Contraceptive Need Among Cambodian Refugees In Khao Phlu Camp

By Virginia Morrison

Context: *Women living in a refugee situation may have a serious need for family planning services, yet may face obstacles (both cultural and logistical) to practicing contraception. Understanding the reproductive health needs of women in these difficult circumstances is critical to devising comprehensive programs.*

Methods: *Data on contraceptive knowledge, beliefs and practices were collected from a random sample of 102 women (94 married, five single and three widowed) living in Khao Phlu refugee camp in Thailand and from the 10 midwives employed at the maternal and child health center serving the refugees. In addition, focus groups were held with 28 married male refugees and with 21 traditional birth attendants serving the camp population.*

Results: *While 82% of married women in the camp wanted to stop or delay childbearing, only 12% of all women interviewed reported using a modern method of contraception. Reasons for nonuse of contraceptives varied: Sixty-one percent of respondents mentioned fear of side effects; 24% cited lack of information; 20% mentioned a current illness; and 42% reported discomfort over seeking contraceptives. In addition, some 32–48% of women did not know that various contraceptive methods were available at the refugee health center. Nearly all midwives indicated that they would not provide contraceptives to an unmarried woman, and many indicated they would not provide contraceptives to a woman who was older than 42, had no children or was unhealthy. In focus groups, men demonstrated a lack of knowledge about contraception and held restrictive attitudes about which women should have access to family planning. Few midwives, no traditional birth attendants and none of the women or men knew about emergency contraception.*

Conclusions: *The stress of refugee situations may intensify existing barriers to the use of contraceptives. Concerted efforts at education must be made to dispel misperceptions about safety and increase awareness that services are available. The availability of providers with whom women are comfortable is critical to expanding both awareness of and access to family planning.*

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Fleeing from war and settling in a refugee camp are extreme and unstable circumstances that place women at an increased risk for unwanted pregnancy, obstetric complications and rape.[1] Resources that may have been available to women in their own country, such as contraceptive supplies and reproductive health personnel, are often not available during the upheaval of a refugee crisis.

Until recently, research on reproductive health services for refugees received little attention from the academic community. Aside from the difficulties in obtaining access to refugee camps, research in a refugee environment is difficult because of constant refugee movement and the possibility that armed conflict may interfere with data collection. Nonetheless, documentation of family planning needs among refugee populations is greatly needed.

Reproductive Health in Refugee Situations: An Inter-agency Field Manual serves as a guideline for the provision of reproductive health services at the outset of an emergency and later when the situation stabilizes.[2] As part of the Minimum Initial Service Package, the field manual recommends that steps be taken during the initial crisis period to prevent and manage the consequences of sexual violence, including providing emergency contraception. Once the situation has stabilized, the field manual calls for more complete reproductive health services, including the provision of a wide range of modern contraceptive methods and a more comprehensive response to sexual and gender-based violence.[3]

The Khao Phlu Camp

The United Nations High Commissioner for Refugees (UNHCR) established Khao Phlu refugee camp on the Thailand-Cambodia border in September 1997 for Cambodians fleeing their country to escape the internal fighting between rival forces.[4] By July 1998, approximately 12,000 Cambodian refugees were living in 12 distinct camp sections, representing the villages from which they had fled.[5] From September 1997 to March 1999, under the auspices of UNHCR, the American Refugee Committee provided health, sanitation and laboratory services to Cambodian refugees in the camp. By spring 1999, all refugees had been repatriated to Cambodia.

By December 1997, contraceptive supplies and reproductive health education, including information about emergency contraception, were available in Khao Phlu. In June 1998, Khmer reproductive health staff at Khao Phlu included 10 midwives at the maternal and child health center. Midwives performed prenatal visits, diagnosed and treated sexually transmitted diseases and distributed contraceptives. In addition, 41 traditional birth attendants assisted deliveries throughout the camp, calling a midwife when necessary. Midwives earned a salary from the American Refugee Committee, and traditional birth attendants were given monthly supplies, including birth kits, sugar and cooking oil, as compensation for their services.

The American Refugee Committee also employed 24 Khmer community health workers from the 12 camp sections to collect health statistics, provide referrals to the health center and communicate health-related announcements to the population of the camp. The American Refugee Committee was not able to provide regular tubal ligation services to refugees; Khmer medics provided the service to a few select women in the camps, and several women had the procedure when referred to Thai hospitals for obstetric emergencies. Because of societal, cultural and legal norms, abortion was not openly available to women in the camp.

Midwives and traditional birth attendants received extensive training about family planning, including use of emergency contraception for women forced to have intercourse (as well as for other

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women who may have had a need for this method). However, many young and inexperienced midwives had to be recruited as the camp expanded and as older midwives were repatriated to Cambodia, draining the camp of personnel who could dispense and teach about contraceptives. To keep midwives' knowledge up to date, training by the American Refugee Committee staff was repeated periodically. Although training included discussions on how to counsel and treat women who had been victims of sexual and gender-based violence, there was no formal rape crisis intervention in place.

Research Objectives

As many as 50% of married Cambodian women in Khao I Dang camp (in existence during the 1980s) had used modern contraceptive methods,[6] and current demand for contraception in many parts of Cambodia is high.[7] Anecdotal reports from Khao Phlu in 1997 suggested that women in the camp wanted greater access to contraception. Nonetheless, by May 1998, only an estimated 10% of women of reproductive age in Khao Phlu had received oral contraceptives, condoms or hormonal injectables, and almost no women had received emergency contraception.[8]

Therefore, the first research objective was to document the need for contraception among women in Khao Phlu; a second objective was to document barriers to obtaining and using contraceptive methods in the camp. The third objective was to document the need for emergency contraception within the refugee population and to examine possible barriers to its use.

In part, interest in examining use of and access to emergency contraception arose out of concern about sexual and gender-based violence in the camp, which has been identified as a problem among many married Cambodian women.[9] Several factors suggested that women in Khao Phlu may have been exposed to such violence. Recent reports indicate an increase in rape and unwanted pregnancy among refugees in other parts of the world,[10] and during the early 1990s, many Cambodian refugees had experienced sexual violence at the hands of Thai soldiers and Khmer men during the refugee crisis that preceded the Paris Peace Accords in 1992.[11]

Additionally, a vulnerability assessment of the population at Khao Phlu revealed that approximately 8% of women of reproductive age lived in female-headed households.[12] Women in Khao Phlu who were not accompanied by men were believed to be confronted often with unwanted sexual advances and extortion of sex for protection.

Because of the sensitive nature of abortion, this research was unable to examine access to and incidence and consequences of abortion in Khao Phlu.

Methods

To better understand the complex social, political and economic norms that may influence the need for contraception, and to best capture data in the rapidly changing environment of a refugee situation, the research approach combined quantitative and qualitative methods. Three distinct populations were targeted for data collection: women of reproductive age; midwives and traditional birth attendants; and married men.

Data were collected from May to August 1998 in Khao Phlu camp using in-depth individual interviews among women and midwives and focus groups among married men and traditional birth attendants. Separate survey instruments were used to collect data from women and from midwives. The survey tool was formulated to elicit general perceptions about family planning to help illustrate cultural norms in Khao Phlu. Women were also asked for demographic information and about their use and understanding of family planning methods. General questions were included to elicit women's beliefs about why they or others they knew might not practice contraception, as well as specific questions regarding their own contraceptive practice. Finally, women were questioned about knowledge and use of emergency contraception and experience with sexual and gender-based violence.

Midwives were asked how and to whom they provided contraceptives, about their perceptions of the need and demand for contraceptives in Khao Phlu (compared with the situation in Cambodia), and about contraceptive side effects. Midwives were also asked specific questions regarding knowledge of emergency contraception, and whom they would consider an appropriate candidate for use of this method.

Qualitative data were collected through separate focus groups with men and traditional birth attendants, and were intended to identify social norms, examine inconsistencies among respondents and corroborate results of data collected among women and midwives. Focus groups with traditional birth attendants concentrated on reasons why contraceptives were not used, and on the use of and beliefs about emergency contraception. Along with these issues, focus groups with men addressed questions about preferred family size and appropriate behavior among couples trying to prevent pregnancy. In addition, data entered by midwives into the maternal and child health center register were tabulated to determine the number of women coming to receive contraceptive services at the clinic.

Six pilot interviews were completed before the survey instrument for women was revised and finalized; pilot data from these surveys are not included in the analyses. At the end of each interview, women were informed that contraceptives were available free of charge at the maternal and child health center and were shown samples of emergency contraception. Interviewees who had been raped were referred to a specialist working with the UNHCR in Khao Phlu.

In an attempt to interview women with and without experience at the maternal and child health center, women were selected for interviews in two ways. While walking through each section of the camp, researchers randomly asked women if they wanted to participate in a confidential study about family planning. A total of 77 women (at least six per section) were recruited in this manner. This number reflects the number of interviews possible in the three-month study period, given the limitations of travel within the camp. Fifty percent of women approached in the camp refused to participate, most stating that they were too shy to talk about contraception. An additional 28 respondents were randomly selected from among women leaving the maternal and child health center following a clinic visit; 10% of these women refused to participate, leaving 25 participants recruited in this manner.

Young and unmarried women were most likely to refuse to participate. Because the number of unmarried women was small (5% of those interviewed), no attempt was made to examine their responses separately. (Thus, a question about delaying or stopping childbearing was addressed to only married women.)

In-depth structured interviews were also conducted with the 10 midwives working at the maternal and child health center. The first two interviews served as pilot tests; questionnaires were altered for the remaining interviews, and some data were therefore discarded. Additionally, two 90-minute focus groups were conducted with a total of 21 Khmer traditional birth attendants (10 in one group and 11 in the other). Dates for these focus groups were arranged

around monthly staff meetings at the maternal and child health clinic, and traditional birth attendants were invited to participate as their schedules permitted.

Three 90-minute focus groups were conducted with a total of 28 married men. Each group consisted of 9–10 participants. Community health workers were asked to recruit two men from each section of the camp for each of three focus groups. The workers read a description of the content and goals of the focus group to potential participants and asked them to attend the group if interested. More than half of the men approached refused to participate in the study.

Interview data were recorded and analyzed for frequencies. Focus-group data were audiotaped, translated into English and coded for common themes by the primary researcher. All focus groups were led by women. All participants gave oral consent. Any questions about contraception or general health were answered after sessions. After each interview and all focus groups, participants were given 10–30 minutes (depending on the number of questions) of contraceptive education, using a picture chart prepared by the United Nations Population Fund in Cambodia.

Camp leaders and community health workers were informed about the study prior to data collection. All interviews and focus groups were conducted in Khmer, with translation performed by a Khmer physician and a Thai community health worker (both female employees of the American Refugee Committee). The primary researcher wrote the instruments, combining questions from the Demographic and Health Survey and the Reproductive Health for Refugees Consortium's Needs Assessment Field Tools. Original instruments were translated into Khmer and backtranslated into English to confirm the accuracy of the translation.

Results

Sample Characteristics

Of the 102 women who participated in interviews, 94 were married, five were single and three were widowed. The mean age of interviewees was 33.3 (age range, 17–45). Women in the sample had a mean of 2.2 years of education; 36% had no formal schooling. The average age of the interviewed midwives was 24.8 (age range, 14–42). Four of the 10 midwives were unmarried and younger than 17. Two midwives had practiced since the 1970s, while the remaining eight midwives were trained at the camp. The average age of the 28 men participating in the focus groups was 40.2 (age range, 22–50).

Need for Contraception

Among married women, 82% wanted to stop or delay childbearing. Among all women interviewed, only 12% reported currently using a modern method of contraception. All women were asked what contraceptive method they would prefer to use: Twenty percent preferred tubal ligation, 14% oral contraceptives, 10% the injectable and 5% condoms.

Traditional birth attendants who had been serving the same population before fleeing Cambodia indicated that refugee status had increased the need for family planning services. As one traditional birth attendant stated: "Now many women want family planning because the standard of living is not so good and they are poor." Men in all of the focus groups reported that they wanted their wives to practice contraception and agreed that refugee status had increased the need to stop or delay having children. One participant stated: "I think it is a good idea to use contraception… when there is peace it is better to have children. When you don't move so much it is better to have children."

Barriers to Contraception

Barriers to contraception included beliefs, cultural norms or misinformation among the population that existed before they became refugees, as well as obstacles that stemmed from circumstances surrounding the flight from Cambodia and life in the camp.

Sixty-one percent of respondents mentioned fear of side effects as a reason why they or others they know did not use contraceptives; weight loss (26%) and bleeding (20%) were the specific concerns cited most often. Other reasons given for not practicing contraception included lack of information (24%), current illness (20%), expense (9%), being too old (8%), being unable to obtain them (4%) and husband's refusal (2%). Although a large proportion of women recognized oral contraceptives (91%), condoms (86%), hormonal injectables (88%), IUDs (73%) and tubal ligation (85%) as contraceptive methods, many had only heard about these methods on the radio and had never actually seen or talked to someone who had used them.

Midwives, traditional birth attendants and men also mentioned side effects as the main reason why women did not practice contraception. In focus groups, men also mentioned vaginal infection as a barrier to use. While it is unclear why this misperception persisted, it is noteworthy that many men and women stated that traditional herbal methods of contraception had effects such as weight loss, fever and infection, suggesting that the effects of herbal formulas may have been reassigned to modern methods.

When asked specifically about their individual contraceptive practices, many women (42%) noted that they were uncomfortable seeking contraception. Shyness was mentioned in focus groups with men and with traditional birth attendants as a reason why both men and women did not obtain contraceptives from the maternal and child health clinic. The young age of many of the midwives may also have been a factor. In one observed incident, a female survey respondent attending the maternal and child health clinic wanted condoms, but did not wish to ask a young midwife because she was embarrassed to request contraceptives from an unmarried woman.

Men in all three focus groups lacked knowledge about contraception. One man indicated that he thought men needed to take oral contraceptives to prevent pregnancy, while another suggested that the pill needed to be taken only on the days when intercourse occurred.

Finally, the great importance placed on marriage and fidelity created a barrier to practicing contraception. Even though men reported a desire to use family planning, they did not want unmarried women or women from a rival political faction to have access to these resources. Use of contraceptives was associated with promiscuity. As one man said, "There should be a law to prevent unmarried women from going to get contraception." Another participant related a story common to all groups: a woman whose husband beat her after she had sought contraceptives at the maternal and child health clinic because he questioned her morality.

Barriers to contraceptive use found in the camps probably existed before the refugee crisis as well. However, their impact may have been exacerbated by conditions in the camp, where 12 villages were condensed into one area and people were unfamiliar with one another. One male focus-group respondent summarized these fears: "When the family lives in the camp with so many strangers and the husband goes back to the home to take care of the rice fields, the woman may go outside of the relationship." A common sentiment expressed among individuals in each target group was that contraception was beneficial for the individual or group being interviewed, but bad for the population as a whole because it encourages promiscuity, particularly among

people who came from the cities, or among those suspected of being part of the government.

Other barriers to contraceptive use for individual women were a direct result of living in the camp. For example, 34% of women reported that heavy rains during the monsoon season made it difficult to travel to the maternal and child health center, or that these facilities were too far from their section in the camp. Although a majority of women thought oral contraceptives (68%), condoms (52%) and injectables (65%) were more available in the camp than in Cambodia, 32% were unaware that oral contraceptives were supplied through the maternal and child health clinic, 36% that the injectable was available and 48% that condoms were supplied.

Women also noted providers' unwillingness to prescribe contraception as an additional barrier to contraceptive use in Khao Phlu. Thirteen percent of women reported that midwives at the maternal and child health clinic were unwilling to supply them with contraceptives. Interviews with midwives confirmed this: Nearly all indicated that they would not provide oral contraceptives, injectables or condoms to an unmarried woman, and a majority stated they would not provide hormonal contraception to a woman who was older than 42, who had not had children or who was unhealthy (Table 1). Several midwives also indicated they would not provide women with contraceptives if they were younger than 18, if they had recently given birth or had had an abortion, or if they were commercial sex workers. In general, midwives were less reluctant to offer women condoms than they were to provide hormonal contraceptives.

In the case of tubal ligation, interviews revealed that women were considered candidates for this procedure only after receiving approval from their husbands, their section leader and the camp leader. Although the American Refugee Committee did not sanction the procedure, Khmer surgeons provided instruments and supplies and performed the procedure under general anesthesia in the camp. Sixty-three percent of women felt that tubal ligation was more available in Cambodia than in the camp, whereas 27% felt they had more access to this method in the camp. Cost may have been a barrier to obtaining this method. Although one interviewee stated that the price for the procedure was determined on a sliding scale based on need, another woman reported the cost was 3,000 Baht (approximately $75).

Emergency Contraception

None of the women interviewed or the men participating in focus groups were familiar with emergency contraception. Only two of the 10 midwives interviewed and none of the traditional birth attendants knew about this method. One midwife familiar with emergency contraception was not aware that it could be used in situations other than rape, nor was she aware that emergency contraception was simply oral contraceptives taken at a higher dose.

Participants were educated about the use of emergency contraception, and subsequently, 98% of interviewees stated that they would like to see this method available at the camp. Three traditional birth attendants indicated that they knew women who could use the method that very day. Men in all three focus groups indicated that they found postcoital contraception acceptable. In fact, men in each focus group mentioned the existence of an herbal preparation (a mixture of herbs, papaya leaves and wine) that a woman could take after she had missed her period. Men were interested in a pill that would not cause as much pain and bleeding as herbal methods. Thirty-six percent of women also reported knowing of oral herbal methods for preventing pregnancy either before or after a missed period.

Women respondents had reservations about providing unmarried women access to emergency contraception. Although women unanimously endorsed use of emergency contraception in cases of rape, only 10% said it was acceptable for all women to receive emergency contraception regardless of age or marital status; 40% said women younger than 18 should not have access to the method. Women were more likely to endorse use of emergency contraception for commercial sex workers (38%) than for unmarried women (23%).

Other barriers also existed. Men in all focus groups indicated that women believed it was fate whether they became pregnant, suggesting that women might not utilize emergency contraception. In addition, traditional birth attendants had difficulty understanding the specifics of using the method.

Although 30% of women interviewees stated that they knew of women who had been forced into trading sex for food, money or protection and 16% said that either they or someone they knew had been raped at the camp, midwives did not express knowledge about exploitation and rape. This difference may serve as another barrier to contraceptive use and may result from differences in perceptions.

Table 1. Number of midwives who said they would not provide women with a contraceptive, by reason for refusal, according to method (N=10)

Reason	Pill	Injectable	Condom
Age <18	5	4	1
Age >42	6	7	1
Unmarried*	9	8	9
No children	7	7	3
Recent abortion†	4	3	2
Recent birth	4	4	1
Commercial sex worker	5	5	4
Unhealthy‡	7	7	1

*Single or a widow. †Induced or spontaneous. ‡For any reason. *Note:* All reasons refer specifically to married women, except "unmarried" and "commercial sex workers" (who could be married or single).

While Western observers may consider as rape any situation in which a women is forced to have intercourse, Cambodians do not necessarily perceive that intercourse is something a married or widowed woman can choose not to have. A Cambodian man is usually considered head of the family, and if a husband wants to have intercourse with his wife, she may have little choice in the matter.[13] Similarly, if a man wants to extort sex for food, protection or money from a widow, she may have little recourse but to accept the situation. Moreover, shame and secrecy surround rape.[14] Traditional birth attendants in both focus groups said that rape is rarely reported and that providers may not be aware of it unless it happens to a close friend. As one stated, "For the lady who was raped, it is confidential and she does not tell us...and sometimes the maternal and child health center is too faraway."

Change over Time

From a review of data entered by midwives into the clinic register, it was possible to determine the number of refugee women who obtained contraceptives over the study period. Demand for oral contraceptives and condoms increased dramatically. During the six months prior to the study, 310 women obtained contraceptives from the center. During the three-month study period, a total of 523 women received contraceptive supplies (Table 2, page 192). In a neighboring camp (also administered by the American Refugee Committee), there was no significant increase in contraceptive requests in either June or July 1998. While a number of factors might explain these data, the increase may have resulted from the information given to interviewees and subsequent word-of-mouth communication to friends and family in the camp.

Table 2. Number of women obtaining contraceptives from the Khao Phlu maternal and child health center, by method obtained, according to month, Nov. 1997–July 1998

Month	Pill	Injectable	Condom
November	6	0	6
December	25	25	6
January	7	14	7
February	22	21	27
March	40	27	3
April	57	17	0
May	54	21	16
June	99	23	51
July	136	28	95

Discussion

Women, midwives, traditional birth attendants and men all clearly indicated the need for contraceptive services in Khao Phlu. Misconceptions about method safety combined with problems typically encountered in refugee situations (such as distance to the health center and difficulties communicating about the availability of services) present complex obstacles to providing comprehensive reproductive health services in refugee camps. That refugee populations under stress may cling to cultural beliefs more strongly than they would in their own country may explain why fears of promiscuity created a formidable barrier to contraceptive use in Khao Phlu.

Individual and group education among providers and women alike can raise awareness about the nature and availability of contraception, and can dispel myths surrounding its side effects. In the current study, contraceptive education offered during interviews appeared to play a role in encouraging women to seek contraceptives from the maternal and child health center.

Because traditional birth attendants are so numerous and can work so closely with women in refugee situations, involving them in contraceptive distribution among women may alleviate problems of shyness and lessen the difficulty of traveling to the maternal and child health center. Involving men in decision-making may reduce the threat that fertility control presents, and may increase the effectiveness of a reproductive health initiative. However, it should not hinder the preservation of confidentiality and human rights for women who may want to gain access to contraception without a man's approval.

Any plan to implement emergency contraception services as part of a response to sexual and gender-based violence must first address women's need for confidential and discreet care to help deal with shame, possible ostracism and trauma after rape. In addition, refugee camp workers should be aware of issues of rape, even if women's health is not their designated field.

It is important to stress that women can use emergency contraception for any unplanned intercourse. Women's need for emergency contraception may best be assessed by examining their frequency of unplanned intercourse, rather than by assessing how many women have been victims of rape. If midwives and traditional birth attendants are able to increase knowledge about the existence of emergency contraception, women will be able to avoid the painful and perhaps dangerous side effects of poorly performed abortions or of the herbal methods mentioned in focus groups.

This study has several limitations. The sample size was not large enough to generalize results to the camp as a whole. It was difficult to obtain a random sample of women interviewees and male focus-group participants. The paucity of data collected from young, single and widowed women reflects the difficulties of reaching these vulnerable groups. In addition, all focus-group leaders were women, which may have affected the answers given by men. Finally, generalizability of results to camps in other parts of the world is limited because of specific cultural norms in the border areas of Cambodia.

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