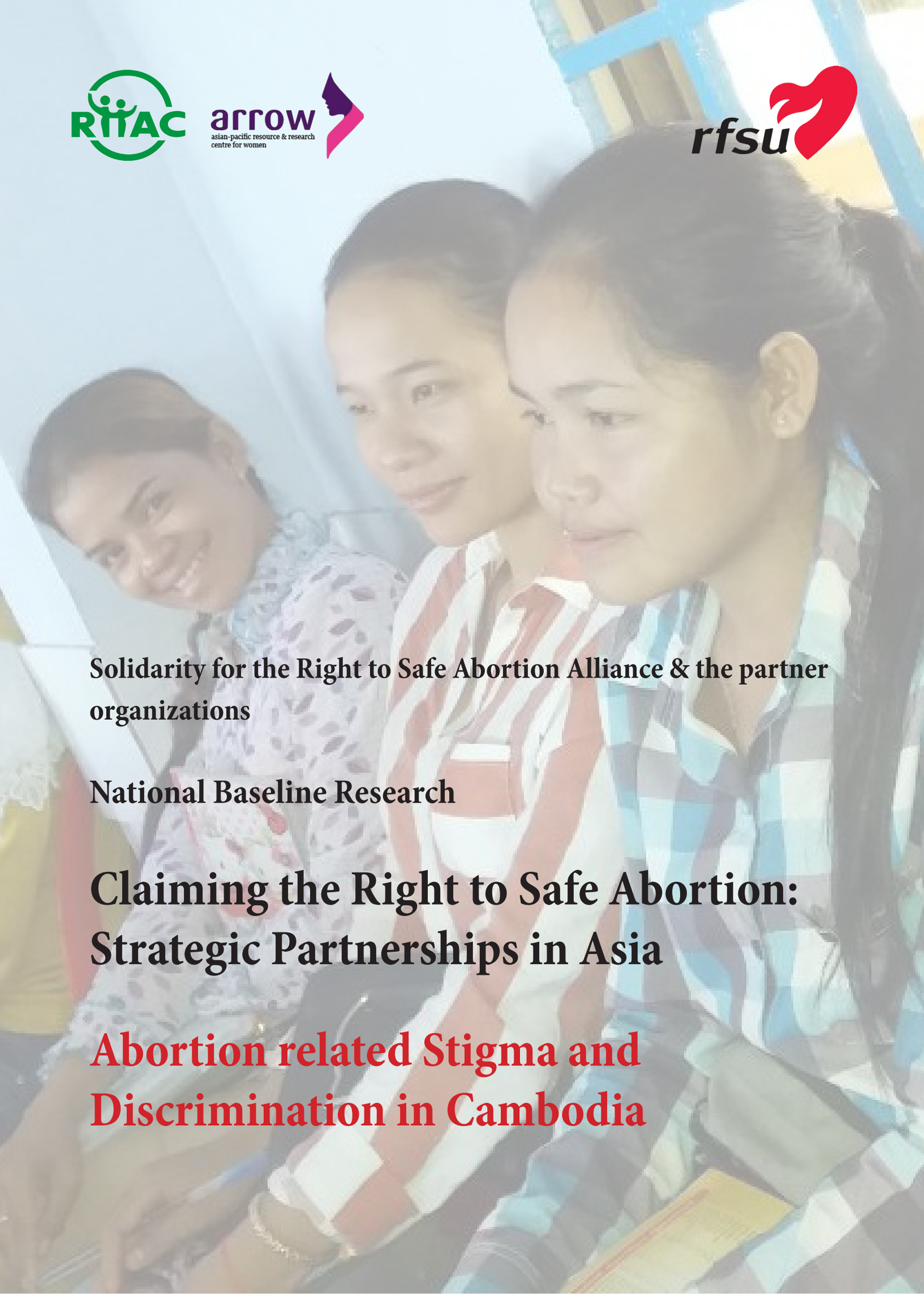

Solidarity for the Right to Safe Abortion Alliance & the partner organizations

National Baseline Research

Claiming the Right to Safe Abortion: Strategic Partnerships in Asia

Abortion related Stigma and Discrimination in Cambodia

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At Angkor Research, Mr. John Nicewinter and Mrs. Saing Ratanaksophea managed the project together. John drafted the instruments, selected the sample, conducted analysis and wrote the draft report. Ratanaksophea tested and revised the instruments, conducted field staff training, managed the data collection and supervised the transcription and translation of all qualitative data. Mr. Ian Ramage, Chief Technical Officer, oversaw the project.

LIST OF ACRONYMS AND ABBREVIATIONS

ARROW	Asian-Pacific Resource and Research Centre for Women
CAC	Comprehensive abortion care
CAPI	Computer-assisted personal interview
CDHS	Cambodia Demographic and Health Survey
CSES	Cambodia Socio-Economic Survey
HH	Household
IDI	In-depth interview
ILAS	Individual Level Abortion Stigma Scale
IUD	Intrauterine device
NCDD	National Committee for Sub-National Democratic Development
PPS	Probability proportional to size
RHAC	Reproductive Health Association of Cambodia
SABAS	Stigmatizing Attitudes, Beliefs and Actions Scale
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TOR	Terms of reference
TV	Television

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EXECUTIVE SUMMARY

Lack of information about how women and their communities understand and perceive abortions, women who have abortions, and abortion service providers has resulted in limited knowledge on how women's lives change after an abortion. Despite the fact that abortion was legalized in Cambodia in 1997, available information demonstrates that women greatly hesitate to access safe abortion services, and even when they access them, they are strongly stigmatized within their community after having an abortion.

Therefore, the current study was undertaken to measure the awareness of abortion legality and the levels of stigma and discrimination around abortion in Cambodia. The mixed methods study involved a quantitative survey of 300 women of reproductive age (WRA; 15-49 years old), which is weighted to ensure proportional representation of WRA in the target provinces of Siem Reap and Kampot. As well, 26 in-depth interviews (IDIs) with community leaders and six separate focus group discussions (FGDs) with WRA, their husbands/partners, and their mothers-in-law were conducted. For comparability with similar studies in other countries, two international scales of abortion stigma and discrimination were incorporated: the Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS), for women who have not had an abortion and community members; and the Individual Level Abortion Stigma Scale (ILAS), for women that had an abortion.

1. Awareness of abortion and related issues

Awareness of the legal protections around abortion is very low, with most women not fully understand the legality of abortion; only 2.7% of women correctly knew all aspects of abortion legality. However, around half of the community leaders surveyed knew that abortion was legal and were able to name the circumstances when it was permitted. In addition, around half of all women knew that it was legal for medical staff and hospitals/clinics to perform abortions, and around half were able to identify safe abortion providers.

From the qualitative discussions on abortion legality, there is also a clear conflation between the national law and the moral code of Buddhism – Cambodia's dominant religion. This affects women's understanding of their right to an abortion, and their right to safe abortion services in a medical facility, and may increase their fear of stigma, isolation and self-judgment.

2. Perceptions on abortion

Based on the international scales used to measure stigma and discrimination towards women that have abortions, Cambodian communities show a low to moderate level of stigma towards abortion. Community leaders demonstrate a less discriminatory attitude toward women that have abortions than people in their communities. But, abortion stigma is ever-present in these conservative communities; all IDI and FGD respondents reported stigma or discrimination towards women that have abortions and/or abortion providers. This stigma is greater towards unmarried women that have abortions. While communities can understand the justifications for married women to have abortions (poverty, multiparity, etc.), unmarried women carry the double stigma of having sex outside of marriage and terminating a pregnancy (abortion).

Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS)

Overall, women in the study had SABAS scores of 2.33 (on a Likert scale of 1-5), reflecting attitudes that are not highly stigmatizing towards women that have abortions. Among the three different categories of stigma, negative stereotypes had the highest stigmatization score (mean 2.89). Community members had consistently lower SABAS scores than women, and lower scores across all three sub-categories.

Individual Level Abortion Stigma Scale (ILAS)
Of the 57 women that reported having an abortion, all completed this section. Women that had an abortion had average ILAS scores of 1.57 (on a Likert scale of 0-3 or 0-4 depending on the question); slightly below mid-value. In the different sub-categories, women were most worried about community condemnation and self-judgment, and least worried about individual judgment.

3. Barriers to safe abortion access

Most women do not have full control over their healthcare, and decision-making for abortion follows a similar trend; only around one-third of women reported that they could decide to have an abortion by themselves. The other barriers which were raised by the qualitative respondents pertained to the difficulty accessing abortions. These primarily included cost, distance, time, and quality of care concerns. For women in vulnerable groups, including the poor and those living in remote areas, these barriers were seen as a greater obstacle to abortion access than for other women. Illiterate or uneducated women were also seen as having barriers to receiving a safe abortion, as they may not be aware of safe abortion providers, and may not fully understand medical instructions or advice.

4. Women's experience of abortion

Fifty-seven women (18.2% of the weighted sample) reported that they had an abortion before, with an average of one abortion per woman. The most common reasons for having their last abortion were a lack of money, not wanting children at this time, and abnormal fetal development. Around half of abortions were considered safe abortions; conducted in recognized health facilities using medical abortion techniques. Concerningly, over one-third of abortions were initiated in an unsafe location; usually a pharmacy, drug store, or the respondent's home. Nearly all abortions had to be paid for, with average costs of around US$ 47.51.

Recommendations

- Increase awareness around the legality of abortion and safe abortion providers, especially among the most vulnerable groups.
- Separately address the circumstances of unmarried and married women in campaigns to reduce abortion stigma.
- Include husbands and community leaders in the target audience for awareness raising campaigns.
- Ensure equal access for all women to program materials.

1. Introduction

As in many developing countries, there is limited data on abortion in Cambodia. Part of this is cultural – the majority of Cambodians are Buddhist, and people tend to consider it sinful to have an abortion. Talking about abortion is still a taboo issue, and available data sources for health, such as the Cambodia Demographic Health Survey (CDHS) tend to avoid the topic or provide only limited information due to the sensitive nature of the subject, and the highly charged socio-political environment around abortion. Sex before marriage remains a taboo subject and activity, and so women are often reluctant to openly discuss reproductive health issues before marriage, fearing discrimination. Partly due to the difficulties in collecting accurate data in this environment, no comprehensive study on abortion has been made in Cambodia.

Lack of information about how women and their communities understand and perceive abortions, women that have abortions, and abortion service providers has resulted in limited knowledge on women's access to safe abortion services and how women's lives change after an abortion. Despite the fact abortion was legalized in Cambodia in 1997, available information demonstrates that women greatly hesitate to access safe abortion services, and even when they access them, they are strongly stigmatized within their community after having an abortion. Therefore, a new study on perceptions and awareness of abortion can contribute to identifying why women do not access abortions, or why people avoid talking about the subject. This can directly contribute to policymaking discussions on increasing public awareness of women's right for access to abortion information and services, and assist in the design of projects intended to improve access to abortion services and empower women in their sexual and reproductive health rights.

1. Research rationale

The main rationale for this study is that there has been no evidence-based study on abortion in Cambodia, partly due to a social and cultural taboos surrounding talking on abortion. However, RHAC's clinical service experience has demonstrated that women are strongly stigmatized in seeking abortion services, and service providers are also rather reluctant to carry out legal abortions due to a lack of proper understanding about women's SRHR. RHAC clinical staff members have experienced a variety of challenges in conducting legal abortions, and its staff members also encountered many challenges in addressing abortion in their work. However, no comprehensive studies on abortion have been conducted to document the successes and challenges in the protection of a women's rights to abortion.

To fill this knowledge gap, the current baseline study was commissioned, with three main objectives:

- To determine the level of knowledge, attitudes and practices toward abortion in Cambodia, especially level of awareness of legality of abortion;
- To determine the magnitude of negative beliefs on abortion among community groups;
- To understand the stigma against women who had accessed an abortion;

Objectives

The primary objectives of this study are to understand the awareness of women about the legal status of abortion, and the levels of stigma and discrimination around abortion in Cambodia.

There are two main research questions to be addressed:

- What is the level of awareness on the legality of abortion in Cambodia?
- What are the major negative beliefs on abortion among community groups and how does/can stigmatization occur if women access an abortion?

The result of the study will not directly influence the existing law and policy on abortion; however, it aims to improve the implementation of the legal/policy framework.

3. Methodology

This study utilised a mixed methods approach, incorporating both quantitative and qualitative methods to comprehensively understand the stigma and discriminatory factors around abortion in Cambodia. These methods included:

- A quantitative, cross-sectional survey of 300 women of reproductive age (WRA; 15-49 years old) in two target provinces of Cambodia;
- Qualitative, in-depth interviews (IDIs) with 26 targeted community leaders;
- Focus group discussions (FGDs) with women that completed the individual interviews, divided by age (15-24 years old; 25-49 years old), and FGDs with other decisionmakers of women's reproductive healthcare – husbands and mothers-in-law (six FGDs in total).

Sampling and data collection

Quantitative survey

For the quantitative survey of women of reproductive age, two provinces were selected by RHAC based on specific criteria. Within these provinces, a systematic, random sampling of villages in the two target provinces was conducted using a probability proportional to size (PPS) selection method. PPS selects villages based on the number of households in each village, ensuring the representativeness of the sample among individual households in each province. Ten villages were selected in each province, with targets of 15 individuals per village (300 women total; 150 in each province).

At the village level, households were randomly selected using a modified EPIWalk selection method. First used for vaccination surveys, the modified EPIWalk used for this study involved drawing a map of the village with the village chief, including all intersections within the village and on its boundaries, and calculating the household selection interval (target individuals divided by the number of households in the village). One of these intersections was then randomly selected as a starting point. From the closest house to this point, the field teams walked down the road, selecting every house based on the sampling interval and screening for eligibility. When a household was ineligible or the interview was completed, they continue to the next household based on the interval. When they came to an intersection, they always turned right. In this way, all households in the village had an equal chance of selection, and the entire village was covered by the selection process without exclusion of any geographic areas or neighbourhoods.

One woman of reproductive age was selected in each household. Where multiple eligible women were present, one was randomly selected by the interviewer using a random draw method, which ensured an equal probability of selection. The quantitative portion of this study is thus representative of all women of reproductive age living in households in the two target provinces.

Interviews were conducted on tablet computers, using SurveySolutions data collection software. SurveySolutions is a software package developed and maintained by the World Bank for use in computer-assisted personal interviews (CAPI). It is free for use in social research implemented in developing countries, such as this study. The system provides dual-language support; the interviews were conducted in Khmer, and the data was exported in English.

After a five-day training process for field staff, data was collected for 11 days in early September. Ethical approval was provided pre-departure by the National Ethics Committee for Health Research

(NECHR) of the Ministry of Health; the governmental body providing research approval in Cambodia. All interviewers were female, native Khmer speakers and all interviews were conducted in Khmer to ensure the comfort of respondents.

Response rate

At the start of the interview process, informed consent was sought from all potential respondents to the quantitative interview, as well as for each IDI and FGD. A total of 305 women were approached for the quantitative interview; the completion rate was 98.4%, with three women refusing to participate after reading the informed consent, and two selected women who were absent even after three attempts to interview them. All IDI and FGD participants agreed to participate in the study.

Qualitative survey

Two types of qualitative data were collected for this study: individual IDIs and group discussions (FGDs). IDIs were conducted with 26 community leaders identified by the field teams among the following sub-groups: public health providers (e.g., doctors, nurses and midwives at local health centres), high school teachers, and local authorities (e.g., village chiefs, assistant village chiefs, commune chiefs, and members of the commune council for women's and children's affairs). This sample was evenly divided between the two target provinces. RHAC provided guidance on the number of interviews to be conducted within each of the three target groups. Selection of individuals was based on their understanding of the local context and abortion-related issues, and was at the discretion of the field supervisor for each team. The breakdown of IDI respondent information is included in the table below (**Error! Reference source not found.**).

In addition, there were six FGDs conducted during as the field data collection, divided among four target groups:

- Young women, age 15-24, that completed the quantitative study (2 groups);
- Older women, age 25-49, that completed the quantitative study (2 groups);
- Husbands/partners of women that completed the quantitative study (1 group);
- Mothers-in-law of women completed the quantitative study (1 group).

The FGDs were evenly divided between the two target provinces (**Error! Reference source not found.**). A total of 34 individuals participated in the six FGDs, with an average size of 5-6 participants in each group. The participation of some groups was harder to encourage than others. This was especially true for the FGDs with mothers-in-law and husbands/partners. Some of the participants reported that women's reproductive health was a subject that they had little involvement in, which could be one reason for their reluctance to participate in discussions on these issues. Similar to the IDI respondents, FGD participants were chosen by the field staff based on eligibility criteria and understanding of the area of interest (reproductive health and abortion-related issues).

Table 1: Qualitative sample description.

	Kampot	Siem Reap	Total
In-depth interviews (IDIs)			
Public health provider	5	5	**10**
High school teacher	3	3	**6**
Local authority	5	5	**10**
Total IDIs	**13**	**13**	**26**
Focus group discussions (participants)			
Women age 15-24	1 (8)	1 (5)	**2 (13)**
Women age 25-49	1 (5)	1 (6)	**2 (11)**
Husband/partner	–	1 (5)	1 (**5**)
Mother-in-law	1 (5)	–	1 (**5**)
Total	**3 (18)**	**3 (16)**	**6 (34)**

Questionnaires

The questionnaires were developed by Angkor Research, with inputs and final approval from RHAC and ARROW. They were designed to meet the research objectives of understanding women's experiences with abortion, and the sociocultural issues that surround this issue. Socioeconomic and demographic information was also collected. For comparability with similar studies in other countries, two international scales of abortion stigma and discrimination were incorporated into the questionnaires: the Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS); and the Individual Level Abortion Stigma Scale (ILAS). Further description of these scales is included in the analysis section, below. The quantitative questionnaire was pre-tested twice– once before, and once during the field staff training. All interviewers conducted the second pre-test, ensuring that they were comfortable with the instruments.

Data analysis

After all data was collected, it was cleaned for outliers and incorrect question patterns (including call-backs to confirm questionable data directly with respondents). All data was then analysed according to the analysis plan developed between Angkor Research, RHAC and ARROW.

The results are reported here. Unless otherwise specified, the population of respondents for each indicator is the total sample (n=300). All quantitative data was analysed using SPSS statistical software. Where relevant, tests of statistical significance at standard levels ($p<0.05$) have been conducted; significant differences between sub-groups are indicated in the data tables below using an asterisk (*).
The data from the IDIs and FGDs have been used to inform the interpretation of results from observations and quantitative findings. Quotes throughout the report provide an informed glimpse into the situations of these individuals and their lives.

Weighting

The number of households and individuals sampled in each province was the same, even though the populations of these provinces differ considerably; i.e., there are more WRA in Siem Reap than in Kampot. If the data was analysed "as is", the answers given by women interviewed in Kampot and Siem Reap would have an equal weight within the findings, even though the women interviewed in Siem Reap represent a greater number of women. Therefore, the results need to be weighted, to ensure that the results are representative of all women in both provinces.

The weight of the sample in each province is the inverse of the multiple probabilities of selection, as shown in the formula below:

$w = 1 / (p_1 \times p_2)$

where p_1 and p_2 are the probability of selection at each of the sample stages. The sample was selected in two stages: household and individual. The villages were selected using PPS from among the household population, so that all households in the province had the same probability of selection. There is no probability of selection at the village level, as it was not villages that were selected, but rather clusters of households from within all households in that village. The probability of selecting a household in each province is the household sample divided by the total number of households in that province (p_1). Individual WRA were selected from among all WRA in each selected household, so the probability of selecting an individual (p_2) is one over the average number of WRA per household in each province.

Table 2: Sample selection probabilities and weights, by province.

	HH sample	HH population	WRA population*	WRA/ HH	Probability1 (p_1)	Probability2 p_2	Sample weight *(w)*
	(a)	(b)	(c)	(d=c/b)	(a/b)	(1/d)	
Kampot	150	139,988	155,356	1.11	0.001072	0.900901	1035.911
Siem Reap	150	197,331	226,737	1.15	0.00076	0.869565	1512.871
Total	**300**	**337,319**	**382,093**	**1.13**			
** Provided from NCDD, as included in the TOR for this study.*							

These weights were applied at the start of the data analysis phase and used for the calculation and reporting of all results. Because the use of weights changes the *n*, or number of individuals reporting a specific answer, from a concrete number (a count of all respondents that reported an answer code) to a relative one (a proportion of all women in each province represented by the respondents that reported an answer code), the *n* is not included with the graphs and tables in the results sections below. The number of respondents is often included in the text, especially when the data has been filtered for a specific condition.

Wealth groups and calculations

Information on wealth and household assets, including animal ownership, was collected as part of the WRA interview process. The module for wealth data was derived from the Angkor Research Wealth Ranking methodology developed and tested through multiple previous surveys. This index is based on six socioeconomic indicators of household wealth, including: house type, number of rooms used for sleeping, availability/number of toilets, household assets, household animals/livestock, and an observational assessment of household wealth completed by the interviewer. It is closely aligned to the longer modules to measure household wealth, such as found in the Cambodia Socio-Economic Survey (CSES).

From these questions, wealth scores were calculated using the formula presented in annex 1. Individuals were then sorted into three groups based on these scores. The poorest and better-off groups correspond to roughly the highest and lowest quartiles, while the medium group corresponds to the middle 50%

of all respondents. Calculating wealth groups in this way attempts to provide sufficient numbers of individuals in each group to make statistically significant observations and comparisons between groups.

Disability

The presence and severity of functional impairment was measured among women using the Washington Group on Disability Statistics (or Washington Group) Short Set on Functioning (WG-SS). This is an internationally recognised method of assessing individual disability, and covers six domains: seeing; hearing; walking/climbing stairs; remembering or concentrating; self-washing and dressing; and communicating. The Washington Group is a working group tasked by the United Nations Statistical Commission to develop measures of disability suitable for censuses and surveys.[1] The short form questions used here were designed for use in censuses and large-scale surveys to identify people with similar types and levels of limitations in accomplishing basic and daily tasks (Washington Group, 2006). They are purposefully broad, designed to be used in many different countries, regardless of differences in nationality or culture. They allow individuals to judge and interpret their own impairments across a number of functions, and are therefore highly subjective. The same module was used in CDHS 2014; however, given the highly individual nature of the results, comparisons between population groups should be made cautiously.

Urban/rural

Urban and rural classifications were made at the village level using the information in the 2013 Commune Database (CDB). CDB 2013 is also the source of the sample framework for the village selection. There was one village with a missing urban/rural classification in CDB 2013; in this case the urban/rural classification in the 2015 gazetteer was used.

Abortion stigma scales

Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS)

SABAS was developed by Ipas, an American organization focused on the sexual and reproductive health rights of women and girls, and is available online at the Ipas website (Ipas, 2015). SABAS is designed to measure the levels of stigma around abortion among individuals and community members. It consists of 18 questions with answers on a Likert scale from one to five, ranging from "strongly disagree" to "strongly agree". The questions are grouped into three categories of stigma; negative stereotyping; exclusion and discrimination; and fear of contagion. This scale has been validated in multiple developing countries (Shellenberg et al, 2014), and is a way to quantitatively estimate the levels of abortion stigma in a community which is standardized and comparable with other countries. The mean values of respondent answers were calculated to generate overall scores and sub-scale scores within each of the three categories. Higher values indicate increases in stigmatizing attitudes, perceptions and behaviours toward women that have abortions.

In this study, SABAS was asked to all WRA that reported never having an abortion, and was also included in the in-depth interviews with community members. In the women's interviews, there were 243 women eligible for the SABAS module. Two women did not answer all of the items on the SABAS. One woman declined to answer 1 question, and one woman declined to answer 2 questions. These cases have thus been removed from the calculation of SABAS scores, both for overall and categorical scores. The total number of complete respondents for the SABAS calculation is 241 WRA. Among the IDI respondents, the SABAS was administered to all 26 respondents. There were no refusals

1. For more information on the Washington Group, see website: https://www.cdc.gov/nchs/washington_group/index.htm (last accessed 11 April 2018).

or unanswered questions in this section. Due to differences in sampling and representation between the two groups (WRA and community leaders), the SABAS scores for WRA and community respondents are reported separately in the results section, below.

Individual Level Abortion Stigma Scale (ILAS)

ILAS was developed as an internationally applicable measure of women's feelings and experiences about their abortion (Cockrill et al 2013). It was designed to be administered to women that have had at least one abortion; for women with multiple abortions, the most recent abortion was referenced. It is available online at the Stigma Toolkit (www.stigmatoolkit.org) in both English and Spanish. There are 20 questions in the scale, grouped into four main categories: worries about judgment; isolation; self-judgment; and, community condemnation.

ILAS uses Likert scales for respondent reporting, with values ranging from 0-3 or 0-4 depending on the question phrasing. The scales report levels of worry, frequency of events, levels of agreement, or frequency of beliefs held by others. Similar to SABAS, ILAS scores are calculated as a mean value of respondent answers to all questions and in each sub-category. Higher values indicate increasing levels of stigma around abortion.

Originally designed to only be asked to women that have ever had an abortion, the decision was made at the start of this study to include all women in the first section on individual worries about judgment. For this section, women that had not experienced an abortion were asked to imagine their level of worry if they were to have an abortion. This is a similar exercise to the one used in the sexual and reproductive health empowerment section, where women who have not been in a relationship are asked to imagine their ability to use contraception and refuse sex if they were in a relationship.

This revised targeting worked well in the instrument pre-testing, and so was included in the final instruments. The number of women that answered the ILAS is 299; 57 women that ever had an abortion, and 242 women that never had an abortion and answered only the initial section. One of the women that did not have an abortion declined to answer all seven items in the ILAS This case has therefore been removed from the calculation of the ILAS score for the negative stereotyping sub-scale for women that did not have an abortion.

Limitations

As with any researches, there are a number of factors which can limit the interpretation and analysis of these findings. All data for this study is self-reported, and as such is vulnerable to a number of biases regarding the recall of temporal data, social desirability, and the dynamic between the interviewer and the respondent. Especially for this study, social desirability bias may cause women to underreport undesirable activities, such as premarital sex or abortion, and the level of stigma that they may feel toward women that have abortions.

The research team has tried to minimize the influence of these effects as much as possible, through a number of mitigation techniques. These include the use of only female interviewers, as Cambodian women are generally more willing to discuss matters of reproductive health with other women. There were also a number of prompts and instructions throughout the interview, which were used to advise women of a topic change, and to help remove any notion of an acceptability or desirability bias by the interviewer. Where there were concerns of the accuracy of recalled information, time bounds were established to limit potential inaccuracies caused by respondent forgetfulness. As with all studies, care should thus be taken in interpreting the results described below and generalizing to

a larger population.

2. Country Profile: Socio-economic and Political Context

The Kingdom of Cambodia is located in Southeast Asia. A member state of the Association of Southeast Asian Nations (ASEAN), it shares borders with Thailand, Laos, and Vietnam. It has a total land area of 181,035 square kilometres (National Institute of Statistics, 2014). Cambodia experienced decades of civil war from the 1960s to the early 1990s, and basic social infrastructure was completely devastated. Huge efforts have been made to reconstruct and rebuild the country after the UN-backed first national election in 1993.

With a democratic government in place, the decentralization process has progressed. However, it is rather slow, and a centralized system still governs the country. The healthcare system in Cambodia is decentralized, although the Ministry of Health still controls regulatory authority at the central level and supervises implementation across the nation.

Despite legal and policy frameworks to ensure basic health services, service provision is limited. The public health sector in Cambodia is characterized by low salaries and incentives for staff, as well as unregulated private providers, which negatively impact on service delivery. People in remote areas and people who are extremely poor lack access to basic health services due to a lack of health-related budget. A situational analysis of the state of health financing in Cambodia points to inadequate access to health services for the most vulnerable population and a high out-of-pocket expenditure on health. In Cambodia, 74.2% of total health expenditures (public and private) are from household out-of-pocket expenditures (World Bank, 2014).

3. Profiling Cambodia: SRHR

Reproductive health policies in Cambodia have been framed by the International Conference on Population and Development, as well as the Fourth World Conference on Women, which affirmed women's rights to reproductive and sexual health. National policies related to SRHR are:

- National Reproductive Health Program (1994-1995)
- Birth Spacing Policies (1995)
- National Safe Motherhood Action Plan (2001-2005)
- National Population Policies (2003)
- Cambodian Millennium Development Goal (2000)
- National Action Plan to Prevent Violence Against Women (2014-2018)

Despite a strong commitment by the government to ensure sexual and reproductive health and rights (SRHR) amongst people, the improvement of SRHR has been rather slow due to:

- Declines in donor funding support for Cambodia, limiting accessibility to sexual and reproductive health services amongst poor people;
- Increasing demand for quality sexual and reproductive health services from the general public, especially the middle class, which has overwhelmed the limited financial and human resource capacity at public health facilities;
- A surge in the number of urban poor, and a lack of access to medical facilities due to a lack of knowledge and awareness of sexual and reproductive health issues;
- Growth in internal migration (including factory workers), who are living at the margins of society and lack information about sexual and reproductive health services, or lack financial resources to access these services.

Women and girls are more vulnerable to sexual and reproductive health issues; however, they often lack information to make effective choices. Even when they know some basic information on sexual and reproductive health, they may hesitate to seek services due to social stigmatization, or a lack of financial means. Rigid social norms that prevent women and girls from openly talking about these issues is also a key factor that prevents them from asking for assistance. In addition, transgender people also lack access to decent health care, especially due to stigma and discrimination in society. They are commonly denied or refused health care services.

Cambodia has shown notable progress on SRHR, although there are some limitations with respect to the realization of gender equality, equity and women's empowerment, and adolescent and lesbian, gay, bisexual and transgender (LGBTQ) SRHR. Accountability and monitoring of public health services is another area that needs further strengthening. Barriers to the full realization of sexual and reproductive rights also include social taboos around sexuality, which have an impact on the spread of sexually transmitted infections (STIs), including HIV, unwanted pregnancies, and consequent abortions among women, especially young women.

On the process of strengthening SRHR status, Cambodia needs to increase the quality and utilization of sexual and reproductive health services, which is targeted in the National Strategy for Reproductive and Sexual Health 2017-2020 (MOH, 2017).

RHAC has been supporting and providing sexual and reproductive health information and services to fill the gap at state health facilities. RHAC's 15 clinics are the most prominent private/non-profit health facilities for reproductive health matters and are well known and accessed, especially in urban areas.

4. Abortion: Country Situation, Critical Issues and Attempts to Ensure the Right to Safe Abortion

The abortion and high adolescent fertility rates remain the major issues in Cambodia. About one in eight women age 15-19 (12%) has become a mother or is currently pregnant with her first child, per CDHS 2014. Research studies show that at least 30% of maternal death in Cambodia is caused by abortion-related complications.

The legality of abortion was enshrined in 1997, but awareness of this law is limited. This limited knowledge extends to service providers; RHAC's decades of work on reproductive health with medical professionals have shown that many service providers believe abortion is illegal, although there is limited data on this. Negative beliefs and discriminatory perceptions associated with abortion are also believed to be strong in society. These factors may force women to turn to unsafe, unregistered service providers which puts woman at risk of morbidity and/or mortality, contributing to the high rates of maternal mortality in Cambodia (Sotheary et al, 2017).

Between 2010 and 2016, Cambodia made notable progress in strengthening safe abortion services; however, unsafe abortion remains one of the root causes of maternal mortality. There has been no progress in decreasing the proportion of women seeking multiple abortion services or the proportion of women reporting unsafe abortions. In 2014, more urban and poorly educated women reported having an abortion than their rural and educated counterparts (CDHS).

5. Abortion: Gaps in Understanding the Issues and Addresses of the Issues

As in many developing countries, there is limited data on abortion in Cambodia. Talking about abortion is still a taboo issue and conducting a study about abortion has been not a priority of the state institutions. The majority of Cambodian people are devoted Buddhist, and people tend to believe abortion is a

sin that should be avoided. In addition, cultural and social sensitivity on abortion related stigma and discrimination resulted in difficulty and obstacle to perform and carry out a study on abortion. Furthermore, there is no comprehensive study on abortion has been made in Cambodia according to the limitation of capacity in conducting research/study on such topic which is considered as sensitive issue.

Lack of information about why and how women access abortions, how abortion is carried out, and after care for women has resulted in limited knowledge on how women's life change or improve after abortion. Despite the fact abortion was legalized in Cambodia in 1997, available information demonstrates that women greatly hesitate to access abortions and even when they access them, they are strongly stigmatized after experiencing the abortion. Therefore, a new innovative study on abortion can contribute to identifying why women do not access abortions, or why people avoid talking about abortion. This can directly contribute to policy and decision-making that will increase awareness of women's rights to access abortion information and services in the general public.

6. Baseline Research Findings

1. Socio-demographic information

Quantitative survey respondents

The quantitative interviews were targeted to women age 15 to 49 years old; all women fell into this age range. The average respondent in the study was 30 to 31 years old (Table 3). Around one-quarter of women (26.3%) can be considered youth, between the ages of 15-24 years old. A further third (34.0%) were 25-34 years old, and slightly more (39.7%) were 35 years old or older. Differences in age ranges between the two provinces were slight – generally only a few percentage points – but were statistically significant.

The average woman in the study had at least some primary education (primary is defined as grades 1-6 in Cambodia), completing grade four. Around one-third had some secondary or higher education; 3 individuals had higher education; above grade 12. Around one in six women (17.7%) had no formal schooling at all. Education levels were higher in Kampot province than in Siem Reap, with women in Kampot completing around 2-3 years more of school than their counterparts in Siem Reap.

Disability was measured using the WG-SS (see explanation in the analysis section, above). Around one in ten women (10.6%) reported a severe or complete lack of function in at least one of the six areas of disability measured by the WG-SS. This incidence was significantly higher in Siem Reap than in Kampot (14.7% compared to only 4.7% in Kampot). One woman in the study reported having a complete lack of ability in one of the areas measured by the WG-SS; she was blind, as confirmed by the interviewer.

The incidence of severe or total disability among women in the study is considerably higher than the prevalence among women in the general population (2.3% among all women older than 5 years old, as reported in CDHS 2014). But it is important to remember that the WG-SS is highly subjective and based on self-reported data.

Nearly all women were currently or had previously been married (widowed, divorced, separated, etc.) or in a domestic partnership. This includes the two women that reported living with their current partner, but are not currently married. One in ten women (10.0%) were also currently pregnant at the time of the interview.

All women in Siem Reap reported to be Buddhist. Women in Kampot had more diverse religious views, with 12.7% reporting to follow Islam, and 2% following Christianity.

At the village level, 20% of interviews were conducted with women that lived in urban areas in each of the two provinces. This is similar to the urban/rural makeup of the country, where 20.9% of the population lives in urban areas (ESCAP, 2016).

Table 3: Quantitative respondent sociodemographic characteristics, by province.

	Kampot	Siem Reap	Total
Age in years, mean (median)	30.38* (30.00)	32.05* (32.00)	31.37 (30.00)
Age 15-24	28.7%*	24.7%*	26.3%
Age 25-34	34.0%	34.0%	34.0%
Age 35-49	37.3%*	41.3%*	39.7%
Last school grade completed, mean (median)	5.76* (6.00)	3.77* (3.00)	4.58 (4.00)
No education	11.3%*	22.0%*	17.7%
Primary	45.3%*	54.7%*	50.9%
Secondary and higher	43.3%*	23.3%*	31.5%
Severe or total disability	4.7%*	14.7%*	10.6%
Marital status			
Ever married/partnered	83.3%*	85.3%*	84.5%
Never married	16.7%*	14.7%*	15.5%
Currently pregnant	8.0%*	11.3%*	10.0%
Religion			
Buddhist	85.3%*	100%*	94.0%
Muslim	12.7%	0%	5.1%
Christian	2.0%	0%	0.8%
Geographic location			
Urban	20.0%	20.0%	20.0%
Rural	80.0%	80.0%	80.0%
** Statistically significant difference (p<0.05).*			

Qualitative survey respondents

Among the 26 IDI respondents, the average age was 43 years old. Nearly one-third of these respondents (30.8%) were men, although there is considerable discrepancy between the two target provinces (Table 4). All but one of the IDI respondents in Siem Reap was female, as opposed to Kampot where more than half of the respondents (53.9%) were male. IDI respondents in Kampot were also older, with an average age of 52.2, compared to an average age of 34.1 in Siem Reap.

FGD participants were already targeted by age and sex. Within these groups, women of reproductive age that participated in the FGDs in Siem Reap were older than the women that participated in the FGDs in Kampot; a reversal from the age differences seen in the IDIs.

Note that tests of statistical significance cannot be conducted on data collected from the qualitative survey.

Table 4: Qualitative respondent characteristics, by province.

	Kampot	Siem Reap	Total
In-depth interviews (IDIs)			
Age in years, mean	52.2	34.1	43.2
Sex ratio, % male	53.9%	7.7%	30.8%
Focus group discussions (FGDs)			
Age in years, mean			
Women age 15-24	18.5	21.8	19.5
Women age 25-49	34.4	41.5	38.3
Husband/partner	–	32.8	32.8
Mother-in-law	66.2	–	66.2

2. Income, employment and wealth groups

The average household in the study made around US$ 6,000 annually from all sources (Table 5). Although, the considerable difference between the mean and the median values (the mean is more than twice as large as the median) highlight the large differences in household income reported by women; from a high of US$ 225,675 per year to a low of only around US $12. Farming and fishing were the primary source of income in most households (51.4%), followed by labour or factory work (21.1%) and owning a business (19.9%). Other forms of work made up the primary source of income in less than 10% of households. Nearly all households (96.8%) owned some amount of land; either their own house (90.1% overall) or agricultural land (69.3%).

Households in Siem Reap had significantly higher mean incomes than households in Kampot, although the median income in Kampot (US$ 2,700) was higher than the median in Siem Reap (US$ 2,143.75). Land ownership was slightly higher for households in Siem Reap, possibly reflecting the greater wealth available in that area. Households that owned land had an average of 163are of land; equivalent to 16,300m^2 (one are equals 100m^2) or 1.63 hectares of land.

Table 5: Household income in the last 12 months, by province.

	Kampot	Siem Reap	Total
Household income, mean (median)[†]	**4,558.45* (2,700.00)**	**7,012.93* (2,143.75)**	**6,015.35 (2,400.00)**
Household business	2,172.07* (0.00)	2,964.85* (0.00)	2,642.64 (0.00)
Head of household employment	1,064.40* (5.88)	2,430.47* (500.00)	1,875.25 (450.00)
Household agriculture	660.23* (208.13)	506.13* (250.00)	568.76 (250.00)
Other family member employment	248.47* (0.00)	320.35* (0.00)	291.14 (0.00)
Other sources	399.55* (0.00)	773.13* (0.00)	621.29 (0.00)
Main source of income			
Farming/fishing	59.3%*	46.0%*	51.4%
Labour/factory work	16.0%*	24.7%*	21.1%

Own business (shop/seller)	18.7%*	20.7%*	19.9%
NGO/business work	2.0%*	4.0%*	3.2%
Government work	3.3%*	2.7%*	2.9%
Other	0.7%*	2.0%*	1.5%
Own any land	94.0%*	98.7%*	96.8%
Land owned, mean are (median)	122.89* (105.00)	189.93* (126.00)	163.46 (115.00)
** Statistically significant difference (p<0.05).* *† Due to rounding, values in sub-rows do not total exactly to the overall household income.*			

In addition to the household wealth described above, around three-quarters of women reported that they were also currently working for money. Most of these women were conducting farming or fishing activities (outside of the household activities mentioned previously), followed by running their own business, and factory or manual labour work. On average, employed women earned around US$ 2,794.68 in the last 12 months, or around half (46.5%) of the household income. However, the considerable difference between the mean and median values in women's incomes means that the earning potential of these women varies greatly, and the results should be interpreted carefully.

Table 6: Respondent income in the last 12 months, by province.

	Kampot	Siem Reap	Total
Respondents employed	75.3%*	73.3%*	74.1%
Respondent income, mean (median)	3,363.78* (668.75)	2,394.37* (917.50)	2,794.68 (875.00)
Main source of income			
Farming/fishing	57.5%*	40.0%*	47.2%
Own business (shop/seller)	28.3%*	31.8%*	30.4%
Labour/factory work	10.6%*	20.9%*	16.7%
NGO/business work	0.0%	3.6%	2.1%
Government work	0.9%*	1.8%*	1.4%
Other	2.7%*	1.8%*	2.2%
** Statistically significant difference (p<0.05).*			

Using the economic indicators presented in the analysis section, above, wealth scores were calculated for all respondent households, based on their reported wealth and assets. Cut-off values were then established and three wealth groups were created, dividing the households into poorest, medium, and better-off groups, whereby the medium group would comprise around 50% of the households. These groups are shown in Table 7, below. As shown, there are more households classified as better-off in Kampot than in Siem Reap, despite households in Siem Reap reporting higher overall incomes. As the wealth scores and groups are composed of a variety of metrics, including asset and animal ownership, and interviewer observations of household type, the wealth groups are most likely a better representation of actual household circumstances, and will be used for the cross-tabulation analysis for the rest of the results section.

Table 7: Wealth groups, by province.

	Kampot	Siem Reap	Total
Poorest	18.0%*	28.0%*	23.9%
Medium	44.7%*	51.3%*	48.6%
Better-off	37.3%*	20.7%*	27.4%
** Statistically significant difference (p<0.05).*			

Looking at household income sources by wealth group (Figure 1), around half of families in all wealth groups are dependent on farming/fishing for their primary income, reflecting the importance of agriculture and aquaculture in the Cambodian economy. Besides farming/fishing, the poorest families are more likely to have their primary income come from labour/factory work. Medium and better-off households are more likely to receive their income primarily from a family business or work in the government.

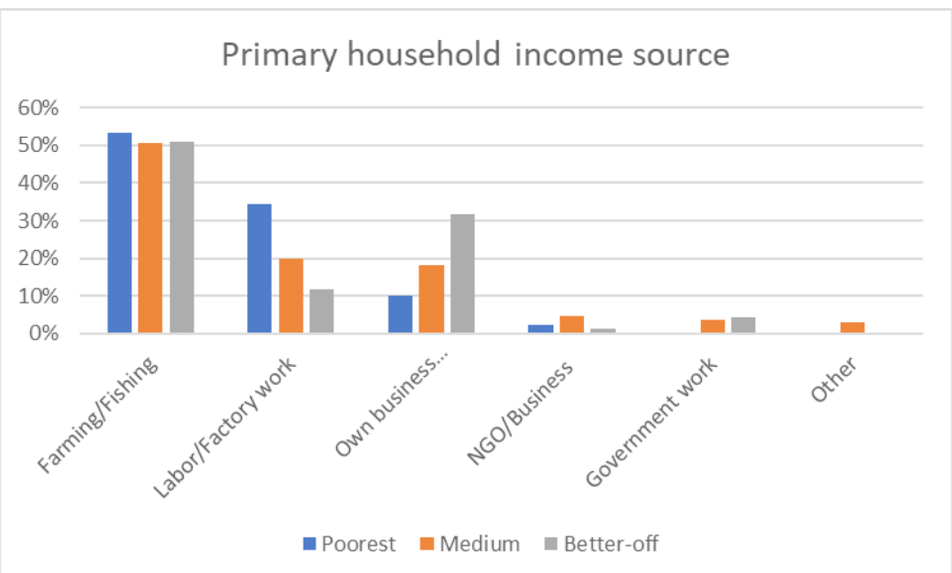


Figure 1: Primary household income source, by household wealth group.

3. Media access and use

Around two-thirds of women (68.3%) have access to a mobile phone, of which around half of these women (57.6%) have access to a smartphone that can connect to the internet. That is, around one-third of all women (39.4%) have access to a smartphone.

Three-quarters of women (78.1%) accessed some form of media (television, radio, internet, etc.) at least once a week. The primary form of media accessed by women was television (TV), followed by facebook, radio, and the internet.[2] Print media (newspapers, magazines, etc.) was not mentioned as the primary media by any women.

Women in Kampot were somewhat more likely to have a mobile phone and/or a smartphone, and to access media more frequently than women in Siem Reap. Their primary media were generally the same, with TV and facebook being the most common media. Radio primacy was more common in Siem Reap, however, while internet usage was more common in Kampot.

2. Some Cambodians make a distinction between accessing the internet through Facebook and through other websites, so they were separated in the questionnaire for this study.

Table 8: Respondent mobile phone and media access.

	Kampot	Siem Reap	Total
Mobile phone access	72.7%*	65.3%*	68.3%
Smartphone access	56.9%*	58.2%*	57.6%
Access any form of media at least once per week	84.0%*	74.0%*	78.1%
Primary media accessed			
TV	57.1%*	55.0%*	55.9%
Facebook	23.0%*	22.5%*	22.7%
Radio	8.7%*	17.1%*	13.4%
Internet	11.1%*	5.4%*	7.9%
** Statistically significant difference (p<0.05).*			

4. Sources of reproductive health information

Next in this section, women were asked to rate the different ways that they receive information about contraception and reproductive health. In order to do this, they were shown cards with different information sources on them (internet, Facebook, friends, factory infirmary staff, etc.) and asked to rank these sources based on how frequently they receive reproductive health information, or to imagine how often they would use this source, in the case of women who have not accessed any reproductive health information. The women were asked to put the cards in order from 1 (most important) to 10 (least important), with the result recorded by the interviewer.

Interestingly, TV was the most common source of information on reproductive health cited by women (Figure 2). This was followed by local sources of information: medical staff, members of the village women's group, and members of the village health support group (VHSG). Facebook was the next most common source of information, although it was more important in Kampot (where it ranked 2nd) than in Siem Reap (ranked 8th). Local medical staff were also more important in Kampot; being the most important information source in that province. However, women in Siem Reap prioritized local authorities (e.g., the deputy village chief for women and children's affairs) more than women in Kampot. In both provinces, information found on common promotional items – such as leaflets, banners and T-shirts used by organizations to promote health messages or events – was the least important source of reproductive health information.

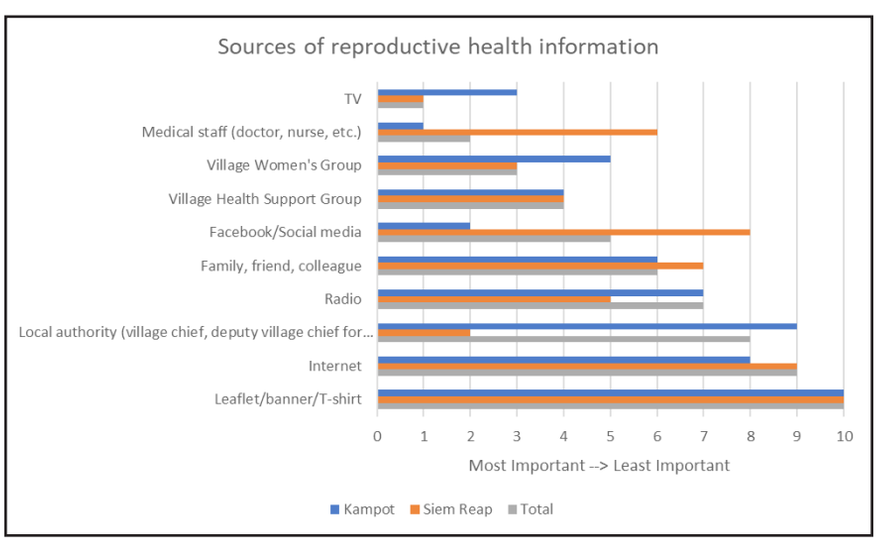


Figure 2: Sources of reproductive health information for women, from most important (1) to least important (10), by province.

5. Reproductive health knowledge, attitudes and practices

Sexual and reproductive health knowledge

Women's knowledge of conception (when a woman is most likely to become pregnant) and contraception (ways that a woman can prevent pregnancy) was ascertained by asking them a few questions. First, women were asked if they knew when, during the menstrual cycle, a woman could become pregnant after having intercourse. Only around 14% of women correctly stated that a woman was most likely to conceive if she had intercourse halfway between her two periods (Table 9). Based on this information, women in Kampot were significantly more knowledgeable about conception than women in Siem Reap (22% in Kampot, compared to 9% in Siem Reap). Knowledge of conception in Kampot is similar to the knowledge of this issue reported among women in Cambodia nationwide (20.5%; CDHS 2014). Knowledge of conception among women in Siem Reap is well below the national average.

Nearly all women (98.1%) had heard about some form of contraception (defined in the questionnaire as "things that a man or woman can do to prevent pregnancy"). Of these women, all of them had heard of at least one form of modern contraception, with most women knowing an average of three to four modern contraceptive methods. This awareness was similar between the two provinces, and similar to the awareness of contraception reported in CDHS 2014, where 99.8% of currently married women knew at least one modern method.[3]

Table 9: Sexual and reproductive health knowledge, by province.

	Kampot	Siem Reap	Total
Know when during the menstrual cycle a woman can become pregnant	22.0%*	8.7%*	14.1%
Know about contraception	97.3%*	98.7%*	98.1%
Know at least one modern method	100%	100%	100%
Modern methods known, mean (median)	3.61* (4.00)	3.57* (4.00)	3.58 (4.00)
**** Statistically significant difference (p<0.05).***			

The most common contraceptive methods known by women were the daily pill, implant and intrauterine device (IUD); each known by more than half of women that know about contraception (Figure 3). The daily pill is nearly universally recognized in Cambodia, known by around 90% of women in both provinces. Male sterilization, female condoms, and emergency contraception were the least known modern methods; each known by less than 5% of women.

3. Note that CDHS 2014 is among currently married women age 15-49. The current study includes all women age 15-49, regardless of marital status.

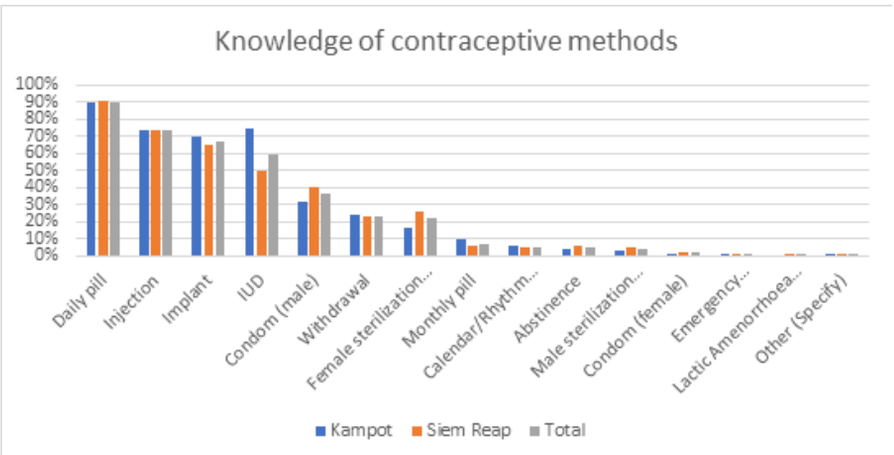


Figure 3: Contraceptive methods known by women that know of any contraceptive method, by province (multiple response; answers do not total to 100%).

Use of modern contraception

Next, women were asked if they were ever sexually active, and if so, had they ever used any form of contraception. The question of sexual activity helps to determine the number of women who may have a need for contraception, and filters out women for whom contraception is unnecessary. A large majority (84.5%) of women reported having been sexually active in their lifetime (Table 9). This is a similar rate to the number of ever married/partnered women (84.5%) reported in the previous section. Sexual activity before marriage is not well accepted in Cambodia culture, and unmarried women are hesitant to discuss this topic. Nevertheless, 2.6% of women who had never been married/partnered reported having sexual activity.

Around three-quarters (79.0%) of women that had ever been sexually active reported using some form of contraception (Table 10). Among these women, approximately two-thirds (62.8%) had ever used a modern contraceptive method. The daily pill was the most commonly used method overall, used by around 64.8% of women, followed by the injection (35.1%) (Figure 4). Withdrawal was the most common traditional method used, with nearly 20% of women (17.4%) using it.

Table 10: Use of contraception, by province.

	Kampot	Siem Reap	Total
Ever sexually active	83.3%*	85.3%*	84.5%
Ever used contraception	76.8%*	80.5%*	79.0%
Ever used modern contraception	60.0%*	64.7%*	62.8%
** Statistically significant difference (p<0.05).*			

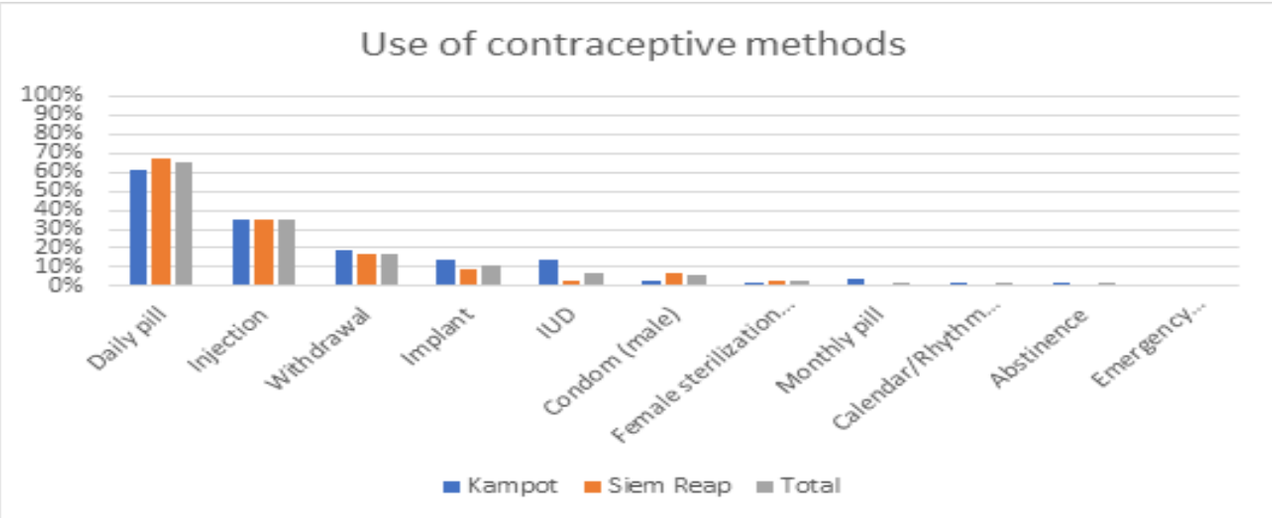


Figure 4: Use of contraceptive methods, among women that had ever used any contraceptive, by province (multiple response).

6. Sexual and reproductive decision-making

This section of the study examined the attitudes and confidence levels of women around various issues related to sexual and reproductive health and healthcare decision-making. For the first part, women were asked to imagine four scenarios where they would discuss or use contraception with their partner, and gauge how likely they were to respond to the situation. Next, the women were asked how confident they were that they could refuse sex with their partner in five different scenarios. Answers were given on a five-point scale, where one was "not at all sure" and five was "completely sure". The confidence of women in these scenarios provides insight into how confident women are in their own sexual and reproductive lives. If women did not have a husband/partner, they were asked to imagine how they would respond in the same scenarios.

The last questions in this section are around the decision-making process for women's health. Women are often not in full control of their own bodies, and their ability to make decisions about their healthcare and contraceptive use is restricted by those around them, including their husbands/partners and parents.

Contraceptive decision-making

Examining the results on the ability of women to discuss and use contraception with their partner, women showed high confidence in all four scenarios (Table 11). Over half of all women were completely confident in each scenario, but were least confident in using contraception against their husband/partner's wishes – the scenario where women had the lowest confidence (53.2% overall). Women in the study had mean confidence scores of 4.3 (median 4.5) across all four scenarios, indicating that they were somewhat or completely confident in their contraceptive empowerment. Women in Siem Reap were slightly more confident in these scenarios, although the average scores were very similar.

Table 11: Contraceptive decision-making, by province.

	Kampot	Siem Reap	Total
Women that are completely sure they could:			
Bring up the topic of family planning with their husband/partner	66.7%*	72.7%*	70.2%
Tell their husband/partner they want to use family planning	68.0%*	71.3%*	70.0%

Use family planning	63.3%*	70.0%*	67.3%
Use family planning, even if their husband/partner does not want to	54.0%*	52.7%*	53.2%
Contraceptive decision-making score, mean (median)	4.27* (4.50)	4.26* (4.50)	4.26 (4.50)
** Statistically significant difference (p<0.05).*			

Sexual decision-making

In regard to the ability of women to refuse sex with their husband/partner, over two-thirds of women (70.9%) were completely confident that they could refuse sex if they were tired; the highest confidence rate for these scenarios (Table 12). Average confidence scores were slightly lower for this section than for contraceptive empowerment, above (mean scores of 4.23, compared with 4.26), but the number of women that report being completely confident that they could refuse sex in all five scenarios remained above 50%. The lowest confidence was when a husband/partner threatened to have sex with another woman; only 58.6% of women reported being completely confident that they could refuse sex in this situation.

Table 12: Sexual decision-making, by province.

	Kampot	Siem Reap	Total
Women that are completely sure they could refuse sex:			
When they're tired	76.0%*	67.3%*	70.9%
When they don't want to, but their husband/partner does	60.0%*	62.7%*	61.6%
When their husband/partner threatens to hurt them if they don't want to	60.0%*	62.7%*	61.6%
When their husband/partner gets angry if they don't want to	57.3%*	63.3%*	60.9%
When their husband/partner threatens to have sex with another woman if they don't want to	54.7%*	61.3%*	58.6%
Sexual decision-making score, mean (median)	4.29* (4.40)	4.19* (4.60)	4.23 (4.40)
** Statistically significant difference (p<0.05).*			

Healthcare decision-making

Lastly in this section, women were asked who made decisions about three aspects of their health care: their use of contraception, their reproductive health care, and their general health care. In the cases of healthcare and reproductive healthcare, only around half of women (45.8%) reported that they were the primary decisionmaker for their health (Table 13), with a further one-third of women being joint decision-makers with their husband/partner. This is slightly lower than the same metric reported in CDHS, where over 90% of women nationwide reported that they were either the primarily or jointly involved in making decisions about their own health care (91.5%, compared to 84.7% of women in the current study). Participation in decision-making for reproductive health was not included in CDHS 2014.

Slightly more than half of women (52.8%) reported being responsible for their reproductive health than their overall healthcare. About one-third of women report making decisions about their health and reproductive health jointly with their husbands/partners, while around 10% of women report that their husband is the primary decision maker for both their reproductive health (8.6%) and their

general health (11.2%). In addition, only around one-quarter of women (23.9%) reported being the primary decisionmaker for their use of contraception, with nearly two-thirds of women (62.8%) responding that this was a joint decision between the woman and her partner.

The results by province were mixed, but in general women in Siem Reap tended to have less autonomy over their health care decision-making, with more women in Siem Reap stating that their husband/partner or someone else was their primary decisionmaker for all three of these metrics.

Table 13: Primary person responsible for women's contraceptive, reproductive and overall health care decision-making, by province.

	Kampot	Siem Reap	Total
Contraceptive decision-making			
Mainly respondent	16.0%*	29.3%*	23.9%
Respondent and husband/partner jointly	83.3%*	48.7%*	62.8%
Mainly husband/partner	0.7%*	22.0%*	13.3%
Reproductive healthcare decision-making			
Mainly respondent	52.0%*	53.3%*	52.8%
Respondent and husband/partner jointly	42.7%*	32.7%*	36.7%
Mainly husband/partner	4.7%*	11.3%*	8.6%
Parents or other relatives	0.7%*	1.3%*	1.1%
Other	0.0%	1.3%	0.8%
Health care decision-making			
Mainly respondent	51.3%*	42.0%*	45.8%
Respondent and husband/partner jointly	37.3%*	40.0%*	38.9%
Mainly husband/partner	8.0%*	13.3%*	11.2%
Parents or other relatives	2.0%*	3.3%*	2.8%
Other	1.3%	1.3%	1.3%
** Statistically significant difference (p<0.05).*			

Combining the results from each of the three decision-making points in this sub-section reveals that only around one in ten women in the study (11.8%) is the primary decisionmaker for all three aspects of their health: contraceptive, reproductive, and overall (Figure 5). More commonly, women are joint decisionmakers with their husbands/partners; around two-thirds of women (64%) report that their husbands/partners are jointly involved in all of their healthcare decision-making. And somewhat alarmingly, one-quarter of women (24.2%) reported that they did not have full or joint decision-making power for all of their healthcare needs, and that in at least one situation someone else was making decisions about their health.

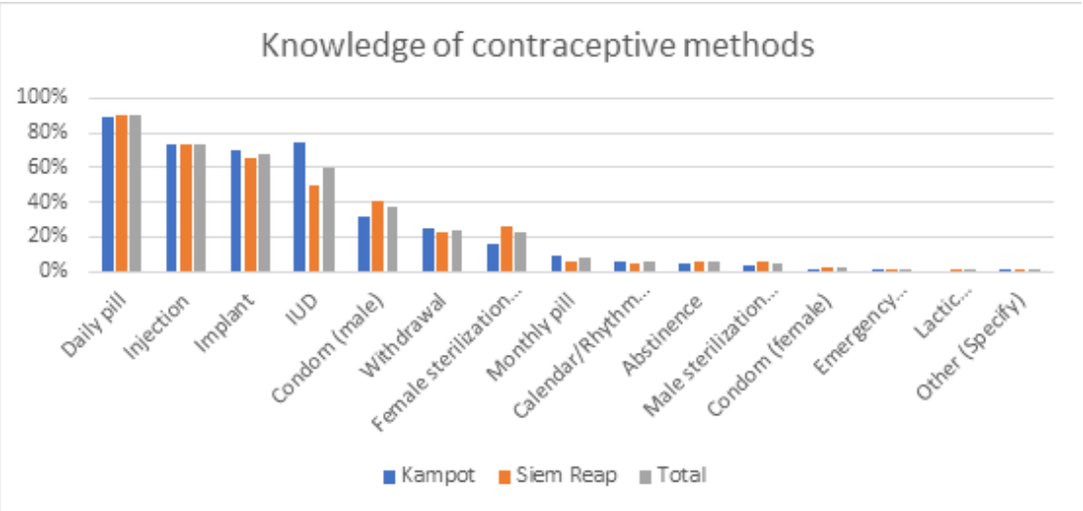
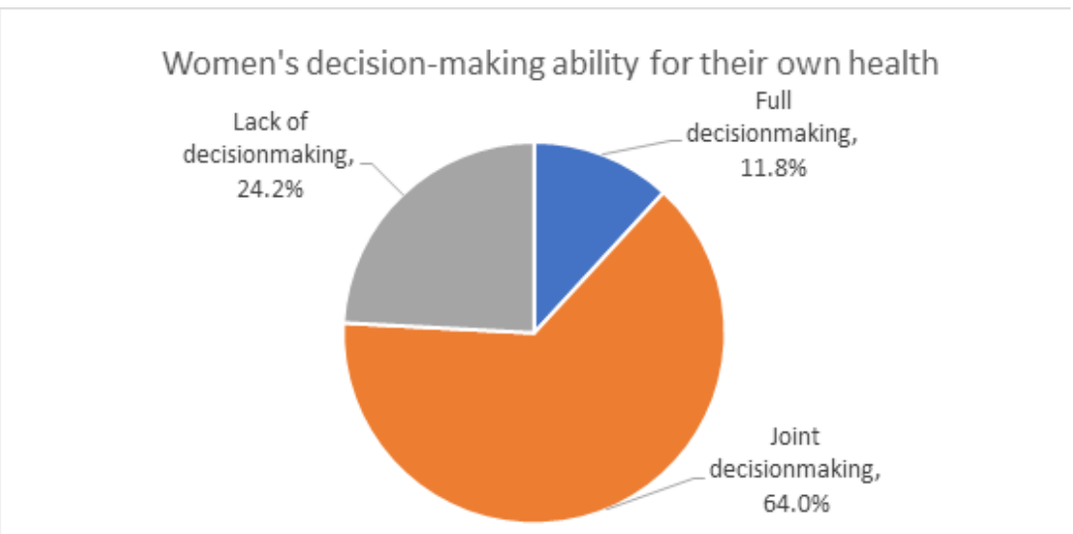


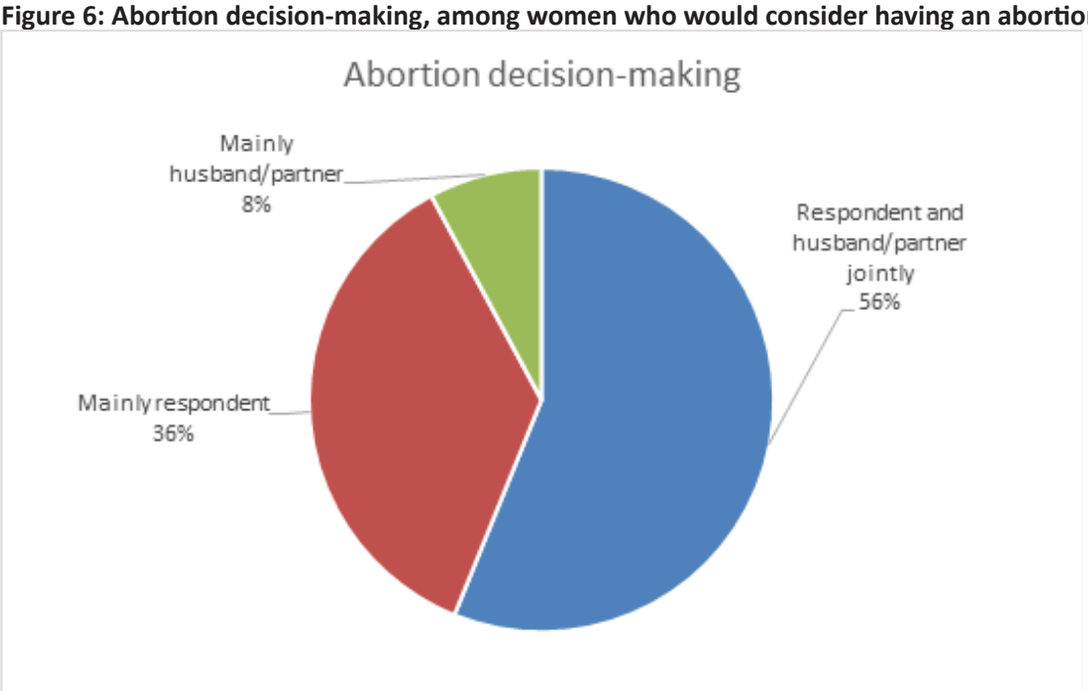
Figure 5: Women's overall decision-making ability for their own health.



Abortion decision-making

As shown in the healthcare decision-making section, most women do not have full control over their healthcare, and decision-making for abortion follows a similar trend. When asked who would make decisions about an abortion, if one was needed, the majority of women (56.1%) reported that it would be a joint decision between the woman and her husband/partner at the time (**Error! Reference source not found.**). Only around one-third of women (36%) reported that they could make that decision primarily by themselves.

Figure 6: Abortion decision-making, among women who would consider having an abortion.



Decision-making on abortion follows a similar pattern, as supported by the FGDs. However, there is a clear distinction made between married and unmarried women's ability to make a decision about an abortion. FGD participants tended to agree that, if a woman is married, then the decision to have an abortion should be a joint discussion between the woman and her partner. But, if a woman is unmarried and gets pregnant, she can make the decision to have an abortion by herself, possibly because the man has not made a commitment to her (as expressed through formal marriage), and so she retains autonomous decision-making power over her own body. There is a clear separation in people's thinking between these two groups of women, which is demonstrated in other areas of the results, below.

> *If our husband disagrees, we cannot have abortion. We need to discuss with husband. If we make our own decision, there will be an argument or separation. – Female FGD respondent*

> *...If they are single they can make their own choice, but if they have family and have a baby which needs to be aborted she cannot make her own decision. Because before we have a baby we discussed the situation already, and then if we want to do abortion we also need to discuss as well. It's different, because in one case there is a family, and in the other there is not. – Male FGD respondent*

In the focus group discussion (FGD) with husbands, the majority of participants expressed that married women cannot seek abortion without agreement from either husband or family members. More research is needed, however, to further elucidate the basis for marital and familial constraints on women's autonomy in health-related decision making, including with respect to abortion. Although patriarchal and age-related hierarchies no doubt influence negotiations, comments made in FGDs suggest that partners and other family members assert participation in the decision on complex

grounds. In the FGD with husbands, economic considerations appeared particularly salient as the group rationalized the need for joint decision making around abortion. For instance, husbands stated that a married woman could not opt for abortion without consulting her family because she would require the care of her husband following the procedure, a possibility that multiple participants described as straining temporal and material resources: "She cannot make decision by her own… because it could affect her health, and no one take care of her. Especially, I worry that the husband will not take care of her"; and "Sickness is wasting the time… Because we need to wash the clothes, no time to do the business, we cannot go wherever we want to. If after abortion is good it's fine, but if it's not it makes us hard from months to months, years to years."

Indeed, adverse health effects were continuously cited by the husbands as one of the chief personal and/or family concerns justifying opposition to abortion. If similar trends were observed in more robust research with male respondents, then this would support the inclusion of content in advocacy efforts to emphasize how access to safe abortion actually improves women's health and, in turn, their economic productivity.

7. Awareness of abortion and related issues

Legality of abortion

Prior studies have shown that women have a low awareness that abortion is legal in Cambodia (e.g., PSL, 2016). Anecdotal evidence suggests that this is a false negative, and that people are confusing the concepts of "legality" and "cultural acceptance" in regard to abortion. This may be combined with an understanding of laws as proscriptive measures (restricting an act), rather than protective of a specific right. Because of this, a number of follow-up questions were asked in this study to better understand women's knowledge and perceptions on the permissibility of abortion within the Cambodian state structure, and to try and separate that thinking from the cultural norms which surround them.

When asked directly if Cambodia has any laws protecting women's rights to an abortion, only around one-quarter of women (28.1%) reported that they knew of the existence of any laws on abortion (Table 14). Women that answered either yes or no to this question were then asked follow-up questions about the grounds on which abortion might be legal. Even though many women said that Cambodia had no law on abortion, these follow-up questions were asked to these women to further probe their understanding of the grounds under which an abortion would be considered "legal".

The answers were somewhat surprising; a large majority of all women (80.4%) reported that an abortion would be legal in cases of abnormal fetal development; this includes women that initially reported that Cambodia does not have laws on abortion (Figure 7). More than half of women replied that an abortion would be legal if the mother's life was at risk or if the pregnancy was a result of rape (68.7% and 55%, respectively). However, women were less likely to understand that an abortion is legal within the first 12 weeks of pregnancy (the first trimester), regardless of the reasons for termination. Less women reported that a first trimester abortion was legal than reported that abortion in general was legal (14.7%, compared to 28.1%).

In addition, only around half of all women knew that it was legal for medical staff (42.1%) and hospitals/clinics (55.9%) to perform abortions. This knowledge was consistently higher in Kampot than in Siem Reap; only around one-third of women in Siem Reap (36.7%) knew that it was legal for doctors to perform abortions, compared to 50% of women in Kampot.

Combining the results for each aspect of abortion law, there were very few women who had a total understanding of the legality of abortion in Cambodia. Only 2.7% of women correctly understood all aspects of the legality of abortion. More women in Kampot correctly knew all aspects of abortion

legality (4.7% of women in Kampot, compared to 1.3% in Siem Reap).

Table 14: Knowledge of abortion legality in Cambodia, by province.

	Kampot	Siem Reap	Total
Know that abortion is legal in Cambodia	38.0%*	21.3%*	28.1%
...When the fetus has some problems or does not develop normally†	79.0%*	81.4%*	80.4%
...When the mother's life is at risk†	83.2%*	58.6%*	68.7%
...When a woman is raped and gets pregnant†	60.1%*	51.4%*	55.0%
...Within the first 12 weeks of the pregnancy†	13.3%*	15.7%*	14.7%
Know that it is legal for medical staff to perform abortions	50.0%*	36.7%*	42.1%
Know that it is legal for hospitals/clinics to provide abortion services in Cambodia	62.7%*	51.3%*	55.9%
Know all aspects of abortion laws in Cambodia	4.7%*	1.3%*	2.7%
Laws known, mean (median)	3.75 (4.00)	3.03 (3.00)	3.32 (3.00)

** Statistically significant difference (p<0.05).*
† Only among women that reported knowing of abortion laws; n=283.

Knowledge, or lack thereof, of abortion legality appeared to reflect a more general deficit in health literacy among study participants. FGD with WRA, their husbands, and mothers-in-law demonstrated confusion and lacking or inaccurate beliefs about sexual health. Across the FGD, a majority of respondents struggled to define sexual health or referred to it only as "how to have sex," while reproductive health was usually described as medical care for pregnancy. Such gaps in understanding limit awareness of women's rights to SRHR.

The information provided by community leaders in the IDIs was more positive, with around half knowing that abortion was legal, and able to name the circumstances when it was permitted. Community leaders were even able to report that abortion was legal within the first trimester – the component of legality that had the lowest knowledge among women in the quantitative survey. However, community leaders were not without bias; many said that abortion was illegal if the fetus was alive (e.g., a healthy fetus), as that would constitute murder. Others conflated government and religion, explaining that abortion is illegal because it is a sin.

> *It is legal for women to do abortion while the fetus is under 12 weeks old. There are places that legally provide abortion services, which have received training.* – S09

> *[Abortion] is not legal in the laws of Buddhism and the world. The Buddha says it is a sin and the law calls it murder, because the baby is one life.* – S05

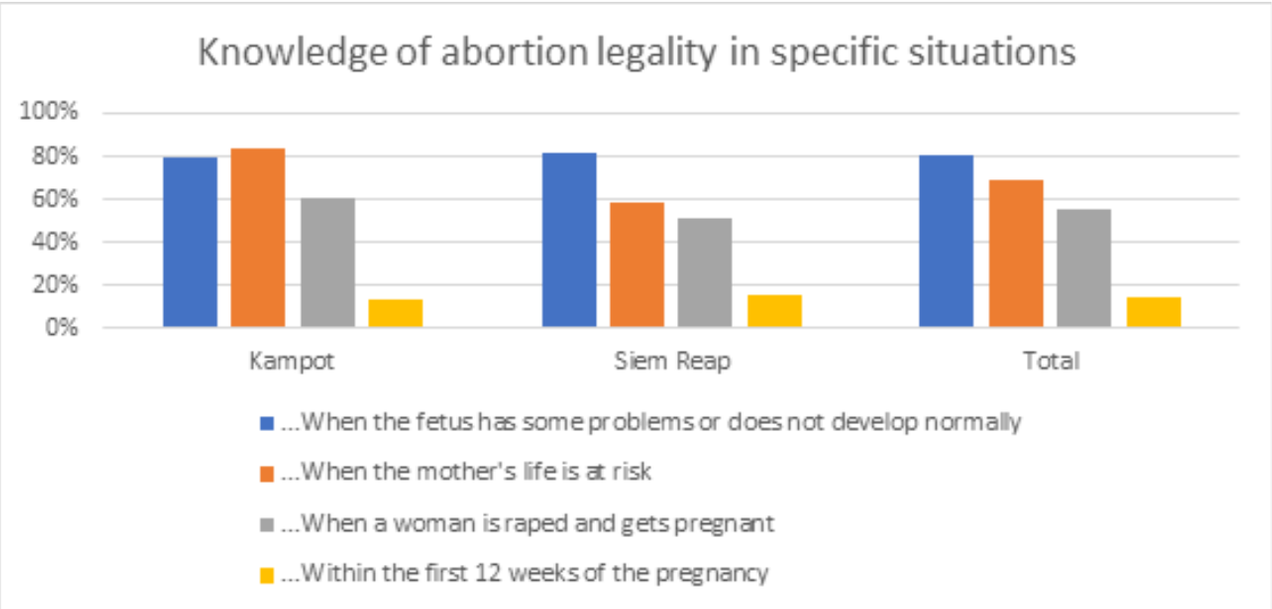


Figure 7: Knowledge of abortion legality in specific situations, by province (only among women that reported knowing of abortion laws; n=283).

Looking at knowledge of abortion legality by the different types of respondents in the study provides some interesting results. The mean number of abortion laws known by women was used as a proxy for their general knowledge on the subject. That is, the more laws or aspects of the abortion law that a woman knows, the greater their understanding. Women that live in urban areas, younger women, ever married women, physically able women, and wealthier women all have better understanding of abortion legality than their counterparts. Interestingly, women that report being joint decisionmakers for their own healthcare had better understanding than women who were full decisionmakers. Women who already had an abortion also had a better understanding of legality than women that never had an abortion.

	Abortion laws known, mean
Urban-rural villages	
Urban	3.53*
Rural	3.27*
Age groups	
15-24	3.32*
25-34	3.61*
35-49	3.07*
Education groups	
No education	3.06*
Primary	3.12*
Secondary and higher	3.80*
Marital status	
Never married	3.29*
Ever married/partnered	3.33*
Wealth groups	

Poorest	2.99*
Medium	3.23*
Better-off	3.76*
Disability	
No serious disability	3.43*
Serious disability	2.40*
Women's decision-making	
Lack of decision-making	3.29*
Joint decision-making	3.40*
Full decision-making	2.99*
Abortion experience	
No abortion experience	3.17*
Any abortion experience	4.02*
Total	**3.32**
** Statistically significant difference (p<0.05).*	

Likelihood of arrest

Next, two questions were asked to confirm respondents' understanding of the legal process. That is, how likely would it be for a woman that had an abortion, or a medical professional that performed one, to be arrested by the police. These questions attempt to understand how women think about the enforcement of the legal framework around abortion, regardless of their thoughts on its legality.

Around two-thirds of women (68.9%) said that it would be highly unlikely for women to be arrested for having an abortion (Figure 8). A similar proportion (65.1%) said that it would also be highly unlikely for medical staff to be arrest for performing abortions. However, around one in five women said that it would be likely (either somewhat likely or very likely) for women (19.1%) or medical staff (23.1%) to be arrested for being involved in abortion activities, demonstrating a lack of understanding about abortion laws and legal practices in Cambodia. Appropriate knowledge for both indicators was higher in Kampot than in Siem Reap.

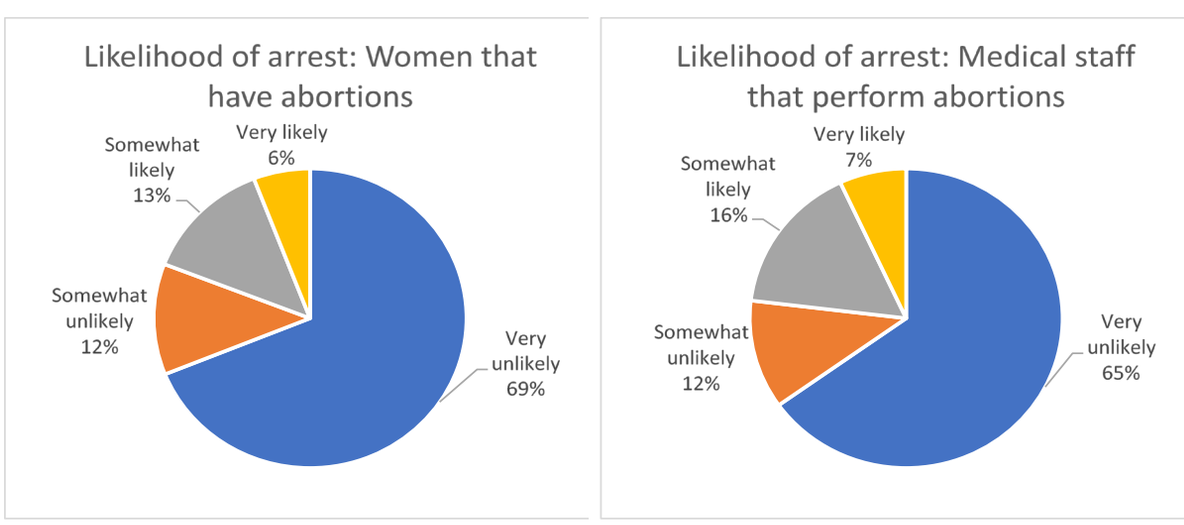


Figure 8: Likelihood of arrest for women having (L) and medical staff performing (R) abortions in Cambodia.

Knowledge of safe abortion providers

Women were asked if they knew where to access safe abortion services. This knowledge is directly related to access to these providers. Only around 60% of women reported that they knew of any safe abortion service providers. However, only around half of women (53.9%) correctly named at least one safe abortion provider, and did not name any unsafe providers. The most common safe abortion provider mentioned was public health facilities (44.0%); private medical providers were also mentioned by around one-third of women (33.8%) (Figure 9). NGO clinics were mentioned by around 16% of women. Some women incorrectly named pharmacies, traditional birth attendants (TBAs) and other clinics as safe abortion providers.

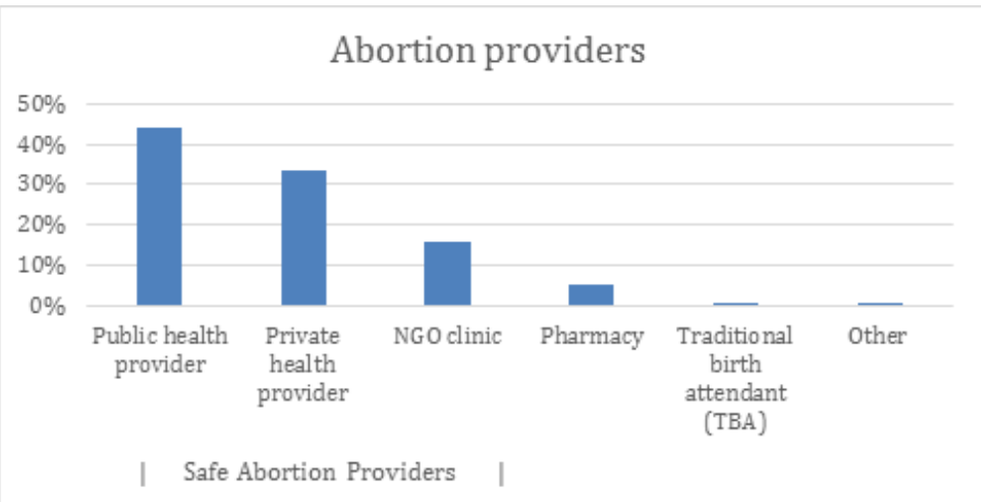


Figure 9: Abortion providers, as identified by women (multiple response).

Women in Kampot were significantly more likely to know safe abortion providers than women in Siem Reap (71.3%, compared to 42.0%). Knowledge of these providers also increased with wealth, education, and abortion experience.

Perceived accessibility of abortion services

From the quantitative IDIs and FGDs, most respondents feel that abortion services are accessible in their communities. Many respondents were able to name safe abortion providers; usually public or private health facilities. They cited the training of doctors and midwives in providing abortion services, and stated that outreach services had already been provided, which increased knowledge of abortion providers in these areas.

> *In the community, RHAC coordinates to send [women that want abortions] to their clinic directly, or contacts the midwife at the health centre and sets an appointment.*
> *– K08*

However, some of them named unsafe abortion providers; e.g., they noted the ready availability of abortifacient drugs at local pharmacies. They also noted that there are remote areas of the country where medical facilities (and therefore abortion services) are not available, which limits women's access to abortion services in these areas.

In these discussions, the respondents astutely made a difference made between the availability of abortion services at sites, and the accessibility of these services by women based on women's conditions. This discussion is included in the section on barriers to abortion, below.

7. Perceptions on abortion

In the study, women were asked a number of questions about their perceptions on women who have abortions and the individuals associated with it (women that have an abortion, medical staff that provide it, etc.). Two scales were used to understand these perceptions: SABAS, for women who have not had an abortion; and ILAS, for women that have had an abortion. These scales are described in-depth in the analysis section, above. For each scale, average scores were calculated for the different categories of discrimination, as well as overall.

Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS)

The SABAS scale is used to understand individual attitudes toward women that have abortions. Questions were only asked to women that never had an abortion (n=243). In addition, two women declined to answer some of the questions, and so their answers were removed from the calculation of the indicator score. In total, responses from 241 women in the quantitative study were used to form the SABAS scores.

SABAS was also asked to the community members and service providers that were interviewed in the key informant interviews (KIIs). Of the 26 KIIs conducted, one declined to answer one of the SABAS scale questions, and so their responses were not used to formulate the SABAS score. In total, 25 eligible individuals comprise the SABAS scores for community members and service providers. With such a small sample, the results should not be considered representative (especially as respondents were not randomly selected), but as an interesting comparison with the perceptions of women in the same communities.

SABAS scores range from one to five, with a higher score representing a greater level of stigmatization or discrimination. There are no prescribed cut-off values for specific attitudes. Overall, women in the study had SABAS scores of 2.33 (Table 15). This corresponds to answers of “disagree” (code 2) or “unsure” (code 3) on most of the questions, and reflects attitudes that are not highly stigmatizing towards women that have abortions. Among the three different categories of stigma, negative stereotypes had the highest stigmatization score (mean 2.89). Both the exclusion and discrimination and fear of contagion categories had average scores below 2.0, reflecting lower stigma towards women in these areas of community life. Exclusion and discrimination was the stigma category with the lowest score. In the context of abortion, fear of contagion implies that a woman who has an abortion has contracted an illness or other contagious medical condition, which could infect other people that come into contact with her.

Although women in Kampot have higher awareness of abortion issues than women in Siem Reap, they also reported higher levels of stigma towards women that have abortions. This was reflected in both the overall SABAS score, and within all three SABAS categories.

Looking across sub-groups of the sample, single women (never married) and women who were joint decisionmakers for their own health had the highest mean stigma scores (2.44 each). Rural and poor women also had higher stigma than their urban and better-off counterparts. Educated women demonstrated higher stigma overall and in the negative stereotyping category but had lower stigma around exclusion/discrimination, and were less afraid of contagion.

Interestingly, the community members had consistently lower SABAS scores than women, with a mean SABAS score of 2.01. SABAS scores were lower across all three sub-categories as well, and within each province. It is thus possible that the community leaders interviewed have lower SABAS scores than the average woman in their community, which could be one positive takeaway of the study. The community leaders in Kampot had lower SABAS scores than their counterparts in Siem

Reap, which is the opposite trend from the SABAS scores of women. Community leaders in Siem Reap had greater stigma scores for negative stereotypes than women in the quantitative survey; this was the only area where community leaders had greater stigma scores than women.

Table 15: SABAS scores, by province.

	Kampot	Siem Reap	Total
Female SABAS score, mean	**2.53***	**2.20***	**2.33**
Negative stereotyping, mean	3.14*	2.74*	2.89
Exclusion and discrimination, mean	1.99*	1.76*	1.85
Fear of contagion, mean	2.18*	1.79*	1.94
Community leader SABAS score, mean	**1.87**	**2.14**	**2.01**
Negative stereotyping, mean	2.53	2.96	2.76
Exclusion and discrimination, mean	1.35	1.55	1.45
Fear of contagion, mean	1.33	1.33	1.33
** Statistically significant difference (p<0.05).* *NB: 2 eligible respondents missing.*			

In terms of individual areas of stigma, women most strongly agreed with the statements "A woman who has an abortion is committing a sin", and "The health of a woman who has an abortion is never as good as it was before the abortion", reflecting the negative views of abortion in traditional Cambodian culture and religion. These statements had mean scores of 3.9 and 3.7, respectively, indicating a high level of stigma in these areas (Table 16). Stigma in these areas was significantly higher in Kampot than in Siem Reap.

Table 16: Individual SABAS questions, by province.

	Kampot	Siem Reap	Total
Negative stereotyping			
A woman who has an abortion is committing a sin	4.00*	3.88*	3.92
The health of a woman who has an abortion is never as good as it was before the abortion	3.93*	3.57*	3.71
A woman who has an abortion brings shame to her family	3.17*	2.91*	3.01
A woman who has an abortion is a bad mother	3.22*	2.77*	2.94
A woman who has had an abortion cannot be trusted	2.98*	2.54*	2.71
Once a woman has one abortion, she will make it a habit	2.82*	2.24*	2.46
A woman who has an abortion brings shame to her community	2.73*	2.23*	2.42
A woman who has had an abortion might encourage other woman to get an abortion	2.28*	1.79*	1.98
Exclusion and discrimination			
A woman who has had an abortion should be prohibited from going to religious services	3.30*	2.53*	2.83
A woman who has an abortion should be treated the same as everyone else	1.79*	2.13*	2.00
A man should not marry a woman who has had an abortion because she may not be able to bear children	2.17*	1.76*	1.91

I would tease a woman who has had an abortion so that she will be ashamed about her decision	1.70*	1.89*	1.82
I would stop being friends with someone if I found out that she had an abortion	1.82*	1.48*	1.61
I would try to disgrace a woman in my community if I found out she had an abortion	1.63*	1.24*	1.39
I would point my fingers at a woman who had an abortion so that other people would know what she has done	1.54*	1.26*	1.37
Fear of contagion			
If a man has sex with a woman who has had an abortion, he will become infected with a disease	2.24*	1.99*	2.09
A woman who has an abortion can make other people fall ill or get sick	2.15*	1.76*	1.91
A woman who has an abortion should be isolated from other people in the community for at least one month after having an abortion	2.16*	1.63*	1.83
** Statistically significant difference (p<0.05).* *NB: 2 eligible respondents missing.*			

Focus Group Discussions reinforced the primacy of religious proscription (abortion as sin) and adverse health effects in the formation of negative abortion-related beliefs. Indeed, the fact that statements dealing with these two particular stigmas received markedly strong support from SABAS may be most indicative of the level of overall abortion-related stigma in Cambodian communities, where Buddhism strongly shapes traditions and both public and private life, and the survival of many families depends on the physical ability of its members to do work.

FGDs revealed varying prioritizations of these concerns. The belief that doing abortion would seriously affect women's health remained a particularly pronounced obstacle to promoting safe abortion among partners of WRA, while sin was voiced more often as the central concern of mothers-in-law.

Indeed, adverse health effects were continuously cited by the husbands as one of the chief personal and/or family concerns justifying opposition to abortion, while sin was invoked more often in response to general prompts about widespread cultural perceptions of abortion. In a similar vein, abortion was reported relatively understandable by the husbands if a family decided collectively that having another child would worsen their economic situation; in such a case, some of the participants seemed willing to allow the practical realities of poverty to take precedence over perceived religious proscription of abortion.

Domestic violence between married partners, marital neglect, rape, and dire health of the mother or child also evoked sympathy in husbands' responses; in other words, they voiced greater acceptance of abortion in such cases. The former of these reasons comprise an interesting area to examine further, because while husbands insisted on having input on abortion, they painted this participation as contingent upon the fulfilment of certain familial duties. If a husband abused his wife, had an affair, or did not provide requisite material support, the husband FGD participants stated that a woman may need to decide privately to seek an abortion. It is necessary to consider, then, how best to raise awareness on the rights of women to make independent SRHR decisions unconditionally – that is, whether in the presence of absence of poverty, marital strife, and/or ill health.

Meanwhile, absence of paternal support emerged as a reason husbands thought motivated unmarried women to seek abortion, but these scenarios were discussed with clear disapproval and stigmatization of women who have premarital sex. According to traditional norms of Cambodia, women are not allowed to have any close interaction with the opposite sex before marriage. Therefore, unmarried women who become pregnant women are not considered a proper woman in society, including rape victim. Of course, women are then not only victims of sexual harassment and rape, but also blame from other members of society, who often believe that the victim created environment of sexual interaction. Accordingly, husbands in the FGD described an unmarried pregnant woman, should she carry the pregnancy to term, as facing not only material scarcity, but also a high level of embarrassment and shame. So, the focus group participants appeared to understand why a woman would seek an abortion under these circumstances, but they described negative perceptions of her character and low subsequent marriageability, critiques that that they did not assign so readily to married women. Again, this highlights the key observation that communities may be distinguishing on the basis of marital status when reacting to abortion.

When prompted on their personal beliefs on abortion, mothers-in-law as a group tended to use stronger and more unambiguously negative language, invoking religious opposition to abortion when asked about their own individual views on the topic, stating numerous times that abortion is sinful and even stating "I hate abortion." In other FGDs and IDIs, participants tended to bring up Buddhism once they were prompted to discuss the acceptability of abortion in Cambodian culture generally, but the mothers-in-law raised these points immediately as personal justification for their opposition to the practice. MIL also had more grave reactions to abortion in the sense that they described severe hypothetical consequences for women who sought abortion services, including being disowned by family, forbidden from living at home, and being excluded from important community events like weddings.

Age and the passage of time also seemed to figure prominently into the understanding of these participants, both in that they often invoked old age as a reason for not knowing very much about SRHR, and in that they often contrasted their knowledge, beliefs, and practices to those of younger women: "Elder people did not learn well; Only young people learnt," "I just answer. If it is right or wrong, don't mind me. We did not study at all," and, "Elder people did not like [abortion], but young people follow the trends." The mothers-in-law sometimes wondered aloud if their worldview was sustained in contemporary practice: "R2: For Buddhism, it is committing a sin, but for now, I have no idea. R3: I don't know now, but before it is a big sin for having abortion. R5: For elder people, if unmarried have baby, they did not allow to go in home. But now, I don't know".

Targeting MIL as a key person for promoting safe abortion may therefore not to be effective. Although there is a belief that parents and MIL could potentially provide abortion information to women, their concepts and capability to receive new contexts of knowledge appears doubtful due to the self-identified lack of SRHR knowledge cited above and the feeling of parents and MIL that they are increasingly excluded from these decision-making processes and dialogues on the basis of age. They seem to understand a change of mind set on abortion, however, they believe that this is a result of globalization which is not for their generation or their family members.

In keeping with a key trend observed across the qualitative data set, the MIL distinguished explicitly between married and unmarried women, the latter of whom they described as "thoughtless" and "[having a pregnancy] they dare not to keep." The MIL, however, seemed less receptive than other FGD and IDI respondents to justifications a married woman may have for seeking abortion in some situations. Although they used more derogatory terms to describe unmarried pregnant women, these participants still stated disapproval of married women seeking abortion across several hypothetical scenarios posed to them. They did voice awareness that lack of resources and spousal abuse or infidelity

might result in a situation whereby “we are angry and want to have an abortion” but they tended to conclude: “R2: For me, if they have baby, do not have abortion. R3: just keep baby.”

Multiple MIL also reiterated the idea that abortion causes health problems: “R5: If they have abortion, they have no longevity and they become skinny. Even using implant also causes trouble if it is not being used properly.”

Stigma against abortion providers

As a further measure of stigma against abortion, women that were eligible for the SABAS section of the interview (women that never had an abortion) were asked four questions about the stigma associated with abortion providers. These statements have been calculated in a similar way to SABAS, on a scale of 1-5 for increasing stigma.

Examining the overall SABAS scores showed that women had slightly more discriminatory attitudes towards abortion providers than towards women that received abortions, with an average score of 2.68 for the four abortion provider statements, compared to 2.33 for the overall SABAS score (Table 17). There was no significant difference between women in Kampot and Siem Reap on the overall view of abortion providers, although there were significant differences in their views of each statement. The belief that abortion providers were committing a sin was the most strongly held stigma against abortion provider (mean 3.13), and was higher among women in Kampot than women in Siem Reap. However, this is lower than the stigma score for the belief that women who have an abortion are committing a sin (3.13, compared to 3.92).

However, community leaders had lower stigma scores (in SABAS) than women in the quantitative survey, demonstrating a less discriminatory attitude toward women that have abortions than people in their community. This could possibly be a result of their greater age (43 years, on average, compared to 31 for WRA in this study), higher education, greater knowledge of abortion laws, or increased sensitization toward vulnerable groups within their community. They could therefore be good exemplars, or models, for programs designed to reduce stigma around abortion. That is, they could be supportive of program objectives, and with proper training and support they could advocate for reduced stigmatisation of women that have abortions and abortion service providers among their communities.

Average stigma scores for the other three statements in this section are lower than 3.0, indicating a low level of stigmatization around abortion providers. Even the statement that "Traditional healers (*Kru khmer)* who help women terminate a pregnancy should go to jail" was not often agreed with, although this is an example of an unsafe abortion practice. This attitude was reflected in the IDIs and FDGs, where community leaders and FGD participants did not report that medical abortion faced discrimination. Respondents did acknowledge that these providers were committing a sin by taking a life, but some of them also countered this rationale by saying that medical providers were also doing a good deed by helping someone. Some respondents also stated that medical providers only performed abortions when request them, and so they were "exempt" from the sin of the abortive act.

> *Sometimes [performing an abortion] is a sin but sometimes it is not. Killing someone's life is a sin, and helping people is good.*
> *– S13*
>
> *Women seek for [abortion] service; medical providers do not tend to perform abortions. So, no one talk bad about them... Nobody blames medical provider who perform abortion.*
> – FGD respondent (MIL)

Interestingly, the participants in the MIL FGD, who had strong abortion-related stigma on the basis of sin, unanimously and emphatically denied that providers of abortion were sinning by performing these services. The group was prompted on the issue at several different times, and the participants remained very clear in their statements that medical providers were not sinning because women "beg" or "force" them to perform abortions: "R4: Medical provider did not really want to perform abortion, but women force them to do that service." The MIL said that these medical providers would not be gossiped about, discriminated against, or otherwise treated differently in the community. The patients themselves, however, were understood by the MIL as being very concerned about confidentiality. Multiple participants in this FGD said that women avoided seeking abortion services at the health center due to privacy concerns: "Some people go to health center. But if people know that women have abortion there. They will go to private hospital or home based so they can have abortion very confidential."

Table 17: Attitudes toward abortion providers, by province.

	Kampot	Siem Reap	Total
Discriminatory attitudes against abortion providers, mean	**2.69**	**2.68**	**2.68**
Doctors and midwives who perform abortions in a clinic are committing a sin.	3.27*	3.04*	3.13
Doctors and midwives who perform abortions are murderers.	2.79*	2.81*	2.80
Traditional healers (Kru khmer) who help women terminate a pregnancy should go to jail.	2.43*	2.60*	2.54
Doctors and midwives who perform abortion should go to jail.	2.26*	2.29*	2.28
** Statistically significant difference (p<0.05).* *NB: 2 eligible respondents missing.*			

Individual Level Abortion Stigma Scale (ILAS)

ILAS was asked to women that had ever had an abortion, to measure their levels of stigma and feelings on the experience of abortion in their community. Of the 57 eligible women in the study, all of them

answered each question (n=57). Women that had multiple abortions were asked to consider their feelings at the time of their most recent abortion. Separately, women that never had an abortion were asked to imagine how they might worry about judgment if they were to have an abortion. Their scores are computed and reported separately from women that had an abortion, in the table and figures below.

Overall, women that had an abortion had average ILAS scores of 1.57. Scales for questions in the scale range from zero to three or four, so this overall score is slightly below mid-value. In the different sub-categories, women were most worried about community condemnation and self-judgment; both with average scores above 2.0. Women that had abortions were reported least worried about individual judgment; this category had the lowest scores in the ILAS section, with average scores below 1.0.

Similar to the SABAS, above, women in Kampot reported higher overall levels of stigma than women in Siem Reap, although the score value was only slightly higher (1.6, compared to 1.54 in Siem Reap) and scores by sub-category were more mixed. Women in Siem Reap were more worried about how their community judges abortion, while women in Kampot had stronger feelings of self-judgment around their decision.

Women that did not have abortions but were asked their worries about judgment if they were to have an abortion had higher stigma scores in this category than women that had an abortion; their stigma scores were almost double those reported for women that had an abortion (mean 1.84, compared to 0.96). This may reflect the higher levels of worry that women would feel before an abortion, when they do not know what the outcome would be, than afterwards. Women without an abortion in Kampot had lower stigma scores than their counterparts in Siem Reap (1.75 and 1.90, respectively), which is the opposite trend from the stigma scores in this category among women that had abortions.

> *In case she has not yet get married but has a baby, then the other people will talk down to her, but in case that she is already married and they don't want a baby and then they did an abortion, that is fine, it's normal. The women who not have a family or married would not be valued. Khmer culture thinks that having a baby before marriage is not valuable.*
> *– S03*

Table 18: ILAS scores, by province.

	Kampot	Siem Reap	Total
ILAS score, women that had an abortion, mean	**1.60***	**1.54***	**1.57**
Community condemnation, mean	1.97*	2.23*	2.09
Self-judgment, mean	2.16*	1.90*	2.04
Isolation, mean	1.74*	1.70*	1.72
Worries of judgment, mean	0.98*	0.94*	0.96
ILAS score, women that never had an abortion, mean[†]			
Worries of judgment, mean[†]	1.75*	1.90*	1.84

** Statistically significant difference (p<0.05).*
[†] n=242; 1 missing.

The low score for worries about judgment is interesting, as discussions from the IDIs and FGDs show that many of the community leaders and FGD respondents reported that women would be worried about community judgment. These worries included that other people would find out about the abortion, that the abortion would negatively impact their other relationships, and that people would gossip about them. The scores among women that did not have abortions may therefore more accurately reflect community stigma levels on this metric than the scores of women that did have abortions.

ILAS scores were higher for women in rural areas and those in the middle of their lives (25-34 years old). Interestingly, there is a trend in the ILAS scores, whereby women in the lowest and highest sub-groups have higher scores than those in the middle. For instance, women with no education and women with secondary education both had higher ILAS scores than those with primary education (1.69, 1.59, and 1.54, respectively). Also, women in the poorest and better-off (wealthiest) groups had higher ILAS scores than women with medium household wealth (1.64, 1.77, and 1.44, respectively). These results are statistically significant.

As the scores for individual questions show, within the worries about judgment category, women that had abortions were most worried about other people finding out about their abortion (mean 1.18), or about being humiliated (1.15) (Table **19**). In terms of isolation, women did not feel that they could have a conversation about their abortion (mean 2.14) or talk openly about their feelings about their abortion with someone close to them (mean 2.29); the highest stigma scores in this sub-category.

Some people gossip about women who have abortions, and then their husbands know about it. The husbands may make trouble with their wives until they get divorced. It is because women hide [abortions] from their husbands. – K10

Mostly, people think doing abortion is not good because it is sin, and then they look down on them. –S07

Self-judgment was the sub-category with the highest stigma scores for personal feelings (the community condemnation section asks women to think about how others feel about abortion). Within this sub-category, women were most likely to feel guilty (mean 2.61) or feel like a bad person (mean 2.43) after an abortion. Of the five metrics in this sub-category, all but one had mean stigma scores above 2.0. The only metric in this category where women did not feel stigma was in decision-making; women generally agreed that they were confident they had made the right decision (mean 0.76); among all 20 ILAS questions, this was also the metric with the lowest score. Women in Siem Reap had a much lower ILAS score on this metric than women in Kampot (0.5 compared to 1.0), reflecting more confidence with their decision.

Table 19: ILAS individual questions, mean scores by province.

	Kampot	Siem Reap	Total
Worries about judgment			
Other people might find out about my abortion.	1.34*	1.00*	1.18
My abortion would negatively affect my relationship with someone I love.	0.89*	0.86*	0.88

I would disappoint someone I love.	0.91*	0.86*	0.89
I would be humiliated.	1.03*	1.27*	1.15
People would gossip about me.	0.83*	0.73*	0.78
I would be rejected by someone I love.	0.89*	0.96*	0.92
People would judge me negatively.	0.97*	0.91*	0.94
Isolation			
I have had a conversation with someone I am close with about my abortion	2.31*	1.96*	2.14
I was open with someone that I am close with about my feelings about my abortion	2.26*	2.32*	2.29
I felt the support of someone that I am close with at the time of my abortion	1.91*	1.96*	1.93
I can talk to the people I am close with about my abortion.	1.63	1.64	1.63
I can trust the people I am close to with information about my abortion	1.14*	1.46*	1.29
When I had my abortion, I felt supported by the people I was close with	1.20*	0.91*	1.06
Self-judgment			
I felt like a bad person.	2.40*	2.46*	2.43
I felt confident I had made the right decision.	1.00*	0.50*	0.76
I felt ashamed about my abortion.	2.14	2.14	2.14
I felt selfish.	2.43*	2.05*	2.25
I felt guilty.	2.83*	2.36*	2.61
Community condemnation: How many people in your community held the belief that…			
Abortion is always wrong	2.03*	2.32*	2.17
Abortion is the same as murder	1.91*	2.14*	2.02
** Statistically significant difference (p<0.05).*			

Additional observation from FGD

The FGD with mothers-in-law of survey participants also revealed that further awareness-raising may be required to demonstrate the ongoing need for abortion despite the growing availability of family planning methods. All of the MIL FGD participants stressed repeatedly throughout the discussion that there was little or no abortion taking place in their community due to the availability of contraceptives: "R3: There is no that such of thing because women use contraception such as IUD/implant. R4: Yeah! Women use pill and injection. Now they stop having abortion. R5: Before there was abortion because there was no contraception. R3: because nowadays, there is no abortion;" and "R5: I think that there are no women who have abortion in my village. R4: look like they all use contraception."

Another point raised and necessitating further inquiry was that several MILs described being dissuaded from gossiping about abortion in the community because the subject of the gossip would "sue us" or "fight us at home": "When women have abortion, they don't let us know. If we accuse them that they have baby, they will say they are not pregnant (can see their tummy). Sometimes, they sue us." Several MILs described minding their own business and avoiding discussions of abortions in other families because of this risk. Though this point was not rigorously elaborated upon in the FGD, its implication – that there may be cases of women confronting rumors or stigma surrounding abortion

through different forms of mediation – is intriguing indeed, and it may be relevant to outreach and advocacy strategies. The phenomenon should be further examined in subsequent research.

The FGDS suggested the influence of egocentrism in Khmer society, as many respondents differentiated actions they were willing to tolerate in the broader community from those they would support for themselves and/or their family members. With respect to abortion, respondents sometimes expressed not caring very much about others' issues, stating, as mentioned above, that they only focus their attention on protecting themselves and their family. In this context, being devalued by others and losing face is a significant cause for concern. It appeared that respondents tried to minimize any concept which could reflect poorly on them, including their understanding on abortion. This phenomenon, coupled with the fact that many respondents seemed cognizant of changing attitudes with respect to abortion, presented a barrier to soliciting thorough or frank answers from respondents on these sensitive topics. The majority of FGD respondents stated that they do not discriminate against people who have experiences of abortion and they understand the rationale of others' for seeking abortion. It is challenging to discern the extent to which such statements were given in earnest or in an attempt to follow the recent context of eliminating abortion stigmas elimination in Cambodian society. They may be concerned about being differentiated and discredited in the next context of understanding. As an example, most of women respondents replied: "Same answer with her/him. I dare not to speak; I am scared that I am wrong."

8. Women's experience of abortion

Among the 300 women interviewed in the quantitative survey, 57 reported that they had an abortion before. This corresponds to 18.2% of the weighted sample (Table 20). There were significantly more women in Kampot that had abortions than in Siem Reap; almost one-quarter of women (23.3%) in Kampot ever had an abortion, compared to 14.7% of women in Siem Reap. All women that reported having an abortion had ever been married/partnered (currently married/partnered, divorced, widowed, or separated); however, their marital status at the time of the abortion is not known.

For the most recent abortion, the primary reason for having the abortion was asked to women. The most common reason for women having their last abortion was a lack of money; cited by around one-quarter of women (27.3%) (Figure 10). A further 17.6% reported that they did not want children at this time; the same number of women initiated the most recent abortion because the fetus was not healthy. The health of the mother was also frequently cited as the primary reason for abortion among 16.3% of women. Other reasons were less mentioned, but include already having multiple children, separation from husband/partner, and an unplanned pregnancy. One woman reported that she had an abortion because the place where she worked did not employ women that had children.

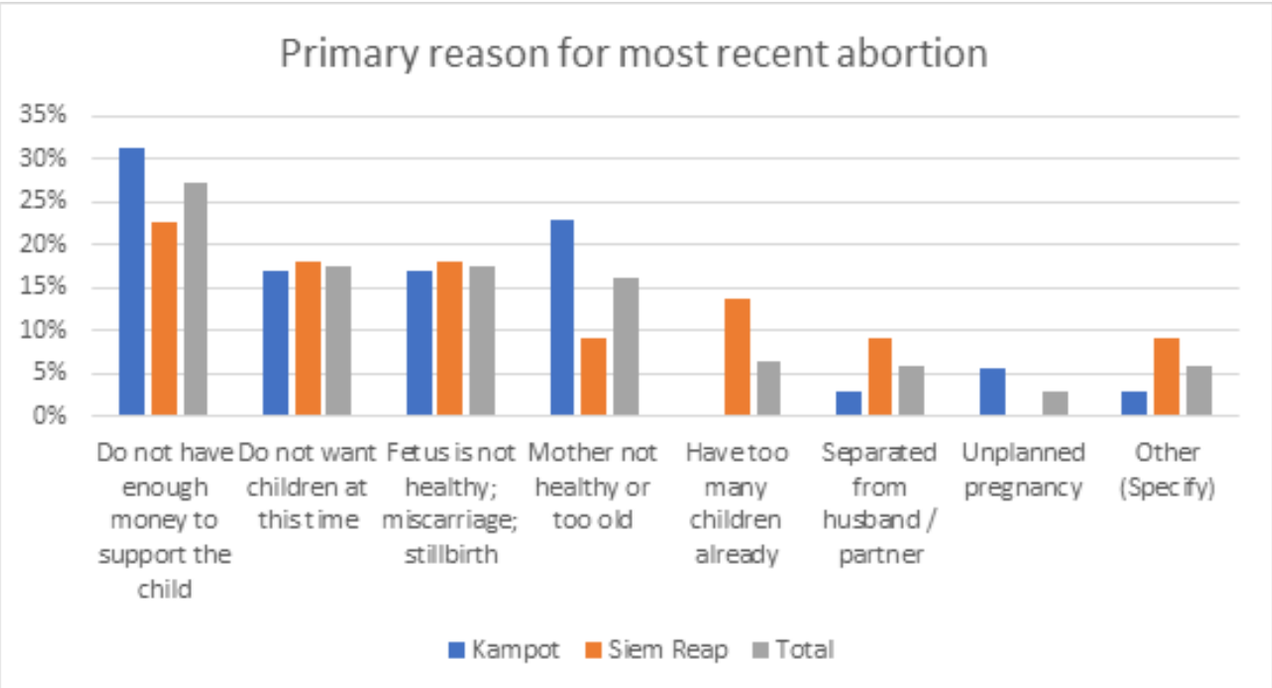


Figure 10: Primary reason for most recent abortion, among women that ever had an abortion, by province

Women in the study reported having a total of 73 abortions; an average of one abortion per woman (mean 1.2; median 1). Nearly two-thirds of these abortions (63.0%) were conducted by women in Kampot province (unweighted value), reflecting the greater number of women that had abortions living there. Over three-quarters of women that had an abortion (78.7%) had only one abortion. The maximum number of abortions a woman in the study had is four. For the following section on the characteristics of abortions, the analysis uses the unweighted sample of individual abortions (n=73).

It is interesting to note that women in Kampot were more likely to have abortions than women in Siem Reap, and to have greater numbers of abortions, especially given that these women reported higher stigma scores from both women with abortions (ILAS) and women without abortions (SABAS). It could be that there is greater accessibility and/or visibility of abortions and abortion service providers in this province, which makes the issue more open and therefore stigmatic. Further research could be conducted to examine accessibility from the supply side (medical facilities, specially trained medical staff, etc.) in these areas to better understand this issue.

Table 20: Experience with abortion, by province.

	Kampot	Siem Reap	Total
Ever had abortion	23.3%*	14.7%*	18.2%
Number of abortions, mean (median)	1.3* (1.0)	1.2* (1.0)	1.2 (1.0)
Talked with someone before most recent abortion†	80.0%*	77.3%*	78.7%
Spoke with someone after the most recent abortion†	34.3%*	27.3%*	30.9%
** Statistically significant difference (p<0.05).* *† Among women that ever had an abortion (n=57).*			

For the most recent abortion, women were asked if they discussed the issue with anyone before and after they had the abortion. Around three-quarters of women (78.7%) discussed their abortion with someone before it was performed. Note that discussing an impending abortion with someone else

does not imply giving them decision-making power over the abortion. Nearly all of these women discussed their upcoming abortion with their husband/partner (87.9%); around one-third (30.9%) also discussed it with another family member or friend. Very few women (8.7%) sought out a discussion with a medical provider before the abortion consultation.

After their most recent abortion, the number of women that discussed their abortion dropped to around one-third (30.9%). While a very small sub-sample of women (n=18), this shows that women were less likely to talk to their husbands/partners after their abortion than before. However, they were more likely to discuss the abortion afterwards with a family member, friend, or colleague (54.8%) or with medical staff (16.7%).

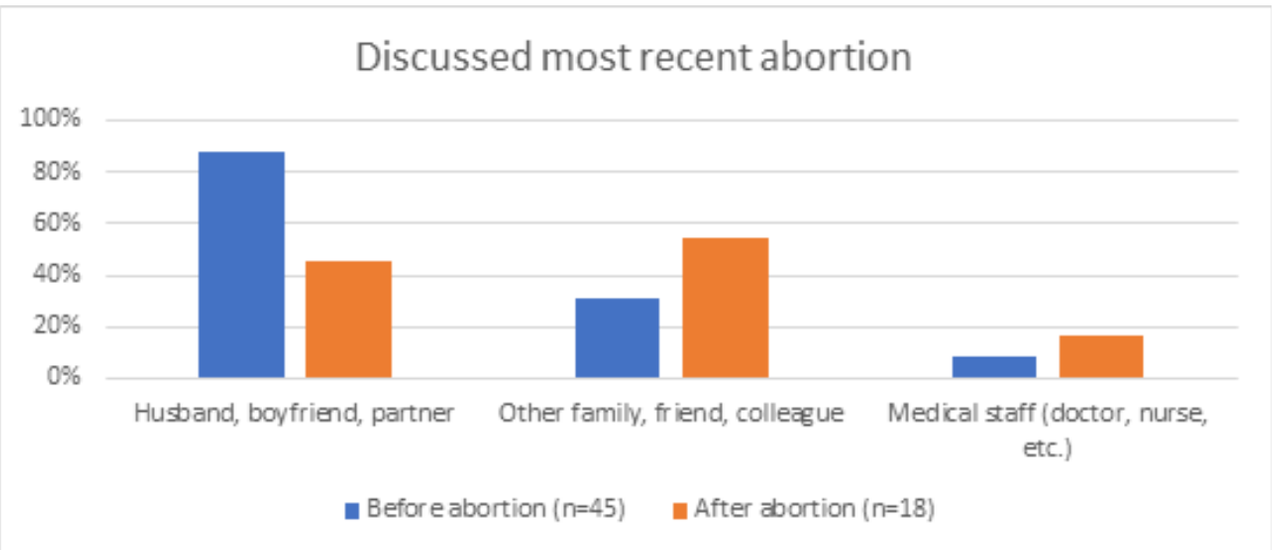


Figure 11: Person that women discussed their abortion with before/after the most recent abortion (multiple response; unweighted n).

Abortion characteristics

Briefly examining the abortions described by women in the quantitative survey shows that, on average, the abortions were conducted between five and six years before the interview (Table 21), when most women were around one to two months' pregnant (mean 1.7 months; within the first trimester). However, the latest abortion conducted was at the end of the second trimester (six months' pregnant).

Comprehensive abortion care (CAC) refers to the use of medically appropriate abortion methods (vacuum aspiration, medical abortifacient pills) administered in medical facilities (public facilities, private facilities, and NGO clinics), based on the Cambodian government's *Fast Track Initiative Road Map for Reducing Maternal & New born Mortality: 2016-2020* (MOH, 2016). Altogether, slightly more than half of all abortions reported in this study (57.5%) were considered safe abortions; conducted in medical facilities using medical abortion techniques.

Nearly all abortions (93.2%) used at least one safe abortion method; either vacuum aspiration methods (54.8%) and/or a medical abortifacient drug (49.3%). Four percent of abortions were reportedly spontaneous, while the use of traditional abortion methods appears to be very low (1.4%). Note that it is not rare for women or medical facilities to use multiple abortive methods for one abortion. In this study, there were an average of 1.1 methods used per abortion.

The majority of abortions (60.3%) were conducted in a safe-abortion medical facility; most commonly a public health facility (30.1%), of which local health centers were the most common facility (hosting

19.2% of all abortions). Around one-quarter of abortions (23.3%) were held in private medical facilities. NGO medical facilities (also considered safe-abortion facilities) accounted for a small percentage of abortion locations (6.8%). Concerningly, over one-third of abortions (39.7%) were initiated in an unsafe location; usually a pharmacy or drug store (21.9%), or a respondent's home (13.7%).

The majority of abortions (60.3%) were assisted by a medical professional (i.e., a doctor, nurse or midwife), including nearly all abortions initiated in a medical facility. Three abortions performed in public health centers did not have medical assistance; in these cases, women received medical abortion pills. A small percentage of women (6.8%) had only non-medical assistance for their abortion, such as a traditional birth attendant (TBA) or pharmacist. In one-third of abortions (32.9%) there was no one present to assist the woman at the time of the abortion.

These numbers are similar to those reported in CDHS 2014. In that study, vacuum aspiration and medical abortion pills accounted for 57.0% and 51.9% of abortion methods employed by women for their last abortion in the last five years, respectively.[4] Around 60% of women reported having their last abortion in the last five years in a medical facility, and the proportion of abortions assisted by medical staff reported in CDHS 2014 is 61.4%. However, it should be noted that these numbers are not directly comparable due to differences in sampling and eligibility criteria between CDHS and the current study.

Table 21: Abortion characteristics, by abortion (n=73).

	Total abortions (n=73)
Years since abortion, mean (median)	6.0 (5.0)
Duration of pregnancy at time of abortion, mean months (median)	1.7 (1.0)
Abortion procedure[†]	
Vacuum aspiration	54.8%
Medical abortion pill	49.3%
Self-aborted	4.1%
Traditional method	1.4%
Other	2.7%
Assistance with abortion	
Medical assistance	60.3%
No assistance	32.9%
Non-medical assistance	6.8%
Location of abortion	
Public health facility	30.1%
Private health facility	23.3%
Pharmacy/drug store	21.9%
Your home	13.7%
NGO health facility	6.8%
Other	4.1%
Safe abortions (CAC)	57.5%
Spent money for abortion	94.5%

4. Note that CDHS 2014 also uses a multiple-response method for this indicator; results are greater than 100%.

Total costs, mean USD (median)	47.51 (30.00)
Abortion services, mean USD (median)	25.13 (15.00)
Post-abortion services, mean USD (median)	18.40 (0.00)
Transportation, mean USD (median)	4.61 (1.25)
† *Multiple response; answers do not total to 100%.*	

Nearly all abortions (94.5%) had to be paid for, with average costs of around US$ 47.51, although women spent less than US$ 30.00 on half of all abortions (the median value), indicating that there were considerable differences in costs between abortions. These differences could be due to time (the oldest prior abortion was 25 years ago), location (private medical providers charge more for their services), transportation difficulties for women living in remote areas, and additional expenses due to complications or costly follow-up care. On average, the greatest proportion of abortion expenses was for the service itself; women spent around US$ 25 to US$ 15 on each abortion service. Post-abortion follow-up care was also somewhat costly (mean US$ 18.40), although these costs were incurred in less than half of all abortion cases (median of zero). Transportation costs accounted for less than 10% of the average cost of an abortion (mean US$ 4.61, compared to US$ 47.51 in total), but this could still be a prohibitive amount for some women, especially poor women and those living in remote areas who have to travel further to access abortion services (see discussion on barriers, below).

Post-abortion care

Lastly in this section, women were asked about any problems they experienced after each abortion, and if they discussed or began using contraception - especially modern contraception. Around one in five abortions had problems (19.2%), the most common of which were heavy bleeding and abdominal pain or cramps (42.9% of abortions each) (Table 22). A few abortions resulted in women experiencing a high fever (7.1% of abortions). Around one-quarter of abortions with problems showed other side effects; mostly tiredness and fatigue.

Around half of abortions (52.1%) were followed by discussions on modern contraceptive methods within 14 days; either by the medical professional that assisted with the abortion (when present), or someone else. Uptake of a modern contraceptive method within 14 days after an abortion was slightly less common; modern contraceptive use was initiated in less than half of the abortions in the study (42.5%).

Table 22: Post-abortion follow-up and contraceptive use.

	Total abortions (n=73)
Problems after abortion†	19.2%
Heavy bleeding	42.9%
Abdominal pain or cramps	42.9%
High fever	7.1%
Other (tiredness, fatigue, etc.)	28.6%
Discussed modern contraception within 14 days of abortion	**52.1%**
Started to use contraception within 14 days of abortion	**42.5%**
† *Multiple response; answers do not total to 100%.*	

Among all contraceptive methods used after an abortion (both modern and traditional methods), the injection and the daily pill were the most common (Figure 12). Other modern methods used after abortions included the IUD, implant, and condoms. The traditional methods of withdrawal and abstinence were also mentioned.

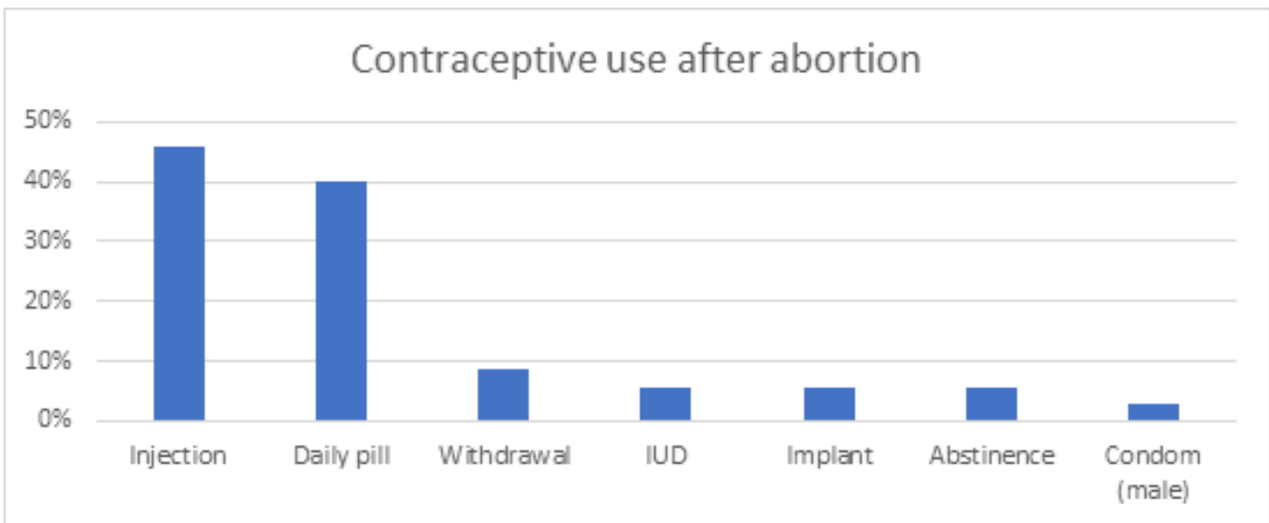


Figure 12: Contraceptive use after each abortion where women started using contraception (multiple response; n=35).

7. Conclusions

1. Awareness of abortion and related issues

Awareness of the legal protections around abortion is very low, with most women not understanding that abortion is legal, and the legal conditions around an abortion (first trimester, in cases of rape, etc.). From the qualitative discussions, there is also a clear conflation between the national law and the moral code of Buddhism – Cambodia's dominant religion. This affects women's understanding of their right to an abortion, and their right to safe abortion services in a medical facility, and may increase their fear of stigma, isolation and self-judgment. It may also empower other members of society in their discrimination of women who have an abortion, as they feel that their views are in agreement with both the law and religion.

2. Perceptions, stigma and discrimination

Abortion is still seen as a sin in Cambodia, and the idea that abortion is murder is still very present within Cambodian society. Based on the international scales used to measure stigma and discrimination towards women that have abortions, Cambodian communities do not show high level of stigma towards women that have abortions or abortion providers. But this stigma is ever-present within the community; all IDI and FGD respondents also reported some level of stigma or discrimination towards women that have abortions, and many reported of stigma toward abortion providers.

Abortion stigma is especially strong towards unmarried women that have abortions. While respondents report that married women who have abortions have many valid justifications for not wanting to deliver their child (poverty, unplanned pregnancy, etc.), unmarried women carry the double stigma of having sex outside of marriage, and having an abortion. One IDI respondent described women that had premarital sex as "overjoyed"; a few respondents said that unmarried mothers had no value, reinforcing the idea that unmarried pregnant women are forced to make a decision between two highly stigmatizing actions – abortion or single motherhood.

In addition, female respondents and community leaders reported generally lower levels of stigma toward medical providers, with a nuanced understanding of providers' roles in the abortion process. That is, that abortion providers were providing a necessary service at the request of women (some also acknowledged the legality of this service in their responses), and thus the stigma lies with the woman rather than the service provider. They also acknowledged that sometimes abortions were necessary (abnormal fetal development, etc.), and in these cases the abortion providers were performing a good deed by helping the mother.

3. Barriers to safe abortion access

There are many barriers to women accessing abortions which were raised in the qualitative interviews and throughout the survey. These will be discussed here, drawing on supporting information from the women's responses in the quantitative survey.

Cost, distance, time and quality of care. The other points which were raised by the qualitative respondents pertained to the difficulty women have accessing abortions because of specific aspects of the care. These primarily included:

Cost. Respondents reported that the costs of abortions were prohibitive for many women, especially poor women. Part of the reason for this was that many women prefer to have abortions in private clinics or hospitals, or at the provincial public hospital, due to concerns over anonymity and quality of care within the local public health centers. These options had higher perceived quality of care, but also higher costs associated with them (even at the provincial public hospital, there were concerns

of higher travel costs). These costs thus form a barrier to poor women, and women that live in remote areas, from accessing care.

Distance. The distance required for some women to receive an abortion was also a factor in reducing access to abortions. Distance also has effects on the overall costs of an abortion, as women in remote areas spend more money on transportation to access health services, including abortions. Although this additional cost for abortions is generally small relative to the costs of the procedure and follow-up care (as shown in the section on women's experience of abortion, above), they can be significant for poorer women.

Time. This aspect was primarily raised by the mothers-in-law group, but they mentioned that the time it takes to have an abortion, including time away from home, is one thing that prevents women from accessing abortions. Time can be a factor for both single women, who may be working long hours in a factory or farm, and for married women who may be the primary caregiver for a household including elderly individuals and their own children.

Quality of care. The quality of abortion service providers was also raised as a concern by respondents, especially for the unsafe abortion providers of pharmacies/drug stores, which is where many women initiate their abortions. There were concerns over the quality of drugs, and the lack of clear instructions or follow-up care provided by pharmacists, with some respondents reporting that women that take abortifacient drugs from pharmacies then need to go see a medical professional due to complications or problems with the abortion. However, quality of care among doctors and other medical professionals was considered to be good, and to have improved over the years due to increased training.

> *I worry about women that never discuss [abortion] with us, and they buy the medicine to do abortion by their own from pharmacy. The first person that they talk to may tell them that this is something to be ashamed about, and then they just go and buy the medicine and it can be dangerous. – S07*

Vulnerable groups. Vulnerable groups include the poor, illiterate or uneducated, those that live in rural areas, those with a serious disability, and those that are otherwise marginalized from society. Women in vulnerable groups are seen as having additional barriers to accessing abortion care when they need it. For poor and rural women, many of these barriers are related to the factors involved in receiving an abortion (cost, distance and time expenditures), as described in the sub-section above. Illiterate or uneducated women are seen as having additional barriers to receiving a safe abortion, as they may be less aware of safe abortion resources in their communities, and may have limited comprehension of medical instructions or advice. Women in vulnerable groups had lower knowledge of abortion laws and safe abortion providers, lower contraceptive and sexual decision-making capability, and subsequently lower access to safe abortions (CAC). Women in vulnerable groups generally had more discriminatory attitudes toward women that have abortions. Rural women, women with serious disabilities and women in the poorest wealth group had greater SABAS scores than their counterparts. Among women that had an abortion, rural women, those with no education, and those with serious disabilities had greater ILAS scores, indicating feelings of increased stigma.

8. Recommendations

There are a number of recommendations that can be made for programs looking to increase access to safe abortion and reduce abortion-related stigma in the two target provinces.

1. Awareness of abortion and related issues

Awareness of abortion legality, and specific conditions of legality, is very low in these provinces. Legal and cultural taboo are also often conflated, with the implication that murder in the Buddhist sense is the same as murder in the legal sense, which is not the case. Providing information that clearly highlight these differences would help to remove this aspect of stigma and the unawareness of the legal protections afforded to abortion.

- Awareness raising activities should also consider how to reach the most vulnerable groups, who often have the lowest knowledge of abortion legality. These include specific targeting for rural women, the poor, those with disabilities, and those with limited education/literacy.
- Increase awareness around the legality of abortion and safe abortion providers, especially among the most vulnerable groups should be taken into account.
- Empowering women and communities in the understanding of a woman's right to an abortion, and their decision-making ability therein, is an important first step in removing the stigma and discrimination that surround abortion.

2. Perception on abortion

Married women apparently face less social stigma in having an abortion, provided that they have made the decision jointly with their husband/partner and have their support.

- Communication materials should consider these differences, and be designed to address the stigma towards unmarried pregnant women which exists in Cambodian communities.
- Empower women in their own reproductive healthcare, including abortion.

3. Barriers to safe abortion access

Husbands/partners play a key decision-making role in their wives' healthcare, including for reproductive health and abortions. Their support is necessary to ensure that their wives do not suffer negative discrimination within the community, and that an abortion does not cause domestic disturbances within the family structure. Likewise, community leaders show a high level of understanding of their communities, and low levels of discrimination/stigmatization. They could therefore be a positive influence in reducing stigma among community members. A focus on these groups could help ensure the sustainable success of an abortion awareness and sensitization campaign. In addition, women in these groups generally appear to have more barriers to abortion knowledge and access than more educated women, partly due to their limited language comprehension abilities.

- Include husbands and community leaders in the target audience for awareness raising campaigns on safe abortion.
- Abortion access programs should consider the needs of women that cannot read or that have limited literacy when designing their informational materials,
- Ensure equal access to program materials for all women.

9. List of references

Cockrill, K, Upadhyay U, Turan J, Foster D. (2013). The Stigma of Having an Abortion: Development of a Scale and Characteristics of Women Experiencing Abortion Stigma. *Perspectives on Sexual and Reproductive Health*, 45: 79-88.

Economic and Social Commission for Asia and the Pacific (ESCAP). (2016). *Statistical Yearbook for Asia and the Pacific 2015*. Bangkok, Thailand: Economic and Social Commission for Asia and the Pacific. [https://www.unescap.org/sites/default/files/SYB2015_Full_Publication.pdf. Accessed 16 Oct. 2018]

Ipas. (2015). SABAS E-15: The stigmatizing attitudes, beliefs and actions scale. Chapel Hill, NC, USA: Ipas. [https://ipas.azureedge.net/files/SABASE15-StigmatizingAttitudesBeliefsActionsScale.pdf. Accessed 02 Oct. 2018]

Ministry of Health. (2016). *Fast Track Initiative Road Map for Reducing Maternal & Newborn Mortality: 2016-2020*. Phnom Penh, Cambodia: MOH.

Ministry of Health. (2017). *National Strategy for Reproductive and Sexual Health in Cambodia 2017-2020*. Phnom Penh, Cambodia: MOH.

National Institute of Statistics, Directorate General for Health, and ICF International. (2015). *Cambodia Demographic and Health Survey 2014.* Phnom Penh, Cambodia, and Rockville, Maryland, USA: National Institute of Statistics, Directorate General for Health, and ICF International.

Partnering to Save Lives (PSL). (2016). *Endline Survey and Evaluation of Reproductive, Maternal and Neonatal Health Knowledge, Attitudes and Practices among Garment Factory Workers*. Phnom Penh, Cambodia: Partnering to Save Lives.

Sea Change Program. The Individual Level Abortion Stigma Scale. Oakland, CA, USA: The Sea Change Program. [https://daks2k3a4ib2z.cloudfront.net/58dbdbdd9253572852dfd9f4/59407d-3b0a970119608f200f_Using%20the%20Individual%20Level%20Abortion%20Stigma%20Scale.pdf. Accessed 02 October 2018]

Shellenberg, KM, Levandowski, B, Hessini, L. (2014). Developing a scale to measure stigmatizing attitudes and beliefs about women who have abortions: Results from Ghana and Zambia. *Women & Health*. Vol. 54, Issue 7, Pages 599-616.

Sotheary, K, *et al*. (2017). Abortion choices among women in Cambodia after introduction of a socially marketed medicated abortion product. *International Journal of Gynaecology and Obstetrics*. Vol. 136, Issue 2, Pages 205-209.

Washington Group on Disability Statistics. (2006). *Overview of Implementation Protocols for Testing the Washington Group Short Set of Questions on Disability.* Maryland, USA: National Center for Health Statistics, Centers for Disease Control and Prevention.

Washington Group on Disability Statistics. (2017). *Analytic Guidelines: Creating Disability Identifiers Using the Washington Group Short Set (WG-SS) SPSS Syntax*. Maryland, USA: National Center for Health Statistics, Centers for Disease Control and Prevention.

World Bank. (2014). Cambodia - Out-of-pocket health expenditure. [tradingeconomics.com/cambodia/out-of-pocket-health-expenditure-percent-of-total-expenditure-on-health-wb-data.html. Accessed 20 Nov. 2018]

10. APPENDICES

1. *Appendix 1: Wealth Index*

The index used to estimate household wealth is computed from basic information on socio-economic characteristics of households.

We categorised respondents into three groups to assess possible inequities in health. Cut-off values are percentile values of a wealth score computed on the sample.

We defined wealth categories (poorest, poor and better off) using the following data: housing type and rooms, assets, animals, and toilets. Interviewers also observed and ranked each household in three categories, from poorest to richest. We then used the algorithm below to attribute points for each answer and compute a wealth score for each respondent using the formula below.

Housing type index (from 0 to 4):
4 if they have a brick or concrete house;
3 if they have a wooden house and tiled roof;
2 if they have a wooden house and a tin roof;
1 if they have a wooden house with palm leaf roof;
0 if they have a house of palm leaves/thatched roof.

Room index (from 1-3):
3 if they have more than 2 rooms for sleeping;
2 if they have 2 rooms for sleeping;
1 if they have 1 room for sleeping.

Asset index (from 0 to 4):
4 if they have a car and/or tuk-tuk;
3 if they have a boat and/or ox-cart and/or motorbike;
2 if they have a TV, bicycle and/or refrigerator;
1 if they have a radio/phone;
0 if they have none of the above.

Toilet index (from 0-3):
3 if two or more toilets;
2 if one toilet;
1 if share with another family;
0 if no toilets.

Animal ownership index:
The value of animal ownership was calculated by using the following formula:
Animal = round(poultry/2+(pig+goat)/2+(cow+buffalo+horse)/2)

Subjective wealth category (as rated by surveyor):
2 if least poor group;
1 if middle group;
0 if poorest group.

The wealth score is computed by adding the computed values of house type, animals, assets, toilets and subjective wealth category:

Wealth Score = housing index(0-4) *+ room index*(1-3) *+ asset index*(0-4) *+ subjective wealth index*(0-2) *+ animal index*(0-3) *+ toilet index*(0-3)

Scores range from 1 to a maximum of 19 points. We then establish two cut-off points, such that the "Poorest" category corresponds as closely as possible to the lowest quintile (20%), and the "Better-off" category corresponds to the highest quintile (20%).

2. *Appendix 2: Specific indicator table*

This annex includes the disaggregation for specific baseline indicators of abortion, stigma, discrimination and contraceptive/sexual confidence, disaggregated by six key metrics:

- Urban/rural location;
- Age;
- Education;
- Wealth group;
- Marital status;
- Disability.

Statistically significant differences between sub-groups have been indicated with an asterisk (*) where relevant.

	Urban/rural		**Age**			**Education**			**Marital status**		**Wealth group**			**Disability**	
	Urban	**Rural**	**15-24**	**25-34**	**35-49**	**No education**	**Primary**	**Secondary and higher**	**Never married**	**Ever married/ partnered**	**Poorest**	**Medium**	**Better-off**	**No serious disability**	**Serious disability**
Number of abortion laws known, mean	3.53*	3.27*	3.32*	3.61*	3.07*	3.06*	3.12*	3.80*	3.29*	3.33*	2.99*	3.23*	3.76*	3.43*	2.40*
WRA that know at least one safe abortion provider	48.1%*	55.4%*	53.5%*	47.7%*	59.5%*	43.8%*	50.7%*	64.9%*	54.4%*	53.8%*	51.2%*	53.1%*	57.8%*	53.5%*	57.6%*
Contraceptive decision-making score, mean	4.38*	4.24*	3.88*	4.44*	4.37*	4.22*	4.29*	4.25*	3.59*	4.39*	4.21*	4.31*	4.23*	4.31*	3.86*
Sexual decision-making score, mean	4.18*	4.24*	4.11*	4.41*	4.15*	4.12*	4.17*	4.39*	4.05*	4.26*	4.37*	4.14*	4.27*	4.26*	4.02*
Female SABAS score, mean	2.27*	2.34*	2.39	2.20*	2.39	2.30*	2.32*	2.35*	2.44*	2.30*	2.36*	2.33*	2.30*	2.31*	2.45*

	Urban/rural		Age			Education			Marital status		Wealth group			Disability	
	Urban	**Rural**	**15-24**	**25-34**	**35-49**	**No education**	**Primary**	**Secondary and higher**	**Never married**	**Ever married/ partnered**	**Poorest**	**Medium**	**Better-off**	**No serious disability**	**Serious disability**
Negative stereotyping	2.83*	2.91*	2.90*	2.86*	2.92*	2.76*	2.84*	3.05*	2.96*	2.88*	2.78*	2.91*	2.96*	2.87*	3.10*
Exclusion & discrimination	1.75*	1.87*	1.97*	1.64*	1.93*	1.89*	1.88*	1.77*	2.03*	1.80*	1.98*	1.84*	1.73*	1.84*	1.89*
Fear of contagion	1.98*	1.93*	2.03	1.75*	2.03	2.02*	1.95*	1.87*	1.98*	1.93*	2.05*	1.93*	1.84*	1.92*	2.06*
ILAS score, mean†	1.53*	1.59*	1.45*	1.62*	1.57*	1.69*	1.54*	1.59*	--	1.57	1.64*	1.44*	1.77*	1.55*	1.93*
Worries of judgment	0.74*	1.04*	0.92*	1.12*	0.85*	1.18*	0.99*	0.81*	--	0.961	1.30*	0.76*	1.09*	0.90*	1.86*
Isolation	1.90*	1.66*	1.42*	1.65*	1.85*	1.64*	1.62*	1.98*	--	1.72	1.88*	1.57*	1.90*	1.77*	1.11*
Self-judgment	1.74*	2.15*	1.81*	1.99*	2.12*	2.20*	2.00*	2.05*	--	2.04	1.66*	2.00*	2.37*	2.01*	2.47*
Community condemnation	2.63*	1.89*	2.53*	2.32*	1.83*	2.40*	2.09*	1.98*	--	2.09	2.05*	2.04*	2.22*	2.01*	3.33*
Any CAC abortions†	**67.8%***	**56.7%***	**73.2%***	**59.8%***	**56.7%***	**40.2%***	**53.6%***	**81.2%***	**0.0%***	**59.7%***	**60.9%***	**50.1%***	**76.3%***	**56.9%***	**100.0%***

** Statistically significant difference (p<0.05).*
† Among women that reported having any abortions (n=57).

3. *Appendix 3: Quantitative questionnaire*

Province:				Kampot 7 Siem Reap 17 Other (specify) 88	
District:					
Commune:					
Village:					
CAPI: If >49 or <15, skip to RESULT and code 8 "Respondent ineligible" Q1. How old are you? **Only women age 15-49 are eligible for study. If older than 49 or younger than 15, skip to RESULT and code 8 "Respondent ineligible"**				Age (years):	
Wealth Ranking *(please record your observation)*				Poorest 0 Medium 1 Better off 2	
House type *(please record your observation)*				House palm leaves/thatched roof 0 Wooden house/palm leaves roof 1 Wooden house/tin roof 2 Wooden house/tiled roof 3 Brick or concrete house 4	
	1st attempt	1st appointment	2nd attempt	2nd appointment	3rd attempt
Date	/ /18	/ /18	/ /18	/ /18	/ /18
Time					
Location					
Interviewer					
Result Codes - Circle the correct code					
Completed					1
Incomplete-respondent termination					2
Incomplete-third party interruption					3
Respondent refusal					4
Parent/ administrator/ husband refusal					5
Respondent absent at 2nd appointment					6
Cannot interview respondent. e.g. mute/deaf/mental health etc					7
Respondent not eligible **CAPI: Only if AGE <15 or >49**					8

INFORMED CONSENT

I am (Your name) working for Angkor Research in collaboration with RHAC and ARROW, and with the support of the Ministry of Health. We are conducting a survey of women in Cambodia. The purpose of this survey is to assess women's knowledge, attitudes and practices about reproductive health services in Cambodia. Your house was randomly selected for the survey. We would like to request your cooperation for approximately 30 minutes to ask you some questions.

I would like to ask you some questions about yourself and your community. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important. What you tell me will be kept strictly confidential. We won't share your information with anyone. Please be totally truthful in your responses. Your participation is very important and will help our partners to improve health services for women in Cambodia. You can refuse to answer any question that you don't want to answer, or to pause or terminate the interview at any time.

If you have any questions about this research or the survey, you can contact the Angkor Research administrator, Khim Sarun, on 023 222 501.

Do you have any questions for me?

CONSENT	Do you agree to be interviewed? **If NO, skip to RESULT and code 4.**	Do not agree **(Skip to RESULT)** Agree	0 1

Section 1: Socio-demographics			
1	Have you ever been to school?	No (**Skip to Q3**) **Yes**	0 1
2	What is the highest grade you completed? **Grade number. Code 13 if university level.**	Grade:	
3	What is your current marital status?	Single and **NOT** in a regular relationship **(Skip to Q5)** Single in regular relationship Married **(Skip to Q5)** Widowed/ Divorced **(Skip to Q5)**	1 2 3 4
4	**CAPI: If Q3=2 (Single in regular relationship).** Are you currently living with your boyfriend/sweet-heart?	No **Yes**	0 1
5	What is your religion?	Buddhist Muslim Christian Other (Specify)	1 2 3 88

6	Are you currently pregnant?	No Yes Don't know	0 1 99
Section 2: Household Assets, Wealth and Debt ***Now, we would like to ask you some questions about the income and assets in your household.***			
7	What is the main source of income in your household?	Farming/Fishing Labour/Factory work Government work NGO/Business work Own business (shop/seller) Other (specify)	1 2 3 4 5 88
8	How much money did **your household** earn from all sources of income in the last 12 months? ***Code -99 if don't know.***	KHR:	
9	Please tell me how much money your household made from each different source in the last 12 months: **Check that they don't repeat the same income for multiple different sources.** **Code 0 if no income from that source in the last year.** **Code -99 if don't know.**	A. Income from agriculture (KHR): B. Income from businesses (KHR): C. Income from husband/head of household (KHR) D. Income from other family members (KHR) E. Income from any other sources (KHR):	
10	In the last 12 months, have you done any jobs or activities to make money?	No (skip to Q13) Yes	0 1
11	**CAPI: If Q10 =1(yes).** In the last 12 months, what was your primary woress work	Farming/Fishing Labour/Factory work Government work NGO/Business work Own business (shop/seller) Other (specify)	1 2 3 4 5 88
12	**CAPI: If Q10 =1(yes).** How much money did you make from all jobs/activities in the last 12 months? ***All income sources. Check that income in Q9 is not repeated.*** ***Code -99 if don't know.***	KHR:	
13	How many rooms in your house are used for sleeping?	Number:	

14	How many toilets does your house have?	Not have/field Share with other family One toilet Two or more	0 1 2 3
15	Which assets do your family own? **Prompt by reading the list. Multiple answers possible.** **Circle all answers given/Check your own observations as well.**	None listed Radio Television Bicycle Refrigerator Motorcycle Ox cart Boat Car / Koyun Tuk-tuk/PassApp Mobile phone	0 1 2 3 4 5 6 7 8 9 10
16	Does your family own any of the following farm animals? **Multiple answers possible. Prompt by reading the list and record each animal owned. Check that they do not mind the animals for someone else.**	Cattle Buffalo Horse Pig Sheep Goat Chicken Duck Quail None listed	1 2 3 4 5 6 7 8 9 10
17	Does your family own this house and the land it is on? **"Family" means the immediate family (father, mother, children). If yes, check that the house is not owned by an extended family member (grandparent, cousin, uncle/aunt, etc.).**	No Yes	0 1
18	Besides this house, does anyone in your family own any land? **"Family" means the immediate family (father, mother, children). If yes, check that the house is not owned by an extended family member (grandparent, cousin, uncle/aunt, etc.).**	No Yes	0 1
19	**CAPI: If Q17=1 OR Q18=1.** What is the total area of all land your family owns?	Are(s)	

Section 3. Disability (Washington Group short module) ***Now, I would like to ask some questions about your general health. The next questions ask about difficulties you may have doing certain activities because of a health problem. Please tell me if you have no difficulty, some difficulty, a lot of difficulty, or if you cannot do at all.***			
20	Do you have difficulty seeing, even if wearing glasses?	No difficulty Yes, some difficulty Yes, a lot of difficulty Yes, cannot do it at all	0 1 2 3
21	Do you have difficulty hearing, even if using a hearing aid?	No difficulty Yes, some difficulty Yes, a lot of difficulty Yes, cannot do it at all	0 1 2 3
22	Do you have difficulty walking or climbing stairs?	No difficulty Yes, some difficulty Yes, a lot of difficulty Yes, cannot do it at all	0 1 2 3
23	Do you have difficulty remembering or concentrating?	No difficulty Yes, some difficulty Yes, a lot of difficulty Yes, cannot do it at all	0 1 2 3
24	Do you have difficulty with self-care, such as washing all over or dressing?	No difficulty Yes, some difficulty Yes, a lot of difficulty Yes, cannot do it at all	0 1 2 3
25	Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?	No difficulty Yes, some difficulty Yes, a lot of difficulty Yes, cannot do it at all	0 1 2 3

Section 4: Media access and use ***Now, I want to ask you some questions about how you access information.***			
26	Do you have a mobile phone?	No **(skip to Q28)** Yes	0 1
27	**CAPI: If Q26 = 1 (yes). Check answer with Q15_10 (household mobile phone ownership).** Do you have a mobile phone that you can use to access the internet?	No Yes	0 1
28	Do you access any forms of media, like newspapers, radio, TV or internet at least once per week?	No (**Skip to Q31**) Yes	0 1
29	Which forms of media do you access at least once per week? **Multiple answers possible. Read each type of media and check if they access it.**	Radio Television Printed newspapers Printed magazines Internet Facebook Other (specify)	1 2 3 4 5 6 88
30	**CAPI: Only show codes selected in Q29 above.** Which form of media do you access the most? **Only one answer.**	Radio Television Printed newspapers Printed magazines Internet Facebook Other (specify)	1 2 3 4 5 6 88
Now, I want to show you some cards with different sources of information. **Give respondent the cards for information sources. Read the question, and then ask them to rate from 1-10 and get the cards with answers back. Number in order from 1 to 10 by asking and answering the following question.**			
31	Which sources of information do you use to get information on women's health and reproductive health? The next source? **Rank all answers from 1-10, with 1 being most used and 10 being least used.** **If women report not accessing information on reproductive health, ask them to rank sources by trustworthiness or quality of information.**	Family, friend, colleague Local authority (village chief, deputy village chief for women's affairs, etc.) Village Health Support Group Village Women's Group Medical staff (doctor, nurse, etc.) TV Radio Facebook / Social media Internet Leaflet / banner / T-shirt	

Section 5: Reproductive health knowledge, attitudes and practices			
32	From one menstrual period to the next, are there certain days when a woman is more likely to become pregnant if she has sexual intercourse?	No **(Skip to Q34)** Don't know **(Skip to Q34)** Yes	0 1 99
33	**CAPI: If Q32 =1.** Is this time just before her period begins, during her period, right after her period has ended, or halfway between two periods?	Just before her period begins During her period Right after her period Halfway between two periods Other (specify) Don't know	1 2 3 4 88 99
34	Have you ever heard about contraception (things that a man or woman can do to stop the woman from becoming pregnant)?	No **(skip to Q36)** Yes	0 1
35	**CAPI: If Q34=1.** What contraceptive methods have you heard of? **Multiple response possible. After each response, ask "*Do you know any other methods?*"**	Female sterilisation (Ligation/tubectomy) Male sterilisation (vasectomy) IUD Injection Implant Daily pill Monthly pill Condom (male) Condom (female) Emergency contraception Lactic Amenorrhoea Method Calendar/Rhythm method Withdrawal Abstinence Other (specify)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 88
36	Have you ever been sexually active?	No **(Skip to Q39)** Yes No answer	0 1 77
37	Have you ever used any methods of contraception?	No **(Skip to Q39)** Yes	0 1
38	**CAPI: If Q37 =1.** Which contraceptive methods have you used?	Female sterilisation (Ligation/tubectomy) Male sterilisation (vasectomy) IUD Injection Implant Daily pill Monthly pill	1 2 3 4 5 6 7

38	**Multiple response possible. After each response, ask *"Have you ever used any other method?"***	Condom (male) Condom (female) Emergency contraception Lactic Amenorrhoea Method Calendar/Rhythm method Withdrawal Abstinence Other (specify)	8 9 10 11 12 13 14 88
Section 6. Sexual and reproductive health rights ***Now I am going to ask you some questions about how confident or sure you are that you could use family planning if you wanted to do so. Even if you do not have a husband/partner, or do not want to use family planning right now, try to imagine sometime in the future when you might wish to use it.***			
How sure are you that you could:			
39	***How Sure are you that you could:*** ...Bring up the topoic of family planning with your husband or partner? **Prompt.**	Not at all sure Somewhat unsure Neither sure/Unsure Somewhat sure Completely sure	1 2 3 4 5
40	***How sure are you that you could:*** …Tell your husband (or partner) that you wanted to use family planning? **Prompt.**	Not at all sure Somewhat unsure Neither sure/Unsure Somewhat sure Completely sure	1 2 3 4 5
41	***How sure are you that you could:*** …Use family planning? **Prompt.**	Not at all sure Somewhat unsure Neither sure/Unsure Somewhat sure Completely sure	1 2 3 4 5
42	***How sure are you that you could:*** …Use family planning, even if your husband (or partner) did not want to? **Prompt.**	Not at all sure Somewhat unsure Neither sure/Unsure Somewhat sure Completely sure	1 2 3 4 5
43	Would you say that using contraception is mainly your decision, mainly your husband's/partner's decision, or did you both decide together?	Mainly respondent Mainly husband/partner Respondent and husband/partner jointly Other (specify)	1 2 3 88
The next questions ask about decision making for your health care. Please let us know about your current situation.			

44	Who usually makes decisions on when you can go to seek **reproductive health care**, for example, if you experience a painful or burning sensation when urinating?	Mainly respondent Mainly husband/partner Respondent and husband/partner jointly Other (specify)	1 2 3 88
45	Who usually makes decisions about **health care** for yourself: you, your husband/partner, you and your husband/partner jointly, or someone else?	Mainly respondent Mainly husband/partner Respondent and husband/partner jointly Other (specify)	1 2 3 88
Now I am going to ask you some questions about whether you feel you can refuse to have sex in certain situations. Even if you are not in a relationship right now, try to imagine a time when you might be in a relationship. Your answers will be kept completely secret and you don't have to answer questions you don't want to.			
How sure are you that you could refuse to have sex with your husband or partner:			
46	…When you don't want to, but he does? **Prompt.**	Not at all sure Somewhat unsure Unsure Somewhat sure Completely sure	1 2 3 4 5
47	…When you are tired? **Prompt.**	Not at all sure Somewhat unsure Unsure Somewhat sure Completely sure	1 2 3 4 5
48	…When he gets angry with you if you don't want to? **Prompt.**	Not at all sure Somewhat unsure Unsure Somewhat sure Completely sure	1 2 3 4 5
49	…When he threatens to hurt you if you don't want to? **Prompt.**	Not at all sure Somewhat unsure Unsure Somewhat sure Completely sure	1 2 3 4 5
50	…When he threatens to have sex with other women if you don't want to? **Prompt.**	Not at all sure Somewhat unsure Unsure Somewhat sure Completely sure	1 2 3 4 5
Section 7: Abortion knowledge and decision-making			
51	Do you think there are laws in Cambodia that give a woman the right to have an abortion?	No Yes Don't know **(skip to Q56)**	0 1 99

Legality of abortion ***In each of the following situations, please tell me whether you think an abortion is legal or illegal in Cambodia in this situation:***			
52	**CAPI: If Q51=0 OR 1.** Within the first 12 weeks of the pregnancy?	Legal Illegal Don't know	1 2 99
53	**CAPI: If Q51=0 OR 1.** When a woman is raped and gets pregnant?	Legal Illegal Don't know	1 2 99
54	**CAPI: If Q51=0 OR 1.** When the mother's life is at risk?	Legal Illegal Don't know	1 2 99
55	**CAPI: If Q51=0 OR 1.** When the fetus has some problems or does not develop normally?	Legal Illegal Don't know	1 2 99
56	Is it legal or illegal for **doctors** to provide abortions in Cambodia?	Legal Illegal Don't know	1 2 99
57	Is it legal or illegal for **hospitals and clinics** to provide abortions in Cambodia?	Legal Illegal Don't know	1 2 99
58	Do you know where women can access safe abortion services?	No **(Skip to Q60)** Yes	0 1
59	**CAPI: Only if Q58 =1.** Where can women access safe abortion services? **Multiple response possible.**	Public health provider Private health provider NGO clinic Pharmacy Traditional birth attendant (TBA) Other (specify)	1 2 3 4 5 88
60	If a woman had an abortion, do you think they would be very likely, somewhat likely, somewhat unlikely, or very unlikely to be arrested by the police? **Prompt answers.**	Very likely Somewhat likely Somewhat unlikely Very unlikely	4 3 2 1
61	If a midwife, nurse or doctor performed an abortion, do you think they would be very likely, somewhat likely, somewhat unlikely, or very unlikely to be arrested by the police? **Prompt answers.**	Very likely Somewhat likely Somewhat unlikely Very unlikely	4 3 2 1
62	**CAPI: If Q6=0 or 99 (not currently pregnant)** Imagine that you become pregnant. Are there any circumstances when you would decide to have an	No **(Skip to Q66)** Yes No answer **(Skip to Q66)**	0 1 99

63	**CAPI: Only if Q62 =1 AND Q6=0 or 99 (not currently pregnant).** What circumstances would prompt you to decide to have an abortion? **Multiple responses possible. Prompt.**	Unplanned pregnancy Contraceptive method failed Not married Do not want children at this time Do not have enough money to support the child Have too many children already Separated from husband/partner Was raped and got pregnant Fetus is not healthy; miscarriage; stillbirth Other (specify)	1 2 3 4 5 6 7 8 9 88
64	**CAPI: Only if Q62 =1 AND Q6=0 or 99 (not currently pregnant).** If you decided to have an abortion, where would you go to have the abortion?	National hospital (PP) Provincial hospital Referral hospital (RH) Health center or health post Military hospital Private hospital Private clinic/cabinet NGO facility Pharmacy/drug store Traditional birth attendant (TBA) Kru Khmer Other (specify)	1 2 3 4 5 6 7 8 9 10 11 88
65	**CAPI: Only if Q62 =1 AND Q6=0 or 99 (not currently pregnant).** If you needed to have an abortion, who would mainly make the decision about **having an abortion**: you, your husband/partner, you and your husband/partner jointly, or someone else?	Mainly respondent Mainly husband/partner Respondent and husband/partner jointly Other (specify)	1 2 3 88
Section 8: Experience with Abortion and Post-abortion Care ***Now, we would like to ask some questions about your personal thoughts and experiences with abortion. We will keep all information confidential. You can refuse to answer any question that you do not want to answer, and you can pause or stop the interview at any time.***			
66	Do you know anyone that has ever had an abortion?	No Yes	0 1
67	Have you ever had an abortion?	No **(Skip to Q97)** Yes	0 1
68	**CAPI: If Q67=1. Limit range >0.** How many times have you had an abortion?	Times:	

Abortion Roster. **Complete each question below for each abortion mentioned in Q68, above.** ***Please provide us with some information about each abortion that you experienced, starting with the oldest and going to the most recent.***		
69	**CAPI: Limit range 0-40.** How many years ago was the abortion? **If this year, code 0. If don't know, code -99.**	Years before now:
70	**CAPI: Range 1-9 and -99.** How many months' pregnant were you when you had the abortion? **If don't know, code -99.**	Months:
71	**H**ow was the abortion performed? **Multiple answers possible.**	Vacuum aspiration 1 Medical abortion pill 2 Traditional method 3 Self-aborted 4 Other (specify) 88 Don't know 99
72	Did anyone help you to initiate the abortion?	No **(skip to Q74)** 0 Yes 1
73	**CAPI: Only if Q72 = 1.** Who helped you to initiate this abortion? **Multiple answers possible.**	Doctor or Medical Assistant 1 Nurse 2 Midwife 3 Traditional birth attendant 4 Pharmacist 5 Kru Khmer 6 Relative/Friend 7 Other (specify) 88
74	Where did this abortion take place?	National hospital (PP) 1 Provincial hospital 2 Referral hospital (RH) 3 Health center or health post 4 Military hospital 5 Private hospital 6 Private clinic/cabinet 7 NGO facility 8 Pharmacy/drug store 9 Your home 10 Other home 11 Other (specify) 88

75	Was anyone present to help you at the time of the abortion? **Multiple answers possible. Record all persons assisting.**	No one	0
		Doctor or Medical Assistant	1
		Nurse	2
		Midwife	3
		Traditional birth attendant	4
		Pharmacist	5
		Kru Khmer	6
		Relative/Friend	7
		Other (specify)	88
76	Did you experience any problems after this abortion?	No **(skip to Q81)**	0
		Yes	1
77	**CAPI: If Q76=1.** What problems did you experience? **Multiple answers possible.**	Heavy bleeding	1
		Loss of consciousness	2
		Abdominal pain or cramps	3
		High fever	4
		Amenorrhea	5
		Other (specify)	88
78	**CAPI: If Q76=1.** Did you seek help from someone to take care of these problems?	No **(skip to Q81)**	0
		Yes	1
79	**CAPI: If Q78=1.** Who did you seek help from? **Multiple answers possible.**	Doctor or Medical Assistant	1
		Nurse	2
		Midwife	3
		Traditional birth attendant	4
		Pharmacist	5
		Kru Khmer	6
		Relative/Friend	7
		Other (specify)	88
80	**CAPI: If Q78=1.** Where did you receive this help?	National hospital (PP)	1
		Provincial hospital	2
		Referral hospital (RH)	3
		Health center or health post	4
		Military hospital	5
		Private hospital	6
		Private clinic/cabinet	7
		NGO facility	8
		Pharmacy/drug store	9
		Your home	10
		Other home	11
		Other (specify)	88
81	Did you spend money for **this abortion and related services**?	No **(Skip to Q85**)	0
		Yes	1

82	How much money did you spend for **fees for abortion-related services**? ***Includes costs of medicines, doctor's visits, etc. for the abortion.*** ***-99 = Don't know or don't remember***	Riel:
83	How much money did you spend for **fees for post-abortion services**? ***Includes costs of post-abortion care (e.g., follow-up visits, medicines, etc.).*** ***-99 = Don't know or don't remember***	Riel:
84	How much money did you spend for **transport for all abortion-related services**? ***-99 = Don't know or don't remember***	Riel:
85	Why did you decide to have this abortion at *[LOCATION IN Q74]*? **Multiple response.**	Trust in the medical staff 1 Good skill of the medical staff 2 Good reputation of the facility 3 Good reputation of the medical staff 4 Can use HEF card or insurance 5 Low cost 6 Convenient / Close to my house 7 Private / No one knows me there 8 Far away from my house/village 9 Other (specify) 88
86	**CAPI: If Q72=1 OR Q75=1 (someone assisted with abortion)** Did any of the people that assisted with your abortion discuss your contraception choices with you within 14 days after you had the abortion?	No **(Skip to Q88)** 0 Yes 1
87	**CAPI: If Q86=1.** Which methods did they talk to you about? ***Do not prompt. Multiple response.***	Female sterilization 1 Male sterilization 2 IUD 3 Injection 4 Implant 5 Daily pills 6 Monthly pills 7 Condom (male) 8 Female condom 9 Emergency contraception 10 Lactational amenorrhea method 11 Rhythm method 12 Withdrawal 13 Abstinence 14 Other (specify) 88

88	Did **anyone** discuss your contraception choices with you within 14 days after you had the abortion?	No **(Skip to Q90)** Yes	0 1
89	**CAPI: If Q88=1.** Which methods did they talk to you about? ***Do not prompt. Multiple response.***	Female sterilization Male sterilization IUD Injection Implant Daily pills Monthly pills Condom (male) Female condom Emergency contraception Lactational amenorrhea method Rhythm method Withdrawal Abstinence Other (specify)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 88
90	Did you start to use any contraceptive method within 14 days of the abortion?	No **(Skip to Q93)** Yes	0 1
91	**CAPI: If Q90 =1.** Which method**s** did you use? **Multiple answers possible. Do not prompt.**	Female sterilization Male sterilization IUD Injection Implant Daily pills Monthly pills Condom (male) Female condom Emergency contraception Lactational amenorrhea method Rhythm method Withdrawal Abstinence Other (specify)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 88
CAPI: END Abortion Roster. ***Complete questions below only for the MOST RECENT ABORTION mentioned in the abortion roster, above.***			
		Unplanned pregnancy Contraceptive method failed Not married Do not want children at this time	1 2 3 4

92	For your most recent abortion, what was the primary reason you decided to have an abortion?	Do not have enough money to support the child	5
		Have too many children already	6
		Separated from husband/partner	7
		Was raped and got pregnant	8
		Fetus is not healthy; miscarriage; stillbirth	9
		Other (specify)	88
93	**Before** your most recent abortion, did you talk with anyone about having an abortion before you decided	No **(skip to Q95)**	0
		Yes	1
94	**CAPI: If Q93 = 1.** Who did you talk with **before** your most recent abortion? **Multiple response possible. Do not prompt.**	Husband, boyfriend, partner	1
		Other family, friend, colleague	2
		Local authority (village chief, deputy village chief for women's affairs, etc.)	3
		Village Health Support Group	4
		Village Women's Group	5
		Medical staff (doctor, nurse, etc.)	6
		Other (specify)	88
95	**After** your most recent abortion, did you tell anyone about the abortion?	No **(skip to Q97)**	0
		Yes	1
96	**CAPI: If Q95 = 1.** Who did you talk with **after** your most recent abortion? **Multiple response possible. Do not prompt.**	Husband, boyfriend, partner	1
		Other family, friend, colleague	2
		Local authority (village chief, deputy village chief for women's affairs, etc.)	3
		Village Health Support Group	4
		Village Women's Group	5
		Medical staff (doctor, nurse, etc.)	6
		Other (specify)	88

Section 9: Individual Level Abortion Stigma Scale (ILAS)

The first 7 questions in the ILAS are to be asked to all women in the study. The remaining questions in ILAS are only to be asked to women that have had at least one abortion.

CAPI: Only for women that have had at least one abortion (if Q67 =1).

FOR WOMEN WITH AN ABORTION, READ THE FOLLOWING STATEMENT:

The following questions are about the things you worried about around the time of your most recent abortion. For each statement, please tell me if you were not worried, a little worried, somewhat worried, or very worried.

CAPI: For women that have not had an abortion (if Q67 =0).

FOR WOMEN WITHOUT AN ABORTION, READ THE FOLLOWING STATEMENT:

Please imagine if you were to have an abortion. The following questions are things you may worry about if you were to have an abortion. For each statement, please tell me if you were not worried, a little worried, somewhat worried, or very worried.

97	1. Other people might find out about my abortion. **Prompt.**	Not worried A little worried Somewhat worried Very worried No answer	1 2 3 4 0
98	2. My abortion would negatively affect my relationship with someone I love. **Prompt.**	Not worried A little worried Somewhat worried Very worried No answer	1 2 3 4 0
99	3. I would disappoint someone I love. **Prompt.**	Not worried A little worried Somewhat worried Very worried No answer	1 2 3 4 0
100	4. I would be humiliated. **Prompt.**	Not worried A little worried Somewhat worried Very worried No answer	1 2 3 4 0
101	5. People would gossip about me. **Prompt.**	Not worried A little worried Somewhat worried Very worried No answer	1 2 3 4 0
102	6. I would be rejected by someone I love. **Prompt.**	Not worried A little worried Somewhat worried Very worried No answer	1 2 3 4 0
103	7. People would judge me negatively. **Prompt.**	Not worried A little worried Somewhat worried Very worried No answer	1 2 3 4 0

CAPI: Only if Q 67=1.

FOR WOMEN WITH AN ABORTION ONLY,

The following questions are about talking to your close friends and relatives about your most recent abortion. Think about your most recent abortion. Make the selection that best describes your experience.

104	8. I have had a conversation with someone I am close with about my abortion. **Prompt.**	Never Once More than once Many times No answer	1 2 3 4 0
105	9. I was open with someone that I am close with about my feelings about my abortion. **Prompt.**	Never Once More than once Many times No answer	1 2 3 4 0
106	10. I felt the support of someone that I am close with at the time of my abortion. **Prompt.**	Never Once More than once Many times No answer	1 2 3 4 0
107	11. I can talk to the people I am close with about my abortion. **Prompt.**	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree No answer	5 4 3 2 1 0
108	12. I can trust the people I am close to with information about my abortion. **Prompt.**	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree No answer	5 4 3 2 1 0
109	13. When I had my abortion, I felt supported by the people I was close with. **Prompt.**	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree No answer	5 4 3 2 1 0
The following questions are about how you felt around the time of your most recent abortion. Please make the selection that best describes your feelings.			
110	14. I felt like a bad person. **Prompt.**	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree No answer	5 4 3 2 1 0

111	15. I felt confident I had made the right decision. **Prompt.**	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree No answer	5 4 3 2 1 0
112	16. I felt ashamed about my abortion. **Prompt.**	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree No answer	5 4 3 2 1 0
113	17. I felt selfish. **Prompt.**	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree No answer	5 4 3 2 1 0
114	18. I felt guilty. **Prompt.**	Strongly agree Agree Neither agree nor disagree Disagree Strongly disagree No answer	5 4 3 2 1 0
The following questions are about the community you lived in around the time of your most recent abortion. How many people in your community held the following beliefs:			
115	19. Abortion is always wrong? **Prompt.**	No one A few people About half of people Many people Most people No answer	1 2 3 4 5 0
116	20. Abortion is the same as murder? **Prompt.** **CAPI: After this question, skip to Q901 FOR ALL WOMEN WITH ABORTION.**	No one A few people About half of people Many people Most people No answer	1 2 3 4 5 0

Section 10: Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS) CAPI: Only if Q67 =0 (women that have not had an abortion). *Please indicate how much you agree or disagree with the following statements:*			
117	1. A woman who has an abortion is committing a sin. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
118	2. Once a woman has one abortion, she will make it a habit **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
119	3. A woman who has had an abortion cannot be trusted. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
120	4. A woman who has an abortion brings shame to her family **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
121	5. The health of a woman who has an abortion is never as good as it was before the abortion. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
122	6. A woman who has had an abortion might encourage other women to get abortions. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0

123	7. A woman who has an abortion is a bad mother. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
124	8. A woman who has an abortion brings shame to her community. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
125	9. A woman who has had an abortion should be prohibited from going to religious services. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
126	10. I would tease a woman who has had an abortion so that she will be ashamed about her decision. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
127	11. I would try to disgrace a woman in my community if I found out she'd had an abortion. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
128	12. A man should not marry a woman who has had an abortion because she may not be able to bear children. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
129	13. I would stop being friends with someone if I found out that she had an abortion. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0

130	14. I would point my fingers at a woman who had an abortion so that other people would know what she has done. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
131	15. A woman who has an abortion should be treated the same as everyone else. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
132	16. A woman who has an abortion can make other people fall ill or get sick. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
133	17. A woman who has an abortion should be isolated from other people in the community for at least 1 month after having an abortion.	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
134	18. If a man has sex with a woman who has had an abortion, he will become infected with a disease. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
135	Doctors and midwives who perform abortions in a clinic are committing a sin. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
136	Doctors and midwives who perform abortions should go to jail. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0

137	Kru khmer who help women terminate a pregnancy should go to jail. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
138	Doctors and midwives who perform abortions are murderers. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
139	Abortion is always wrong. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
140	Abortion is the same as murder. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0

901	Thank you very much for your time today. We might need to contact you again in the future to confirm your answers or find out some more details. Would it be ok if we contact you by phone?	No **(skip to COMMENTS)** Yes	0 1
902	What is your phone number?	Number:	
903	Do you have a second phone number?	No **(skip to COMMENTS)** Yes	0 1
904	What is your second phone number?	Number:	
COMMENTS	**INTERVIEWER NOTES OR OPINIONS:** **Please note anything unusual or interesting about the interview.**		
THANK YOU FOR YOUR PARTICIPATION IN THIS INTERVIEW !			

4. *Appendix 4: FGD guide*

PROVINCE:				Kampot 7 Siem Reap 17 Other (specify) 88	
DISTRICT:					
COMMUNE:					
VILLAGE:					
FGD TYPE:				Women age 15-24 1 Women age 25-49 2 Husband of respondent 3 Mother-in-law of respondent 4	
PARTICIPANTS (# of people)				Number:	
	1st attempt	1st appointment	2nd attempt	2nd appointment	3rd attempt
Date	/ /18	/ /18	/ /18	/ /18	/ /18
Time					
Location					
Interviewer					

INFORMED CONSENT

I am (Your name) working for Angkor Research in collaboration with RHAC and ARROW, and with the support of the Ministry of Health. We are conducting a survey of women in Cambodia. The purpose of this survey is to assess women's knowledge, attitudes and practices about reproductive health services in Cambodia. You were selected for the survey based on your position in the community. We would like to request your cooperation for approximately **one hour** to ask you some questions **in a group**.

I would like to ask you some questions about yourself and your community. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important. What you tell me will be kept strictly confidential. We won't share your information with anyone. Please be totally truthful in your responses. Your participation is very important and will help our partners to improve health services for women in Cambodia. You can refuse to answer any question that you don't want to answer, pause or stop participating in the discussion at any time.

If you have any questions about this research or the survey, you can contact the Angkor Research administrator, Khim Sarun, on 023 222 501.

Do you have any questions for me?

CONSENT	***Ask every participant:*** Do you agree to participate? **If NO, let that participant leave the group before continuing to ask questions.**	Number agree: Number not agree:

Respondent Characteristics				
	AGE Years	**SEX** Male=0 Female=1	**What is the highest grade that you completed?** 0 – No school; 1-12 – Grade; 13 – University	**What is the main source of income in your household?** 1 – Farming/fishing 2 – Labour/factory work 3 – Government work 4 – NGO/Business work 5 – Own business (shop/seller) 88 – Other (specify)
Participant 1				
Participant 2				
Participant 3				
Participant 4				
Participant 5				
Participant 6				
Participant 7				
Participant 8				
Participant 9				
Participant 10				

RMNH Participation

1. What do you think that sexual and reproductive health means? Do you think that women have a right to sexual and reproductive health?
    a. Why do you think this?
2. Do you think that women should have the right to access abortion?
    a. Why do you think this?
3. Do you think that the right to have an abortion should be considered part of women's sexual and reproductive health rights?
    a. Why do you think this?

Understanding and Views of Abortion

4. What do you think is the view of Cambodian culture on abortion? Is it acceptable or unacceptable

in Cambodian culture?
    a. Why do you think this?
5. How do people in your village feel about abortion?
    a. Why do you think they feel this way?
6. How does your family feel about abortion?
    a. Why do you think they feel this way?
7. Do you know, in what situations are abortions legal in Cambodia? For example, if the mother is raped or the baby is not healthy.

Understanding and Views on Women that have Abortions

8. What kinds of situations would cause a woman to want an abortion? Can you think of any?
9. Are there certain types of women that are more likely to have an abortion?
    a. If yes, which types of women do you think are more likely to have an abortion? (Example: young women, factory workers, married women, etc.)
10. Can any woman needing/intending to have an abortion take the decision by herself?
    a. If no, what is the decision-making process?
11. Is it viewed differently if a married woman has an abortion than if a single woman has an abortion?
    a. How is it viewed differently?
12. Are women that have abortions treated differently?
    a. In what ways are they treated differently in their village?
    b. In what ways are they treated differently in their family?
    a. In what ways are they treated differently at work?
    b. In what ways are they treated differently at the facility where they receive the abortion?
13. Do some people think women that have abortions are committing a sin?
    a. If yes, why do some people think this?
14. Do some people think that a woman should be punished or not punished for having an abortion?
    a. If yes, what do they think that punishment should be?
    b. If no, why?

Understandings and Views on Abortion Access and Providers

15. Do you think that women should have access to safe abortion services?
    a. Why do you think this?
16. How accessible do you think abortion services are in your community?
17. What are the most common barriers to women accessing safe abortion services in your community? (Example: price, distance, time, cultural discrimination, etc.)
18. Do you think all women in Cambodia have equal access to safe abortion services? How about illiterate, rural, poor, marginalized or unmarried women?
19. Do you know of any women that wanted to have a safe abortion, but were not able to?
    a. Why were they not able to access safe abortion services?
    b. What did they do instead?
20. Are women able to access medical care after an abortion?
    a. If no, why?
21. How do you think doctors and other medical staff in this community feel about abortion? Is this a common view? Or are there others who may feel differently?
22. Are medical providers that perform abortions treated differently?
    c. If yes, in what ways are they treated differently in their village?
    c. If yes, in what ways are they treated differently in their family?

d. If yes, in what ways are they treated differently at work?

23. Do some people think medical providers that perform abortions have any physical or mental problems as a result of performing abortions?
    a. If yes, what kind of problems do they have? If no, why?
24. Do some people think medical providers that perform abortions are committing a sin?
    a. If yes, why do they think this?
25. Do you know any medical providers that perform abortions?
    a. If yes, are these medical providers treated differently by yourself or your community?
    b. If yes, how are they treated differently?
    c. Do they have any other problems that you know of?

Recommendations

26. Do you think that access to safe abortion services for women should be improved?
    a. If yes, what are some ways that women's access to safe abortion services can be improved?
27. Do you think there are ways that the discrimination against women that have abortions can be reduced?
    a. If yes, what are some ways that discrimination against women can be reduced?
28. Do you think there are ways that the discrimination against medical providers that perform abortions can be reduced?
    a. If yes, what are some ways that stigma and discrimination against medical providers can be reduced?

COMMENTS	**INTERVIEWER NOTES OR OPINIONS:** **Please note anything unusual or interesting about the interview.**
THANK YOU FOR YOUR PARTICIPATION IN THIS INTERVIEW!	

5. *Appendix 5: IDI guide*

PROVINCE:	Kampot 7 Siem Reap 17 Other (specify) 88
DISTRICT:	
COMMUNE:	
VILLAGE:	
AGE:	Years:
SEX:	Male 0 Female 1
POSITION:	Public health provider 1 High school teacher 2 Local authority 3
JOB:	Job title:

	1st attempt	1st appointment	2nd attempt	2nd appointment	3rd attempt
Date	/ /18	/ /18	/ /18	/ /18	/ /18
Time					
Location					
Interviewer					

Result Codes - Circle the correct code	
Completed	1
Incomplete-respondent termination	2
Incomplete-third party interruption	3
Respondent refusal	4
Parent/ administrator/ husband refusal	5
Respondent absent at 2nd appointment	6
Cannot interview respondent. e.g. mute/deaf/mental health etc	7

INFORMED CONSENT

I am (Your name) working for Angkor Research in collaboration with RHAC and ARROW, and with the support of the Ministry of Health. We are conducting a survey of women in Cambodia. The purpose of this survey is to assess women's knowledge, attitudes and practices about reproductive health services in Cambodia. You were selected for the survey based on your position in the community. We would like to request your cooperation for approximately 30 minutes to ask you some questions.

I would like to ask you some questions about yourself and your community. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important. What you tell me will be kept strictly confidential. We won't share your information with anyone. Please be totally truthful in your responses. Your participation is very important and will help our partners to improve health services for women in Cambodia. You can refuse to answer any question that you don't want to answer, or to pause or terminate the interview at any time.

If you have any questions about this research or the survey, you can contact the Angkor Research administrator, Khim Sarun, on 023 222 501.

Do you have any questions for me?

CONSENT	Do you agree to be interviewed? **If NO, skip to RESULT and code 4.**	Do not agree **(Skip to RESULT)** Agree	0 1

Respondent Characteristics		
1	Education level (last grade, or last professional course completed):	
2	Number of years worked in this job:	Years:
RMNH Participation		
3	What do you think that sexual and reproductive health means? Do you think that women have a right to sexual and reproductive health? Why do you think this?	
4	Do you think that women should have the right to access abortion? Why do you think this?	
Understanding and Views of Abortion		

5	Do you think abortion is acceptable or unacceptable in Cambodian culture? Why do you think this?
6	Do you know if abortion is legal or illegal in Cambodia?
7	Do you know, in what situations are abortions legal in Cambodia? For example, if the mother is raped or the baby is not healthy.
Understanding and Views on Women that have Abortions	
8	What kinds of situations would cause a woman to want an abortion? Can you think of any?
9	Can any woman needing/intending to have an abortion take the decision by herself? If no, what is the decision-making process?
10	How do you think **other people in this community** feel about women who have abortions?
11	Are **women that have abortions** treated differently? a. In what ways are they treated differently in their **village**? b. In what ways are they treated differently in their **family**? c. In what ways are they treated differently at **work**? d. In what ways are they treated differently at the **facility where they receive the abortion**?
12	How do you feel about women who have abortions?
	a. Have you ever treated a woman that had an abortion differently from other women? How did you treat them differently? Why did you treat them differently?
13	Do you think **women that have abortions** are committing a sin? If yes, why do you think this?
Understandings and Views on Abortion Access and Providers	
14	Do you think that women should have access to safe abortion services? Why do you think this? If no, why?
15	How accessible do you think abortion services are in your community?
16	What are the most common barriers to women accessing safe abortion services in Cambodia? (Example: price, distance, time, cultural discrimination, etc.)
17	Do you think all women in Cambodia have equal access to safe abortion services? How about illiterate, rural, poor, marginalized or unmarried women?

18	Are women able to access medical care after an abortion? If no, why?
19	Do you think medical providers that perform abortions have any physical or mental problems as a result of performing abortions? If yes, what kind of problems do you think they have?
20	Do you think medical providers that perform abortions are committing a sin? If yes, why do you think this?
21	Do you know any medical providers that perform **legal** abortions? If yes, are these medical providers treated differently by yourself or your community? If yes, how are they treated differently? If no, why not? Do they have any other problems or challenges faced that you know of? What are they?
22	Do you know any medical providers that perform illegal or unsafe abortions? If yes, are these medical providers treated differently by yourself or your community? If yes, how are they treated differently? If no, why not? Do they have any other problems or challenges faced that you know of? What are they?

Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS) Please indicate how much you agree or disagree with the following statements:			
23	1. A woman who has an abortion is committing a sin. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
24	2. Once a woman has one abortion, she will make it a habit **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
25	3. A woman who has had an abortion cannot be trusted. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0

26	4. A woman who has an abortion brings shame to her family **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
27	5. The health of a woman who has an abortion is never as good as it was before the abortion. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
28	6. A woman who has had an abortion might encourage other women to get abortions. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
29	7. A woman who has an abortion is a bad mother. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
30	8. A woman who has an abortion brings shame to her community. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
31	9. A woman who has had an abortion should be prohibited from going to religious services. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
32	10. I would tease a woman who has had an abortion so that she will be ashamed about her decision. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree	5 4 3 2 1

		No answer	0
33	11. I would try to disgrace a woman in my community if I found out she'd had an abortion. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
34	12. A man should not marry a woman who has had an abortion because she may not be able to bear children. Prompt.	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
35	13. I would stop being friends with someone if I found out that she had an abortion. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
36	14. I would point my fingers at a woman who had an abortion so that other people would know what she has done. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
37	15. A woman who has an abortion should be treated the same as everyone else. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
38	16. A woman who has an abortion can make other people fall ill or get sick. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0

39	17. A woman who has an abortion should be isolated from other people in the community for at least 1 month after having an abortion. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0
40	18. If a man has sex with a woman who has had an abortion, he will become infected with a disease. **Prompt.**	Strongly agree Agree Unsure Disagree Strongly disagree No answer	5 4 3 2 1 0

Recommendations	
	If the respondent thinks that women should have access to safe and hygienic abortion services (Q15 = YES):
41	Do you think there are ways that access can be improved for safe abortion services? If yes, what are some ways that women's access to safe abortion services can be improved?
42	Do you think there are ways that the discrimination against women that have abortions can be reduced? a. If yes, what are some ways that stigma and discrimination against women can be reduced?
43	Do you think there are ways that the discrimination **against medical providers that perform abortions** can be reduced? If yes, what are some ways that stigma and discrimination against **medical providers** can be reduced?

COMMENTS	INTERVIEWER NOTES OR OPINIONS: Please note anything unusual or interesting about the interview.
THANK YOU FOR YOUR PARTICIPATION IN THIS INTERVIEW!	