of at least one woman who has died in the local community from an unsafe abortion in the past year, but 34% of TBAs report at least one such death.

**Table 7: Percent of Providers who Report at least one Abortion-Related Maternal Death in their Community**

	Death from Unsafe abortion
<b>All Providers (n=75)</b>	25%
<b>Midwives (n=75)</b>	13%
<b>TBAs (n=14)</b>	34%

As indicated in Figure 3, when we compared midwives and TBAs on the basis of whether they knew of an abortion-related death in their community, we found that 34% of TBAs knew of such a death, while only 13% of midwives did. This difference, however, did not reach statistical significance.

**Figure 3: Percentage of Providers who know of abortion-related death in their community (p=.15)**



### **Laws and Regulations**

When asked about the status of abortion law in Cambodia, only 17% of providers knew that abortion was legal. The rest of the providers believed that abortion was illegal except under certain circumstances, that there was no abortion law, or stated that they did not know whether or not services were legal. Only 18% of providers thought that women in their community believe that abortion is legal.

### **Vision for the Future**

During the fieldwork phase of the study, practitioners in Pursat and Takeo were asked what they thought should be done to make abortion safer. Ninety-two percent of

those interviewed suggested that services be improved by making services legally available and publicized, offering more training, offering services at more accessible locations, or generally improving the quality of services. Thirty-nine percent of all practitioners and 45% of midwives spontaneously suggested that they would like more training; thus training was the most commonly cited means suggested to improve services.

## *Phase 2:*

### **Key Informant Interviews**

In order to understand the status of abortion policy and programs at the central level, we interviewed program planners, policy-makers, and providers from the MoH, NRHP, local and international NGOs, and donor agencies in Phnom Penh.

#### *Design, Study Population, and Methodology*

We interviewed twelve key informants through in-depth, semi-structured interviews. Key informants were defined as individuals who work with governmental, local or international non-governmental, or donor organizations and who could offer background information and insight on the subject based on their experience with abortion-related issues and their current professional positions. We identified key informants through a review of publications that list key actors in the reproductive health field in Cambodia, and through discussions with UNFPA staff and staff from other RH-related organizations.<sup>139</sup> The author conducted all interviews, ten of which were conducted in English, and two of which were conducted with the aid of an interpreter. Verbal informed consent was obtained before the interview, and the author recorded responses by hand during the interviews and later analyzed them through thematic coding. We collected case studies during some of the interviews.

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<sup>139</sup> Beaufils. 2000.

## **Findings**

### **Service Delivery**

There was a virtual consensus on the part of those interviewed in Phnom Penh regarding the current status of service delivery.

### ***Providers***

According to key informants, the main providers of abortion services are practitioners who work in the public sector, but who also have their own private clinics, often attached to their home. Though doctors, nurses, medical assistants, and midwives provide services in this way, midwives are reported to be the most common providers of abortion services. Additionally, TBAs are also thought to be important providers, especially in rural areas and to poor women.

### ***Training***

There is no formal training in abortion procedures for any level of practitioner. Physicians interviewed stated that they did not receive training in the formal medical curriculum, but learned in their clinical practice. There has been no training in abortion techniques held since the law was passed in 1997. Most practitioners learn by talking to other practitioners who explain the technique or by apprenticing with other practitioners. It is thought that most TBAs learn by apprenticing or feel that they gain their skills through dreams, or ghosts.

### ***Methods***

The main methods used to induce abortion by midwives and doctors are said to be manual vacuum aspiration and dilation and curettage in the first trimester. MVA

equipment (consisting of a handheld syringe and a cannula) is imported from Vietnam and can be purchased in the Olympic Market in Phnom Penh at a cost of \$1.50 to \$2.00 for the handheld syringe, which can be used for approximately 5 procedures. The cost for 100 cannulas is \$2.50 to \$3.00. Electrical vacuum aspiration and cytotec were also mentioned. For later term abortions, curettage and a method called "Covac", which involves flushing the uterus with saline and oxytocin in order to induce a stillbirth delivery, were discussed. TBAs are thought to use the traditional deep, repetitive massage technique, which is even depicted on the bas reliefs at Angkor Wat. They are also said to use some of the more modern, technical methods, though without training.

#### *Public vs. Private Provision of Services*

In Phnom Penh, the official providers of abortion services are the NMCHC and two clinics operated by CWC, a local NGO funded by MSI. Additionally, a clinic in Sihanoukville just received approval from the MoH for a pilot project to offer abortion services, and two doctors associated with this project are being trained in Vietnam in vacuum aspiration. When they return, they will train three midwives in this technique. Though non-TBA practitioners reportedly practice in both the public and private sector, TBAs are said to be primarily private practitioners, providing services out of their home, or at the home of the client.

Because of the lack of guidelines, as well as the low reimbursement that providers receive for providing any services in the public sector, even practitioners who work in both the public and private sector tend to ask women requesting such services in the public sector to visit their private clinics instead, because they can supplement their income through the private provision of these services. Such practitioners can tell clients

that it is simply not allowed for them to provide such services in the public setting. One key informant who used to provide abortion services privately stated that abortion procedures tend to be quickly and easily provided by experienced practitioners, and the cost charged for such services far exceeds the input costs. Therefore, it is a boon for providers who can make a significant profit by providing services in their private clinics, often operated out of their homes. This key informant went on to say, “abortion is the only way you can make a lot of money easily; it’s not like general healthcare which takes time and requires follow-up visits; they come in for a quick and easy procedure, and you never see them again.”

This creates a conflict of interest for the private sector physicians and for those earning more from their private sector clinics than from their public sector salaries to encourage the use of public sector facilities. According to one key informant, “politically, practitioners support public access to safe abortion, but economically there is a problem.” This sentiment was spontaneously expressed by the majority of those interviewed, particularly those who are not current providers. Upon direct questioning about this aspect of abortion services in Cambodia, other interviewees corroborated this story.

### *Cost*

The cost of quality services ranges from \$15 for under 7 weeks, to \$50 dollars for over 12 weeks, though reports in the private sector range from \$30 to \$100 for first trimester, with the cost rising significantly after 12 weeks. These costs, which are charged by private practitioners, are high, but ostensibly linked to higher quality services. However, informants consistently stated that there is no real way to know about the



quality of private services and when seeking out services, one is merely going by word of mouth. Even so, these costs are prohibitive to poor women in both the city and the rural areas, and often cause women to go into debt to pay for abortion services, and/or seek poor quality care. One interviewee stated, “a garment worker who makes under \$40/month and is responsible for sending money back to her family simply can’t afford a \$20 procedure, but nor can she afford to have a child, especially in light of being single, working, and away from home.” This assertion was echoed by most of those interviewed, indicating that poor women are forced to risk the danger of receiving unsafe, more affordable services.

A more reasonable cost for early abortion services is thought to be approximately 10% of a woman’s monthly income, or \$4-\$5 in the case of garment workers, and several key informants suggested a fee of \$5-\$10 for first trimester procedures. The Ministry of Health has a public exemption for the poor, but the process of being certified as “poor” for the purposes of receiving less expensive or free services is not thought to be efficient. The NGO that provides abortions is said to have a payment plan for women who cannot afford the cost all at once, but due to the need for financial sustainability, they do not often offer this alternative. Some private providers reduce their fee on a case-by-case basis, or allow some clients to pay in installments over time.

### *Quality*

Key informants reported that the quality of abortion services varies greatly by region and type of provider and is often closely correlated with the cost of services. Therefore poor women obtain services from the poorest quality providers and are subject to the greatest risk of complications. One key informant had observed a massage abortion

provided by a TBA and reported that it was a very prolonged, seemingly very painful procedure. She had also observed an abortion by a rural midwife in the private sector who did not use gloves, did not use appropriate methods to sterilize the instruments, and did not use enough anesthesia to control the patient's pain.

#### CASE STUDY

Those interviewed pointed to the prohibitive cost of quality services for less well-off women. This situation forces these women to seek care from poor quality providers. One NGO worker told a story about a young HIV+ sex worker who had an unwanted pregnancy. The NGO worker knew that there had been a liberal abortion law passed by parliament, but when she approached the provincial hospital with the young woman, who asked for an abortion, she was denied the service. At that time, her agency was not restricted in their ability to help clients obtain safe abortion services, and she was able to find a private abortion provider who offered safe services, and her agency supplemented the cost. If this girl was not able to obtain help and supplement funds from the NGO, the girl would have gone to an unqualified TBA and would have undergone a cheap, likely unhygienic, unsafe procedure. There is no doubt that this is the case for many girls and women in Cambodia today.

#### *Post-abortion birth spacing services*

Though it is thought by those interviewed that it is important to promote post-abortion BS, most believe that counseling and the provision of the methods is not done as often as necessary. Reasons cited for this shortcoming include: the provider not wanting to confuse the client by first treating and then promoting a preventative measure; the client not being interested or prepared to deal with such a service at the time of an abortion; the provider forgets, doesn't have the methods, or doesn't know how to provide the methods; and, most widely stated, the threat of the potential role of birth spacing in reducing abortion clientele and therefore the profit potential of the provision of abortion services. One key informant stated, "they are afraid that if they provide birth-spacing

counseling, they will not have any business the next time around.” Recommending birth spacing is a conflict of interest for some abortion providers.

### **Demand and Demographics**

Based on information gathered through key informant interviews in Phnom Penh, there is a significant demand for abortion services. A key informant that works for an NGO that offers reproductive health services (but not abortion due to the restrictive policy of the donors who fund their program), stated that at least 20% of their clients request abortion services at their clinic. The assertion that abortion provision is a large source of revenue for many providers in their private clinics was also cited as evidence for this. One doctor who used to provide abortion services said, “75-80% of my patients came to me for abortion services, maybe because they trusted me.” Such evidence points to the high demand for such services, and therefore a potentially high profit for providers who supply services.

The demand for abortion services is significant among all sectors of the population, according to the key informant interviews. Though most of those interviewed stated that in the past the only significant demand for abortion services came from married women, they now find increasing demand among young, single women, especially those working in the garment and sex industries.

- *Vulnerable populations*

In addition to poor and/or rural women, several other groups of vulnerable populations that face great obstacles to receiving quality care were identified by some of the key informants. Sex workers, indirect sex workers (such as “beer girls”), HIV+ women, garment workers, and adolescents, both rural and urban, were the main groups

identified. Sex workers face stigma, and are therefore denied services from public practitioners more often than other women. Moreover, they are often debt-bonded and obtaining the funds for such services can be a difficult task. Even those who are not debt-bonded are very poor, often illiterate, and are not familiar with the city because they are from the provinces. Additionally, the brothel owner will often dictate the service provider that the girl or woman is allowed to go to, and this provider will charge a higher price on paper than he or she actually charges the brothel owner. Because the brothel owner pays for the service initially and the girl is required to pay him back, she will be charged more than the price charged for the actual service. Not only does this impose an additional financial burden, but it also limits her choice of providers to those who knowingly engage in unethical accounting procedures. Key informants stated that sex workers and indirect sex workers have relatively high rates of abortions, and therefore it is even more imperative that safe services be created to meet their needs.<sup>140</sup>

Adolescents are another group with special needs. As pre-marital sex is stigmatized for girls and women, and adults are often in denial of adolescent sexual activity, there is a need for confidential reproductive health services of all kinds for adolescents, including abortion services. Rural adolescents have even less access to services due to their geographic isolation, which is a problem for all rural women, but especially for adolescents who are likely to have even fewer financial resources for travel as well as require more secrecy for any journey that would be necessary. The issue of confidentiality is also an especially difficult one for rural adolescents, as any provider in a small village is likely to know the girl and her family. Moreover, many providers are

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<sup>140</sup> This assertion is corroborated by the study of beer girls cited earlier which estimated an abortion prevalence of 56%. NCHADS, 2002.

reluctant to offer services to single women and some don't recognize or don't accept that unmarried women and girls are in need of reproductive health services.

### **Health Consequences**

All key informants interviewed stated that complications that result from unsafe induced abortion are a significant health problem, especially among certain sectors of the population. Moreover, interviewees responded quickly and affirmatively that unsafe abortion is a significant contributor to maternal mortality in this country. There is currently a maternal mortality audit underway, and the results from that will be interesting in this context.

### **Laws and Regulations**

Key informants identified the lack of abortion guidelines as a major problem and reported that neither the public nor many practitioners know the status of the legality of abortion in Cambodia. In fact, one of the key informants, a director of one of the large international reproductive health NGOs, was not clear on the status of the abortion law.

Because the PRAKAS have not been issued, there is a significant amount of confusion about the legality of public sector services. It seems that abortions are sometimes provided at provincial-level referral hospitals, but there is no official authorization or prohibition for this, and therefore no official obligation. This leaves the decision of whether or not to provide abortion services to the individual provider or director, for each individual case. Some women are therefore granted services at some referral hospitals, while others are denied such services.

## **Vision for the Future**

Key informants highlighted several important strategies to improve the situation of unsafe abortion. The central players identified in these interviews were the MoH, the NRHP, the providers (especially midwives), donors, such as the UNFPA and the EC, NGOs, and women seeking care. Fortunately, results show that these key players are basically in agreement when it comes to supporting improved abortion services. Positive features of the current climate identified were:

- Stated commitment of the MoH to take action to make abortion services safer and more accessible;
- Desire of midwives for more training and better skills for performing abortion; and
- Interest on the part of international organizations in working with the stakeholders to improve services.

There is consensus among interviewees that action is needed to issue the PRAKAS, offer training to providers, and educate the public, as well as practitioners, about the law. The practical application of the law was seen as absolutely necessary to move towards safer, more available services.

Key informants indicated that training of midwives is one of the most viable ways to make abortion services more accessible. Not only did program planners suggest that midwives ought to be trained in abortion techniques, but midwives themselves also express interest in receiving training in proper abortion procedures and in the establishment of a nationwide training program for this purpose.

Interviewees also suggested the need for collaboration between donors, government, professional organizations, and NGOs in order to finance and ensure the quality of training, monitoring, and service provision. It was suggested that it is the duty of the

UNFPA to move a safe abortion program forward, especially in terms of funding training and monitoring, coordinating key players, and ensuring quality.

## **Discussion**

### **Limitations**

#### ***Recall Bias***

As abortion services are not included on standard medical forms and practitioners do not record the provision of abortion services informally, answers from practitioners were based on recall of services provided over the period of time indicated in each question. Therefore, much of the information provided by ASPs is subject to significant recall bias.

#### ***Reporting Bias***

Because no records are kept and there is therefore no way to check the accuracy of ASPs' responses, interviewers and local informants suspect that reporting bias may have been encountered in this study. Due to fear of sanction, taxation and regulation, as well as general stigma around abortion, data may represent significant under-reporting of the volume of abortion services provided, complications seen, death from unsafe abortion, income from private practice, and cost per procedure.

#### ***Sampling Bias***

Because the local informants in Takeo and Pursat were from RHAC and CARE respectively, our sample is biased in that it probably represents practitioners who have an association with these organizations. Therefore, our sample may represent a more well-connected, more highly trained group of practitioners who are more well-monitored, and likely provide higher quality services than would be expected from a randomly drawn sample. Additionally, because all of the collaborating organizations promote birth spacing, there may be over-reporting of the provision of BS services. While there is no



reason to think that the five ASPs we were unable to reach are different in important ways from those who were surveyed, we do not know if they are.

### *Selection Bias*

Selection bias may have been introduced in that those practitioners who refused to speak with us may be different in important ways from those who agreed to the interview. In our sample, we had only two practitioners (who operate a private clinic together out of their home) refuse to speak with us. The local informant suspected that these practitioners provide a significant portion of the abortion services in the area and may be worried about sanction. In fact, when we visited the private clinic of these practitioners, we found that the home of the practitioners was one of the largest, most expensive homes in the area. Though admittedly circumstantial, this may indicate that these practitioners make a relatively large income through their private practice, specifically, according to our local informant, through the provision of abortion services. Key informants in Phnom Penh substantiate the likelihood of this bias. Therefore, the overall numbers of services provided and the mean of these figures are likely lower than they would have been if these practitioners had not refused to participate in the study.

Because Takeo and Pursat were chosen for reasons of convenience and not randomly selected, it is necessary to consider how these provinces may be similar to and different from other areas of Cambodia. Takeo borders Vietnam and it was stated by both key informants and providers that many women who live in Takeo go to Vietnam for abortion services, as they are more readily available and inexpensive there. This may mean that providers in Takeo see fewer women for abortion-related services than providers in provinces that do not border Vietnam. Pursat was not perceived to have any specific

characteristics that would differentiate it from other Cambodian provinces in terms of abortion provision.<sup>141</sup>

### **Service Delivery, Demand, Demographics, and Health Outcomes**

The lack of training of many providers is a cause of significant concern. Given the procedures used to induce abortion, it is a cause for alarm and distress that providers have not received formal training in these methods. Although MVA is a widely used technique that is relatively simple to employ safely and effectively, it is still important to have formal training in the method. Additionally, methods like D&C require much greater technical skill and when employed incorrectly, can cause severe complications. Therefore, it is extremely worrisome that 50% of TBAs use this technique, but that very few of the TBAs surveyed have received any formal technical training, but rather learn by apprenticing, are self-taught, or report gaining their skills from a “ghost”.

Reports of the use of “Covac,” a method used to induce late-term, stillbirth deliveries, is a cause of great concern. This method is dangerous and runs the risk of significant complications, especially when employed by untrained, unskilled personnel. This notwithstanding, some untrained practitioners are using this method in the second trimester, including TBAs. The use of a method involving inserting a sharp object into the uterus was only reported by one TBA, but deep massage was reported by 5 of the 14 TBAs, representing 36% of the TBAs interviewed. Use of antiquated, dangerous techniques by untrained personnel must be addressed by future programs. Training in safe and effective techniques should be provided to qualified personnel such as midwives, some nurses, medical assistants, and doctors, especially in rural areas, and women should be encouraged to seek services from trained personnel.

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<sup>141</sup> See the Appendix for a map of Cambodia.

The cost of services varies by practitioner, with TBAs providing services at the lowest prices. This supports the assertion by key informants that poorer women will be enticed to seek care from less qualified personnel due to the lower cost of such services. Poor women therefore face greater risks than do women with access to more resources.

The majority, 73%, of the study population works in both the private and public sector; however, only one TBA practices in both sectors. Of the 61 non-TBA practitioners surveyed, 89% practice in both the public and private sector. Over half of these provide abortion services *exclusively* in their private practices. Though this sample is relatively small, the private provision of services by public sector staff represents an estimated lost annual gross public revenue of \$47,800, if we assume an average cost of \$10 per procedure. This figure does not include the lost public revenue of practitioners who practice in both the public and private sector and reported that they have provided some abortion-related services in the public sector in the past 12 months. These data corroborate the assertion that providers are making a relatively large amount of money by providing abortion services privately, over \$2,000 per year compared to an average annual public income of just over \$300. The assertion that practitioners earn the majority of their income from their private sector jobs seems to hold true in the study population, as our survey indicates that their private sector income is an average of four times greater than their earnings in the public sector. Key informants also reported this pattern, and indicated that providing abortion services is a relatively easy way for practitioners to make a lot of money, as the procedure is inexpensive and quick to provide, the clients don't return for follow-up, and you can charge a lot because people are desperate for the service.

According to the survey of ASPs, the provision of birth spacing services is offered by the majority of doctors, midwives, nurses and medical assistants. However, as stated in the limitations section of this report, interviewers who conducted the survey are affiliated with organizations that promote birth spacing and respondents may therefore be more likely to report the provision of such services, even if they don't offer them in reality. In any case, only 41% of TBAs report offering such services. Key informants do not believe that post-abortion birth spacing is consistently offered by ASPs, and stated that providers may not offer such services because they are afraid it will adversely impact their future income from the provision of abortion services. This is a cause for great concern and must be addressed in conjunction with access to safe abortion services.

Results from both key informant interviews and the survey of ASPs indicate that there is a high demand for abortion services among a diverse population of women. More women seek services from midwives than from other providers, but midwives have an average of 120 clients per year, while TBAs have an average of 140. This may indicate a lower concentration of practitioners where TBAs practice and therefore a higher average per practitioner. It may also indicate under-reporting by midwives as compared to TBAs, because they may be more prone to fear sanction, since most of them work within the public and private sector. Services are requested by rural women, urban women, young women, older women, married and single women, and women with few and many children. That most practitioners have seen the same woman multiple times for abortion services calls into question the effective provision of post-abortion BS methods.

Complications from unsafe abortion are also a reportedly common occurrence. Additionally, death from unsafe abortion is reported among a minority of respondents, 25% overall, but a noticeably larger proportion of TBAs, with 34% reporting such occurrences. This indicates that death from unsafe abortion may be more prevalent in the most rural areas, where women either self-induce or where TBAs are likely to be the main providers of induced abortion. This is also the pattern that key informant interviewees suggested. These results bring the issue of inequitable distribution of quality services, and an inversely related inequitable distribution of morbidity and mortality, to the fore.

Based on this study, it seems that the quality of services ranges widely depending on the type of provider. Moreover, because the cost correlates to the quality, poor women are likely to seek services from poorly trained providers. It is therefore necessary that steps be taken to make safe services available at all public sector facilities, particularly those in rural areas where women are more likely to be poor and otherwise obtain services from TBAs. Training of qualified personnel who serve at the commune health centers must be undertaken and equipment and monitoring provided. The cost of these services must be affordable to rural women, and comparable to the cost of services from other potential providers, such as TBAs. As these services become known to be available, affordable, and of high quality to local women, the number of women seeking services from the public sector will rise, as will the total public revenue from such services. Most importantly, women will obtain high quality services and the risk of complications and death will be reduced.

## **Laws and Regulations**

These results are highly distressing, as providers are the very people who are largely responsible for the accessibility, or lack thereof, of abortion services for women. If the providers don't know that abortion is legal, they may be more reluctant to provide services, especially to women who don't have the means to compensate them well for such services. Moreover, because many practitioners and clients alike think that the services are somewhat, if not altogether, illegal, the price is driven up due to the risk the provider is believed to take when offering services. Additionally, if people think that induced abortion is illegal, but that providing "clean-up" for complications is acceptable, women are more likely to attempt to induce abortion on their own in order to then arrive at the hospital or clinic for follow-up care.<sup>142</sup> The risk involved in such self-induced miscarriage is potentially very great, and absolutely unnecessary in a country where the law ostensibly exists to provide access to safe abortion services, and therefore avoid unsafe methods of induced abortion and the associated potential health risks.

## **Vision for the Future**

Results from this section indicate the need for three key steps to be taken to improve accessibility and quality of abortion services. First of all, there is consensus that a declaration of the PRAKAS, that would make the 1997 law a reality, should be issued immediately. Secondly, a nationwide training of practitioners, including mid-level practitioners such as midwives, should ensue in order to make services accessible at all levels so that rural and poor women can access quality services. Training of mid-level practitioners, such as midwives, in abortion techniques has been shown to successfully

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<sup>142</sup> Rance. 1997.

expand services for abortion in other countries.<sup>143</sup> Thirdly, a collaborative project between donors, the MoH, and NGOs should be established in order to provide funding, training, and monitoring, as well as to ensure the quality and sustainability of services. Additionally, results show that it is necessary to educate practitioners and women alike about the legality of abortion services, where, and at what cost they can be obtained. Without public education about such services, people will continue to seek care clandestinely and from less expensive, untrained providers.

### **Obstacles**

Unfortunately, before making this vision a reality, there are several obstacles to overcome. The first of these is that the PRAKAS have yet to be formulated and published by the MoH. The MoH is responsible for this key step in implementing the law in a practical sense. Several areas of concern were raised that have slowed the process considerably. To begin with, in order to approve the provision of services by skilled practitioners in both the public and private sector, there is a need to create a mechanism to monitor services in both sectors. This is a challenge faced not only by those involved in reproductive health, but by the health sector reform process as a whole. Therefore, it is a larger problem that is not the sole responsibility of the MoH or the NRHP to solve alone. Change in this area can only be achieved through collaboration with the health sector reform process, and should not be a stumbling block in the formulation and promulgation of the PRAKAS.

Additionally, in order to offer abortion services at public facilities, there is a desire to first expand the availability of all birth spacing methods (including the IUD) to all of

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<sup>143</sup> Hord. 2002.

these facilities, so that services are not provided without the basis for preventing future recourse to abortion. This also relates to the larger issue of capacity of the health sector. In order to build this capacity, funds are necessary, and these funds are often limited. Therefore changes in this area will require the commitment not only of the MoH, but also of donors. This should not be seen as an obstacle that is necessary to overcome before the establishment of safe abortion services, however, as abortion services will be offered in conjunction with post-abortion birth spacing services and therefore should be seen as a means of increasing BS coverage while simultaneously offering safe abortion care.

There is some concern that practitioners who currently earn a significant portion of their income through the private provision of abortion services may be reluctant to provide services in the public sector as long as public salaries remain as low as they are today. During the survey of ASPs, the experience of having some high-profile abortion providers refuse to speak with us may indicate that they fear regulation and taxation, and are concerned that this will adversely impact the income that they currently earn by providing abortion services privately. This problem relates to larger issues for the MoH and the RGC, as the low compensation for public providers is often raised as a key factor in preventing capacity building in the public sector. As long as practitioners are not paid fairly for their work, there is only so much that can be done in terms of improving quality. Again, this is a larger problem that should not be seen as an obstacle to the immediate declaration of the PRAKAS.<sup>144</sup>

Other potential obstacles mentioned by those interviewed relate to the cost and accessibility of abortion services. The point raised earlier regarding the relatively high

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<sup>144</sup> This is part of the Civil Administration Reform of the RGC, and is not only the responsibility of MOH, nor is it within its sole capacity.



cost of services poses a difficult problem. Even if services are more accessible in the public sector, how can we ensure that poor women can afford these services?

Additionally, what can be done about vulnerable populations such as sex workers, garment workers, and adolescents? Moreover, accessibility issues that have to do with distance from services, the difficulty of transport given road conditions, the lack of transport funds, and the lack of means of transportation are significant concerns. These problems cannot be expected to be solved by one program alone and will certainly require the commitment and creative thinking of individuals and organizations involved in providing health services to all people, especially those who are most vulnerable. Inter-sectorial development efforts between departments and programs such as health, education, and transportation are necessary to address these obstacles.

### **Policy Recommendations**

The abortion law is an important first step in making abortion services as accessible as other health services. However, it is evident from both components of this study that abortion services are less accessible than the law states they should be. This calls for immediate action on the part of the MoH, donor agencies, and NGOs to ensure that the law that guarantees women access to safe services, now five years old, is finally implemented in practice. It is the task of the MoH and the NRHP to take the necessary steps to issue the PRAKAS in order to make abortion services legal in a real sense, and it is the role of donors and advocates to aid the MoH and the NRHP with the implementation of these guidelines and to offer financial and technical support for related projects.

***Step 1:*** Immediate action needs to be taken in the following areas in order to make the abortion law a reality and promote the safety and accessibility of abortion services.

1. Immediately issue the PRAKAS in order to make services available at public referral hospitals, district hospitals and health centers.

- a. These guidelines should include:<sup>145</sup>
  - i. Procedural guidelines for when, where and how abortion is to be provided;
  - ii. Clear and simple protocols for obtaining authorization to perform abortions (when such authorization is required);
  - iii. Guidelines for clinical training in the skills required to provide abortion services;

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<sup>145</sup>Adapted from: Hord. 2002.

- iv. Specification of skills needed for abortion-related counseling; and
      - v. A statement outlining health care professionals' ethical responsibility to provide legal health services.
    - b. Ensure that health workers have access to guidelines, protocols, and standards for abortion services
  2. Provide training to practitioners in WHO-recommended abortion techniques, and post-abortion birth spacing services.
    - a. This should include:
      - i. On-going monitoring and refresher training to ensure that the skills gained are incorporated effectively into practice;
      - ii. Training in all preferred techniques should be offered according to the skill level of the practitioner; and
      - iii. Training in quality BS counseling and the provision of a wide range of effective contraceptive methods.
    - b. Systems must be in place to allow for adequate human and financial resources to provide training and monitoring;
  3. Educate practitioners and women alike about the legality of abortion services, where, and at what cost they can be obtained.
  4. Provide the equipment and initial monitoring and record-keeping necessary for the provision of abortion services and post-abortion birth spacing services at all levels.
  5. Create a collaborative monitoring and supervision project on safe abortion.

**Step 2:** Simultaneously, the following steps should be undertaken to ensure the sustainability, quality, and accessibility of the project:

6. Work with the larger health sector reform project to ensure that monitoring and support for abortion services, including those in the private sector, is built into the system;
7. Work with larger health sector reform and stakeholders to devise a method of encouraging practitioners to offer quality services in the public sector, perhaps through increase in salary, incentives for those who provide quality services, or some such scheme.<sup>146</sup>
8. Provide for longer term abortion training, including:
  - i. Make abortion training a standard component of education for health care providers, including doctors, nurses, midwives, and medical assistants; and
  - ii. Address how private providers are trained and monitored.
9. Incorporate abortion care into country programs and assessments.
10. Add abortion equipment to standard equipment lists for all facilities.
11. Create links with NGOs, provider organizations, women's groups, and other relevant organizations to educate women and providers about the law and where they can obtain services safely and legally as well as the appropriate cost for such services.
12. Create a system for the long-term efficient and complete record keeping of abortion services and abortion-related care, including client feedback.

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<sup>146</sup> This is part of the Civil Administration Reform of the RGC, and is not only the responsibility of MOH, nor is it within its sole capacity.

13. Create a functional referral system for abortion care.
14. Devise creative solutions to address the problem of quality, cost, and accessibility, especially for vulnerable populations.

**Long Term:** Long-term work should be done in the following areas to facilitate support for the project:

15. Continue to expand birth spacing services to meet the needs of women who want to control their fertility.
16. Conduct research that will test the impact of this project on key outcomes of interest, as well as address the issue of quality of care and use results of such research to improve the long-term quality of services.
17. Collect and use service statistics including: patient demographics, gestational age, reasons for seeking abortion services, type of complications treated, the cost of unsafe abortion to the health system, percentage of deaths due to unsafe abortion, percentage of hospital admissions for the treatment of unsafe abortion, and the cost of treatment of complications from unsafe abortion:
  - a. Train people to use statistics and issue useful reports;
  - b. Review statistics periodically and make any necessary changes to services to meet the needs of clients; and
  - c. Develop an infrastructure that allows data to be used to affect change.
18. Involve reproductive health and health-related NGOs in advocacy and the dissemination of information on safe abortion and post-abortion care.
19. Make linkages with other organizations that may be potential allies for safe abortion, such as human rights organizations and women's organizations.

20. Support girls' education, delayed marriage, and delayed first birth, as well as programs that offer employment opportunities to women, and equal pay.
21. Attempt to de-stigmatize and legitimize abortion services through public discussion of the issue, the media, and professional and other local organizations.

Many of these steps require the immediate action of policy-makers and programmers in the MoH and NRHP. However, the need for funding and on-going support requires strong collaboration between donors, the MoH, and NGOs. International donors must provide the necessary financial and technical support and be key partners in moving these steps forward.

The creation of a collaborative monitoring and supervision project on safe abortion could provide the organizational structure necessary to move this vision forward. Donors should support focused technical assistance from key agencies that can work in collaboration with country partners and the MoH to introduce new technologies, recommend and help implement changes in service delivery, and build the skills necessary to continue important monitoring activities. Donors should be directly involved in financing and monitoring training and follow-up; equipment procurement and distribution; incorporating abortion-related services into the health sector reform; record-keeping and research; as well as on-going support, monitoring, and capacity-building. NGOs should be involved in advocacy, helping to support and conduct training, and community education on the legal and practical status of abortion.

## Conclusion

As the case of Cambodia illustrates, the availability of access to safe abortion is a complex issue. Though ostensibly the government responded to the problem of unsafe abortion by legalizing abortion in 1997, this study indicates that safe, accessible services are still not widely available. The details of how legislation is drafted can have a significant impact on whether officially legal abortion services are actually provided. Because the 1997 law required MoH implementation guidelines, abortion is not as accessible as the law states it ought to be. This impacts the quality of services available, especially for poor, marginalized women, and therefore has a potentially harmful effect on women's health in Cambodia. It also has important implications for those advocating for legislative changes in countries where abortion is illegal. Specifically, laws that are the least restrictive and conceptualize abortion within the realm of human rights may have a stronger foundation on which to ensure access to safe abortion services. However, as the situation in the U.S. demonstrates, even a rights-based abortion law can be undermined by special interest groups through restrictive amendments, as well as policy and funding changes.

Moreover, whether the law is implemented is likely to depend largely on the extent to which human rights in general are respected, the level of political accountability, and the degree to which gender equality has been achieved, rather than the wording of the law itself. Furthermore, restrictions on the implementation of the law are likely to stem from attitudes of the medical profession, policy changes, and the administration of the public health system. In the case of Cambodia, the main obstacle to the implementation of the abortion law seems to be based on financial incentives of current private providers who

are able to influence people who make policy decisions. This situation reflects a conflict of personal financial interests with public health rights, which is symptomatic of the general state of corruption, impunity, and lack of accountability that is prevalent in Cambodia today. Though these problems exist to a varying degree and with different levels of sophistication in countries around the world, they are especially visible in many countries burdened with economic difficulty, where individual professionals earn low salaries and personally struggle with financial hardship.

Cambodia is a country where significant gender discrimination is evident in many realms, including women and child trafficking, lack of girls' education, lack of representation of women in positions of power, domestic abuse, and sexual violence. The lack of access to safe abortion, even after the legislative mandate, is part and parcel of a lack of respect for women's human, sexual, and reproductive and health rights. According to one researcher:<sup>147</sup> "women have but one body and one life – not two separate or divisible public and private lives - [the] exclusion of women's voices from the 'public' realm permits the abuses carried out in the 'private' realm" and, I would argue, *visa versa*.

Access to safe abortion is deeply rooted in social, political, and economic power structures and the promotion of safe abortion is inherently tied to the restructuring of those power relations.<sup>148</sup> If women are unable to access abortion and therefore make decisions about their own fertility and destiny, they will be less able to advocate for their rights in these other realms, which is crucial in Cambodia. Not only does the lack of access to safe abortion contribute to maternal mortality and therefore threaten a woman's

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<sup>147</sup> Yamin, A. Transformative Combinations: Women's Health and Human Rights. *Journal of the American Medical Women's Association*. 52(4). 1997.

<sup>148</sup> Yamin. 1997.



right to life, health, and security of person, but it also affects her human rights in terms of the right to privacy and the right to benefit from scientific progress and have access to information. Moreover, it undermines her ability to fully experience the range of political, civil, economic, social, and cultural rights to which she is entitled – these rights, including the right to safe abortion, are part of the same fabric.

Positive action on the part of the state is needed to ensure the necessary programs and services to make safe abortion accessible to all women in Cambodia and therefore contribute to the women's ability to fully exercise their full range of human rights. Access to safe abortion cannot be decoupled from political efforts to transform oppressive social and political relations that deny women of fundamental rights.<sup>149</sup> To remedy this situation will require not only immediate action to implement the law and provide safe abortion services, but also longer-term advocacy to eliminate gender discrimination and establish rule of law in Cambodia to limit corruption, judicial ineffectuality, impunity, and allow for the protection of human rights.

Future research in Cambodia in this area should attempt to delineate specific abortion rates among various sectors of the population, both before and after the guidelines are implemented, training of providers is undertaken, and services are available publicly. It would also be useful to develop human rights indicators that could then be analyzed in relation to contraceptive use, safe and unsafe abortion, and maternal mortality and morbidity. Such research will help elucidate how differences in power translate into measurable effects on health and will likely help demonstrate that these rights are indivisible and interdependent.

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<sup>149</sup> Yamin. 1997.

The integrity of each of the threads that represent women's rights, reproductive rights, and human rights determines the strength of the fabric they weave and the opportunity of each individual to live life fully. This fabric, in turn, is the basis for the tapestry of society and the stitches that bind each piece to the next to create the structure of our relations, which can either jeopardize, or provide resiliency, to the whole. Respect for human rights affords each individual the opportunity to reach his or her full potential and contribute fully to their community and society as a whole. The structure of social, economic, and political relations must protect and promote a full range of human rights, including access to safe abortion, if it is to foster the healthy development of individuals and society.

## **Postscript**

At the time that this research was conducted in Cambodia, the guidelines for the implementation of the 1997 Abortion Law had not been issued. Since the completion of the study, however, the guidelines have been signed and issued. This important step was necessary to open the door to safe abortion services. However, there is still a long way to go to ensure that what is now ink on paper translates into access to safe abortion for Cambodian women. The continued dedication and collaboration of the MoH, donors, and NGOs will be essential in the next phase of implementation of the law, including: training providers in appropriate techniques; public education about the law and the availability of services; procurement and maintenance of equipment; and monitoring and supervision. Research on the effects of the implementation of the law will be vital in the years to come, not only to elucidate the impact of this change in policy on the health of women in Cambodia, but also to illustrate the relationship between human rights, domestic law and policy, and reproductive health.

## References

- Abrams, P. Reservations About Women: Population Policy and Reproductive Rights. *Cornell International Law Journal*. 1996.
- ADHOC (Cambodia Human Rights and Development Association). Last visited 2003. [www.bigpond.com.kh/users/adhoc/women/Women.htm](http://www.bigpond.com.kh/users/adhoc/women/Women.htm)
- Anderson, David. Abortion, Women's Health and Fertility. International Union for the Scientific Study of Population. 1998. [www.iussp.org/Publications\\_on\\_site/PRP/prp15.htm](http://www.iussp.org/Publications_on_site/PRP/prp15.htm) Last visited 2003.
- Baird, D. Mode of Action of Medical Methods of Abortion. *Journal of the American Medical Women's Association*. Vol. 55, No.3. supplement. pp 121-126. 2000.
- Beaufils, Laure. *Population Matters in Cambodia*. UNFPA. 2000.
- Beijing Platform*. 1995. [www.un.org/womenwatch/daw/beijing/platform/plat1.htm](http://www.un.org/womenwatch/daw/beijing/platform/plat1.htm). Last visited 2002.
- Bruce, J., and A. Jain. A Reproductive Health Approach to Objectives and Assessment of Family Planning Programs. In Sen, G., Germain, A. and L. Chen (eds): *Population Policies Reconsidered: Health, Empowerment and Rights*. Boston, MA: Harvard University Press. pp 193-210. 1994.
- Cambodian 2000 Demographic and Health Survey*. National Institute of Statistics. 2001.
- Cambodian Safe Motherhood National Strategy*. Section 1.C.1.24. 1997.
- Charmichael, Robert. Managing Editor of the Phnom Penh Post. Personal Communication. 2002.
- Catholics for a Free Choice. Abortion in Good Faith: Reforming Irish Law. 1999. [www.cath4choice.org/international/irish%20paper/abortionsingoodfaith1999.htm](http://www.cath4choice.org/international/irish%20paper/abortionsingoodfaith1999.htm) Last visited 2003.
- Center for Reproductive Law and Policy (CRLP-1). Safe and Legal Abortion is a Woman's Human Right. 2000. [www.crlp.org](http://www.crlp.org) Last visited 2002.
- Center for Reproductive Law and Policy (CRLP-2). Religious Voices Worldwide Support Choice. 2000. [www.crlp.org](http://www.crlp.org) Last visited 2002.
- Cook, Rebecca J., and Mahmoud F. Fathalla. Advancing Reproductive Rights Beyond Cairo and Beijing. *Studies in Family Planning* 22(3): 115-121.1996.

- Flemming, J and Warwick, N. Submission to the Northern Ireland Human Rights Commission on Abortion and the Proposed Bill of Rights. 2000.
- Freedman, L, and S. Isaacs. Human Rights and Reproductive Choice. *Studies in Family Planning*. 24(1). pp18-30. 1993.
- Freedman, L. and D. Maine. Facing Facts: The Role of Epidemiology in Reproductive Rights Advocacy. *The American University Law Review*. Vol.44. pp 1085-1092. 1995.
- Gabriel-Cox, Katie. Medical student who spent time in South African Hospitals. Personal Communication. 2002.
- General Population Census of Cambodia, 1998*. National Institute of Statistics, Ministry of Planning. Phnom Penh, Cambodia. Funded by, UNFPA. July, 2000.
- Green, Caroline. Abortion in Cambodia stigma and controversy. *Phnom Penh Post*. August 16, 2002.
- Green Paper on Abortion.  
<http://www.irlgov.ie/taoiseach/publication/greenpaper/chapter3.htm#7> Last visited 2002.
- Gruskin, Sofia. Director of the François-Xavier Bagnoud Center for Health and Human Rights at Harvard University. Personal Communication. 2002.
- Hammarburg, Thomas. Report on Human Rights in Cambodia.  
[http://members.aol.com/cambodia/un\\_rep3-3.htm](http://members.aol.com/cambodia/un_rep3-3.htm) Last visted 2003.
- Hord, Charlothe. *Making Safe Abortion Accessible: A Practical Guide for Advocates*. Ipas. [www.ipas.org](http://www.ipas.org). Last visited 2002.
- Hubbard, R. The Politics of Fetal/Maternal Conflict.  
[www.hsph.edu/Organizations/healthnet/gender/docs/hubbard.html](http://www.hsph.edu/Organizations/healthnet/gender/docs/hubbard.html)  
Last visited 2002
- ICPD+5 Review of Progress*. New York, 1999.
- Ipas. *Unsafe Abortion in the ESCAP Region*. [www.ipas.org](http://www.ipas.org) Last visited 2002.
- Kim, Andrea. Unpublished study from UCSF and NCHADS collaborative work on beer girls in Battambang. Personal communication. 2002.
- Law on Abortion*. Cambodia. October, 1997.

- Lawless, J.M. Fertility, Bodies and Politics: The Irish Case.  
[www.hsph.harvard.edu/Organizations/healthnet/reprorights/docs/murphy/html](http://www.hsph.harvard.edu/Organizations/healthnet/reprorights/docs/murphy/html)  
 Last visited 2002
- Long, Dr. Chhun. Unpublished study from the National Reproductive Health Program.  
 Personal Communication. 2002.
- Mann, J. et al. Health and Human Rights. *Health and Human Rights*. 1(8). 1994.
- NARAL. Who Decides? A State-by-State Review of Abortion and Reproductive Rights,  
 10<sup>th</sup> Edition. 2001.
- Obermeyer, C. A Cross-Cultural Perspective on Reproductive Rights. *Human Rights Quarterly*. 17(2). pp 366-381. 1995.
- Office of the United Nations High Commissioner for Human Rights (UNHCHR). Status  
 of Ratifications of the Principal International Human Rights Treaties. December,  
 2002.
- Population Policy Database maintained by the Population Division of the Department of  
 Economic and Social Affairs of the United Nations Secretariat.
- Pine, Rachael, N, Law, Sylvia A. Principals Governing Reproductive Freedom. *The Lawyers*. 8(10). pp 13-15. 1993.
- Rahman, A. et al. A Global Review of Laws on Induced Abortion, 1985-1997.  
*International Family Planning Perspectives*. 24(2). Pp 56-64. 1998.
- Rance, S. 1997. Safe Motherhood, Unsafe Abortion: A Reflection on the Impact of  
 Discourse. *Reproductive Health Matters*. No. 9. pp10-19.
- Robinson, B.A. 1997. Balancing the rights of the woman and her fetus.  
[www.religioustolerance.org/abo\\_feta.htm](http://www.religioustolerance.org/abo_feta.htm) Last visited 2002.
- Safe Motherhood Situation Analysis based on Qualitative Data*. Royal Kingdom of  
 Cambodia, MOH. 1997.
- Sprechmann, Sophia, Soeung, Sann Chan, Kerr, Helen, Long, Chun, and Meakea, Mey.  
*Estimating the Magnitude of Maternal Mortality in Cambodia: An Application of  
 the Sisterhood Method*. NMCHC. July 1996.
- UN. Situation of Human Rights in Cambodia. Report of the Secretary General. Fifty-  
 fourth session. Agenda item 116 (b). September, 1999.
- UNFPA. Country Population Assessment Report. Cambodia.

UNFPA. The State of World Population 2000. Chapter 6: Women's Rights are Human Rights. [www.unfpa.org/swp/2000/english/ch06.html](http://www.unfpa.org/swp/2000/english/ch06.html)

Unmacht, E. Women's Rights Often Come Last in Cambodian Sex Trade. Asian Human Rights Commission. 2002.  
<http://cambodia.ahrchk.net/mainfile.php/news200211/503/> Last visited 2003.

*Unsafe Abortion: Global and Regional Estimates.* WHO 1997 & World Abortion Policies, UN.

Uprety, Aruna. Abortion Laws in Nepal.  
[www.hsph.harvard.edu/Organizations/healthnet/Sasia/repro/aruna.html](http://www.hsph.harvard.edu/Organizations/healthnet/Sasia/repro/aruna.html)  
Last visited 2002.

WHO. *Considerations for formulating reproductive health laws.*  
[www.who.int/reproductive-health/publications](http://www.who.int/reproductive-health/publications) Last visited 2002.

WHO. *Studying Unsafe Abortion: a practical guide for programme managers.* 1995.

Yamin, Alicia and D. Maine. Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations. *Human Rights Quarterly.* 12(3). pp 563-607. 1999.

Yamin, A. Transformative Combinations: Women's Health and Human Rights. *Journal of the American Medical Women's Association.* 52(4). 1997.

## **Appendix**

Map of Cambodia

Informed Consent Form (English and Khmer)

Abortion Service Provider Questionnaire (English and Khmer)

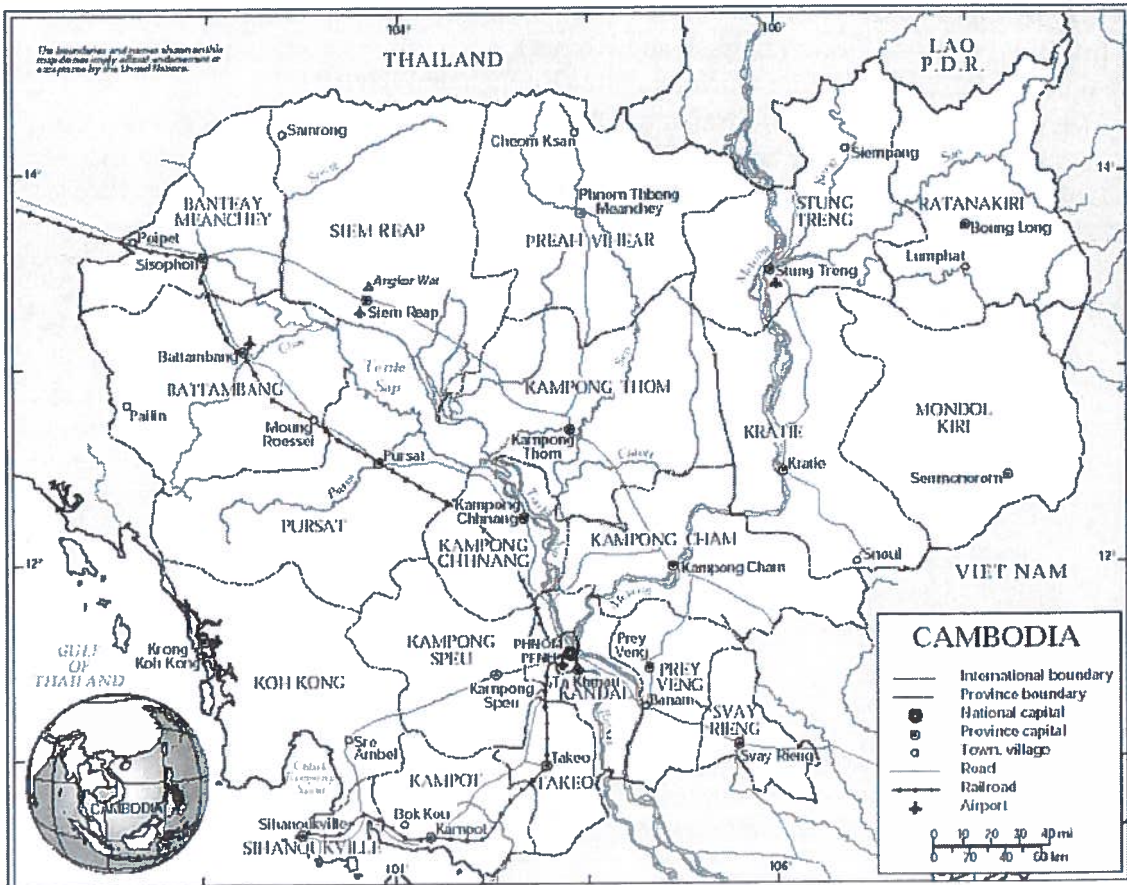
Interview Guide for Key Informants (English)

Law on Abortion in Cambodia, 1997 (English and Khmer)

Letter of Support from Professor Eng Huot



# Map of Cambodia



## INFORMED CONSENT FORM FOR PROVIDER SURVEY

My name is Felicia Lester. I am a graduate student in the School of Public Health at the University of California at Berkeley and I am working with the UNFPA and the MOH. I would like to invite to take part in my research. It concerns the provision of abortion services in Cambodia. I am interested in your experience providing abortion services to women in this area.

If you agree to take part in my research, an interviewer will conduct an interview with you at the clinic or at your home, or wherever else you choose. The interview will involve questions about the number of abortions you have provided, the procedures you use to induce abortion, the characteristics of women who seek abortion, the fees charged for abortion services, and complications that can arise from abortion procedures. The interview should last about 30 minutes.

There are no foreseeable risks to you from participating in this research. There is no direct benefit to you, however we hope that the research will help make abortion safer in Cambodia and make sure services are available to the women who need them. There will be no costs to you, other than your time.

All of the information that I obtain from you during the research will be kept confidential. I will not use your name or other identifying information in any reports of the research. After this research is completed, the survey documents will be kept in a locked file at the Ministry of Health or the National Institute of Statistics. However, the same confidentiality guarantees given here will apply to future storage and use of the materials.

Your participation in this research is voluntary. You are free to refuse to take part. You may refuse to answer any questions and may stop taking part in the study at any time. Whether or not you participate in this research will have no bearing on your standing in your job.

If you have any questions about the research, you may call me, Felicia Lester, at the UNFPA at 23-21 5519. If you agree to take part in the research, please sign the form below. Please keep the other copy of this agreement for future reference.

If you have any questions about your rights or treatment as a participant in this research project, please contact the University of California at Berkeley's Committee for Protection of Human Subjects at (510) 642-7461, or e-mail: [subjects@uclink4.berkeley.edu](mailto:subjects@uclink4.berkeley.edu).

**បែបបទក្នុងការអនុញ្ញាតិអ្នកផ្តល់សេវា ដើម្បីធ្វើការអង្កេតចំណេះដឹង**

ខ្ញុំឈ្មោះ ..... បំរើការងារនៅក្រសួងកិច្ចការនារី និង អតីតយុទ្ធជន ក្រោមការឧបត្ថម្ភរបស់អង្គការ UNFPA រួមសហការជាមួយក្រសួងសុខាភិបាល ព្រមទាំងកញ្ញា Felicia Lester ដែលអញ្ជើញមកពី សកលវិទ្យាល័យកាលីហ្វ័រញ៉ា Berkeley នៃសហរដ្ឋអាមេរិក ខ្ញុំសូមការអនុញ្ញាតិ ពីលោក-លោកស្រី ដើម្បីចូលរួមក្នុងការសិក្សាស្រាវជ្រាវ និង ស្វែងយល់ពីទស្សនៈនៃសេវារំលូតកូននៅប្រទេស កម្ពុជា ។ ខ្ញុំមានការចាប់អារម្មណ៍យ៉ាងខ្លាំងទៅលើបទពិសោធន៍របស់លោក-លោកស្រី ទាក់ទិននឹងការផ្តល់សេវា រំលូតកូនចំពោះស្ត្រីនៅតំបន់នេះ ។

ប្រសិនបើលោក-លោកស្រី អនុញ្ញាតិ អ្នកសំភាសន៍នឹងចាប់ផ្តើមការសំភាសន៍ នៅឯគ្លីនិក ឬ ផ្ទះរបស់លោក-លោកស្រី ឬក៏ទីកន្លែងផ្សេងទៀតក៏បាន ។ ការសំភាសន៍នេះ នឹងមានសំណួរ ជាច្រើនទាក់ទិននឹង ការផ្តល់សេវារំលូត ដំណើរការក្នុងការរំលូត អាកប្បកិរិយារបស់ស្ត្រីដែលមកធ្វើការរំលូត តំលៃនៃការរំលូត និង គ្រោះថ្នាក់ដែលអាចកើតមានបណ្តាលមកពីការរំលូត ។ ការសំភាសន៍នេះ នឹងមានរយៈពេលប្រហែល 30 នាទី ប៉ុណ្ណោះ ។

ការចូលរួមក្នុងការសំភាសន៍នេះ នឹងមិនមានបញ្ហាប៉ះពាល់ដល់លោក-លោកស្រីទេ ។ ទោះជាផល ប្រយោជន៍ដែលទទួលបានពីការធ្វើអង្កេតនេះ មិនផ្តល់ជាផលប្រយោជន៍ផ្ទាល់ដល់លោក-លោកស្រីក៏ពិតមែន ប៉ុន្តែយើងសង្ឃឹមថា ការសិក្សាស្រាវជ្រាវនេះ ជាជំនួយដល់ការរំលូតកូននៅប្រទេសកម្ពុជា ឱ្យកាន់តែមានភាព ប្រសើរឡើង និង អាចធ្វើអោយស្ត្រីទទួលបាននូវសេវារំលូតនេះទៅតាមសេចក្តីត្រូវការរបស់គេ ។ ការចំណាយ ពេលវេលារបស់ លោក-លោកស្រីនៅពេលនេះ មានតំលៃមិនអាចកាត់ថ្លៃបាន ចំពោះយើងខ្ញុំ ។

ព្រមទាំងឡាយដែលយើងខ្ញុំបានទទួលពីលោក-លោកស្រី ក្នុងពេលនេះ នឹងទុកជាការលំដាប់ ហើយ យើងខ្ញុំនឹងមិនប្រើប្រាស់ឈ្មោះ ឬព័ត៌មានដែលទាក់ទិននឹងលោក-លោកស្រី ក្នុងរបាយការណ៍នៃការសិក្សាស្រាវ ជ្រាវនេះទេ ។ បន្ទាប់ពីការធ្វើអង្កេតនេះត្រូវបានបញ្ចប់ជាស្ថាពរហើយ ឯកសារដែលជាលទ្ធផល និងសំភារៈ ពាក់ព័ន្ធទាំងឡាយ នឹងត្រូវបានរក្សាទុកនៅកន្លែងដែលមានសុវត្ថិភាពបំផុត នៅក្រសួងសុខាភិបាល និងវិទ្យាស្ថាន ជាតិស្ថិតិ មិនថាពេលនេះ ឬទៅថ្ងៃអនាគត ។

ការចូលរួមរបស់លោក-លោកស្រី ត្រូវបានចាត់ទុកថា ជាការស្ម័គ្រចិត្ត ដូចនេះ លោក-លោកស្រីមាន សិទ្ធិក្នុងការបដិសេធន៍មិនចូលរួមក៏បាន ហើយលោក-លោកស្រី ក៏មានសិទ្ធិមិនឆ្លើយនឹងសំណួរណាមួយដែល លោក-លោកស្រីមិនពេញចិត្ត ឬលោក-លោកស្រី អាចសុំបញ្ឈប់មុនពេលក៏បាន ។ ប៉ុន្តែទោះជាយ៉ាងណាក៏ដោយ ការចូលរួមនេះ នឹងមិនមានការប៉ះពាល់ដល់ការងារ ឬការប្រកបរបររកស៊ីរបស់លោក-លោកស្រីឡើយ ។

ប្រសិនបើលោក-លោកស្រី មានចំណង់ទាក់ទិននឹងការធ្វើអង្កេតនេះ លោក-លោកស្រីអាចទូរស័ព្ទទំនាក់ទំនងជាមួយ កញ្ញា Felicia Lester នៃអង្គការ UNFPA តាមរយៈទូរស័ព្ទលេខ 023-215 519 ។ ប្រសិនបើ លោក-លោកស្រី យល់ព្រមចូលរួមក្នុងការសំភាសន៍នេះ សូមមេត្តាបំពេញបែបបទខាងក្រោមនេះ និងរក្សាមួយ ច្បាប់ទុកជាអំណះអំណាងសំរាប់ថ្ងៃក្រោយ ។

ប្រសិនបើលោក-លោកស្រីមានចំណង់ដែលទាក់ទិននឹងសិទ្ធិ ឬ ដំណើរការប្រព្រឹត្តទៅក្នុងការចូលរួមនេះ លោក-លោកស្រី អាចធ្វើការទំនាក់ទំនងជាមួយគណៈកម្មការ សំរាប់ការពារសិទ្ធិមនុស្ស នៃសកលវិទ្យាល័យ កាលីហ្វ័រញ៉ា Berkeley សហរដ្ឋអាមេរិក តាមរយៈទូរស័ព្ទលេខ (501) 642-7461 ឬ អ៊ីម៉ែល: [Subjects@uclink4.berkeley.edu](mailto:Subjects@uclink4.berkeley.edu) ។

Questionnaire for Abortion Service Providers

NO	Question	Response	Skip	CODE
Q1	How old are you?	Enter age		
Q2	What is your profession?	1=Doctor 2=Nurse 3=Midwife 4=TBA 5=Kru Khmer 6=Other, specify		
Q3	Where do you work?	1=public sector 2=provate sector 3=both, explain _____ _____ _____		
Q4	Where do you reside?	1=city 2=town 3=village 4=other, specify		
Q5	What is your highest level of education?	0=never attended school 1=primary incomplete 2=primary complete 3=lower secondary 4=upper secondary 5=technical training school 6=university 7=other, specify		
Q6	Where did you receive your professional training?	1=self-taught, learning by doing 2=apprentice with Kru Khmer 3=apprentice with TBA 4=apprentice with midwife 5=some technical training, specify type, where _____ _____ 6=university 7=other, specify		
Q7	Does your household have:	0=none of these 1=electricity 2=radio 3=television		

		4=video		
Q8	Does any member of your household own:	0=none of these 1=oxcart 2=bicycle 3=boat 4=motorcycle 5=motorized boat 6=car 7= other, specify		
Q9	What are your sources of income? MARK ALL THAT APPLY	1=public sector job 2=my own practice 3=other private sector job, specify _____ 4=other, _____ specify _____		
Q10	What is your average monthly income from each individual source of income mentioned above.	Public sector \$ _____ My own practice \$ _____ Other Private sector\$ _____ Other \$ _____		
Q11	What kinds of services do you generally offer in your practice?	Specify all _____ _____ _____		
Q12	What kinds of services do your clients generally request?	Specify all _____ _____ _____		
Q13	How many women have come to you in the last 12 months because they were pregnant and didn't want to be?	Enter number _____		
Q14	How many women have come to you in the last 12 months because their menstruation was late?	Enter number _____		
Q15	How many women have come to you in the last 12 months with heavy bleeding, infection, or other complications that you believe to have been caused by	Enter number _____		

	an induced abortion?			
Q16	What kinds of services did you provide to these women? (mark all that apply)	0=none 1=referral elsewhere 2=menstrual regulation 3=induced abortion 4=counseling 5=other, specify _____	⇒ 23 ⇒ 19 ⇒ 19 ⇒ 23	
Q17	Why didn't you provide services?	Enter answer _____ _____ _____		
Q18	What did these women do after you denied them services?	Enter answer _____ _____ _____ 99=don't know	⇒ 43	
Q19	What methods do you use to bring on menstruation?	Specify method _____ _____ _____		
Q20	What methods do you use to induce an abortion in the first trimester?	1=dilation and curettage 2=electric vacuum aspiration 3>manual vacuum aspiration 4=caesarean section 5=insert object into the cervix, specify object _____ 5=herbal remedy, specify _____  6=deep massage, explain how, when, how many times _____ _____  7=other medications, specify kind, amount, etc _____  8=other, specify _____ _____		

Q21	What methods do you use to induce an abortion in the second trimester?	<p>1=dilation and curettage  2=electric vacuum aspiration  3&gt;manual vacuum aspiration  4=caesarean section  5=insert object into the cervix, specify object _____  5=herbal remedy, specify _____</p> <hr/> <p>6=deep massage, explain how, when, how many times _____</p> <hr/> <hr/> <p>7=other medications, specify kind, amount, etc _____</p> <hr/> <p>8=other, specify _____</p> <hr/>		
Q22	What methods do you use to induce an abortion in the third trimester?	<p>1=dilation and curettage  2=electric vacuum aspiration  3&gt;manual vacuum aspiration  4=caesarean section  5=insert object into the cervix, specify object _____  5=herbal remedy, specify _____</p> <hr/> <p>6=deep massage, explain how, when, how many times _____</p> <hr/> <hr/> <p>7=other medications, specify kind, amount, etc _____</p> <hr/> <p>8=other, specify _____</p> <hr/>		



Q23	How much do you charge for these services?	Specify amount for each kind of service and method _____ _____ _____ _____		
Q24	Where do you provide these services?  MARK ALL THAT APPLY	1=public hospital 2=public health center 3=private clinic/facility 4=home of respondent 5=home of client 6=other, specify		
Q25	What do women feel when they come to you for these services? Why do they feel those ways? (examples: scared someone will find out, worried about the health consequences, relieved, sad)  BE DETAILED IN YOUR RECORDING OF THE RESPONSE	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____		
Q26	What do you feel when you provide services to these women? Why do you feel those ways? (examples: happy to help someone in need, worried that people will find out I provide these services (specify, police, MOH, other people in community)  BE DETAILED IN YOUR RECORDING OF THE RESPONSE	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____		
Q27	How are your clients referred to you?	1=family 2=friend 3=other health practitioner, specify kind		

		4=other, specify _____		
Q28	What is the age of the youngest woman who has come to you for services?	Enter age _____ 99=don't know		
Q29	What is the age of the oldest woman who has come to you for services/	Enter age _____ 99=don't know		
Q30	Do you provide these kinds of services mostly to younger women or mostly to older women?	1=about the same of each 2=mostly younger 3=mostly older 99=don't know		
Q31	What is the largest number of children women who come to you already have? What is the fewest number of children these women have?	Largest number _____ Fewest number _____		
Q32	Do you see women from urban areas?	0=NO 1=YES		
Q33	Do you see women from rural areas?	0=NO 1=YES		
Q34	Do you see more women from rural areas or from urban areas?	1=about the same from each 2=more urban 3=more rural 99=don't know		
Q35	What is the average level of education of women you see?	0=never attended school 1=primary incomplete 2=primary complete 3=lower secondary 4=upper secondary 5=technical school 6=university 7=other, specify _____ 99=don't know		
Q36	Do you see married women?	0=NO 1=YES		
Q37	Do you see single women?	0=NO 1=YES		
Q38	Do you see mostly married women or mostly single women?	1=about the same of each 2=more married 3=more single 99=don't know		
Q39	Does the man involved in the pregnancy know that the woman is terminating the pregnancy?	0=NO 1=YES 2=some yes, some no 99=don't know		
Q40	How do women usually get the money for the services?	1=their own income 2=income of man involved 3=other family member		

		4=other, specify _____ 99=don't know _____		
Q41	Do some women come to you for these kinds of services many times over their lifetime?	0=never 1=sometimes 2=often		
Q42	Do women usually come to you in the first trimester, second trimester, or third trimester of their pregnancies? MARK ALL THAT APPLY	1=first trimester 2=second trimester 3=third trimester		
Q43	What is the furthest along a woman has been when you have provided services to her?	Enter gestational age _____		
Q44	What are some common reasons women come to get services? Please indicate the percentage of women you see who come for each reason.  MARK ALL THAT APPLY	1=failure of BS method % _____ 2= don't want anymore children % _____ 3=want to space next birth % _____ 4=financial problems % _____ 5=want to continue studies % _____ 6=want to continue work % _____ 7=pressure from someone else to abort, specify who _____ % _____ 8=other, specify _____ % _____		
Q45	What kinds of complications have you seen arise from induced abortion?	0=none 1=pain 2=bleeding 3=infection 4=other, specify _____  99=don't know _____		
Q46	What aspects of the procedure or the woman do you believe are linked to these complications?	1=duration of pregnancy 2=methods used to induce abortion 3=skill level of person performing procedure 4=woman had too many pregnancies 5=woman's pregnancies too closely spaced		

		6=other aspects of woman's body 7=woman's beliefs 8=other, specify _____ 99=don't know		
Q47	Do women come to you with these complications?	0=never 1=sometimes 2=often	⇒ 55	
Q48	How do you manage these complications?	Enter response _____ _____ _____		
Q49	How many women have died in your community in the past year due to complications of induced abortion?	Enter number _____		
Q50	What kind of counseling do you provide women after these procedures?	_____ _____ _____		
Q51	Do you provide birth spacing methods to women after the abortion?	0=NO 1=YES 2=refer out for those services	⇒ 53 ⇒ 54	
Q52	What methods do you provide?	1=condom 2=daily pill 3=monthly pill 4=injection 5=IUD 6=sterilization 7=other, specify		
Q53	Why don't you provide birth spacing services?	1=don't have training 2=don't have methods 3=don't know how to provide 99=don't know		
Q54	Where do you refer women for birth spacing methods?	1=public hospital 2=public health center 3=private provider/facility, specify _____ _____ 4=pharmacist 5=other, specify		

Q55	What other abortion services are available to women in your community?	Enter answer _____ _____ _____ 99=don't know		
Q56	What is the legal status of abortion in Cambodia?	Enter answer _____ _____ _____ _____ _____ 99=don't know		
Q57	Do women in your community think abortion is legal or illegal in Cambodia?	0=illegal 1=legal 99=don't know		
Q58	What do you think should be done to improve abortion services in your community?	Enter answer _____ _____ _____ _____ _____		

**បញ្ជីសំណួរសំរាប់សាកសួរអ្នកផ្តល់សេវាកម្មវិបត្តិកូន**

ល.រ	បញ្ជីសំណួរ	ចំណើយ	សញ្ញាណភាព រំលង	លេខ ក្នុង
1-	តើអ្នកមានអាយុប៉ុន្មាន?	.....ឆ្នាំ		
2-	តើអ្នកមានមុខរបរជាអ្វី?	1-វេជ្ជបណ្ឌិត 2-គិលានុប្បដ្ឋាយិកា 3-ឆ្មប 4-ឆ្មបបុរាណ 5- គ្រូខ្មែរ 6-ផ្សេងៗ ( បញ្ជាក់ ) ..... .....		
3-	តើអ្នកធ្វើការនៅឯណា?	1-ការងាររដ្ឋ 2-ការងារឯកជន 3-ការងារទាំងពីរ ចូរបញ្ជាក់ .....		
4-	តើស្នូលថ្ងៃនេះ អ្នកកំពុងរស់នៅឯណា?	1-នៅទីក្រុង 2-នៅទីរួមខេត្ត 3-នៅក្នុងភូមិ 4-ផ្សេងៗ ( បញ្ជាក់ ) ..... .....		
5-	តើអ្នកបានទទួលការសិក្សាខ្ពស់បំផុតដល់	0-មិនដែលចូលរៀនសោះ		

	<p>ថ្នាក់ទីប៉ុន្មាន?</p>	<p>1-រៀនមិនទាន់ចប់ថ្នាក់បឋមសិក្សា          2-រៀនចប់ថ្នាក់បឋមសិក្សា          3-ក្រោមថ្នាក់មធ្យមសិក្សា          4-លើសថ្នាក់មធ្យមសិក្សា          5-សាសាបច្ចេកទេស          6-សាកលវិទ្យាល័យ          7-ផ្សេងៗ (បញ្ជាក់)</p> <p>.....</p> <p>.....</p>		
<p>6-</p>	<p>តើអ្នកទទួលបានការបណ្តុះបណ្តាលមុខវិជ្ជាជីវៈនេះនៅឯណា?</p>	<p>1-រៀនខ្លួនឯង ឬ រៀនតាមរយៈការអនុវត្តផ្ទាល់          2-រៀនតាមរយៈគ្រូខ្មែរ          3-រៀនតាមរយៈឆ្មបបុរាណ          4-តាមរយៈឆ្មប          5-តាមរយៈវគ្គបណ្តុះបណ្តាលផ្នែកបច្ចេកទេស          បញ្ជាក់ឈ្មោះវគ្គ និង កាលបរិច្ឆេទ</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>6-រៀននៅមហាវិទ្យាល័យ          7-ផ្សេងៗ (បញ្ជាក់ )</p> <p>.....</p>		

7-	តើនៅក្នុងផ្ទះរបស់អ្នកមាន :	0-គ្មានអ្វីទាំងអស់ 1-ភ្លើងអគ្គិសនី 2-វិទ្យុ 3-ទូរទស្សន៍ 4-វិដេអូ		
8-	តើអ្នកមានមធ្យោបាយធ្វើដំណើរអ្វីខ្លះ?	0-គ្មានអ្វីទាំងអស់ 1-រទេះគោ 2-កង់ 3-ទូក 4-ម៉ូតូ 5-ទូកម៉ាស៊ីន 6-ឡាន 7-ផ្សេងៗ ( បញ្ជាក់ ) ..... .....		
9-	តើប្រភពចំណូលរបស់អ្នកបានមកពីណាខ្លះ?	1-ការងាររដ្ឋ 2-ការងាររកកំរៃផ្ទាល់ខ្លួន 3-ការងារឯកជន ចូរបញ្ជាក់ ..... ..... 4-ផ្សេងៗ ( បញ្ជាក់ ) ..... .....		



10-	តើរកចំណូលជាមធ្យមប្រចាំខែបានប៉ុន្មាន ដែរពីប្រភពនីមួយៗរបស់អ្នក?	ការងាររដ្ឋ ..... ការងាររកកំរៃផ្ទាល់ខ្លួន ..... ការងារឯកជន ..... ផ្សេងៗ ..... .....		
11-	តើអ្នកបានផ្តល់សេវាកម្មអ្វីខ្លះ ជាទូទៅនៅ ក្នុងការងាររបស់អ្នក?	បញ្ជាក់គ្រប់ចំណើយទាំងអស់ ..... ..... ..... .....		
12-	ជាទូទៅតើសេវាកម្មប្រភេទណាខ្លះ ដែល ស្ត្រីរបស់អ្នកចង់បាន?	បញ្ជាក់គ្រប់ចំណើយទាំងអស់ ..... ..... ..... .....		
13-	កាលពីមួយឆ្នាំកន្លងទៅតើស្ត្រីមានផ្ទៃពោះ ដែលគាត់មិនចង់បានកូន មានប៉ុន្មាននាក់ បានមកជួបអ្នក?	ចំនួន.....នាក់		
14-	កាលពីមួយឆ្នាំកន្លងទៅ តើស្ត្រីដែលមាន បញ្ហារដូវយឺតយ៉ាវមានចំនួនប៉ុន្មាននាក់ បានមកជួបអ្នក?	ចំនួន.....នាក់		

15-	កាលពីមួយឆ្នាំកន្លងទៅ តើមានស្ត្រីចំនួន ប៉ុន្មាននាក់ ដែលធ្លាក់ឈាមច្រន់ច្រូរ ហើយ មានការឆ្លងរោគ ឬ ក៏មានផលវិបាកស្មុគ្រ ស្នាញផ្សេងៗ ដែលអ្នកគិតថាបណ្តាលមកពី ការរំលូតកូន?	ចំនួន.....នាក់		
16-	តើអ្នកបានផ្តល់សេវាកម្មប្រភេទណាខ្លះ ជូនដល់ស្ត្រីទាំងនេះ? (សូមកត់ត្រាអោយ គ្រប់ចំនុចនូវអ្វីដែលគេបានផ្តល់ទៅស្ត្រី)	0-មិនបានផ្តល់សេវាកម្មអ្វីទេ 1-បញ្ជូនទៅកន្លែងផ្សេង → 2-ធ្លាក់ឈាមរដូវធម្មតា → 3-រំលូតកូន → 4-ផ្តល់ការពិគ្រោះយោបល់ → 5-ផ្សេងៗ (បញ្ជាក់ ) ..... .....	រំលងទៅ23 រំលងទៅ19 រំលងទៅ19 រំលងទៅ23	
17-	តើហេតុអ្វីបានជាអ្នកមិនផ្តល់សេវាកម្មនេះ ជូនគាត់?	កត់ត្រាចំលើយ ..... ..... .....		
18-	តើស្ត្រីទាំងនោះបានធ្វើអ្វីខ្លះនៅពេលដែល អ្នកមិនផ្តល់សេវាកម្មជូនគាត់?	កត់ត្រាចំលើយ → ..... ..... 99-មិនដឹង	រំលងទៅ43	
19-	តើមធ្យោបាយអ្វីខ្លះដែលអ្នកប្រើដើម្បីធ្វើ អោយគាត់មានឈាមរដូវឡើងវិញ?	ត្រូវរៀបរាប់ពីមធ្យោបាយ ..... .....		

		.....		
20-	តើអ្នកប្រើវិធីអ្វីខ្លះក្នុងការរំលូតកូន នៅត្រី មាត់ទីមួយ?	<p>1-មាត់ស្សនបើក និងកោសយកកូនចេញ</p> <p>2-យកកូនចេញដោយប្រើប្រដាប់បូមអគ្គីសនី</p> <p>3-យកកូនចេញដោយប្រើប្រដាប់បូមដោយដៃ</p> <p>4-ការរំកាត់យកកូនចេញ</p> <p>5-ការសឹកវត្ថុផ្សេងៗទៅក្នុងមាត់ស្សន ចូរបញ្ជាក់ប្រភេទវត្ថុនោះ.....</p> <p>.....</p> <p>6-ការសង្កត់ខ្លាំង ឬ កាយពោះអោយរំលូត ឬ កាច់កូនចូរពន្យល់ពីការធ្វើនៅពេលណា និង ធ្វើប៉ុន្មានដង</p> <p>.....</p> <p>.....</p> <p>7-ផឹកថ្នាំពេទ្យ ឬ ថ្នាំខ្មែរ ចូរបញ្ជាក់ប្រភេទថ្នាំ ចំនួន. . .</p> <p>.....</p> <p>.....</p> <p>8-ផ្សេងៗ (បញ្ជាក់)</p> <p>.....</p>		
21-	តើអ្នកប្រើវិធីអ្វីខ្លះក្នុងការរំលូតកូន នៅត្រី	1-មាត់ស្សនបើក និងកោស		

	<p>មាសទីពីរ?</p>	<p>យកកូនចេញ</p> <p>2-យកកូនចេញដោយប្រើ ប្រដាប់បូមអគ្គិសនី</p> <p>3-យកកូនចេញដោយប្រើ ប្រដាប់បូមដោយដៃ</p> <p>4-ការវះកាត់យកកូនចេញ</p> <p>5-ការសិកវត្ថុផ្សេងៗទៅក្នុង មាត់ស្បូន ចូរបញ្ជាក់ប្រភេទ វត្ថុនោះ..... .....</p> <p>6-ការសង្កត់ខ្លាំង ឬ កាយ ពោះអោយរំលូត ឬ កាច់កូន ចូរពន្យល់ពីការធ្វើនៅពេល ណា និង ធ្វើប៉ុន្មានដង ..... .....</p> <p>7-ផឹកថ្នាំពេទ្យ ឬ ថ្នាំខ្មែរ ចូរបញ្ជាក់ប្រភេទថ្នាំ ចំនួន... ..... .....</p> <p>8-ផ្សេងៗ (បញ្ជាក់) .....</p>		
22-	<p>តើអ្នកប្រើវិធីអ្វីខ្លះក្នុងការរំលូតកូន នៅត្រី មាសទីបី?</p>	<p>1-មាត់ស្បូនបើក និងកោស យកកូនចេញ</p> <p>2-យកកូនចេញដោយប្រើ</p>		

		<p>ប្រដាប់បូមអគ្គិសនី</p> <p>3-យកកូនចេញដោយប្រើ ប្រដាប់បូមដោយដៃ</p> <p>4-ការវះកាត់យកកូនចេញ</p> <p>5-ការសិក្សាវត្ថុផ្សេងៗទៅក្នុង មាត់ស្បូន ចូរបញ្ជាក់ប្រភេទ វត្ថុនោះ.....</p> <p>.....</p> <p>6-ការសង្កត់ខ្លាំង ឬ កាយ ពោះអោយរំលូត ឬ កាច់កូន ចូរពន្យល់ពីការធ្វើនៅពេល ណា និង ធ្វើប៉ុន្មានដង</p> <p>.....</p> <p>.....</p> <p>7-ផឹកថ្នាំពេទ្យ ឬ ថ្នាំខ្មែរ ចូរបញ្ជាក់ប្រភេទថ្នាំ ចំនួន. . .</p> <p>.....</p> <p>.....</p> <p>8-ផ្សេងៗ (បញ្ជាក់)</p> <p>.....</p>		
23-	តើស្ត្រីត្រូវបង់ថ្លៃប៉ុន្មានសំរាប់សេវាកម្មនេះ?	<p>សូមបញ្ជាក់ចំនួននៃការបង់ថ្លៃ សេវានីមួយៗ</p> <p>.....</p> <p>.....</p>		
24-	តើអ្នកផ្តល់សេវាកម្មនៅទីកន្លែងណាខ្លះ?	1-មន្ទីរពេទ្យរដ្ឋ		

	( ត្រូវកត់ត្រាអោយអស់នូវអ្វីដែល គាត់ឆ្លើយ )	2-មណ្ឌលសុខភាព 3-មន្ទីរពេទ្យ ឬ គ្លីនិកឯកជន 4-តាមផ្ទះអ្នកឆ្លើយ 5-តាមផ្ទះស្ត្រី 6-ផ្សេងៗ សូមបញ្ជាក់ .....		
25-	តើស្ត្រីដែលចង់រំលូតកូនមានអារម្មណ៍យ៉ាង ដូចម្តេចនៅពេលដែលគាត់មកជួបអ្នក ដើម្បីទទួលសេវាកម្មទាំងនេះ? ហេតុអ្វី បានជាពួកគាត់មានអារម្មណ៍យ៉ាងដូច្នោះ? ( ត្រូវកត់ត្រាអោយបានក្បោះក្បាយទៅ តាមអ្វីដែលគាត់ឆ្លើយ )	..... ..... ..... ..... ..... .....		
26-	តើអ្នកមានអារម្មណ៍យ៉ាងដូចម្តេចនៅពេល ដែលអ្នកផ្តល់សេវាកម្មរំលូតកូនដល់ស្ត្រី ទាំងនេះ? ហេតុអ្វីបានជាមានអារម្មណ៍ ដូច្នោះ? ឧទាហរណ៍ រីករាយជួយអ្នកដែលត្រូវការ សេវាកម្ម ព្រួយបារម្ភខ្លាចគេដឹងថាខ្ញុំ ផ្តល់សេវាកម្មនេះ . . . មានដូចជា ប៉ូលីស ក្រសួងសុខាភិបាល និងប្រជាជនដែលរស់ នៅក្នុងភូមិ ។ ( កត់ត្រាអោយបានក្បោះ ក្បាយទៅតាមអ្វីដែលគេឆ្លើយ )	..... ..... ..... ..... ..... ..... ..... ..... ..... .....		
27-	តើស្ត្រីមកជួបអ្នកតាមរយៈអ្នកណា?	1-គ្រួសារ 2-មិត្តភក្តិ 3-អ្នកដែលធ្លាប់ធ្វើការនៅ		

		មណ្ឌលសុខភាព បញ្ជាក់សេវាកម្មសុខភាព ..... ..... ..... 4-ផ្សេងៗ ( បញ្ជាក់ ) ..... ..... .....		
28-	តើស្ត្រីក្មេងបំផុតអាយុប៉ុន្មានដែលមកជួប អ្នកដើម្បីធ្វើការរំលូតកូន?	អាយុ.....ឆ្នាំ 99-មិនដឹង		
29-	តើស្ត្រីចំណាស់បំផុតអាយុប៉ុន្មានដែលមក ជួបអ្នកដើម្បីធ្វើការរំលូតកូន?	អាយុ.....ឆ្នាំ 99-មិនដឹង		
30-	តើអ្នកផ្តល់សេវាកម្មរំលូតកូនដល់ស្ត្រីវ័យ ក្មេង ឬ ស្ត្រីវ័យចំណាស់ភាគច្រើន?	1-មានចំនួនប្រហាក់ប្រហែល គ្នាទាំងក្មេងទាំងចាស់ 2-ភាគច្រើនវ័យក្មេង 3-ភាគច្រើនស្ត្រីវ័យចំណាស់ 99-មិនដឹង		
31-	ក្នុងចំណោមស្ត្រីដែលមកជួបអ្នក តើគាត់ មានកូនច្រើនបំផុតចំនួនប៉ុន្មាន? និងតិច បំផុតចំនួនប៉ុន្មាន	ចំនួនកូនច្រើនបំផុត.....នាក់ ចំនួនកូនតិចបំផុត.....នាក់		
32-	តើអ្នកធ្លាប់ឃើញស្ត្រីរស់នៅទីក្រុងមក ទទួលសេវាកម្មរំលូតកូននៅទីនេះដែររឺទេ?	0-ទេ 1-ចាស់/បាទ		
33-	តើអ្នកធ្លាប់ឃើញស្ត្រីដែលរស់នៅជនបទ មកទទួលសេវាកម្មរំលូតកូននៅទីនេះដែររឺទេ?	0-ទេ 1-ចាស់/បាទ		

34-	តើភាគច្រើនស្ត្រីដែលមកទទួលសេវាកម្ម រំលូតកូននេះ មកពីទីក្រុង ឬ ជនបទ?	1-មានចំនួនប្រហាក់ប្រហែលគ្នា 2-ភាគច្រើនមកពីទីក្រុង 3-ភាគច្រើនមកពីជនបទ 99-មិនដឹង		
35-	តើស្ត្រីដែលអ្នកធ្លាប់ជួប អ្នកទាំងនោះជា មធ្យមមានកិរិយាធម៌ត្រឹមថ្នាក់ទីប៉ុន្មាន?	1-មិនបានបញ្ចប់បឋមសិក្សា 2-ចប់បឋមសិក្សា 3-ទាបជាងមធ្យមសិក្សា 4-ចប់មធ្យមសិក្សា 5-សាលាបច្ចេកទេស 6-មហាវិទ្យាល័យ 7-ផ្សេងៗ (បញ្ជាក់ ) ..... ..... 99-មិនដឹង		
36-	តើអ្នកធ្លាប់ជួបប្រទះជាមួយស្ត្រីដែលមាន ប្តីមកទទួលសេវាកម្មរំលូតកូននេះដែររឺទេ?	0-ទេ 1-ចាស់/បាទ		
37-	តើអ្នកធ្លាប់ជួបប្រទះជាមួយស្ត្រីនៅលីវមក ទទួលសេវាកម្មរំលូតកូននេះដែររឺទេ?	0-ទេ 1-ចាស់/បាទ		
38-	តើភាគច្រើនអ្នកធ្លាប់ជួបប្រទះស្ត្រីដែលនៅ លីវ ឬ ស្ត្រីដែលមានប្តី ដែលមកទទួល សេវាកម្មរំលូតកូននេះ?	1-មានចំនួនប្រហាក់ប្រហែលគ្នា 2-ភាគច្រើនស្ត្រីរៀបការរួច 3-ភាគច្រើនស្ត្រីនៅលីវ 99-មិនដឹង		
39-	តើបុរសជាងគ្រូរបស់គាត់បានដឹងដែររឺទេ ថាគ្រូរបស់ខ្លួនមកទទួលសេវាកម្មរំលូត កូននេះ?	0-ទេ 1-ដឹង 2-ពេលខ្លះដឹងពេលខ្លះមិនដឹង		



		99-អត់ដឹង		
40-	តាមធម្មតា តើស្ត្រីទាំងនោះបានថវិកាពីណា ដើម្បីបង់ថ្លៃការរំលូតកូននេះ?	1-ថវិកាដែលគាត់រកបាន ដោយផ្ទាល់ខ្លួន 2-បានមកពីបុរសជាដៃគូរ 3-បានពីសមាជិកនៃក្រុម គ្រួសារគាត់ 4-ផ្សេងៗ (បញ្ជាក់ ) .....		
		99-មិនដឹង		
41-	តើស្ត្រីដែលមកជួបអ្នកទាំងនោះ ធ្លាប់បាន ទទួលសេវាកម្មរំលូតកូនច្រើនដងដែររឺទេ ក្នុងជីវិតរបស់គាត់?	0-មិនដែលសោះ 1-ម្តងម្កាល 2-ច្រើនដង		
42-	ជាធម្មតា តើស្ត្រីទាំងនោះមកជួបអ្នកពេល ដែលគាត់កំពុងមានផ្ទៃពោះក្នុងត្រីមាសទី1 ឬត្រីមាសទី2 ឬ ត្រីមាសទី3?	1-ត្រីមាសទី1 2-ត្រីមាសទី2 3-ត្រីមាសទី3		
43-	តើស្ត្រីមានផ្ទៃពោះប៉ុន្មានខែច្រើនបំផុត ដែលអ្នកធ្លាប់បានផ្តល់សេវាកម្មរំលូតកូន ជូនគាត់?	កត់ត្រាអាយុនៃការមានផ្ទៃ ពោះ:.....		
44-	មូលហេតុចម្បងអ្វីខ្លះ ដែលស្ត្រីមកទទួល សេវាកម្មរំលូតនេះ? ចូរអ្នកបញ្ជាក់ពីភាគ រយរបស់ស្ត្រី ដែលអ្នកធ្លាប់បានជួបប្រទះ តាមមូលហេតុរបស់គាត់	1-បរាជ័យនៃការប្រើប្រាស់ មធ្យោបាយពន្យារកំណើត .....% 2-មិនចង់បានកូន.....% 3-ចង់ពន្យាររយៈពេលមានកូន .....% 4-មានបញ្ហាលុយកាក់		

		.....%		
		5-ចង់បន្តការសិក្សា.....%		
		6-ចង់ធ្វើការសិន.....%		
		7-ទទួលការគោរពសង្កត់ពី នរណាម្នាក់ អោយរំលូតកូន		
		.....%		
		8-ផ្សេងៗបញ្ជាក់.....%		
45-	តើផលវិបាកបែបណាខ្លះដែលអ្នកធ្លាប់បាន ជួបប្រទះចំពោះស្ត្រីក្រោយពីទទួលការ រំលូតកូនរួច?	0-គ្មាន 1-មានការឈឺចាប់ 2-មានការធ្លាក់ឈាម 3-មានការបង្ករោគ 4-ផ្សេងៗ ( បញ្ជាក់ ) ..... ..... 99-មិនដឹង		
46-	តើអ្នកយល់ថាផលវិបាកទាំងនោះវាទាក់ ទងទៅនឹងអ្វីខ្លះ?	1-រយៈពេលនៃការមានផ្ទៃ ពោះ 2-មធ្យោបាយដែលប្រើសំរាប់ ធ្វើការរំលូតកូន 3-ជំនាញរបស់អ្នកផ្តល់សេវា កម្មរំលូតកូន 4-ស្ត្រីមានផ្ទៃពោះច្រើនដង 5-ការមានកូនញឹកញាប់ 6-សិរិរាងរបស់ស្ត្រី 7-ជំនឿរបស់ស្ត្រី		

		8-ផ្សេងៗ (បញ្ជាក់ ) ..... ..... 99-មិនដឹង		
47-	តើស្ត្រីដែលមានផលវិបាកកើតឡើង ក្រោយពីការរំលូតកូននេះ បានមកជួបអ្នក ដែររឺទេ?	0-មិនទាន់មានទេ → 1-មានខ្លះដែរ 2-មានភាគច្រើន	រំលងទៅ55	
48-	តើអ្នកផ្តល់ការព្យាបាលដល់ស្ត្រីដែលមាន បញ្ហាទាំងនេះយ៉ាងដូចម្តេច?	កត់ត្រាចំលើយរបស់គាត់ ..... ..... .....		
49-	កាលពីមួយឆ្នាំកន្លងទៅ តើមានស្ត្រីប៉ុន្មាន នាក់បានស្លាប់នៅក្នុងភូមិរបស់អ្នក ដោយ សារផលវិបាកនៃការរំលូតកូនទាំងនេះ?	ចំនួន.....នាក់		
50-	តើការផ្តល់ប្រឹក្សាបែបណាខ្លះដែលអ្នកបាន ផ្តល់អោយស្ត្រី បន្ទាប់ពីអ្នកបានធ្វើការ រំលូតកូនអោយគាត់រួច?	..... ..... .....		
51-	តើអ្នកបានផ្តល់មធ្យោបាយពន្យារកំណើត ដល់ស្ត្រីដែររឺទេ បន្ទាប់ពីរំលូតកូនរួច?	0-ទេ → 1-ចាស់/បាទ 2-បញ្ជូនទៅកន្លែងផ្តល់ សេវាកម្ម →	រំលងទៅ53 រំលងទៅ54	
52-	តើមធ្យោបាយអ្វីដែលអ្នកផ្តល់អោយស្ត្រី នោះ?	1-ស្រោមអនាម័យ 2-ថ្នាំគ្រាប់លេបប្រចាំថ្ងៃ		

		3-ថ្នាំគ្រាប់លេបមួយគ្រាប់ មួយខែ 4-ថ្នាំចាក់ 5-កងដាក់ក្នុងស្បូន 6-ការវះចងដៃស្បូន 7-ផ្សេងៗ (បញ្ជាក់) ..... ..... .....		
53-	ហេតុអ្វីបានជាអ្នកមិនផ្តល់មធ្យោបាយ ពន្យាកំណើត?	1-មិនបានទទួលការបណ្តុះ បណ្តាល 2-គ្មានមធ្យោបាយពន្យា កំណើត 3-មិនដឹងពីមធ្យោបាយពន្យា កំណើត 4-ផ្សេងៗ (បញ្ជាក់) ..... .....		
54-	តើអ្នកបញ្ជូនស្ត្រីអោយទៅទទួល មធ្យោបាយពន្យាកំណើត នៅកន្លែងណា?	1-មន្ទីរពេទ្យរដ្ឋ 2-មណ្ឌលសុខភាពរដ្ឋ 3-គ្លីនិកឯកជន បញ្ជាក់ទីតាំង ..... 4-ឱសថស្ថាន 5-ផ្សេងៗ (បញ្ជាក់ ) .....		

55-	តើនៅក្នុងភូមិរបស់អ្នកមានសេវាកម្ម វិល្លាតកូនផ្សេងទៀតដែលសមស្របចំពោះ ស្ត្រីដែរឬទេ?	កត់ត្រាចំលើយ ..... ..... 99-មិនដឹង		
56-	តើស្ថានភាពវិល្លាតកូនរបៀបណាដែលស្រប ច្បាប់នៅក្នុងប្រទេសកម្ពុជា?	កត់ត្រាចំលើយ ..... ..... ..... ..... 99-មិនដឹង		
57-	នៅក្នុងប្រទេសកម្ពុជា តើស្ត្រីក្នុងភូមិរបស់ អ្នកគិតថា ការវិល្លាតកូនជាការស្របច្បាប់ ឬមិនស្របច្បាប់?	0-មិនស្របច្បាប់ 1-ស្របច្បាប់ 99-មិនដឹង		
58-	តើអ្នកគិតថា គួរធ្វើដូចម្តេចដើម្បីអោយ សេវាកម្មវិល្លាតកូននៅក្នុងភូមិរបស់អ្នក មានភាពកាន់តែល្អប្រសើរឡើង?	កត់ត្រាចំលើយ ..... ..... ..... ..... .....		

## Interview guide for Key Informants in Phnom Penh

1. What is the current status of abortion law and guidelines in Cambodia?
  - Where can services be provided?
  - Who can provide the services?
  - What is the cost of services?
  - What methods should be used?
2. What is the current status of abortion provision in Cambodia?
  - Where are services provided? (public, private, NGO, MOH)
  - Who provides services?
  - What is the cost of services?
  - What is the quality of services?
  - What methods are used?
  - Is post-abortion birth-spacing counseling provided?
  - Does unsafe abortion contribute to maternal mortality in Cambodia?
3. Where is most of the need for abortion services?
  - Regions
  - Sectors
  - Age-group
  - Rural/urban
4. Where do these different groups attain services now? Is there a significant difference in the quality of services that they can access depending on their economic status, age, sector, region?
5. What can we do to ensure that all women – even poor, rural women who may go to TBAs for services currently – can attain safe, affordable services?
6. What should be charged in the public/private sector?
7. What is the role of your organization in the abortion issue?
8. Who are the key players in the abortion arena?
9. What is your vision for the future of abortion policy, guidelines, and provision?
10. What are the main obstacles to implementing guidelines and making abortion services more accessible?
11. What should be the role of each of the key players in moving forward on this issue?

**Additional questions for Key Informants who were in the past, or are currently, abortion providers**

1. What methods do you think are most effective for 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> trimester abortions?
  - What methods do you use?
2. Do/did you provide abortion services? Is post-abortion birth-spacing counseling provided?
3. What is the demand for abortion services? How many clients do/did you see per month
4. Do/did you see clients who come in with post-abortion complications from abortions induced by unqualified personnel?
5. What can be done to limit these complications?
6. Do/did you see clients in the public sector, private sector, or both?
7. How did you get involved in providing abortion services?
8. Why do you think it is important to provide abortion services?

TIP: Cambodia Law



# ABORTION LAW

(Informally translated)



## Chapter 1 General provision

### Article 1.

This law has as its goals and objectives to determine the formality and the criteria for abortion.

### Article 2.

Abortion is the termination of pregnancy by medical means or by any mean.

### Article 3.

All pregnant women can ask for an abortion from a medical person after having accomplished the criteria described in chapter 8 of this law.

### Article 4.

In any case, abortion must be requested and accepted by the pregnant woman.

### Article 5.

Only medical doctors or medical assistants or midwives who have been authorised by the ministry or health can perform abortion.

## Chapter 2 Formality and Criteria

### Article 6.

Abortion can be performed only in hospitals, health centres, clinics, public or private maternities that have been authorised 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.
- means for hospital referral whenever necessary.

### Article 7.

Medical doctors or medical assistants or secondary midwives who have the duty to perform an abortion must provide counselling to the pregnant woman about possible dangers that may occur eventually following the abortion and about the importance of Birth Spacing services.

If the pregnant woman still keeps requesting to have an abortion, doctors or medical assistants or secondary midwives can perform abortion but must follow criteria described in chapter 8 of the law.

### Article 8.

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 creates a risk to the woman's life.
- after birth the child can have a serious incurable disease.
- in the case that the woman has been raped, the 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 continuously requested by her parents or her ~~parents~~ if she is under 18 years of age.

### Article 9.

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.

### Article 10.

Abortion service adopted by the ministry of health, as described in chapter 6, must prepare neat documents for each abortion and must write monthly reports to the ministry of health regularly stating the number of abortions and the method used for each abortion.

## Chapter 3 Control

### Chapter 11.

The control of abortion following this law is the responsibility of the ministry of health.

## Chapter 4 Sanction

### Article 12.7

Any person who acts against the article 5 or 6 of this law shall be punished as the following:

-if the person is a medical doctor or a medical assistant or a secondary midwife, he/she shall be warned. In the event of another offence, he/she shall be removed from his/her profession or get the clinic or the maternity closed down aside from the following offences.

-if the person is not a medical doctor or a medical assistant or a secondary midwife, he/she shall be imprisoned from 1 month to 1 year.

-if the abortion causes illness or disability to the pregnant woman, the person shall be imprisoned from 5 years to 10 years.

### Article 13.7

A medical doctor or a medical assistant or a secondary midwife who have been authorised to perform abortion but does not follow any one of the criteria described in article 8 of the law shall get the authorisation from the ministry of health confiscated aside from the offences described in article 12 of this law.

Only in serious pregnancy that the woman has to be cared, medical methods are protected by the law.

### Article 14.7

Any person who forces a pregnant woman to have an abortion or provokes abortion voluntarily shall be imprisoned from 1 years to 5 years. If the forcing or voluntarily provoking of abortion to the pregnant woman is resulting to her chronic illness or disability or death, the person shall be imprisoned from 5 years to 10 years.

### Article 15.7

Any person who acts against article 9 of this law shall be punished as the following:

-if he/she is a government official, he/she shall be sanctioned according to the articles 40 and 41 of the law on co-criteria for civil servant officials.

-if he/she is not a government official, he/her private clinic or maternity shall be closed down from 1 month to 3 months or he/she shall be fined from five millions Riels (5000000 Riels) to ten millions Riels (10000000 Riels).

**Chapter 5**  
**Final provision**

**Article 16.**

Any norms which provide against this law shall be null and void.

Phnom Penh, 12 November 1997

# အညွှန်းစာမျက်နှာ

ဗုဒ္ဓ

ဂါထာ



ជលកម្ម១១៩៧០៦

ព្រះរាជក្រឹត្យ

១) ១១ ១១ ១៩៦២

យើង

ព្រះបាទសម្តេច ព្រះនរោត្តម សីហនុ  
រាជហ័រិវង្ស ឧត្តតោសុបាត ចិត្តវិទ្យា ឆន្ទៈឃាតុសៈនិង ឱករណ្តម  
ធម្មិតមហានិរិទ្ធិ បរមនាថ បរមបណ្ឌិត

ព្រះចៅក្រុងកម្ពុជាធិបតី

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- បានឃើញរដ្ឋធម្មនុញ្ញនៃព្រះរាជាណាចក្រកម្ពុជា
- បានឃើញព្រះរាជក្រឹត្យចុះថ្ងៃទី០១ ខែវិច្ឆិកា ឆ្នាំ១៩៥៣ ស្តីពីការតែងតាំង រាជរដ្ឋាភិបាលកម្ពុជា
- បានឃើញព្រះរាជក្របលេខ០២ ទស.៥៥ចុះថ្ងៃទី២០ ខែកក្កដា ឆ្នាំ ១៩៥៤ ស្តីពីការរៀបចំនិងការប្រព្រឹត្តទៅនៃគណៈរដ្ឋមន្ត្រី
- បានឃើញព្រះរាជក្រឹត្យលេខ ទស.រកត.១០៥៥.៥៧ ចុះថ្ងៃទី ២១ ខែតុលា ឆ្នាំ ១៩៥៥ ស្តីពីការតែសំរួលសហសភាពរាជរដ្ឋាភិបាលកម្ពុជា
- បានឃើញព្រះរាជក្រឹត្យលេខ រស.រកត.០៩៥៧.១៥៧ ចុះថ្ងៃទី៧ ខែសីហា ឆ្នាំ១៩៥៧ ស្តីពីការតែសំរួលសហសភាពរាជរដ្ឋាភិបាលកម្ពុជា
- បានឃើញព្រះរាជក្របលេខ ទស.រកប.០១៥៦.០៦ ចុះថ្ងៃទី២៤ ខែមករា ឆ្នាំ១៩៥៦ ស្តីពីការបង្កើតក្រសួងសុខាភិបាល
- តាមរយៈការក្រាបបង្គំទូលស្នើសុំពីវិទាធុនគ្នាមនោរម្យរដ្ឋមន្ត្រី១១និងសម្តេចមហាបក្សមន្ត្រី ៧២ និងស្តី រដ្ឋមន្ត្រីក្រសួងសុខាភិបាល

ព្រះករុណាជម្រាបជូន

ច្បាប់ស្តីពីការប្តូរឈ្មោះ របស់រដ្ឋមន្ត្រីក្រសួងសុខាភិបាល ថ្ងៃទី១១ ខែតុលា ឆ្នាំ១៩៥៧  
នាសម័យព្រះបាទសីហនុ ទី៧៧៧៧១ ដែលបានបោះពុម្ពផ្សាយក្នុងសៀវភៅ

ជំពូកទី ១

បទប្បញ្ញត្តិទូទៅ

មាត្រា ១.-

ច្បាប់នេះមានគោលដៅកំណត់ពីបែបបទនិងលក្ខខណ្ឌនៃការរំលូតរូន ។

មាត្រា ២.-

ការរំលូតរូនគឺជាការបញ្ចប់ភក្តិភាពវិធីវេជ្ជសាស្ត្រឬតាមវិធីណាមួយ ។

មាត្រា ៣.-

ស្ត្រីមានភក្តិទាំងឡាយអាចសុំឱ្យគ្រូពេទ្យធ្វើការរំលូតរូនបាន ក្រោយពីបានបំពេញលក្ខខណ្ឌដូចមានចែងក្នុងមាត្រា ៤ នៃច្បាប់នេះ ។

មាត្រា ៤.-

ក្នុងករណីណាក៏ដោយ ការរំលូតរូនត្រូវតែមានសំណូមពរនិងបានទទួលការយល់ព្រមពីស្ត្រីដែលមានភក្តិ ។

មាត្រា ៥.-

មានតែវេជ្ជបណ្ឌិតឬគ្រូពេទ្យមជ្ឈម ឬឧបមជ្ឈមដែលបានទទួលការអនុញ្ញាតពីក្រសួងសុខាភិបាល ទើបអាចធ្វើការរំលូតរូនបាន ។

ជំពូកទី ៥  
អវសានច្បាប់

មាត្រា ១៦.-

បទប្បញ្ញត្តិទាំងឡាយណាដែលផ្ទុយនឹងច្បាប់នេះ ត្រូវទុកជាមិនប្រក្រតី ។

ធ្វើនៅភ្នំពេញ ថ្ងៃទី ១២ ខែ វិច្ឆិកា ១៩៩៧  
ព្រះរាជាណាចក្រកម្ពុជា

ប្រមុខរដ្ឋស្តីទី  
ហត្ថលេខា  
ជា ស៊ីង

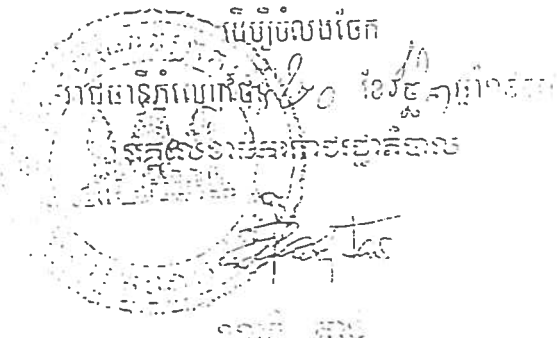
បានដំរើបដូន  
ឯកឧត្តមនាយករដ្ឋមន្ត្រីទី១និងអគ្គនាយករដ្ឋមន្ត្រីទី២  
រដ្ឋមន្ត្រីព្រះស្នងការកិច្ចការ

ហត្ថលេខា  
ឈា ថ្នាំ

បានយកសេចក្តីក្រាបបង្គំទូលថ្វាយ  
សូមច្បាយព្រះហស្តលេខាព្រះមហាក្សត្រ

នាយករដ្ឋមន្ត្រីទី១      នាយករដ្ឋមន្ត្រីទី២  
ហត្ថលេខា                      ហត្ថលេខា  
អ៊ុន ហួត                          ហ៊ុន សែន

លេខ : ២៦០ ចល

ប្រើប្រាស់បច្ចេក  
វិទ្យាបោះពុម្ពផ្សាយ  
នៅភ្នំពេញ ថ្ងៃទី ១២ ខែ វិច្ឆិកា ១៩៩៧  
អគ្គនាយកដ្ឋានព្រះរាជកិច្ចការ  
  
នាយក គារ



មាត្រា ១៤.-

ជនចំណាយណា ដែលបង្កើតបង្កើនស្ត្រីដែលមានភារកិច្ចការរំលូតពូជ ឬធ្វើឱ្យរលូតពូជ ដោយចេតនា ត្រូវផ្តន្ទាទោសដាក់ពន្ធនាគារពី ១ឆ្នាំ ទៅ ៥ឆ្នាំ។ បើការបង្កើតបង្កើនស្ត្រីដែលមានភារកិច្ចការរំលូតពូជ ឬធ្វើឱ្យរលូតពូជដោយចេតនានោះបណ្តាលឱ្យស្ត្រីដែលមានភារកិច្ចការមានជម្ងឺរ៉ាំរ៉ៃ ពិការ ឬ បណ្តាលឱ្យស្លាប់ ត្រូវផ្តន្ទាទោសដាក់ពន្ធនាគារពី ៥ឆ្នាំ ទៅ ១០ឆ្នាំ ។

មាត្រា ១៥.-

ជនណាដែលប្រក្រិញលើសនឹងមាត្រា ៩ នៃច្បាប់នេះ ត្រូវទទួលទណ្ឌកម្មដូចតទៅ :

- បើជាមន្ត្រីរាជការ ត្រូវទទួលទណ្ឌកម្មតាមមាត្រា ៤០ និង ៤១ នៃច្បាប់ រដ្ឋពីសហលក្ខន្តិកៈមន្ត្រីរាជការស៊ីវិល ។
- បើមិនមែនជាមន្ត្រីរាជការ ត្រូវបិទទុក ឬមន្ទីរសម្រាកព្យាបាលពី ១ខែ ទៅ ៣ខែ ឬពិន័យជាប្រាក់ពី ព្រំលានរៀល ( ៥.០០០.០០០រៀល ) ដល់ បំណានរៀល (១០.០០០.០០០រៀល) ។

ជំពូកទី ៤

ទោសប្បទាន

មាត្រា ១២.\_

ជនទាំងឡាយណាដែលបានប្រព្រឹត្តល្មើសនឹងមាត្រា ៥ ឬ ៦ នៃច្បាប់នេះ ត្រូវ  
ទទួលទណ្ឌកម្មនឹងទោសទណ្ឌដូចខាងក្រោម :

បើជាវេជ្ជបណ្ឌិតឬគ្រូពេទ្យមជ្ឈមណ្ឌលឬជាគ្រូបម្រើប្រទេស ។ ក្នុងករណីនិងភាពជា  
ត្រូវបញ្ឈប់ពីមុខងារឬបិទគ្លីនិកឬមន្ទីរសង្គមនោះដោយមិនទាន់គិតដល់បទល្មើសព្រហ្មទណ្ឌដូចចែង  
ខាងក្រោមនេះ ។

បើមិនមែនជាវេជ្ជបណ្ឌិតឬគ្រូពេទ្យមជ្ឈមណ្ឌលឬជាគ្រូបម្រើប្រទេស ត្រូវផ្តន្ទាទោសដាក់ពន្ធនាគារ  
ពី ១ខែ ទៅ ១ឆ្នាំ ។

-បើការរំលូតពូននោះបណ្តាលឱ្យស្ត្រីដែលមានគភ៌មានជម្ងឺរ៉ាំរ៉ៃឬពិការ ត្រូវផ្តន្ទាទោស  
ពី ១ឆ្នាំ ទៅ ៥ឆ្នាំ ។

-បើការរំលូតពូនបណ្តាលឱ្យស្ត្រីដែលមានគភ៌មានគ្រោះថ្នាក់ដល់ស្លាប់ ត្រូវផ្តន្ទាទោស  
ដាក់ពន្ធនាគារពី ៥ឆ្នាំ ទៅ ១០ឆ្នាំ។

មាត្រា ១៣.\_

វេជ្ជបណ្ឌិតឬគ្រូពេទ្យមជ្ឈមណ្ឌលឬជាគ្រូបម្រើប្រទេសដែលបានទទួលការអនុញ្ញាតឱ្យធ្វើការរំលូតពូន  
ហើយមិនគោរពលក្ខខណ្ឌណាមួយដូចចែងក្នុងមាត្រា ៥ នៃច្បាប់នេះ ត្រូវបត់ហុតយេកលីទិកអនុញ្ញាត  
ដែលពេញឱ្យដោយក្រសួងសុខាភិបាល ដោយមិនទាន់គិតដល់បទល្មើសព្រហ្មទណ្ឌដែលមានចែងក្នុង  
មាត្រា ១២ នៃច្បាប់នេះ ។

លើកលែងតែក្នុងករណីទំនងដែលស្ត្រីមានគភ៌ត្រូវសម្រោះបន្ទាន់ វិធីវេជ្ជសាស្ត្រនឹង  
ត្រូវបានដោះស្រាយចំពោះមុខច្បាប់ ។

រាយ ១៨ឆ្នាំ រឿងទៅ ឬការស្នើសុំដោយទទួលបានផ្នែកព្រឹត្តិបត្របុរាណាណាព្រាហ្មណ៍សាមីខ្លួន បើស្រ្តី  
ដែលមានពិការភាពរាយ ១៨ឆ្នាំ ។

ការសិរិលចំនែកនេះ ត្រូវមានការឯកភាពពីក្រុមគ្រូពេទ្យ ២ ឬ ៣រូប រួមទាំង  
សាមីខ្លួនផង។ លើកលែងតែករណីប្រើប្រាស់សម្រាប់ការអនុវត្តនៃមាត្រានេះ ត្រូវកំណត់ដោយប្រកាសរបស់  
ក្រសួងសុខាភិបាល ។

**មាត្រា ៩.-**

រាល់ឯកសារដែលទាក់ទងទៅនឹងការវិលត្រឡប់ ត្រូវរក្សាទុកជាការសម្ងាត់ ហើយអាច  
រៀបចំសម្រាប់ប្រើប្រាស់ ឬពុលការប្រសិនបើមានការស្នើសុំជាលាយលក្ខណ៍អក្សរ ។

**មាត្រា ១០.-**

សេវាដែលក្រសួងសុខាភិបាលបានអនុញ្ញាតឱ្យជាក់ស្តែងធ្វើការវិលត្រឡប់ដូចមានចែងនៅ  
ក្នុងមាត្រា ៦ នៃច្បាប់នេះ ត្រូវរៀបចំឯកសារលាស់លាស់ស្តីពីករណីវិលត្រឡប់នីមួយៗហើយត្រូវធ្វើ  
របាយការណ៍ប្រចាំខែមកក្រសួងសុខាភិបាលដោយទៀងទាត់នូវចំនួនវិលត្រឡប់និងមធ្យមតាមវិលត្រឡប់។

**ជំពូកទី ៣  
សេចក្តីត្រួតពិនិត្យ**

**មាត្រា ១១.-**

ការត្រួតពិនិត្យការវិលត្រឡប់តាមការកំណត់នៃច្បាប់នេះ ជាសេចក្តីត្រួតពិនិត្យ  
សុខាភិបាល ។

## ជំពូកទី ២

### ថែទាំបច្ចេកទេសស្តុកស្តុក

#### មាត្រា ៦.-

ការរំលូតពូជប្រព្រឹត្តទៅបានតែនៅក្នុងមន្ទីរពេទ្យ មណ្ឌលសុខភាព គ្លីនិក មន្ទីរសម្ភព សាធារណៈឬឯកជនដែលបានទទួលការអនុញ្ញាតពីក្រសួងសុខាភិបាល ។ រាល់សេវាដែលក្រសួង សុខាភិបាលបានអនុញ្ញាតឱ្យជាក់ខ្លួនធ្វើការរំលូតពូជត្រូវមាន :

- លទ្ធភាពបច្ចេកទេសល្អបំផុតរបស់បណ្ឌិតសុខាភិបាលនៃការរំលូតពូជ
- មធ្យោបាយបញ្ជូនទៅមន្ទីរពេទ្យ ប្រសិនបើមានការចាំបាច់

#### មាត្រា ៧.-

វេជ្ជបណ្ឌិតឬគ្រូពេទ្យមជ្ឈមណ្ឌលមជ្ឈមណ្ឌលដែលមានភារកិច្ចធ្វើការរំលូតពូជ ត្រូវពន្យល់ ណែនាំដល់ស្ត្រីដែលមានគភ៌ដែលមកសុំធ្វើការរំលូតពូជ ពីគ្រោះថ្នាក់ដែលអាចកើតមានឡើងដោយចៃដន្យ បណ្តាលមកពីការរំលូតពូជនេះនិងពីជលប្រយោជន៍នៃកិច្ចពន្យារកំណើត ។

ប្រសិនបើស្ត្រីដែលមានគភ៌នោះ នៅតែទទួលសុំធ្វើការរំលូតពូជ វេជ្ជបណ្ឌិតឬគ្រូពេទ្យមជ្ឈមណ្ឌល មជ្ឈមណ្ឌលអាចធ្វើការរំលូតបាន តែត្រូវស្ថិតក្នុងលីក្លីនិកមានចែងក្នុងមាត្រា ៨ នៃច្បាប់នេះ ។

#### មាត្រា ៨.-

ការរំលូតពូជអាចធ្វើទៅបាន ចំពោះតែគភ៌ណាដែលមានអាយុតិចជាង ១២សប្តាហ៍ រឺ ១២សប្តាហ៍នៃអាយុភិ ការរំលូតពូជអាចទទួលបានអនុញ្ញាតបាន លុះតែក្នុងករណីធ្វើ រោគវិនិច្ឆ័យឃើញថា :

- គភ៌នោះមានភារវន្តិយភាពមិនល្អលាស់ដូចប្រព្រឹត្តិឬបង្កគ្រោះថ្នាក់ដល់ជីវិតម្តាយ
- ពូជដែលទទួលបានអាចមានជម្ងឺធ្ងន់ធ្ងរល្អប្រសើរ
- ក្នុងករណីដែលត្រូវការលើកលែងលម្អិតមានគភ៌ ការរំលូតពូជអាចប្រព្រឹត្តិបានដោយ យោងមិនតិចពីលីក្លីនិកមានចែងខាងលើ តែត្រូវមានការស្នើសុំពីសាមីខ្លួន បើស្ត្រីនោះមាន



MINISTRY OF HEALTH

No. 505 / D.G.H. IR  
2002

KINGDOM OF CAMBODIA  
NATION- RELIGION- KING

Phnom Penh, Date : 02 / 5 / 2002

John Swartzberg, M.D., FACP  
Clinical Professor of Medicine  
Acting Chair, UCB-UCSF Joint Medical Program  
University of California, Berkeley

Dear Prof. Swartzberg,


**Subject: Proposed research on abortion in Cambodia**

With reference to your letter dated 25<sup>th</sup> April 2002 in connection with the above subject, the Ministry of Health of the Kingdom of Cambodia is pleased to inform you that it has agreed to Ms. Lester's proposed research on abortion in Cambodia .

The Ministry of Health found that this project is beneficial to the National Reproductive Health and Safe Motherhood Program.

Thank you for your kind cooperation.

With best regards.

Sincerely,  


Prof. ENG HUOT  
Director General for Health

CC:  
-Ms. Yoshiko Zenda, UNFPA Representative  
-Dr. Chhun Long, National Program Manager