

Advanced Medical Science – International Health (01518)

**“No need to spend
time on them,
they are useless”**

**The specific needs, perceptions and
vulnerabilities of and surrounding pregnant
women who use drugs in Phnom Penh,
Cambodia.**

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Abstract

This study took place in Phnom Penh, Cambodia and explored the specific needs and perceptions and subsequently the vulnerabilities that pregnant women who use drugs experience in their day-to-day life. Women who use drugs make up 6.5% of all people who use drugs in Cambodia, and NGO Friends-International identified an increase in the number of pregnant women accessing their various programs and services. The study involved 18 participant interviews with women who use(d) drugs during their pregnancy and 21 interviews with key informants from various organisations in Cambodia, conducted in January and February 2011. Oral consent was obtained to preserve the identities of participants and KIs. Thematic analysis of transcripts identified that women who use drugs during pregnancy have needs associated with survival on the street, harm reduction, and reintegration into their community. In addition to these general needs, pregnant women who use drugs also have specific needs concerning their health and that of their unborn child. Stigma in the community and discrimination towards pregnant women who use drugs was also identified. Contributing factors to the vulnerability of women who use drugs during pregnancy were fear of or actual arrest, influence of partner and the status of women in Cambodian society according to the “Chbap Srey”.

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Abbreviations and Acronyms

ATS - Amphetamine-type stimulants

FI – Friends-International

IDI – In-Depth Interview

KI – Key Informant

KII – Key Informant Interview

MS – Mith Samlanh

NGO – Non-Government Organisation

PWID – People who inject drugs

PWUD – People who use (illicit) drugs

SMO – Sun and Moon Organisation

WWID – Women who inject drugs

WWUD – Women who use (illicit) drugs

Definition of Terms

Ice – Crystalline Methamphetamine (smoked or injected)

Khmer – As a noun, the Cambodian language, or as an adjective, Cambodian.

Yama – Methamphetamine in pill form (may be swallowed or smoked)

INTRODUCTION

Research Question

“What are the specific needs, perceptions and vulnerabilities of and surrounding pregnant women who use drugs in Phnom Penh, Cambodia?”

Rationale

This project was suggested by FI after a noted increase in the number of pregnant WWUD in their services. Relevant literature and awareness concerning pregnant WWUD in development settings is currently lacking.

Aims and objectives

This study aims to contribute to the gap in information and current literature in Cambodia surrounding pregnant WWUD by beginning;

- To investigate the specific needs of WWUD whilst pregnant in Cambodia;
- To explore the perceptions, knowledge, attitudes and practices of pregnant WWUD surrounding their drug use and the health impacts to themselves and their unborn baby;
- To explore the opinions, experiences, attitudes and practices of health care professionals and NGO workers towards pregnant WWUD
- To determine the vulnerabilities that exist for pregnant WWUD; and
- To provide Friends-International with helpful information to tailor existing programs to better support WWUD who become pregnant.

CHAPTER 1: BACKGROUND

1.1 Cambodia (context and history)

The Kingdom of Cambodia is a country in South-East Asia with a population of 13.4 million people, eighty per cent of whom live in rural areas. (1) It borders Thailand, Laos and Vietnam, three of the four major players in the Golden Triangle of opium production and trade, which means Cambodia is frequently affected by drug trafficking routes.

Cambodia has a tragic history, including the reign of the Khmer Rouge under Pol Pot and the following events that resulted in the massacre of over a fifth of the country's population. (2) During the Pol Pot regime, many health professionals were killed and this has led to widespread skill shortages and gaps in technical capacity that negatively impact the current health system in Cambodia. (3, 4)

1.2 Maternal Health in Cambodia

Cambodia is one of seventy-five countries where 97% of worldwide maternal deaths occur. In 2008, women in Cambodia had a lifetime risk of maternal death as high as 1 in 110. (5) In 2005, it had a maternal mortality rate of 450 per 100000 live births. Contributing factors were anaemia, malnutrition and frequent unsafe abortions (3)

1.2.1 Barriers to access

For women in general in Cambodia, there are several reasons why a pregnant woman would not go to a health service for antenatal care or delivery. These include (but are certainly not limited to) financial reasons such as “unofficial user fees” (3) the cost of time and loss of income that results from visiting a health service and misconceptions or beliefs about the services available and perceived ill-treatment by health-care providers. (6) This study endeavours to determine whether a pregnant woman’s drug-using status also increases perceived or real barriers to accessing health care services.

1.3 Global impact of drugs

Illicit drug use is a worldwide problem. The United Nations Office on Drugs and Crime (UNODC) estimates that around the world, between 155 and 250 million people had used an illicit substance in the past year. (7) It is estimated that around 16 million people inject drugs around the world, but it is not possible to get an exact prevalence rate for people who use drugs (PWUD) due to the lack of accurate reporting systems in place. (8) However, it is known that drug use is a major global problem. The most commonly used illicit substance worldwide is cannabis, which makes up a large majority of all situations of drug use, followed by amphetamine-type stimulants (ATS), cocaine and opiates. (7)

1.3.1 Illicit drug use in Cambodia

Drug use in Cambodia is a fairly recent phenomenon and has appeared to escalate significantly over the past decade. Changes to drug trafficking routes (9) and Cambodia’s porous borders, as well as the country’s economic status (9) are

believed to be contributing to its rising drug problem. Previously cannabis, it is now methamphetamine in the tablet form, known as “yama” that is most commonly the drug of choice, (9, 10) Cheap ATS have become readily available in Cambodia. ATS encompasses methamphetamine in both crystalline (“ice”) and tablet (“yama”) forms, amphetamine (“speed”), methcathinone and ecstasy-group substances, (10) but the latter three are less commonly used in Cambodia.(9) In Phnom Penh, methamphetamine tablets are reportedly most common, (11) but crystalline methamphetamine is rapidly gaining popularity since its introduction to Cambodia in 2005. (12) Inhalants, opiates (especially heroin) and other injectable drugs, such as benzodiazepines, have been reported to be on the increase too. (9) Methamphetamine, such as yama or ice, is mostly consumed by swallowing or smoking, but injection is becoming more prevalent.(13) The first clandestine Cambodian methamphetamine laboratory was found in the province of Kampong Speu in the first half of 2007, (10) and many more have been found since. (14)

1.3.2 People who use illicit drugs

In Cambodia, young people make up an overwhelming majority of people who use illicit drugs (PWUD); with people under 25 years of age contributing about 80% of the population of PWUD. Of these young people, many are under 18, and some are as young as eight years old. About half of the young people living on the streets of Phnom Penh regularly use illicit drugs. (15) Eighty-one per cent of PWUD in Cambodia use methamphetamine in some form. Ninety-four per cent of drug related arrests were for methamphetamine and of these, most involved methamphetamine pills. However, the crystalline form of methamphetamine is becoming increasingly prevalent amongst PWUD in Cambodia. (10) Injecting crystalline methamphetamine,

as with any injecting drug, can expose injectors to HIV, Hepatitis C and other blood-borne infections. Approximately 25% of people who inject drugs (PWID) in the community are HIV positive and rates of sharing needles at last injection were at around 35%. (16)

1.3.3 Women who use illicit drugs

Women who use drugs (WWUD) make up 6.5% of all PWUD in Cambodia. (9, 16) Although prevalence of drug use is higher among males than females, (13) there has been a recent increase in the number of WWUD (7) and as a result, there are more women in need of specific drug services than previously believed. (17) WWUD experience both stigma and hostility from their society at large and their families, and this makes it more difficult to access the available services such as methadone maintenance and other harm reduction programs.

“The stigma attached to women's drug and alcohol use has been documented throughout the world. Hostile attitudes promote sexual and physical abuse of women drug users, suggesting that those who use drugs do not deserve respect.” (17)

There has been little research done on WWUD in developing countries. It has been acknowledged, however, that male-dominated services present a significant barrier to women who wish to access them. (18) Women who inject drugs (WWID) are particularly vulnerable to HIV, Hepatitis C and other infections, as they are often the last in line to use shared injecting equipment and are commonly injected by others. (17) It has also been found that women are biologically more susceptible to addiction and bodily harm associated with drug use. (19) Specific support services are

required to cater for WWUD, including places specifically and exclusively available for women to access. (20)

1.3.4 Pregnant women who use illicit drugs

There is scant research literature available on WWUD during pregnancy in developing countries. The literature available is based in countries of the Western world, and mostly quantitative, determining the physiological and physical effect of illicit drugs on the foetus, especially injecting drug use. (21-26) The use of illicit drugs during pregnancy is thought to lead to negative impacts on foetal development (24) but exact effects have not been definitively established as they have for licit drugs such as tobacco and alcohol. (25) It is unclear if it is the effects of the drugs, the lifestyle associated with drug use or the social risk factors that often contribute to drug use such as poverty, unemployment and no education that is responsible for these outcomes. (26) There is a lot of stigma surrounding illicit drug use during pregnancy, across the world. If present in Cambodia, this may be responsible for pregnant WWUD not accessing services such as drug treatment or antenatal care (17) or it may be that these services either do not exist, do not meet the needs of WWUD or that WWUD are unfamiliar with these services.

1.4 Support services for people who use illicit drugs

There are many organisations in Phnom Penh that have direct or indirect contact with PWUD, be they focussed or incidental. The majority of drug services are provided by Non-Government Organisations (NGOs), and many target PWUD who have overlapping risk with other at-risk populations such as entertainment workers and street-based populations.(9) There are two NGOs in Phnom Penh that play

important roles of providing services for drug-using populations, Mith Samlanh and Korsang.

Mith Samlanh (MS), when it was initiated by Friends-International (FI) in Cambodia in 1993, was a leader in developing services for young PWUD. MS became a Cambodian NGO in 2003, with its own 250 staff and Board of Directors, and receives technical assistance and ongoing support from FI. The drug services offered now include harm reduction programs such as needle and syringe exchanges; health education and promotion; and detoxification and rehabilitation for young PWUD. FI has contributed, along with concerned international institutions, to the development of governmental policies in response to the situations that many children and youth find themselves in, including an official national policy on harm reduction. (27) FI also provides technical support to other programs, such as Kaliyan Mith in the Chum Chao district of Phnom Penh, and other NGOs such as Sun & Moon Organization (SMO).

Korsang is a small Cambodian program that began in late 2004, organised and run by a group of Cambodian Americans who were deported from the USA. The program's focus is on risk reduction and prevention of HIV amongst drug users in Phnom Penh. (28) In July 2010, a section available only to women and children at the Korsang drop-in centre was made available, and this provides them a safe place during the day or at night. (18)

CHAPTER 2: METHODS

2.1 Study Design

This study used a qualitative research design to meet the study aims. Data collection was conducted from 6 January 2011 to 7 February 2011, in Phnom Penh, Cambodia, in conjunction with FI. The researcher conducted 18 semi-structured in-depth interviews (IDIs) with participants and 21 semi-structured key informant interviews (KIIs) with various NGO workers at differing levels within organisations, and of differing nationalities. Where KIs felt comfortable, interviews were conducted in English. For grassroots workers and participants, a Khmer-English interpreter was used. Each interview was between thirty minutes and one hour in duration. For the interviews that were audio-recorded, all English was transcribed and used in thematic analysis of data. For interviews not audio-recorded, handwritten notes were taken, typed up and also used in thematic analysis.

2.2 Inclusion Criteria and Recruitment

2.2.1 In-depth interviews

Eighteen interviews were conducted with female drug users between 18 and 31 years of age, who were pregnant or had a history of recent pregnancy. “Recent” was originally considered to be in the last 5 years, but one participant had a single

pregnancy 10 years ago. Participants were recruited directly by staff members at MS and other partner organisations of FI from existing participants in their programs, by purposive sampling. The researcher also visited the Korsang Women's Centre to directly recruit participants from the women living in the centre. The interview process and the purpose of the research project were explained to eligible women in the centre, and these women volunteered to share their experiences, one by one, with the researcher and the interpreter. Study information was shared and oral consent was obtained before each individual interview.

2.2.2 Key Informant Interviews

Key informants (KI) were people who work with services or sectors relevant to the study, whether that be firsthand or through their implementing partners. For the most part, the KIs in this study were from various NGOs, including 9 interviews with staff from MS. The 21 KIIs were designed to get important, qualitative, in-depth information from people with particular knowledge and understanding about pregnant WWUD in Phnom Penh. KIs were suggested by supervisors at FI and the Nossal Institute and also by other KIs. Some potential KIs were sent emails by supervisors or other KIs introducing the researcher and they were followed up by the researcher herself; others were telephoned directly by other KIs or supervisors; still more were recruited directly by staff members at MS based on their experience. Three potential KIs did not respond to either emails or telephone calls from the researcher or were not able to be interviewed for the study.

2.3 Data Collection Process

2.3.1 Data Collection Tools

Before any field work could begin, a number of data collection tools were devised.

2.3.1.1 Question Guides

Question guides were drafted for participants and KIs. The participant question guide was piloted in Khmer, and the KI guide in English. Feedback from piloting was used to revise question guides. Both sets of pilot responses were included in this study.

Both guides were translated to Khmer by staff members at FI and given to the interpreter, along with an English copy, to ensure the quality of the translation and that the meanings of the questions were accurate. (see Appendix 3 and 4 for question guides)

2.3.1.2 Plain Language Statement

A plain language statement explaining the purpose and the principles of the project was devised. (see Appendix 2) This provided the participants and KIs with information about the voluntary and confidential nature of the study and that they would be in no way disadvantaged if they choose to not participate. This statement was translated from English to Khmer and back-translated by a different company to ensure the correct translation. The statement was also proof-read by several FI staff, in both Khmer and English. The statement was provided in English or Khmer as preferred for KIs to read and keep, and was read in Khmer to participants by the interpreter and a copy provided for them at their wish to keep.

2.3.1.3 Consent Forms

The interviewer obtained consent from each participant and KI, and did so after the plain language statement had been read. Once the researcher and the interpreter

were satisfied that the participant or KI understood that there were no right or wrong answers; that their participation would not disadvantage them in any way (nor would it result in direct action), consent was sought. (see Appendix 1) Due to issues concerning the illegality of the participants' behaviour, the recording of names or signatures could have resulted in women declining to participate for fear of being detained by law enforcement, so verbal consent was obtained and noted by the interviewer. Names and identities of KIs were also preserved by obtaining verbal consent in the same manner as for participants.

2.3.1.4 Interviews

IDIs with participants were conducted to obtain first-hand information from pregnant WWUD in Phnom Penh. Information sought included but was not limited to the participants' perceptions surrounding their drug use and how they were treated in health facilities, the effects of drug use on their unborn child, and how they thought the community perceived them. KIs were conducted to identify barriers associated with pregnant WWUD accessing services, including stigma and discrimination. KIs also gave an overview of services available in Cambodia and gave suggestions for what needs to be done to improve them.

The researcher conducted all interviews. The interviews in English were conducted alone. The interviews in the local language, Khmer, were conducted with the use of a paid and independent interpreter with no prior experience in the drug field of the NGO sector. The interpreter was briefed in Khmer by FI staff about the drug situation in Phnom Penh including street names and slang terms used to allow her to effectively communicate with the study's participants and Khmer-speaking NGO

workers. Due to the unavailability of the paid interpreter, two participant interviews were conducted with the help of a staff member who spoke English and one KII was conducted with another staff member, but the level of English knowledge in the latter circumstance made the interview difficult. The interviews took place in various venues in Phnom Penh, including various NGO headquarters, multiple MS drop-in centres and the Korsang Women's Centre.

With the participants' and KIs' permission, the interviews were audio-recorded and all the English used in the interview was later transcribed, for ease of analysis of the data. If consent was not given to audio-record the interview, the researcher took handwritten notes in English. Thirty-five of the interviews were audio-recorded, one participant and two KIs declined consent to record their interview. One KII was not recorded due to an error in operation of the recording device. For these four interviews, the researcher took handwritten notes that were later typed up to form full sentences. The researcher asked the questions following the question guide, and where applicable, the interpreter relayed the questions to the participants in the local language. If either the interpreter or the researcher felt it appropriate, she would explore issues further. Where the participants or KIs answered in Khmer, the interpreter relayed the responses to the researcher in English. As different issues came up, the semi-structured nature of the interviews allowed for flexibility in questions and exploration of topics.

A small gift of food was given to thank participants for taking the time out to attend interviews or to compensate for costs associated with attending. Some transport

costs for participants were paid by the researcher with the discretion of local staff to ensure the participants were not disadvantaged by participating in this study.

2.4 Data Analysis

Thematic analysis was performed on the transcripts of interviews for both IDIs and KIIs, separately. Based on the objectives of the study, each IDI was categorised into the headings: “Needs”, “Knowledge and Perceptions”, “Others’ Opinions” and “Vulnerabilities”, and then analysed for emerging and sub-themes. KIIs were also categorised and analysed, but due to the varied nature of the KIIs, information was used to formulate a broader picture of the study context.

2.5 Ethics

Ethical Approval for this project was sought through the Human Ethics Advisory Group at the Nossal Institute on behalf of the University of Melbourne. In-country ethical approval in Cambodia was deemed not required, as FI were satisfied with the University of Melbourne process.

CHAPTER 3: FINDINGS

These findings are qualitative in nature.

3.1 Demographic

Age (years)	18 – 32 (mean = 25.1)
No. of Reported Pregnancies	1 – 4 (mean = 1.83)
Living with partner (%)	72.2 (n = 13)
Percentage living without permanent housing (%)	77.7 (n = 14)
Most recent pregnancy planned (%)	16.7 (n = 3)
Prior knowledge about contraception (%)	66.7 (n = 12)
Reduced or quit illicit drug use at some point during pregnancy (%)	72.2 (n = 13)

Table 1: Participant Characteristics

The researcher visited four NGOs: MS, Korsang, SMO and Kaliyan Mith/FI, and interviewed eighteen female participants between 18 and 32 years (mean = 25.2 years), all of whom had a history of drug use during pregnancy in the last 10 years. All but one participant had had a pregnancy in at least the last five years. Three

women were pregnant at the time of interviewing, and where these pregnancies were included, women reported between one and four pregnancies. Seventy-two percent (n=13) had a current partner living with them, and of the twenty-eight percent (n=5) whose partner was not with them, sixty percent (n=3) said this was because he had been arrested. (see Table 1)

3.1.1 *Pregnancy and contraceptive knowledge*

Although only one sixth of women (n=3) claimed that their most recent pregnancy was planned, not all unplanned pregnancies were unwanted.

“If I have the baby so I love the baby. I did not want it but I love it.”

- 23 years

“I want the baby but I don’t have an actual plan”

- 25 years

Before pregnancy, of the seventeen women who responded, only twelve reported knowledge about contraceptive methods.

“I knew, so they told us to use condoms or to use other methods of contraception but I just forgot and I don’t know how to use it”

- 28 years

“I knew about the contraception methods, the use of condoms and the birth spacing, the injection and the use of the thing implanted [contraceptive implant]”

- 28 years

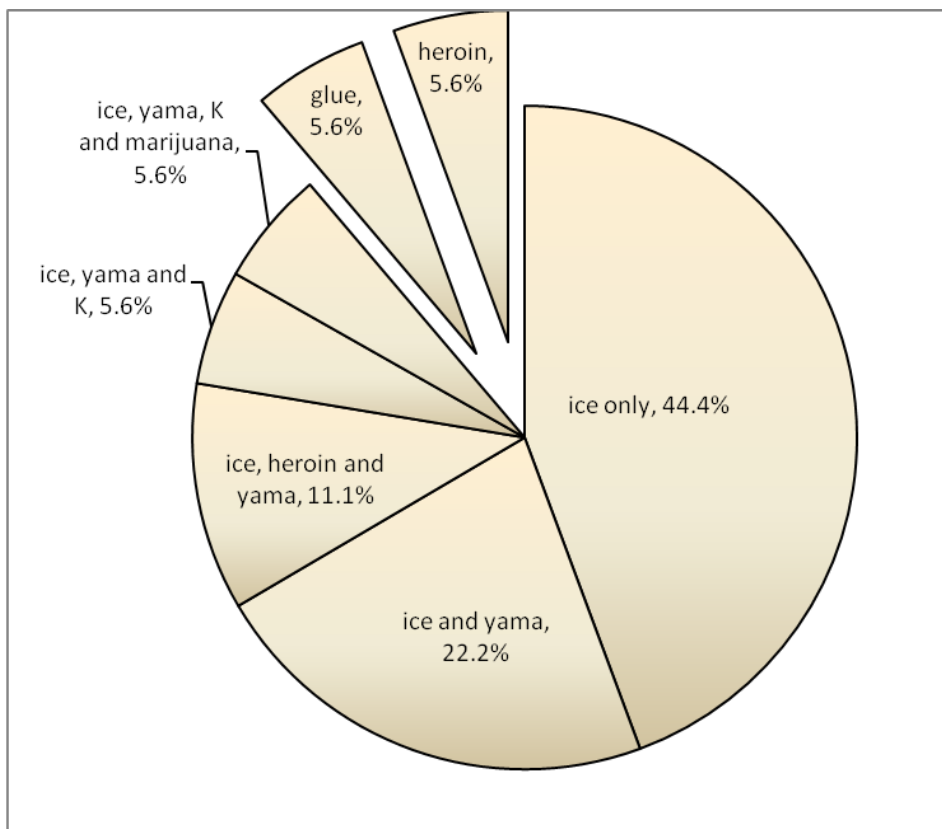
3.1.2 Drug use

All women reported using drugs at least once during their most recent pregnancy.

Over half (55.6%, n=10) claimed their reasons for initiation of drug use was ‘following friends’. Husbands were attributed in one sixth (n=3) of cases, as were nondescript ‘others’.

The use of ice was reported by 88.9% (n=16) of women. Figure 1 shows the drugs reported by participants, and the percentages of women who reported using multiple drugs. Of the two women who did not use ice, one used heroin, and one sniffed glue.

Figure 1: Reported Drugs Used



One third (n=6) of women interviewed quit drug use during their pregnancy, 27.8% (n=5) reduced, 16.7% (n=3) increased, one woman started after she found out she

was pregnant, one “cut down” and then restarted in her seventh month, one initially increased but then reduced, and one said that it depends if she has money or not.

3.2 Emergent themes

From the interviews with the eighteen participants, several themes emerged. These themes were grouped into four broader categories: *Needs, Knowledge and Perceptions, Opinions of Others, and Vulnerabilities*. The results from each theme are outlined below and subsequently interpreted in the discussion section.

3.2.1 Needs

The participants expressed a myriad of different ‘needs’, but four recurrent themes were identified. KIs expressed that pregnant WWUD have “specialist needs, both physical and mental health needs” that are not being addressed in the public health system in Cambodia.

3.2.1.1 Food

Of the women interviewed, 77.8% (n=14) claimed to lack sufficient nutritious food for themselves or for their baby during pregnancy or after delivery. As one participant noted,

“During pregnancy, the doctor told me to eat good food, that [would] provide enough vitamins for me and the baby but when I live on the street, I did not have enough money to get access to good food.”

– 19 years

Of these, two women stated that they would not have had enough food, if it weren't for what Korsang provided.

"I wish that I had enough food, good food, for me and the baby and... Korsang gave me those services, and I am thankful."

- 28 years

"When I stay in the [Korsang] centre, they provide me two meals per day and also one noodle at night."

- 28 years

An 18 year old woman, who lived at home with her family, was the only participant to state that she had *"enough"* in terms of food and nutrition during her pregnancy and after the delivery of her child, without the help of NGO services.

Several KIs at the grassroots level mentioned the pregnant women's lack of food as a particular concern, with two noting;

"What they wish for is food; [we] do not provide food."

"What can help those pregnant women is enough food with nutrition because here they have equipment, material, sanitation, they have already, but money to provide enough food, nutrition, milk, fruit, so this is what they need."

3.2.1.2 Accommodation

Three participants (16.7%) explicitly stated needs for accommodation or appropriate shelter.

“Nowadays... I do not have any proper accommodation; I just sleep in front of the hospital”

- 21 years

Of the participants, 44.4% (n=8) stay in the Korsang centre, and 33.3% (n=6) live on the streets of Phnom Penh. Only 4 women were currently home-based, which means 77.7% of the women interviewed were without a permanent shelter or place to call their own.

“I sleep here [at Korsang]. I have nowhere to stay so I have to stay here.”

- 28 years

A grassroots KI agreed that it is

“a good idea to have a place for those pregnant women to stay during the pregnancy”.

3.2.1.3 Delivery services/ check-ups

KIs noted that they had seen multiple cases where women who had had

“no medical screening or examinations during pregnancy [had] given birth in the street with no medical supervision”,

which resulted in the death of mother, baby, or both.

Of the women in this study, 88.9% (n=16) delivered their most recent baby in hospital or, of those who were pregnant at the time of interviewing, expressed plans or desires to deliver in hospital. A pregnant participant said,

“My first two children were delivered in the hospital and this one I also want to go to hospital but I don’t know whether I have enough money or not because I live on the street and it’s not sure that I have money.”

– 24 years

KIs had mixed opinions about the services on hand for pregnant WWUD.

“Normally the services are available, but the woman does not want to go unless they try to encourage or sometimes [the organisations] take them to the hospital...”

“Effective drug services to reduce vulnerability and risk are difficult to access... There are a remarkably small number of organisations that are cool about [dealing with drug users], which feeds into this whole difficulty for girls and women to be able to access services.”

Many women said that they received what they needed in terms of the delivery services at the hospital,

“I wished during delivery there was support, and I got it... I’m happy with what Mith Samlanh help me”

- 19 years

but some women felt that their needs were not completely catered for.

“...during the delivery I needed more support.”

– 21 years

KIs stated that there are obstacles to in providing ongoing care in terms of pre- and post-natal and support for WWUD as PWUD are a highly mobile population, and often women only come into contact with services when they are ready to deliver.

KIs suggested that others may move back with their families in the provinces, losing contact with urban support services.

One KI mentioned that it depends on the types of drugs used whether the women will attend health checks at the hospital, for example “those who inject [will] not want to go” but for others, for example, women who use ATS or inhalants, “it’s easy... to convince them to go to the hospital”. One KI stated that

“pregnant women who use drugs still have limited access to all those services, due to many reasons ...[because]...in theory, it’s available to everyone, but in practice the reality is not the same.”

3.2.1.4 Services after delivery

Sixty-one percent (n=11) required at least one support service post-delivery that was currently not being provided to them.

One third of women (n=6) wanted assistance to start a small business or get a job, and one specifically mentioned the MS Training Centre.

“If possible, I want some money to go back to my house in [the province] to run a small business, a small grocery in front of my house, with my family.”

- 20 years

KIs recognised this need too:

“Some want to have some vocational training skills, like hairdressing, nail-cutting, something like that, but we don’t have the service in the centre.”

Four women gave mention of a need for post-delivery health care or support with providing sufficient milk for their baby.

“Now the problem is when the baby is sick I have to send the baby to the hospital or to the medical clinic and I have to pay for the baby and I have not enough money for that.”

- 19 years

Other desired plans were for their children to go to school, for the women to return home to their families in the provinces, and for services to help them to stop using drugs.

“Maybe my children do not have a future because I am addicted, I use drugs, but I don’t want any of my children to use drugs like me, I want them to study, to be educated and not use drugs like me.”

- 26 years

3.2.2 Knowledge/ Perceptions

3.2.2.1 Of hospital / check-ups

According to one KI, Cambodians believe that “if your health is ok, so no need to go to the hospital” but among the interviewees, only 22.2% (n=4) had not yet gone to the hospital for a check-up, or did not go for the duration of their pregnancy or delivery.

One participant thought the hospital check-ups were useful during her previous pregnancy but this time was afraid of complications after taking an ‘abortion pill’ at two months gestation. At the time of interviewing, she was seven months pregnant.

“When I was two months pregnant because of the blood, I feel a bit afraid that the baby might lose a hand or leg and I did not want to go if the doctor told me like that I will feel very upset, very scared.”

– 24 years

The same woman also expressed concerns about the costs involved in attending a check-up at the hospital:

“I heard that when we go to the hospital we have to pay five dollar or 15000 [riel] and I don't have money”

KIs informed the researcher that often even the “free services” at government hospitals involve “under-the-counter” costs that some women cannot afford.

Another woman, also seven months pregnant, is similarly restricted by the potential cost of the hospital visit.

“I want to go to the hospital but I don't have money... I just want to go to the hospital to have my health check-up, I don't know when my baby is due and sometimes I feel hurt but I don't know when it will be due.”

– 26 years

One woman, eight months pregnant, had not yet gone to the doctor either, though she had been advised to go to the hospital for a check-up and felt that the service would be useful:

“I feel afraid that when I will go to the hospital they will do the injections so I am afraid of the doctor.”

– 21 years

A 30 year old participant, who has one daughter, wanted to get a health check when she was two months pregnant, but was advised by her friend that there was “no need to do that [because] whenever we deliver we deliver.” She delivered using Traditional Birth Attendants without any institutional assistance.

Over ninety percent (n=13) of the women who attended health check-ups at the hospital during their pregnancy found them to be helpful or useful.

“I think it’s helpful so we can follow the situation of my health and also the baby’s health.”

- 27 years

One participant, whose baby delivered prematurely due to an a violent assault on the street and died after leaving hospital one week later, made no comment on the quality of services she received, but said that:

“only for the first [pregnancy] that I went to the hospital [for check-ups] and the others, I did not... because I got too addicted so if I went to the hospital it took a long time and I can have the withdrawal symptoms which is difficult and also I have to work to earn some money, so I did not want to go.”

– 31 years

One KI agreed that the services at the hospital are helpful, but claimed they

“only save the children but the mother is still addicted”.

3.2.2.2 Of the effects on the baby’s health

All participants (n=18) believed drugs to have a negative effect on the baby's "health", although specific details of these effects were not always known. Some women could give multiple consequences, others did not know any. KIs were equally as varied in their descriptions of the possible effects.

- 33.3% of participants (n=6) said the baby felt "hot" when they used drugs
"It's very difficult for me, when I smoke [ice] I feels very hot in my belly so I think it's affecting the health of the baby as well."

- 21 years

"I feel like fire in my belly"

- 21 years
- 27.8% (n=5) said drugs can affect the baby's intelligence or brain
"Mith Samlanh used to educate me, if we use drugs and then if we have a baby so the baby will not be healthy, it will affect their health, their intelligence."

- 20 years
- 16.7% (n=3) said it can affect the organs in some way or another
"...I came to Mith Samlanh for a check-up and the doctor told me I should quit because if not it will affect the baby's health, and also the baby when it's born, the baby will lose one of the organs..."

- 19 years
- 22.2% (n=4) thought the baby would be weak if they used drugs during pregnancy

“I think it can affect the baby but I do not really know what. But the baby can be weak”

- 21 years

Other problems mentioned by participants were addiction, low birth weight, problems with the respiratory system and that the baby ‘stays awake’ in her womb if the mother does not sleep because she uses drugs.

One of the grassroots KIs, believed that “it is better to explain the impact on the baby and on the mother” rather than simply encouraging the women to reduce their drug use.

3.2.2.3 Information sharing between pregnant women who use drugs

Of the participants, 61.1% (n=11) claimed to “share” with other pregnant women in some way. ‘Sharing’ includes passing on information (helpful or harmful) about their experiences and effects on the baby. One KI suggested that services specific to pregnant WWUD would encourage women to “do the experience sharing, how to stop using or how to reduce the drug.” Some of the women shared in ways that could be considered ‘positive peer influence’, others shared less helpful information, which suggested widespread misconceptions about the needs of a foetus.

“Those women told me that ‘don’t eat the porridge’ or ‘don’t get up after our husband’, ‘don’t sit on the step’, ‘don’t take shower late, if not the baby will be too big and difficult to deliver’ and also I share others about this as well.”

– 26 years

“We did not really talk much, share much experience but they used to tell me to reduce [use] during pregnancy, reduce the drug during pregnancy”

- 28 years

“We did not share any experience or take care of each other, we only discussed how to get the drugs.”

- 30 years

“Drug users said when I smoke during pregnancy my colour, my skin would look healthy... My skin would look nice and my baby would look nice and healthy when I use ice.”

- 25 years

3.2.3 Opinions of others

3.2.3.1 Opinions of the community

Of the women who responded (n=15) to the question of how pregnant WWUD are viewed by the community, 86.7% (n=13) reported negative experiences.

“They hate us. They do not have any pity or sympathy on us. The community, the society hate us, they also wish for us to die soon, because they think that if we use the drugs and then if we don't have money we can do any bad things, any crime possible, so we can steal or we can rob or we can become a sex worker.”

- 30 years

Another grassroots KI, said that the community does not know enough about drug use:

“for them drugs are bad so people who use drug are also bad”.

One-third (n=5) of participants experienced sympathy from people in the community.

“They just give me sympathy, ‘ok now you are pregnant so stop using the drug, it may affect you and the baby, and how can you afford to drug and also to the baby’.”

- 20 years

Over one-quarter (26.7%, n=4) experienced both sympathy and negative experiences

“Some have sympathy, they pity on us who got pregnant and use drugs and some they discriminate us, they said ‘no need to pity on those people and if they are considerate they will not use drugs and got pregnant’ – it depends on people.”

- 27 years

The community does not like drug users in general, but according to one KI,

“The level of anger, the level of unhappiness towards women [who use drugs] might be a bit stronger than as compared to men... because people may feel that girls should behave properly...”

3.2.3.2 Opinions of health care workers at hospital check-ups

Thirteen women commented on their treatment at the hospital.

Over three-quarters (76.9%, n=10) said they were not treated any differently because of their drug use.

“I don’t feel I was treated differently and sometimes they give me sympathy, they don’t charge me.”

- 24 years

“When I went to the hospital for the check-up so my husband called his relatives to come with me so that it looked like I had family, so no one wondered, no one noticed... Normally Mith Samlanh send their people to that hospital, so the doctor treats everyone properly.”

- 23 years

Two women (15.4%) felt they were treated differently to others at the hospital.

“I feel a little bit different but they still treat me very well but maybe they also have some different view of me and especially they treat me different from other patients because they think I might have other diseases...”

- 21 years

“I feel discriminated in the hospital because when we live in Korsang and if Korsang send us to the hospital, so everyone knows that we use drugs because Korsang is helping those who use drugs.”

- 26 years

Many KI were convinced that pregnant WWUD would be discriminated against if they attempted to access health services.

“ I heard from other medical doctors, they talk about the case of drug users and got pregnant and they discriminate, they hate them, they said that after Khmer Rouge Regime, there is still drug using that destroy the society”

One KI expressed concerns that pregnant WWUD will often not “get any further than the reception” at a health care facility due to prejudice and assumptions about ability to pay, or “their appearance”, but MS helps to “prepare” the woman by making sure they shower and dress appropriately because

“if you go to the hospital and you don’t look clean, the [health professionals] will blame you or use bad words”.

3.2.4 Vulnerabilities

The above findings also contribute to the vulnerability of pregnant WWUD. Others brought to the attention of the researcher were *Arrest, Influence of Partner* and *Status of Women in Cambodian Society*.

3.2.4.1 Arrest

KIs recognised the fear among PWUD, including pregnant WWUD, that they might be arrested or detained by police if their drug-using status is disclosed. Some also saw the potential for arrest as a factor in pregnant WWUD not accessing services:

“If they go to a public health facility... and their drug using status is discovered, they’re afraid the health system will inform the police”

Almost half (44%, n=8) the women interviewed mentioned experiences with arrest by police or the Ministry of Social Affairs. According to KIs, if they are not arrested, street-based populations are constantly being ‘relocated’ by government authorities.

“...Normally the police will try to chase all those who live on the street out [of the tourist areas]”

Of these, 62.5% were women who had had a partner who had been arrested

“He was arrested and put in ‘My Chance’ centre”

- 28 years

One of the participants who lived on the street, told the researcher:

“I used to be arrested once by the police and [they] sent me to placement centre [Compulsory Detention Centre for PWUD] and my mum gave them some money to get me back.”

- 24 years

Half of the women who spoke of arrest (n=4) expressed fear of being arrested themselves.

“I am always afraid that the police will come and arrest me and put me in the placement centre. Because now at the placement centre, they have the room for females.”

- 20 years

In the circumstances where PWUD are arrested, according to KI, it is likely that:

“if they are taken to one of these compulsory drug centres, they’ll almost certainly be beaten in there.”

KIs also reported that the few women in the centres are exposed to mistreatment, including,

“abuse [and] sometimes rape.”

3.2.4.2 Influence of partner

KIs reported that partners often give little to no support to the women during their pregnancy, but if the partners are supportive, they can have a positive influence on the pregnant women’s health service-seeking behaviour.

“If the partner encourages her to go, or goes with her, so she will go.”

Most (77.8%, n=14) reported an influence of their partner of some kind in their life. Of these, half (n=7) said it was their husband who wanted the baby, not them, or claimed that he was the reason they did not use contraception.

“Mith Samlanh distribute the condoms to me and my partner but [I got pregnant] because my partner did not use, he did not want to use”

- 21 years

One third (n=6) of women interviewed reported that they followed their husband, either to the streets;

“Before I did not live on the street, but when I got married and my husband is a scavenger so I follow him and we live on the street, under the tree...”

- 28 years

into drug use;

“I saw my husband using and I used too.”

- 18 years

“Normally when our husband smokes, we live with him so we just start smoking with him.”

- 28 years

continued to use because their husband did;

“My husband and I used to go to Green House [MS Detox Centre] to detox but my husband cannot stand it, he has strong withdrawal symptoms so he escaped from

the centre and I also followed my husband. I wanted to detox and to quit but I followed my husband”

- 21 years

or were waiting for their husband to stop using drugs so they can make future plans together.

“I am waiting for my husband, he is receiving the methadone, but he has not yet quit the heroin, the injection, so I wait for him and then I plan to go back home and start up a new family with him.”

- 28 years

The influence of partners did not always have a negative impact on the women’s well-being. One sixth (n=3) of women reduced their drug use because of a partner: for two women, their husbands told them to reduce,

“My husband used to warn me but sometimes I sniff without letting him know”.

- 24 years

But for one woman, her husband did not have enough money to afford drugs for her.

“I reduce it, because my husband could not earn enough money and he is also addicted, he injects heroin, so he is more addicted so I keep the money for him to use the drugs.”

– 26 years

3.2.4.3 Status of women in Cambodian society

KIs brought the concept of “Chbap Srey” to the attention of the researcher. The “Chbap Srey” (or Women’s Code, in English) underlies Cambodian society and requires certain behaviours from the Cambodian women. According to KIs,

“In Cambodia, women they have a very important roles in the families – they need to somehow work, need to take care of the children at home, so if they use drugs, it’s very risky to children and to whole families.”

“There’s a very strong notion about what is femininity and what is supposed to be a good Khmer woman in the society. And if you’re not conformed with that image, you have a difficult time.”

KIs stated that many women including WWUD are victims of stigma, discrimination and even violence that stem from their perceived deviations from the “Chbap Srey”.

“It’s a big binary split between good girls and bad girls and you are either a bad girl or a good girl –there’s a cultural practice here called “bauk” which is a gang-rape which happens against sex workers and girls who are perceived as bad– so it’s kind of like women live in these two different worlds...”

3.2.4.4 Other vulnerabilities

Other vulnerabilities that were mentioned in discussions with KIs or participants included inadequate nutrition and its impact on the health of mother and child; the dangers associated with being a woman alone on the street; and lack of knowledge or misinformation about effects of drugs, health and other services.

CHAPTER 4: DISCUSSION

The aim of this study was to contribute to a gap in current literature surrounding pregnant WWUD in Phnom Penh, Cambodia, by way of the first four objectives. The fifth objective of this project was to make meaningful recommendations in order to inform service design in the future.

Generally, women are more vulnerable than men in Cambodian society, partly due to the expectations placed on a woman by the “Chbap Srey” and the consequences that result if a woman does not obey it. (29) Drug use is one such criterion that determines whether a woman is ‘good’ or ‘bad’, as is becoming pregnant outside a stable partnership.

The stigma in Cambodian society towards PWUD, not only WWUD, stems from lack of information or knowledge surrounding drug use and the factors that lead to drug use. The concept that PWUD are “bad” because drug use is illegal does not allow for the PWUD to be seen as “patients, not criminals” according to Prime Ministerial Decree. (14) Regionally relevant evidence suggests that people engage in drug use for a variety of reasons including the ubiquitous availability of the drug and exposure through peer networks where drugs are being used. (30) As substance dependence is considered by many as a mental illness, including the DSM-IV, (31) PWUD need

to be treated as human beings suffering from an illness, not as moral deviants.

Women are subject to higher moral standards than men in Cambodia, so while there is stigma placed upon the male population of PWUD, there will be an increased burden on the female population of PWUD as they strive to also conform to the rules of the restrictive “Chbap Srey”.

In this study, pregnant WWUD knew that their drug use could affect their unborn child, but for many, this knowledge is not a strong enough motivator to overcome a physiological or indeed a physical drug addiction. For some, encouragement from family members, the community or NGO services is enough to help them overcome their addiction. For others, more support is required, such as medical and symptomatic treatment and ‘life plans’ to ensure women can maintain their abstinence from drug use. If the factors leading to the commencement of drug use are still present, efforts at detoxification will most likely be ineffective. The Training Centre at MS, which provides vocational training to young people, is an example of a service that has long term benefits. Unfortunately, to the researcher’s knowledge, there are no similar services available to adults older than 24 years of age (the TC is for youth - under 25 years), and this was brought to the attention of the researcher by the women in this study.

Participants’ perceptions of the health services were positive, however, despite most women believing that health check-ups were useful, this was not a strong enough motivator to actually visit the hospital for many of the women interviewed in this research project. Barriers such as financial and temporal costs, including perceptions

of official or unofficial fees, such as tips, were not able to be overcome in some cases.

Interestingly, 'sharing experiences' may have both positive and negative impacts on the health of pregnant WWUD and baby. Where the sharing is well informed, for example, encouraging another woman to reduce her drug use, it could have positive impacts on the health of both the mother and the baby. Where the sharing is spurred from myths or misinformation, or how to get drugs, it could cause more harm than good. Despite all participants knowing that drugs were 'bad' for their baby, there is little accurate and definitive information available to WWUD to sufficiently explain what effects drugs have been proven to have on their unborn baby. In light of the general lack of information and the prevailing number of myths and beliefs, service providers should consider the provision of evidence-based information an important aspect of responding to the issue of pregnant WWUD in Cambodia. A study in the UK about cigarette smoking showed that despite women knowing the effects on their foetus, knowledge alone did not impact on their consumption. (21) Therefore, information alone should not be presented to pregnant WWUD, but alongside other support services to help reduce drug use and manage their future, including peer support groups and peer educators.

This study did not interview government health care workers directly, so focussed more on the pregnant women's perception of how they are treated at health facilities. It is difficult to determine the opinion of health care workers concerning pregnant WWUD as drug user status is often not disclosed. Discrimination can also happen based on a patient's ability to pay; and as NGOs often pay for services, the patient is

treated the same as any other fee-paying patient. According to KIs, the ill-treatment and prejudice of pregnant WWUD often stems not from the drug-using status (if disclosed) but from the poor hygiene and appearance of women who live on the street.

Especially for street-based women, but also more generally for PWUD, many are not thinking about their health or their future, but rather focussing on the fundamental requirements to sustain life in the 'here and now'. Many are unable to look as far into the future as tomorrow, let alone remember when their last menstrual period was or when the delivery date of their unborn child might be. It is only when a woman perceives an imminent and immediate risk to her life that she might consider seeking health services. Because of this 'here and now' mentality, the women in this study expressed needs that may have been overlooked by most KIs. Basic needs such as food and shelter were among the priority of most participants.

Based on Article 25 of the Universal Declaration of Human Rights, access to adequate nutrition and appropriate shelter is a fundamental human right. In Cambodia, many people who live on the street lack adequate food and shelter, including many pregnant WWUD despite the Declaration stating "motherhood and childhood are entitled to special care and assistance."⁽³²⁾ Maternal malnutrition may contribute to negative health effects on the foetus; (21) the pregnant woman's lack of food is not only endangering her own life, but also her unborn child's.

General health services in Cambodia are limited, so access to these services for pregnant WWUD is also limited, perhaps even to a greater extent. As many of the

grassroots KIs stated, pregnant WWUD need to be paid more attention to ensure that they are able to access all they need for themselves and their families before, during and after delivery. Pregnant WWUD are among the most vulnerable and voiceless of the Cambodian population and their needs have been long overlooked and this is the first study to illustrate this situation. In Cambodia,

“Females have been neglected by society. Pregnant women are part of that group”

- Key Informant

WWUD are at the intersection of two mistreated minorities: women in general and PWUD. Not only do pregnant WWUD have general needs such as food, accommodation and personal security, they also have the added burden of carrying and caring for a child.

The provision of a complete ‘continuum of care’ to WWUD, including ante- and post-natal care in Cambodia is a significant challenge. In a developed country like Australia, there are challenges that result in gaps in the coverage of comprehensive services. (23) One barrier to this is the mobility of PWUD, and the lack of means for NGO or health workers to contact them. Some women present to health services only when it is time to deliver. The women in this study have similar behaviours and beliefs to the women represented in a recent study on Australian WWUD during pregnancy: chaotic lifestyles, limited financial resources, and late presentation to antenatal health services, (23) which suggests the findings in this study can be generalised to the wider Cambodian population or further afield.

4.1 Limitations

The limitations to this study and attempts to eliminate them are identified below:

As the sample size was quite small, and the research undertaken was qualitative in nature, the results may not be generalisable. However, the information gathered will help to provide a broad contextual understanding of the situation specifically in Phnom Penh, and insight to potentially similar situations. It aims to provide FI with valuable information that may help to tailor existing programs to better suit the needs of the likes of women included in the study.

Obtaining access to the most vulnerable women was impractical. The women interviewed in this study were already in contact with NGOs; therefore their experiences are going to differ from the experiences of women who are not involved in NGO services.

All women interviewed had carried their pregnancies to term. Due to confidentiality issues and difficulties surrounding the identification of women who had had a spontaneous or induced abortion, no women from either of these demographics were identified or interviewed. A grassroots KI, brought to the researchers attention that there are a lot of WWUD who miscarriage within three to four months of pregnancy. Another KI also stated that “we have found that 33.2% of young Cambodian female are having induced abortion.” This creates entirely new vulnerable groups of WWUD. These women require different support for the time following the termination of the pregnancy. Future studies should aim to include these women in their target audience.

Recruiting participants depended greatly on the capacity of FI and other organisations to identify and contact women who were eligible for the study. Due to the mobility of some potential participants, staff members at MS expressed difficulty in contacting some of the women they believed to be eligible for this study. At the time of data collection, some potential participants were unable to be contacted due to routine sweeps of the streets by government officials, and some potential participants were unable to spare the time required to be interviewed for this study. Recruitment at Korsang was also limited by the opening hours of the Korsang centre as the researcher was told women leave the centre after midday.

Drug use is illegal in Cambodia, so women may have been reluctant to participate if they believed law enforcement would be involved. All possible efforts were made to ensure women were not prosecuted as a result of their participation in the study. Women were not asked to provide information that may identify them – the researcher did not request their names – and the researcher aimed to stay sufficiently low key to avoid undue attention from the Cambodian authorities.

The language barrier between the researcher and the participants and some KIs may have led to miscommunication and errors in the interpretation of data. It also limited the breadth and depth of information gathered, as subtle undertones in questions may have been 'lost in translation'. In some cases, the researcher felt that some answers were not completely relayed by the interpreter which may have been due to length of answers or other reasons.

Social desirability bias may affect data as participants may have said what they believed to be an acceptable answer, rather than the truthful response.

Bias on the part of the researcher was dealt with when developing the question guides to avoid questions that encourage the participants to respond in a certain way. Interpretation of responses will carry the bias of the interpreter as she chose which information to relay and how to relay it; or of the researcher who may not completely understand the culture in which she was conducting the interviews. Where possible, the latter was avoided by consulting with staff at FI with local knowledge.

CHAPTER 5: CONCLUSION

This study explored the specific needs and subsequently the vulnerabilities that pregnant WWUD experience in their day-to-day life. WWUD in general may have needs associated with survival on the street, including nutritious food and a safe place to stay; minimising the harm to them and others associated with their drug use; and if desired, medically supervised drug treatment services and reintegration into their community. In addition to these general needs, pregnant WWUD require more attention in NGO services and priority to health services to ensure they have access to all that they need to take care of their own health and the health of their unborn baby. Barriers to these services that must be minimised include perceived or real fees associated with health care, especially at 'free services'; temporal costs such as the money that wasn't earned because the pregnant woman had to take time off work to access a health service; and fear of mistreatment or prejudice by health care providers. Most women interviewed, in contrast to KI perceptions, had had positive experiences with staff at the government hospitals, and this could be in part due to the work MS does to improve both the hygiene and appearance of the women they come into contact with and the perceptions of the health care providers. Pregnant WWUD are physically and emotionally vulnerable and subject to stigma and discrimination in the current Cambodian society. These vulnerabilities stem from various elements of Cambodian society including the status of women, the

perceptions that PWUD are bad people, and the poor existing health system in Cambodia.

NGOs in Cambodia are currently addressing many of these issues with existing programs, but as with anything, more can be done.

5.1 Recommendations

The research team makes the following suggestions for program implementers to consider or expand upon:

- Peer support groups for (currently or previously pregnant) WWUD, facilitated by NGO (ensuring correct information is given). This could create a positive peer influence among pregnant WWUD and encourage them to make decisions that will improve their own health and the health of their unborn child
- This research has highlighted that partners have a strong influence on women's behaviour and consequently on their health, and NGOs and health workers could consider working with the partners of WWUD to improve multiple aspects of this issue. For example, education for partners about the effects drugs can have on the unborn baby, and also the impact that pregnancy can have on WWUD and encourage partners to play a role in supporting the women during their pregnancy
- Develop programs to provide pregnant women with access to healthy and nutritious food and a safe and comfortable place to stay, and work towards achieving sustainable and more permanent solutions.

- Create or extend life skills/ vocational programs for WWUD who are over 24 years to provide these women with alternate options to their drug use
- Continue to work with community members and health care providers to improve their perception of PWUD and more specifically WWUD
- Continue to consider gender as a potential barrier to accessing services and tailor programs to specifically enable women to access them

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Appendices

Appendix 1: Oral Consent Form



THE UNIVERSITY OF
MELBOURNE

Nossal Institute for Global Health

PROJECT TITLE: What are the specific needs, perceptions and vulnerabilities of and surrounding pregnant women who use drugs in Phnom Penh, Cambodia?

Name of participant: _____

Name of investigator(s): _____

1. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written plain language statement to keep.
2. I understand that after I agree to the terms in this consent form, it will be signed and retained by the interviewer.
3. I understand that my participation will involve an interview and I agree that the researcher may use the results as described in the plain language statement.
4. I acknowledge that:
 - a) the possible effects of participating in the interview have been explained to my satisfaction;
 - b) I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data I have provided;
 - c) the project is for the purpose of research;
 - d) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;
 - e) I have been informed that with my consent the interview will be audio-recorded and I understand that these recordings will be transcribed and the transcriptions will be stored at the University of Melbourne and will be destroyed after five years;
 - f) my name will be referred to by a pseudonym in any publications arising from the study;
 - g) I have been informed that a copy of the research findings will be available for me to access through Friends-International.

I consent to this interview being audio-recorded

yes **no**
(interviewer to tick)

Oral Consent given: (signed by interviewer) _____

Date: _____

Appendix 2: Plain Language Statement



An invitation to participate in a study on “the specific needs, perceptions and vulnerabilities of and surrounding pregnant women who use drugs in Phnom Penh, Cambodia”

Dear Friend,

We, Dr Nick Thomson and Dr Timothy Moore (supervisors and researchers at the Nossal Institute for Global Health), and Miss Haylee Walsh (a student of the University of Melbourne) are working with support from Friends-International to conduct the above study. The project will be the basis for Miss Walsh’s Advanced Medical Science Report, and has been approved by the Human Research Ethics Committee (HREC) at the University of Melbourne.

You are invited to participate in the above project, and we would like you to attend an interview of one hour duration. An interviewer (with the help of a Khmer-speaking interpreter as required) will ask your views and opinions concerning people who use illicit drugs and the services available to females who become pregnant while using drugs. **THERE ARE NO RIGHT OR WRONG ANSWERS IN THIS INTERVIEW.** We are interested in hearing your personal opinions and views.

EVERYTHING YOU SAY WILL BE KEPT ANONYMOUS AND CONFIDENTIAL, within the limits of the law. You do not need to give your full name. In the final report, you will be referred to by a pseudonym. We will remove any references to personal information that might allow someone to guess your identity, however, you should note that as the number of people we seek to interview is very small, it is possible that someone may still be able to identify you. With your permission, the interview will be audio-recorded so that we can ensure that we make an accurate record of what you say. After we have transcribed the interviews, the recordings will be destroyed. The transcribed data will be kept securely at the Nossal Institute for Global Health for five years from the date of publication, before being destroyed.

YOUR INVOLVEMENT IN THIS STUDY IS COMPLETELY VOLUNTARY. You may choose not to answer some questions in the interview process. You may choose to stop the interview at any stage, or to withdraw any information you have supplied provided it has not yet been processed. You are free to do this without prejudice. Your decision to participate or not, or to withdraw, will not affect your inclusion into the Friends-International programs, nor will it affect the level of treatment or support you receive in any or all of these programs. We would also like to inform you that your participation in this project will not result in any direct action or interventions.

If you would like any further information, or if you have any concerns, please do not hesitate to contact any of the researchers via the details given below. Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on tel: +61 3 8344 2073, or fax: +61 3 9347 6739.

Thank you for your time,

Miss Haylee Walsh, Dr Timothy Moore, Mr Nicholas Thomson.

HAYLEE WALSH - Student Researcher - h.walsh@ugrad.unimelb.edu.au
TIMOTHY MOORE – Principal Researcher – tim.moore@unimelb.edu.au
NICHOLAS THOMSON – Co- Researcher - nthomson@jhsph.edu

Appendix 3: Participant Question Guide

Semi-structured interview guide for women who use(d) drugs during pregnancy

1. **Please tell me a little about yourself.** *How old are you? Do you work? Do you have a husband or partner? Where is he? Does he work? Where do you live? Do you sleep on the street? How long have you been on the streets? Why did you start living on the streets? How do you feel on the streets? How are you treated by people on the streets?*
2. **Do you have any children? Have you ever been pregnant?** *Is this your first baby? How old is s/he? Do you know the father of your baby? Was this pregnancy planned?*
3. **When did you first come to MS/Korsang?** *Why did you come?*
4. **Did you use any drugs while you were pregnant?** *What types of drugs? What methods did you use? When did you first start? Why did you start? Did you use more or less while you were pregnant? Why? Was it difficult to reduce/quit? Did anyone help you?*
5. **What kind of effects do you think drugs have on an unborn baby?** *Where did you learn this?*
6. **Did you go/have you been to any services for your pregnancy?** *Why not? What, where, how often? Were they helpful? Why not? What would have been better for you? Were you treated differently because you used drugs? Who paid for these services?*
7. **Before you got pregnant, did you know how to prevent pregnancy?** *Where did you learn this? Were you using contraception when you got pregnant? Are you using contraception now?*
8. **Did/will you deliver your baby in the hospital?** *Why not? Did/Will anybody go with you? Why not? How long did you stay?*
9. **Where did you go after delivery?** *Could you go home to your family? Why not?*
10. **Will/did you start using drugs after delivery?** *Why/why not?*
11. **What do/did you need, in terms of support or services?** *During pregnancy? During delivery? After delivery? What sort of things would help a pregnant woman who uses drugs? How do you get food? Is it enough?*
12. **How do you think the general community sees pregnant women who use drugs?** *What do other people think of women who use drug during pregnancy? How are you treated by others?*
13. **Do you know other pregnant women who use drugs?** *Do you support each other? Do you share experiences?*
14. **Is there anything else you'd like to tell me?**

Thank you for your time and your responses.
Discuss here any questions that arose during the interview.

Appendix 4: Key Informant Question Guide

Semi-structured Interview with key informants

1. **What contact do you have with women who use drugs?** *How long have you had this contact? What contact do you have with pregnant women who use drugs?*
2. **What have you observed or know about drug use of women during their pregnancy?** *Age, number, types of drug...*
3. **What health services are available to pregnant women who use drugs?**
 - *Are these services helpful? Why/why not?*
 - *Are these service well used and well received by pregnant women who use drugs? By the community?*
 - *Are there any preventive services available, such as reproductive health or sexual education?*
4. **What enables or disables pregnant women who use drugs to access drug services or antenatal services?** *How are women who use drugs during pregnancy perceived and treated by health care providers?*
5. **Does pregnancy influence drug use by women?** *Do women change their drug-taking behaviour if they become aware that they are pregnant? How does pregnancy influence drug use? Is there support for women who stop using during pregnancy?*
6. **How do you think the general community perceives pregnant women who use drugs?** *What makes you think that they perceive pregnant women who use drugs in that way?*
7. **Do you know of any effects that drugs have on the unborn baby?**
8. **Are all pregnant women who use drugs accessing services?** *Why not?*
9. **Is there anything else you would like to tell me?**