Rural Women and Health Center Use, 
Staff Employment, and Health Seeking Behavior

Sompoav Meas District, 
Pursat Province

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Health Center Use In Pursat -- Sompoav Meas District

I. Purpose

This bulletin reports on the following issues pertaining to reproductive and child health care services in the Sampoav Meas Operating District of Pursat province:

- Health center operations and use by villagers residing in the center’s catchment area,
- Health center staff allocation of work time,
- The relationship between government employment and private practice,
- Health-seeking behavior patterns of village women for self- and child-health care.
- Specifically for midwives, their allocation of work time, the connection between government employment and private practice, and medium-term career aspirations.

The purpose of the this study was to gain insight into the above issues. Information from this study will help the MOH and RACHA link improvements in program planning and management at the Operating District (OD) and health center (health center) levels with community involvement in reproductive and child health (RCH) service delivery through the health centers.

A summary of key recommendations is presented in Section II. This is followed by a discussion of findings in Section III. The key points made in Sections II and are printed in bold. Annex 1 contains the scope of work for this study prepared by RACHA. Annex 2 describes procedures, data collection methods, and questionnaires developed during the course of this work.
II. Key Recommendations

A. The Key Program Implication for the MOH and RACHA

The current disjunction between the MOH’s Health Policy Reform and the reality of health care provision and health-seeking behaviors in rural communities presents the MOH and RACHA with a difficult dilemma. To succeed, the MOH and RACHA must support alternative, additional mechanisms and channels – other than just health centers – to expand RCH service supply, demand and access.

The results from this study support the view that focusing just on the use and quality of care offered by health centers will not accomplish RACHA’s and the MOH’s near-term objectives.

Specifically, the MOH and RACHA should:

Give at least equal (if not greater) priority to developing and expanding the private sector element of the existing health system;
Help the Sampoav Meas OD to work constructively to expand the private provision of RCH services; and
Develop and upgrade the medical skills of private health care providers so that they can accomplish RCH objectives.

B. Key Recommendations for the MOH, RACHA and Sampoav Meas OD

Health Center Operations

- Support more effective and frequent outreach and promotion
- Provide incentives for initial visits
- Encourage health centers to maintain early and regular opening hours
- Promote professionalism and dedication to serving the community
- Increase support for mobile clinics

Health center Staff Development and Further Privatization of RCH Services

- Support health center staff medical skills upgrading and development
- Support short workshops and on-the-job training that minimize interruption of daily services at the health centers.
- Use the training to develop health center staff into medically sound RCH service providers in the provinces for rural villagers.
- Develop training that is service-specific, competency-based, and relevant to service provision both in the health centers and in private practice.
- Monitor the utility of training to identify the skills/training that produce the greatest benefits for clients, whether in health centers or in private practice.
- For midwives, support the following training, perhaps as part of CMA’s continuing education program, but open to all practicing midwives (i.e., in government or retired with a private practice):
IUD counseling and insertion/removal procedures
Birth spacing training
Upgrading basic medical skills of midwives
Basic Safe Motherhood skills development for midwives

Develop private sector sources of RCH training (e.g., CMA, local private training organizations, or NGOs doing training in the health sector); this might first require strengthening their organizational training capacities.
Support the use of health center facilities for private practice.
Pilot the privatization of a health center.

**Health-Seeking Behavior Change**

Support community-level IEC interventions; this includes:

- Provision of inexpensive information materials on a full array of RCH issues
- Brief (e.g., 30 minutes) informal focus group meetings with villagers – particularly women
- Hire local women who are “sound” health seekers or who are successful users of contraception as peer educators
- Evening video presentations or theatrical performances in the villages that present and dramatize key RCH care issues
- Radio messages, perhaps in the form of a daily, continuing “soap opera” that reinforce RCH message from other sources

- Specific attention should be given to reversing potentially dangerous misconceptions and practices; this includes:
- Injections are necessary to regain health
- Use of local injectionists without regard for their medical training or their adherence to one-time/one-use-only of new needles and syringes.
- Disregard for the level of medical training of the local *ped*, injectionist and drug seller.
- Delaying treatment by medical personnel because of reliance on Kru Khmer and other medically untrained “providers”.

**Support for Midwives as Leading RCH Service Providers**

**RACHA and the Sampoav Meas OD should:**

- Actively promote the use of midwives for deliveries
- Support an Apprenticeship Program for young midwives
- Support partnerships between midwives and TBAs
III. Findings

A. Health Centers

1. Health Center Activity Levels, Operating Hours and Drug Supply

   It is an exceptional day when health centers are actually busy for more than an hour or two. Most health centers have only five to fifteen clients on an average day. One health center – Ansa Chambak – located in a remote area, regularly sees 10 to 20 clients a day, with Monday caseloads reaching 30 or more. In contrast, some health centers frequently have only two or three clients per day. In one case, only one client had come to the health center on the day it was visited. Daily client registers kept at the health centers confirmed these observations.

   With such low daily client loads, some health center staff often provide no services during their hours at the health center; this is readily observable. For example, the comparatively small number of women coming to health centers for ANC visits or birth spacing services results in midwives seeing only one or two clients in a day, or sitting idle if none come.

   Furthermore, despite being equipped for deliveries, only those women who are having serious complications might be brought to a health center. Most health centers have never had a delivery case; this reduces the workload of midwives in the centers even further. Nurses are usually somewhat busier since they are treating mother and child illnesses, as well as the various other problems that bring clients to the center (e.g., injuries, dog bites, and chronically ill people).

   Many clients (up to 30%) reported living very close (i.e., less than one to two kilometers away) or traveling for less than 10 or 15 minutes by motorcycle or bicycle to get to the health center. However, distance alone does not determine use. Villagers take into account the condition of the road (reaching some health centers requires travel on very poor roads), the seriousness of their illness, and alternative sources of health care in making a decision about traveling to the health center. For example, some clients at Ta Sas health center reported they would travel the 25 kilometers to the Pursat provincial hospital instead of going to the district hospital that was only 12 kilometers away because of the terrible condition of the road going to the district hospital. On the other hand, one woman with leprosy reported she regularly traveled some 14 kilometers to the health center for treatment.

   Health center staff start arriving at the facility around 8:00, some come a bit earlier, others arrive as late as 8:30. The first clients are usually not served until after 8:30, though clients were observed at each health center that had arrived well before 7:30. Given the relatively few number of clients coming each day, health center staff are essentially done for the day between 10:00 and 10:30,
Improving Reproductive and Child Health through the Supply of, Demand for, and Access to Services

and most leave by 11:00 and do not return in the afternoon. This is readily observable. Health center staff make no secret of their actual work attendance, and villagers all seem to understand exactly what the true operating hours are. The “mystery observer” who was part of the team confirmed that this abbreviated schedule was the routine workday from informants at the health facilities. Some health centers were open in the afternoon with one or two staff “around” (e.g., if they live next to the facility); others were closed and padlocked.

Several directors reported that “night duty” staff were available, and residents living near the health centers confirmed this. Some staff were found who come very irregularly to their assigned health center, particularly those living some distance away, including a medical assistant who resides in Phnom Penh and comes infrequently to his job in Pursat. Disregard for opening hours, staff coverage throughout the day, and irregular attendance reflect weak health center management and supervision, and discourage use by villagers. Brief operating hours is a common complaint heard from villagers.

For example, villagers confirmed that the director of the Ta Sas health center is routinely at the facility throughout the day because of his personal dedication to serving his community. One midwife who actually lives in Pursat town stays at her assigned health center – Boeng Kantout – for two to three weeks at a time and is on-call 24 hours a day. She explained that she does this to build up her private practice, also showing a commendable commitment to providing services. Undoubtedly, other “exceptions to the rule” can be found. However, the only guarantee of staff availability after morning operating hours seems to be when someone lives in the facility, such as the director of Ansa Chambak health center.

In addition to the hours spent at the health center, staff also participate in mobile clinics that are supposed to provide monthly, one-day visits to each village in the catchment area. The mobile clinic provides child immunizations, ANC care by a midwife, and family planning information/counseling. Health center staff reported that advance notice is given to villagers about the upcoming mobile clinic visit so assure that children and pregnant women avail of the services and commodities.

The mobile clinic is the principal (sole) outreach action of the health centers. Security problems reportedly interfere with regular visits to all villages. Health center staff have to provide their own transportation (usually by motorcycle) and fuel for these visits, though some staff reported occasionally receiving small amounts to cover these costs. The mobile clinic day is usually finished by mid-day, and rarely lasts later than early afternoon. Some report that they participate in the mobile clinics and are willing to pay their expenses because they can make new contacts with villagers to build up their private practice.

While efforts are underway to improve the logistics system, a frequently cited reason for not using health centers is that the last time the client went, the center did not have the medicine she needed. She then had to go to a local pharmacy to buy the drug, often at greater expense. This problem was confirmed by health center staff who reported not receiving ordered drugs or that stocks were restricted by the OD, since they saw so few clients.
Checking current stock lists against actual drug stocks on-hand confirmed these reports. Some reported supplies were found to be not actually available or far beyond their expiration date. Other drugs and commodities on hand were not included on the current stock list. These problems were found simply by a few random inspections. Health center staff reported that they had not yet received drug management training, which might account for some of these inventory problems.

2. **Health center Staff Employment – the Public-Private Connection**

The major factor accounting for the 2-3 hour work day at health centers is the very low salary paid to health center staff - $8 per month – but this is only when staff actually get paid. Staff reported that in 1998, they were paid only five out of 12 months – a total of $40 for the year. New staff reported receiving no salary until they become “permanent” after two years of “temporary” status. Revenues taken in for services are divided among health staff on an informal seniority basis. For example, a relatively new midwife stated she and her co-workers received R4,500 monthly for several months. More senior staff with greater family responsibilities received somewhat more. But on other months, revenues had to be used for health center operating costs and materials (e.g., paper, lumber). Revenues were also used on occasion to pay for the “entertainment costs” of visiting high-ranking officials. In short, health center staff receive a meager, almost inconsequential, share of the revenues.

This “alternative” employment actually constitutes the core of their workday and livelihood; their morning attendance at the health center is definitely a secondary engagement. Many health center staff function as the local *ped* to their immediate and surrounding communities. Villagers either come to the home of the staff person/ped for treatment and drugs, or they ask them to come their house. Villagers report that the cost of services charged by the staff person/ped is the same as what they would pay at the health center; some reported paying a little bit more. Whether villagers receive services from health center staff at home or at the health center might not be too important – the quality of care could essentially be the same regardless of location. What is important is that they are using the services of people with actual medical training. The major difference between visiting health center versus receiving care outside of the facility is that the staff person/ped keeps the payment – i.e., this is his/her private practice. There were no reports of staff taking drugs or supplies from the health center for use in their private practice ever.

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1 *Ped* refers to a person with any medical association – actual or generally believed. In rural areas, a *ped* can range from a doctor or medical assistant working in the provincial hospital to a janitor working at the same hospital. More commonly, a *ped* has marginal medical training; many have none. For example, some had only two to four weeks of medec training, while in the army ten or more years ago, that “qualified” them as *peds*. One *ped*, who was actually a TBA, was reported by villagers as being a midwife, because she had received training from an NGO, which gave her “medical credibility” in the eyes of the villagers. Clearly, health center staff who are working as the local *ped* are an asset to their communities in comparison to the majority of other *peds*. Equally clear, even brief training by an external organization bestows credibility on people, which might not be intended nor desirable.
The range of services performed by health center staff in their private practice varies by individual, but the majority offer a broader range of services than those they perform in their government jobs, including injections and dispensing of medications. For example, most midwives reported that in their private practice, they attend home deliveries, treat illnesses with injections and drugs, sell contraceptives, treat gynecological problems, and provide treatment/care to women who had induced abortion (or a TBA-induced abortion). Clearly, they sometimes provide medical services for which they are not adequately trained. But this is far preferable to other peds villagers report using as their front-line, principal care providers who have little or no medical training, such as local drug sellers and Kru Khmer.

A major advantage for health center staff who work as a local ped is that they are unrestricted as to the range of services they can provide (and earn income from) in private practice. Their ability to give injections is very important to their private practice. Under the MOH’s Health Reform Program, health center staff are not permitted to administer injectable drugs (staff who give depo provera and immunization injections are trained to do so). However, the vast majority of villagers firmly believe that injections are essential for regaining health, the same drug in tablet form is not believed to be as efficacious.

A very common complaint heard in the focus groups about health centers is that the individual went to the health center, but received no injection, only pills. In fact, villagers often visit the health center initially to arrange for a staff person to come to their home later to give injections and other medications. This same person is then called upon for future services. Once this arrangement is established, the need for visiting the health center is greatly reduced. Many women reported they much prefer home or local treatment to going to the health center. This preference for home care works directly in favor of health center staff who try to develop a private practice as the local ped.

Running a small pharmacy, as some staff do, is related to their medical skills, but most striking was the finding that a significant percentage of health center staff – perhaps as much as 20 percent or more in some health centers - turn to non-medical sources of employment. While they might also give some injections or sell some medicines, this is done on a much smaller scale than their ped colleagues. Alternative employment includes farming, raising livestock (pigs, chickens and ducks), producing home foodstuffs for sale, selling clothing and other consumer goods at the local market, selling fertilizer, and making loans. Other health center staff (especially younger staff who have not yet built up their private practice) also reported engaging in these activities as a third type of employment, in addition to their jobs at the health center and as a ped.

In addition to working as a ped, many health center staff have additional, alternative employment.

2 A perfect case in point is found at Chouk Meas health center, located some 27 kilometers from Pursat town. The distance from town should discourage villagers from going to the provincial hospital for health care, as many do who live closer to town. However, the health center is only seeing 5 to 10 clients per day. Discussions with women in surrounding villages revealed that they did not go to the health center, but made frequent use of health center staff. The health center is located several kilometers away from the main highway down a very good dirt road. Villagers “flag down” health center workers who travel down the road on their way to the health center to request that the staff person come to their house after finishing work at the health center.
Why, then, do they even bother with their government job given the small salaries they receive – only sometimes – and the opportunity to use the time spent at the health center more profitably elsewhere? A very consistent response to this question was that the health center job constitutes an important connection to government that is very beneficial to private practice.

First, as health center employees, they are eligible for training provided by donor projects and NGOs.

While intended to improve health center services, this training is much more valuable to staff for developing marketable skills that are directly applicable to their private practice.

Second, their government jobs serve as a gateway to other government services, making such services more accessible to their family and friends.

For example, health center staff report that they will accompany their family members and close friends to the provincial hospital to get care for serious problems, assuring that they receive quicker attention and at lower cost in some instances.

Third, their government employment at the health center is known by villagers and is reported to enhance their credibility as competent care providers.

Private practice is highly dependent on the practitioner’s reputation and business grows through local reputations and word-of-mouth recommendations. In short, there is little meaningful distinction to be made between public and private sector employment – government employment directly supports the private practice health center staff must have to survive.

An inverse incentive structure is created by the conditions described above that works against greater use of use of health centers by villagers. Extremely low salary levels combined with the very real need to resort to alternative employment – most commonly, a private practice as a ped – in a totally unregulated environment where anyone can try to treat any health problem, give injections, and sell drugs - are key elements of this incentive structure.

Under these conditions, there is no reason for health center staff to encourage villagers to come to the health center – this works contrary to their goal of building their private practice with these very same people. Established patterns of health seeking behavior by village women (described below) reinforce such inverse incentives to health center use. The result is a powerful, pervasive incentive structure that runs completely contrary to the promotion of health centers as the frontline or principal source of health care services for rural villagers, as envisioned by the Health Reform Program.

B. Client Assessments of Health Center Service Quality

What constitutes “good service/care” for clients?

- Staff are friendly, treat clients politely, and show concern for the client.
• Services are inexpensive (e.g., drugs cost less than those purchased from private pharmacies, treatment costs are low – e.g., R100 to R500).

• Drugs are available/dispensed at the health center.

• One health center visit and dispensed medicine cure the illness with no need for a follow-up or second visit.

These attributes of good service - i.e., what clients liked about the health center, or why they used the health center - were cited frequently. Three additional elements that clients consider to be elements of “good treatment/care” were also mentioned repeatedly, but they reported these in a negative fashion as something lacking in health center services:

• Injections are given.
• Services are available at all hours.
• Treatment is effective

The policy of not permitting some health center staff to give injections delivers something of a “death blow” to the perceived quality of service reported by many villagers. There is a deep-seated belief that injections are essential for curing illness. The brief operating hours of health centers and the lack of 24-hour staff coverage is a serious weakness from the client/villager’s perspective.

For example, this is often cited as an important advantage of TBAs over health center midwives. While the TBA usually lives nearby and will come at any hour, midwives are reported to refuse to travel at night and are unavailable when needed. Related to the “one visit/one treatment” criterion, when asked why they do not use the health centers, villagers frequently reported that they had taken their children for treatment, but they did not get better, despite being told to return in some cases.

**Poor service at health centers is largely just the reverse of good service**

• Health center costs are very high (e.g., why TBAs are preferable to health center midwives).
• Access to treatment depends exclusively on the ability to pay.
• No injections are given.
• Unavailability of services throughout the day.
• Not being cured after one visit.
• The lack of medicines at health centers and the need to go purchase drugs elsewhere.
• Rude or indifferent treatment by health center staff.

The issue of cost is frequently raised as a criticism of health centers. In some instances, clients were required to pay what seemed to be excessive charges at health centers, such as R30,000 for a small suturing and a few hours of observation at the facility. It was not possible to verify many of these claims. When queried about cost, charges either seemed reasonable, or the respondent was not reporting her own experience, but merely repeating

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3 In addition to the convenience of using an injectable contraceptive, the “injection fixation” might also lead users to believe in its effectiveness because it is injected, not swallowed.
what she had heard from a relative or friend. In a few cases, women complained of having to pay health center staff directly for injections and IV fluids, the latter costing as much as R18,000.

The ability to pay in determining access to service is closely linked to complaints about the friendliness of treatment by health center staff. Women who reported rude or unfriendly treatment invariably linked this to an inability to pay the going rate, or to the bad character of the staff person as only interested in money. Again, in probing these comments, many women were often repeating what they had been told, as opposed to their own experience. Others did describe their own personal experiences, which lend some credibility to the claims.

**There are several attributes of health service quality that are apparently of little importance from the perspective of clients.**

Western definitions of cleanliness and sanitary standards
Waiting time (as defined by Western standards)
Level of training of health center staff
Counseling and thorough explanations of problems, causes, etc.

The idea that the place of service delivery should meet Western definitions of clean and sanitary simply has little or no relevance to villagers using the health centers. Even at fairly run-down facilities, clients reported that the health center was sufficiently clean. Many of the health centers are still fairly new and even with the minimum of cleaning they receive, are in quite good condition. However, it is significant that most villagers prefer to have health center staff come their homes to provide health services, avoiding the facility entirely.

A common belief is that excessive waiting time, defined by Western standards, discourages health center use. This was rarely cited by respondents as a major problem. Even people who had waited almost two hours for services, because they arrived long before opening hours, said the wait was not excessive. Those who did mention that waiting time was a problem during their last visit readily admitted that this was unusual and that waiting time is not a serious problem. What constitutes excessive waiting time is highly culture bound – rural Cambodians simply expect to have to wait for government services and will do so patiently for periods of time that others would find intolerable.

Consistent with the priority given to effective treatment, or “one visit/one treatment”, respondents never cited the level of training of health center staff as either a positive or negative attribute of services. What matters to them is that they get cured at the lowest possible cost, the medical training of the service provider is not an issue. Many villagers first turn to a ped of unknown medical training, or to the local drug seller or Kru Khmer, who have no training, for initial health services. Given that so many villagers use these “providers” for their initial response to health needs and problems, medical training is relatively unimportant in their definition of good quality service.

Equally apparent was the lack of concern by clients/villagers about thoroughly understanding the cause of their problems, why certain treatments are prescribed, why they should follow certain practices at home and other standard aspects of counseling and giving information. The lack of such information was never raised as an issue or problem. However, when asked, some clients reported that they really did not understand such information or simply were not
told. Again, counseling and offering information are probably less important concepts to people who are much more familiar with simply being told or ordered what to do without an explanation for why they should do it.

C. Patterns of Health Seeking Behavior Reported by Village Women

To understand the current limited use of health centers by villagers, these facilities and their services need to be placed within the context of established patterns of health seeking behavior of village women. From the interviews and focus group discussions, three general patterns of response to illness and meeting general health and reproductive needs (e.g., birth spacing) emerged.

At one end of spectrum are those who reported that they regularly use the health center, provincial hospital, private clinics or services provided by the staff from these facilities when they or their children become sick as their initial response to the a potentially serious illness. They further stated they usually obtain health care after one to two days of what they consider to be a serious condition, e.g., bad cough, high fever, and persistent diarrhea. In other words, they get access to medical services fairly quickly before the illness becomes serious. This does not necessarily mean they actually visit a health facility. As discussed earlier, many have established arrangements with medical staff for at-home health services – either at the client’s house or at the care providers home. These individuals are the “sound” health service seekers.

At the other end of the spectrum are those who rely principally on local providers, many of whom have minimal or no formal medical training. These respondents report that they typically turn to Kru Khmer, local drug sellers, a ped, or often a combination of these sources. They closely follow traditional views and practices accepted by their immediate circle of family and friends regarding health care and coping with illness. They avoid seeking medical treatment because they consider it to be too expensive unless the illness is clearly life threatening. They rely on medically ill trained (or untrained) providers and will self-medicate themselves or their children for an extended period of time with different drugs until they find something that works.

They acknowledge that such treatment in some instances has been ineffective or detrimental (e.g., infections from injections, adverse reactions from incorrect medications). Some mothers and their children report being chronically ill – they say that they never quite return to full health. Nonetheless, they continue to follow their established patterns of health seeking behavior with the next occurrence of illness. Many to these individuals express an antipathy – almost aggressively so - toward birth spacing, citing common misconceptions about its adverse effects on women’s health. Unfortunately, many of these women and their children poignantly illustrate the importance of birth spacing for family health. This pattern of behavior can be labeled as the “unsound” health service seekers.

Between these two extremes is a large group of respondents who are slower to seek medically based care than the “sound” seekers, who initially follow low-cost/non-medical responses to illness and meeting health needs. These individuals resort to a mixture of service providers and treatments like the “unsound” group. However, this “in between” group appears to get medically based care more quickly when their initial efforts fail. These responses describe the “mixed” health service seekers.
The delineation of these three groups and categories of health-seeking behavior are merely generalizations to summarize the range of actions mothers report taking in response to illness and reproductive health needs. Some people appear to be quite consistent in their health behaviors, while others apparently “drift” between categories depending on the health problem, e.g., “sound” about child illness, “mixed” or “unsound” on birth spacing. In other words, these categories are not as definitive or rigid as the terms imply.

While it is difficult to estimate the distribution of respondents among these three categories, the smallest number are those who consistently turn quickly to medically-based services – the “sound” health seekers. The “mixed” and “unsound” health seekers are far more numerous. Not surprisingly, the “unsound” health seekers appear to be comparatively poorer, less informed, and more marginalized geographically and economically than the “sound” care seekers. Individuals in the focus groups tended to be fairly similar in their patterns of health seeking – i.e., a “sound” group, a “mixed” group, or a “unsound” group. However, within some focus groups, responses sometimes differed sharply. One woman would tell us she used the health center’s services at the on-set of illness, while others in the group reported never or very rarely going to the health center.

While people might not articulate their decision-making in such terms, what emerges from the interviews is that those who turn to medically based sources of treatment more quickly seem to understand the importance of reducing the risk of serious illness.

In sharp contrast, the “unsound” health seekers give priority to minimizing health care expenditures, despite the considerable risks this poses for their own health and that of their children. Health centers are considered to be “very expensive” among this group. They claim this is the main reason why they do not use health centers. Their cost-minimization strategy works frequently enough to encourage its continued use. Perhaps they are fortunate enough to have access to an experienced ped, or they purchase the right drugs from their local seller that cures the illness, or their child is simply able to overcome the illness. In such instances, their cost-minimization strategy has been successful.

However, when this initial response fails, these individuals typically continue their efforts with the same or similar sources, trying alternative drugs, trying another ped or Kru Khmer, until the illness becomes extremely serious. When they reach the point where they or their child are clearly in danger and they (or a family member) believe that further delay could result in death, they go directly to the provincial hospital, by-passing the health center because they know that such serious cases are referred on and not treated at the health center.4 With the start of treatment at the hospital, their costs escalate rapidly, reportedly anywhere from R20,000 to R50,000 for treatment. Their cost-minimization strategy has not only failed, but it has very likely increased their costs above what they would have paid if they had gotten medically sound services from the

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4 As one respondent in this “unsound” group succinctly summarized her actions when asked what she does when her initial efforts fail, “I continue trying until my child is half-dead”.
outset. Though this cannot be confirmed by this study, permanent impairment and death from treatable illnesses are probably greatest among this group.\(^5\)

The major consequence of “mixed” and “unsound” health seeking behaviors is to postpone medically-based treatment which exacerbates the seriousness of the illness, lengthens the amount of time of recovery, and places mothers and children at much greater risk of permanent health problems or death. Whereas “sound” health seekers obtain services from medically trained providers typically after one or two days of major illness, the “mixed” group might not do so for several days more (or longer) depending on the progress of the illness. The “unsound” health seekers seem to avoid contact with medically trained providers for as long as possible, perhaps a week or more, until it becomes undeniably clear that the illness has reached a critical stage that could easily lead to permanent damage or death.

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**Economics clearly has a great deal to do with the health-seeking behaviors and decision-making of villagers**

While there were not a great deal of apparent economic differences among the respondents, even small differences in income and household security (e.g., the woman’s husband is at home, there are other relatives to help her, etc.) can enable some to afford better quality health care than others. This study did not obtain sufficient information to draw firm conclusions about this point, but it might well be that the cheapest, long-run strategy is the “sound” approach to medical care even though the initial outlay is higher than the “unsound” strategy.

It is not uncommon for rural couples to have five or more children in extended family households that include even more children. Several can be sick at the same time and infect each other. Each time the “minimizing expenditures” strategy fails, the final costs of going to the hospital makes the costs of obtaining medically sound care earlier in the illness comparatively less expense. It only takes to a couple of hospital visits for total family or household costs to more than offset the marginal savings of avoiding proper medical services from the outset. In short, those following the “minimizing expenditures” strategy might, in fact, be increasing their costs over the long-term, to say nothing of putting their children’s lives at considerably greater risk.

*Some told of having to sell livestock or land to raise funds to pay for health services. Borrowing to pay for health services is also common, particularly during the months preceding the first rice harvest (i.e., September through November). The provision of credit is another inducement that local drug sellers use to capture and retain the business of villagers short of money for medicines.*

Client were specifically asked at health centers why they choose to come to the center as opposed to a Kru Khmer. A common explanation was that they “believed in the

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\(^5\) Serious sequelae from poor health care are, unfortunately, readily observable in rural villages, such as children who have suffered brain damage from extremely high fever, or from complications at birth.
medical staff” of the health center. This does not merely imply that they trusted the health center staff, rather, they were telling us that they believed in the efficaciousness of the medical or “scientific” practices and treatments they received at the health center. Similarly, some would state that did not believe in using the Kru Khmer. In sharp contrast, the “unsound” groups often told us that they indeed believed in the healing powers of the Kru Khmer and always used them. Others reported they did not yet fully believe in the health center staff, but were beginning to change their minds and maybe they would visit the health center soon.

The power of the group greatly influences the actions and beliefs of an individual in responding to illnesses and meeting other health care needs. This is not unusual in an environment where educational levels are very low and ready access to accurate information is limited. What family members (particularly older women), friends, and neighbors say is accepted by individuals as a collective “group wisdom” about health issues, seemingly without or with very little questioning.

This “group wisdom” provides answers and directs behaviors - rightly or wrongly – by providing the individual with a set of ready-made beliefs, views, etc. about illness, health care, and appropriate treatment. This was clearly reflected by respondents who were highly critical of health center services and staff. When queried, many were recounting what others had said and their views were not based on their own experience. The influence of this “group wisdom” underpins many of the misconceptions, erroneous beliefs, and wrong practices reported by village women. While low educational levels in part might account for this, the lack of accurate information being given to villagers perpetuates misunderstandings about correct health behaviors.

When mothers were asked about what actions they take when their children have severe diarrhea, serious coughing, or high fever, roughly 80 percent or more reported doing things that are either useless or completely opposite of what they should do. For example, many apparently had never heard that they should increase health-promoting fluids, such as boiled water, rice cooking water that had boiled, or even coconut water, for children with diarrhea. Many reduced food and fluid intake, or gave the child the same water they ordinarily drink.

What women are reporting, and doing, is what they have learned from others, i.e., the “group wisdom” that they follow. This “group wisdom” is equally powerful in influencing incorrect views about and resistance to birth spacing even when mothers are quick to say, individually, they want no more children. The vast majority of women in their early thirties and older already have had a minimum of three or four children, with some having given birth 12 times or more. Again, “group wisdom” substitutes for

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6 Interestingly, a number of respondents also observed that they did not go to a Kru Khmer because there was none near their home, not that they did not believe in the Kru Khmer. A couple of clients said they used both – a good example of the “mixed” category of health seeking behavior.

7 Women were asked about actual deliveries because they count every pregnancy as a child, combining live births with miscarriages, abortions and still births. Child mortality among those reporting high numbers of deliveries was often very high – e.g., one mother reported 8 out 12 children had died; another who was 33 years old had 11 children (deliveries), but six had died; another around 30 years old reported 4 out 8 of her children had died, etc.
accurate understanding of female and male sterilization - misconceptions about the procedures and consequences abound.

Contrary to the “group wisdom” position, in almost every group, there would be at least one woman – usually a younger woman - who knew the correct action to take, or who reported that she had been successfully contracepting for a couple of years. This suggests that effective information campaigns targeted on these more receptive individuals could help to persuade some to make behavioral changes “down the road” and to reinforce the behaviors of those who are already following sound health practices.

The present limited use of health centers is understandable when these facilities are viewed as fitting within established patterns of health-seeking behavior of their potential clients. As described by village women, health centers have not become an integral element in their responses to illness, birth spacing, and other health-related matters for many.

In part, this reflects the relative newness of health centers in many locations. With the exception of former district hospitals (e.g., Kandean, Kro Kor, Kravanh) and former infirmaries (Srel Sdok), many health facilities have been open for less than two years (e.g., Prek Thnot has been open for roughly seven months). There is currently very little systematic effort to inform villagers about the services available at the health centers and how to use them effectively. As noted earlier, such community outreach efforts consist exclusively of what occurs during the mobile clinics. Health centers have neither the budget nor resources (e.g., motorcycles) to support more effective community outreach.

Where villagers had met health center staff, they remembered them as “nice/friendly” people. However, most villagers had very limited knowledge about or direct experience with the health centers. The lack of direct personal contact with health center staff only helps to foster the villagers’ perception of the health centers as a something to be avoided and subject to the often unfounded reasons they offer for not using health center services (e.g., too expensive, the staff are not friendly, the services are not good, etc.) Established patterns of health seeking behavior, combined with the inverse incentive structure described above, work contrary to the current MOH policy to promote health centers as the frontline service delivery sites for villagers.

At this time, it is very unlikely that greater use of the health centers will occur without major changes in the factors and conditions that currently discourage such use. This will not be easy or quick. Overcoming the current structure of incentives that work against promoting the use of health centers cannot be reversed with small increases in staff salary. The large increases that would be needed to make government employment competitive with private practice are simply not possible for the government for the foreseeable future. The prevalence of “mixed” and “unsound” health-seeking behaviors similarly must be reversed before health center use will increase.

Innovative approaches, such as “hybrid” arrangements combining government and private sector elements of health care service delivery need to developed and tested. For example, the government might lease the health center facility to staff who would operate it as a private clinic operating within the MOH’s MPA standards. Drug and other commodities might be obtained through the government logistics system, or from private sector suppliers if that is less expensive and/or more reliable. This type of arrangement
might provide the necessary incentive to health center staff for them to encourage their clients to come to the facilities, and to make sure drugs and commodities are in supply. Of course, this will require the MOH to be open to such alternative modes of operating and using these health facilities.

Changing prevailing patterns of health seeking behavior will be equally challenging and difficult. It will take a prolonged, concerted effort of public health information campaigns to overcome the various misconceptions and misinformation that account for unsound health practices so common among rural villagers. Considerable time, money and effort will be required to do this, and to minimize costs, it must be guided by strategies that reflect clear priorities among the array of health issues that could be addressed.

The cumulative worldwide experience of health and population IEC and behavioral change programs provides starting points for this effort. Identifying which messages conveyed through which media, and how to reinforce these messages through additional channels, that are most effective in reaching and influencing rural Cambodians will be essential to make this effort successful.

D. Midwife Career Patterns and Aspirations

The careers of health center midwives exemplify the integration of government and private health service employment that most health center staff engage in to make a living. Of the 20 midwives interviewed, 19 had private practices. Most reported attending from zero to four deliveries per month, with most doing one or two per month. Two midwives reported attending as many as six or seven deliveries per month in private practice. Midwives at former district hospitals and at the health center attached to the provincial hospital reported attending approximately twice as many home deliveries in their private practice as they were doing in their government job. Midwives working in rural health centers reported that all the deliveries they attended were done through their private practice. Women simply did not want to give birth at the health center facility. Older, more established midwives were quite active because of their well-established reputations as good midwives.

The range of services offered by the majority of midwives is extensive, going far beyond their midwifery training. In effect, midwives work as “country doctors” handling a full range of medical services. The standard list of services midwives reported as part of their private practice include: attending home deliveries, dispensing and/or prescribing medicines for mother and child illnesses, giving injections, selling/injecting

8 The earlier discussion of health center employment patterns and motivations – section 2 above – applies to midwives working in these facilities. This section will present additional information specific to midwives.

9 The midwife without a private practice was young and relatively inexperienced – she had never delivered a baby. She had been trying to start a private practice in Pursat town, but had been unsuccessful because of the difficulty of starting a new practice where she lives. The difficulties she is experiencing exemplify the barriers midwives encounter in starting a private practice, discussed later.

10 When we asked women why they did not use the health center for their deliveries, we were usually answered with laughter at such a strange idea – delivering at home in a familiar setting with family members in attendance is the preferred arrangement by the vast majority of women.
contraceptives, treating gynecological problems, and treating abortion cases. Several midwives reported only attending home births, selling contraceptives, or giving injections, but these were exceptions rather than the rule.

One midwife reported that she does IUD insertions for clients at her home. She learned the procedure by watching medical assistants and then trying the procedure herself under their supervision. Several others also reported such “on-the-job” training for IUD insertions. Midwives treating abortion cases stated that they did not induce the abortion. They reported that a TBA or the woman herself induced the abortion and then came to the midwife for care. However, some midwives do induce abortions as a service. The issue was irrelevant to the purposes of the study and further enquiry might have interfered with learning more about their private practices.

While villagers reported that they do not use midwives for deliveries because they consider them to be too expensive compared to TBAs, the charges of midwives working outside of Pursat town were found to be very flexible and actually comparable and competitive with those of TBAs. Midwives working in health centers serving principally small surrounding villages typically reported that they charged R20,000 for a delivery which usually includes no injections or suturing. Injections of oxytocin and vitamin B complex increase the costs to by R5,000 to R10,000. IV drips raise the costs higher by as much as R15,000. Complicated births also increased costs depending on the particular problem(s).

Midwives working in former district hospitals, usually located in small towns or near Pursat town reported charging R40,000 to R80,000 (with injections) for women who “have money”, but only R20,000 for poor women. The highest delivery charges were reported by midwives working in Pursat town. Charges ranged from R50,000 to R70,000 without injections or complications, and there is at least one midwife who charges $100 per delivery for “rich” clients at her private clinic. Many midwives stated that they use a sliding scale based on the ability to pay. Poor clients pay as little as R5,000 (no injections). Several midwives described these deliveries as “free” – i.e., they let the client decide how much to pay similar to the practice of TBAs.

TBA charges were equally varied depending on location, but were more complicated because TBAs require additional forms of payment. In Pursat town, TBAs reportedly charged at least R5,000, but also usually requested payments of one taal of rice, a live chicken, and bananas. In rural areas, cash payments were reported as ranging from as low as R2,000 to a more common charge of R5,000. In addition to rice, chickens and bananas, some TBAs might also request several meters of cloth (white linen), rice wine, candles, and/or kerosene. If all of these charges are converted into a monetary cost for the client, the difference in price between TBAs and midwives in rural areas is not very great.

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11 A taal is a volume unit of measure weighing from 12 to 15 kilos.
12 The upper range of charges for a midwife’s services in rural area seems to be about R20,000. TBAs reportedly charge R5,000 to R10,000 plus various additional forms of payment. Using R5,000 as the cash payment, and assuming that one taal of rice, bananas, and cloth are part of the TBA’s charges, the total cost might be around R10,000 for the TBA. R10,000 is equivalent to $2.63.
Midwives told us that they were intentionally trying to compete with the TBAs for clients. All of the midwives interviewed stated that they believe that the general understanding of the importance or value of having a midwife attend a delivery has increased over the past 5-10 years among women. Nonetheless, they also reported that TBAs continue to be used for the vast majority of deliveries in their area.

Birth spacing is reported by midwives as accounting for the decline in the number of deliveries they are attending now compared to five years ago, and that family planning services have become increasingly important to their private practice. Several of the older midwives stated that they now attend only half as many deliveries as they used to because of the increasing use of contraceptives, particularly depo provera. With only a couple of exceptions, they reported that birth spacing services were becoming a major part of their private practice.

They buy contraceptive supplies from local pharmacies, getting a somewhat better price than regular customers, then mark up the cost to their client to make a small profit. However, none seemed to be managing birth spacing services in an active business manner. That is, most do not keep records of their clients and schedules, and even those that do, reported that they do not track down clients who are due for a re-supply of pills or condoms, or should have their next three-month injection. There were no reports suggesting that they were selling contraceptives obtained from their government work place.

They reported that they are fairly successful in encouraging their clients to contracept, but most report that very few women (and only one man) actually followed advice about sterilization. The cost, fear of an operation (not unfounded in a medical setting weak in infection prevention), and various misconceptions about the consequences of sterilization discourage those who should stop having children.

Two midwives had attended an IUD training program conducted by MSF in 1996; however, they do not include IUD services in their private practice. Several reported informal “on-the-job” training as described above; one “on-the-job” trainee said that she inserts IUDs for clients at her home. The majority of midwives interviewed said they had no formal training for IUDs, but they would be interested in such training if it were offered.

While birth spacing services have become increasingly important to the midwives private practice, few have attended birth spacing training programs in recent years. Several had attended the UNFPA training conducted just recently, but most had not received formal training since their midwifery training that covered family planning very briefly. Therefore, it appears most midwives knowledge about birth spacing is acquired on-the-job, and their knowledge about birth spacing is very likely to be out-of-date, incomplete, and/or inaccurate. There was keen interest in attending birth spacing training if it were made available.
Improving Reproductive and Child Health through the Supply of, Demand for, and Access to Services

Other training sessions several midwives reported having recently attended included third-stage delivery, ANC, birth spacing, and MPA services for health centers. The third-stage delivery program was conducted by the Cambodian Midwives Association (CMA) to which most midwives belong, but few reported they had participated in CMA’s continuing education programs. One said she had received training for the Cambodian Women’s Association on post-partum hemorrhaging, family planning, and danger signs during delivery. Another was a graduate of the MOH/RACHA-supported life-saving, skills upgrading training program now operating in Battambang. In general, however, training offered to the midwives interviewed was limited in subject matter and not very systematic in coverage.

Most midwives stated they were interested in receiving any type of training, but confirmed medical and OB/GYN training could be particularly helpful (one reported that she was trying to teach herself “medicine” on her own from books). From a purist, medically correct perspective that only fully trained health care professionals should be treating such serious medical problems as illnesses, infections, abortion cases, and OB/GYN problems – meaning a medical assistant if not a doctor – such training for midwives would be objectionable. However, midwives are far preferable than the alternative providers many villagers frequently use, and will continue to use.

This training would respond to this reality and, at the very least, could help midwives to recognize important danger signs indicating the need for referral to the provincial hospital, and to prevent dangerous drug treatment and other practices that could harm the patient. In short, midwives are going to provide these services in any case – at least until villagers change their health-seeking behaviors which will be a long-term process – regardless of national policies and international standards for health care. Therefore, training that at least reduces the risks of harm by midwives would be a service to both the midwives and their clients.

Midwives were quite frank saying that their government jobs were important to them because of the potential training opportunities it offered them. While official MOH policy focuses on improving health center services, use, and quality, whether training given to government midwives is used in the health centers or in private practice is secondary to its importance for improving access to better reproductive and health care services for women and their children.

With the exception of three older midwives contemplating retirement from government service, all of the respondents said they intended to keep their government jobs for at least the next five to ten years. However, they made it clear that the main reason for keeping their government jobs was that it provided them with certain advantages for their private practice. Potential access to continued training was most important. Gaining experience, confidence, and access to new clients were also typically cited as important factors.
Others told us quite frankly that these other factors – and not their salary as a government midwife - account for why they come to work at the health facility.

Particularly for younger midwives, their hope for the future is to obtain more skills and see their private practices grow. Some added that they hoped that they could work exclusively as private practitioners some day. The optimism, determination, and energy many exhibited toward achieving their goals were impressive. Among older, more successful midwives (e.g., 35 years of age and up), some foresaw the next five to ten years as simply more of the same without the possibility – or need – for significant expansion of their private practices. Three midwives nearing the end of their government careers intended to retire from government service and focus exclusively on their private practice – the same goal expressed by younger midwives. Others added that while they had no intention of leaving government service in the next five to ten years, they hoped that their government salaries would increase.

While having a large private practice was the aspiration of most midwives, starting a private practice is a major challenge for younger midwives. The barriers to starting a private practice are substantial. In Pursat town, starting up a private practice is very difficult because of the presence of more established midwives and other medical practitioners. The market seems to resemble a “closed shop” where very few new midwives are able to enter the trade. Demand for their services is limited because of their inexperience and lack of an established reputation compared to TBAs and older midwives. Moreover, women strongly prefer to use the same TBA or midwife for their next delivery that attended their last delivery.

Entry into the local market for a young midwife can be facilitated by a relative or close friend, who is an established midwife and makes recommendations and referrals for the new midwife. Even with such assistance, it apparently takes years to build a viable practice. Without such assistance, the task of the new midwife is vastly more difficult. One young midwife, who was nearing defeat in her efforts to start a private practice after several years of trying, had been completely unsuccessful. She reported that she lived in a part of town monopolized by older midwives, TBAs and other medical people, and family responsibilities prevented her from moving or working outside of town.

While competition with more established midwives is formidable, the difficulties younger midwives face are compounded by the prevailing preference for TBAs, especially in rural villages, but also still common in Pursat town. The decision women make is often between a TBA who has attended literally hundreds of deliveries and has an established reputation, versus a young women who has technical training, but little practical experience with deliveries and unproven credentials.

While it is known that midwives solicit new clients during health center hours and during mobile clinic visits, this must be done very discretely. If a midwife is too aggressive in trying to persuade a woman to use her services, they run the risk of being seen as not very good practitioners, because if they were, then there would be no need to try so overtly to get new clients. This kind of thinking even extends to the mildest forms of advertising services. For
example, if a midwife were to post a sign with her name and stating that she is a practicing midwife, the sign would have to be quite small.\textsuperscript{13}

Three young midwives had opted to start their private practice in rural areas because they believed that these areas offered greater opportunities to them than in Pursat town. Midwives depend on clients who understand the advantage of having a midwife attend their deliveries and who can afford to pay an additional $2.00 or $3.00 for their services. In other words, women who are informed about and recognize the importance of midwives, and can afford to pay a little bit more for their deliveries, constitute the main market for midwives.

A greater percentage of women in Pursat town fit this profile than in rural villages. Midwives working in town confirmed that use of midwives is much greater in town than in the villages.\textsuperscript{14} However, these three midwives decided that despite the lower acceptance of midwives in rural communities, they had a better chance of building their private practice in these areas than in town. One resided at the health clinic for two to three weeks at a time and returned to visit her family who remained in town. The other two had built small houses next to the health center where they worked. Their objective was to be on-call 24 hours a day. Their emerging practices are based on a combination of home deliveries (one or two per month); complicated deliveries where a TBA or the woman’s family decided they need the midwife; and other medical services. The determination of these women to succeed at their profession, despite the difficulties they confront, is impressive.

\textsuperscript{13} Interestingly, one midwife said that if the sign were too large, doctors in the area would object.

\textsuperscript{14} One older, well established midwife told us that there was also an element of status for the woman and her family associated with having a midwife attend the delivery as opposed to a TBA at least in Pursat town. Use of a midwife is seen as progressive and modern, as well as reflecting the fact that the family can afford the services of a midwife. These perceptions might be useful themes for IEC efforts to promote the use of midwives.
III. Program Implications and Recommendations

A. The Key Program Implication for RACHA and the MOH

The current disjunction between the MOH’s Health Policy Reform and the reality of health care provision and health-seeking behaviors in rural communities presents RACHA with a potentially difficult dilemma. Official policies that promote government health centers as the frontline health care service site are at best, many years away from becoming a reality in the lives of most rural Cambodians. As a bilateral donor-funded project, RACHA must support official policy, yet at the same time, it must achieve tangible results in the form of improving the supply of, demand for, and access to reproductive and child health (RCH) services in the near-term. The results from this study support the view that focusing just on the use and quality of care offered by health centers will not accomplish RACHA’s near-term objectives. To succeed, RACHA must support alternative, additional mechanisms and channels – other than just health centers – to expand RCH service supply, demand and access

In particular, RACHA and the MOH should:

- Give at least equal (if not greater) priority to developing and expanding the private sector element of the current health system;
- Help government to work constructively to expand the private provision of RCH services; and
- Upgrade and develop the medical skills of private health care providers so that they can accomplish RCH objectives.

B. Specific Recommendations for RACHA and Sampoav Meas OD

1. Health Center Operations

Support more effective and frequent outreach and promotion

RACHA and Sampoav Meas OD need to support more active outreach efforts to inform villagers about services, staffing, and costs available to them at their nearest health center, and provide an opportunity for villagers to meet health center staff.

Provide incentives for initial visits

To encourage initial visits, health centers should provide treatment free of charge for those making their first visit and/or give new clients their first book of payment coupons for free. The rationale for this program is that initial contact that overcomes misperceptions is the first step toward subsequent use of the facilities.

Encourage health centers to maintain early and regular opening hours

OD supervisors need to make random, unannounced visits to health centers to check on and encourage regular opening at 7:30 and that staff remain at the centers at least until 11:00 am. On-the-spot cash rewards to health center staff who open early and regularly should be considered as an inducement/reward.
Promote professionalism and dedication to serving the community

Reward individuals who demonstrate outstanding dedication to their jobs and their communities to foster a culture of professionalism through cash awards or material rewards.15

Increase support for mobile clinics

Sampoav Meas OD should reclaim donor-funded motorcycles from personal use and re-distribute them to the health centers.

At the very least, the OD should reimburse health center staff for personal costs incurred when they participate in a mobile clinic.

2. Support Health Center Staff Medical Skills Upgrading and Development

While RACHA has thus far concentrated on self-improvement approaches to improving services (i.e., CQI, SIS and COPE), RACHA should direct more resources to meet specific needs of health center staff through skills upgrading and development training (the life-saving skills upgrading training for midwives is type of training needed).

Recommendations from this study include:

- Support short workshops and on-the-job training that minimizes interruption of daily services at the health centers.
- Use the training to develop to develop health center staff into the core of medically sound RCH service providers in the provinces for rural villagers.
- Develop training that is service-specific, competency-based, and relevant to service provision both in the health centers and in private practice.
- Monitor the utility of training carefully to identify which training produces the most significant benefits to clients from services obtained either in the health centers or in private practice.
- Support the following training for midwives possibly as part of CMA’s continuing education program, but open to all practicing midwives (i.e., in government or retired but in private practice):
  - IUD counseling and insertion/removal procedures;
  - Birth spacing training;
  - Upgrading basic medical skills of midwives; and
  - Basic Safe Motherhood skills for midwives.
- Develop private sector sources of RCH training (e.g., CMA, private sector training organizations, NGOs that offer training in the health sector); this might first require strengthening organizational training capacities.

15 For example, develop a system for identifying, selecting and announcing such awards that engages health center staff in the planning process to make them aware of it. Make awards on a “pyramid” basis (e.g., a motorcycle for the Professional of the Year, bicycles for runner-ups, small medical equipment for third place finishers) to spread the awards to more recipients to promote participation and recognition.
While use of health centers is now largely limited to a few hours in the early morning, RACHA and the OD health office need to identify and pilot approaches which could make more extensive use of the existing facilities. Health centers might offer certain advantages over at-home treatment (e.g., examination rooms and equipment, adequate storage space for medicines), that might provide an inducement to health center staff or local NGOs to use the facilities for private practice if this were permitted. Since most health centers are only open (or busy) for a few hours in the early morning, the facilities would be available during the afternoons and evenings for non-government services. Cost-reimbursement for the use of government-provided medicines and other commodities might be part of this arrangement.

With the objective of increasing use of health centers for RCH service provision, RACHA should work with one of its local counterpart ODs (e.g., Sampoav Meas) to develop plans for operating a health center as a private clinic run by health center staff. Employment status; rental/lease/reimbursement arrangements for facility use, drugs, and commodities; supervision to assure compliance with government standards; and other various aspects of a pilot privatization would need to be worked out; RACHA should provide the technical assistance for this effort.

3. Health-Seeking Behavioral Change

As part of RACHA’s community-focused activities, IEC interventions to correct misconceptions and lack of knowledge that currently impede use of medically sound RCH services should be designed and implemented. One such effort – the village health motivators – is already underway. Additional types of interventions are also needed, such as:

- Provide inexpensive information materials on a full array of RCH issues using illustrations to communicate messages to health center staff to distribute to clients who come to the center, but also to their private practice clients.
- Brief (e.g., 30 minutes) informal focus group meetings with villagers – particularly women –that provide correct information (and printed materials per above) about RCH care that are conducted by peer-educators and are repeated with different groups in the villages.\(^{16}\)
- Hire local women who are “sound” health seekers or who are successful users of contraception as peer educators in these discussion groups.
- Make evening video presentations or theatrical performances in the villages that present and dramatize key RCH care issues, focusing on correcting misconceptions and showing the benefits of good maternal and child care.

\(^{16}\) This could be done using an experimental design within an OD - villages that are targeted and those that are not - with effectiveness measured by monthly caseload of the health centers and use of health center staff servicing the village as the local ped.
• Sponsor radio messages, perhaps in the form of a daily, continuing “soap opera”, that repeatedly communicate the messages being communicated through other media.

• Specific attention should be given to potentially dangerous misconceptions and practices that are part of villagers current health-seeking behaviors. This includes:

  • Injections are necessary to regain health
  • Use of local injectionists without regard for their medical training or their adherence to one-time/one-use-only of new needles and syringes.
  • Use of untrained local drug sellers for self-medication treatment.
  • Disregard for the level of medical training of the local ped, injectionist and drug seller.
  • Delaying treatment by medical personnel because of reliance on Kru Khmer and other medically untrained “providers”.

4. Support for Midwives as Leading RCH Service Providers

As part of RACHA’s broader efforts to develop an IEC program for RCH, one topic that should be a priority is the promotion of midwife services, e.g., “Midwives for Safe Motherhood and Healthy Babies”. The rationale for such a promotion is that increased use of midwives will: a) increase access to ANC services, b) reduce exposure of women and their babies to unhealthy conditions and practices during delivery, and c) support the role of midwives as RCH service providers by helping to build their private practices.

In response to the barriers young midwives face in starting a private practice, RACHA should examine the possibility of supporting an Apprenticeship Program. For example, working through the local CMA branch, it might be possible to identify older, well-established midwives – especially those considering full retirement - who are willing to mentor a RACHA-sponsored apprentice midwife. Initially, the apprentice merely accompanies her mentor at deliveries to observe. Next, she would assist the mentor to gain practical experience. After the apprentice has gained enough experience (as judged by the mentor), her mentor would then refer some clients to the apprentice on a profit-sharing basis.

In some areas, an Apprenticeship Program might not be feasible (e.g., no well established, older midwife in practice). An alternative approach might be for RACHA (and perhaps the local CMA branch) to promote partnerships between midwives and TBAs. The midwife would gain experience, recognition, and access to village women. Through introductions by the TBA, the midwife could provide ANC services to the client at the woman’s home. The midwife might subsequently join the TBA for the delivery, charging no fee if her services were not needed, or a very modest additional fee if she is involved, to encourage other woman to have her in attendance with the TBA. The TBA would benefit from being able to offer her clients the services of a trained midwife at the time of delivery in case of complications, a “delivery insurance”, at a modest fee. One midwife might “go into partnership” with several local TBAs. Over time, this relationship might develop into a joint RCH business between TBAs and midwives, expanding access to better quality RCH services for village women and their babies.
Annex 1

Scope of Work: Information Needs for SIS/Community Linkage

The “Community” and “Planning & Management” units have planned to link selected RACHA support activities into an interrelated approach. The tactic has been to start or improve each separate activity to the point that when the time came for linkage, the activities would strengthen, rather than inhibit, each other. Enough progress has been made that first steps in linkage can be taken—that is, enough is now known about implementing simplified quality improvement activities in ANC at health center level, about involving villagers in maternal and child health issues and about local activity monitoring.

Villagers will now be involved with quality improvement issues at service delivery points, health center staff will be involved in health promotion and service delivery activities in the villages, and the ODs and RACHA will routinely monitor the results of this linkage. Major issues (interrelated) that need clarification during the trial to link service quality improvement and community action are the community’s definition of “quality,” the benefit “exchange” involved, and the sustainability of the linkage. Information collection is proposed to extend the present understanding of the following issues:

1. **Client Satisfaction**

   Although RACHA undertakes to improve the “technical” quality of ANC services, it has addressed client satisfaction issues only through the eyes of health providers. Health providers have identified “friendliness of the provider,” the availability of chairs, privacy, etc. as client satisfaction issues and routinely monitor these elements. However, no one has asked clients (or non-clients) what they regard as elements of service quality or what they consider to be the ingredients of “satisfactory” service.

   It is proposed that interviews/surveys be conducted with clients and non-clients to determine their perception of:

   - the elements of service quality; and
   - the elements that make them satisfied with service provision (if different).

2. **Health Provider Activities**

   The salary provided to health staff by the government (when such payments are made) are below subsistence level. Staff can not afford to spend much energy or time providing public sector health services. At the same time, staff and their supervisors must “act” as if they provide significant public sector services. RACHA has little understanding of the actual time and energy spent by providers attending to public sector duties. Nor is it known how much of that time is spent in service delivery and how much is spent in “management” activities.
Case studies of health center/staff activities are needed to describe (for a selected period):
  • actual time spent in public sector activities; and
  • tasks undertaken/accomplished.

3. Health Provider Benefit

If current time spent and task accomplishment (see #2 above) are the “exchange” for the “benefit” of being a public sector provider at health center level, what are the sustainable benefits that health workers aspire to outside of the public sector? What is it that some midwives find from superior work and/or village visits that encourage them to spend significant time and energy in the work as compared to other midwives? Are the (moral, social, financial?) benefits that they derive a function of personality and/or circumstance or can similar benefits be made available to others?

Information collection and analysis (in rural settings) is needed to answer the following questions:

  • why some midwives reportedly spend time in communities and what benefit they derive;
  • what “benefits” younger midwives aspire to; and
  • what are the obstacles for midwives to achieve their objectives.
Data Collection Methods and Procedures

The research work was conducted between May 10 through May 21, 1999 and served several purposes. First, it collected qualitative information pertaining to the above issues. Second, it developed and field tested two simple questionnaires for later use, specifically: a) an “exit interview” questionnaire for client assessments of health center service quality; and b) a midwife questionnaire to obtain information about the training, work activities, training needs, and linkages between government and private employment. Third, it helped to train two RACHA staff in using questionnaires for structured interviews and conducting semi-structured, informal focus group discussions.

Three interrelated data collection approaches were used. Each day, a pre-selected health center was visited early in the morning, usually before the center opened. Health centers were selected to capture the range of facilities in terms of their level of activity and accessibility. It is almost certain that the health center had been alerted of the impending visit, meaning if what was seen was biased, then it was biased to create a more positive impression. One member of the study team – a woman - was introduced to the health center staff as a RACHA secretary who would be recording data from their daily register to assess recent levels of client use of the facility.

The real task of the “mystery observer” was to watch what staff actually did while at the health center, how busy they were, and what time they left. An even more important task for the observer was to strike up a conversation with health care staff, usually other women, and tactfully ask about their daily work patterns and what other jobs health center staff engaged in to make a living. Though it was anticipated that getting such information would be difficult, in fact, it proved quite easy. Health center staff were not the least bit reticent in telling the observer about actual health center operations and the work activities of the staff. Nine health centers were visited in Sampoav Meas District.

An initial draft of a client exit interview questionnaire was refined by using it with clients who had come to the health center on the day they were visited. The objective was to develop a questionnaire similar to customer product satisfaction interviews used in the private sector. Because the interviews were conducted just outside of the health facility, clients would not answer any question that implied dissatisfaction with services, need for improvements, or any other negative comment about services or staff. Such questions were eliminated in subsequent revisions – the location was inappropriate for obtaining such information.

It was possible to determine from the clients’ responses what the typical characteristics are of “good service” versus “bad service” from their perspective. 35 client interviews were conducted. Annex 3 contains the final version of the client questionnaire – i.e., the questions that people would/could answer fairly easily.

In the afternoons, random visits to villages were made in the catchment area of the health center visited in the morning. The purpose was to conduct informal, or “spontaneous” focus group interviews with groups of women usually gathered at someone’s house, or at road side food or dry goods sellers’ stall. Groups of several
women served as a starting point. The objective of obtaining information about local health center use and their views about the facility and its services was explained.

Some general categories of information guided the initial discussion, which then expanded to include additional topics. Invariably, other women, curious about what was going on, would approach the group. They would be drawn into the discussion to get as broad a range of views as possible. A concerted effort was made to prevent the discussion from being dominated by just one or two more talkative individuals. Again, there was no difficulty in getting women to answer even rather personal, sensitive questions.

The respondents were asked the reasons for their use of the health center - in most cases, about why they did not use the center – and their satisfaction or dissatisfaction with services. They were asked where they obtained medical treatment and drugs for themselves and their children and the costs and expenditures they typically made. They were also asked how they responded to child respiratory illness, diarrhea, and fever, i.e., the steps or patterns of behaviors taken in dealing with child illness; their use of Kru Khmers, the local ped, and traditional birth attendants (TBAs). Respondents were asked about their number of deliveries and the number of child deaths from illness; and their knowledge and beliefs about birth spacing and sterilization.

These discussions would typically last approximately 20 to 30 minutes, some were longer. At the conclusion of each group discussion, some time was given to providing them with accurate information about topics where their knowledge was especially weak or wrong, e.g., misconceptions about contraception, reducing food and fluids for children with diarrhea. Approximately 150 women participated at least partially in these group discussions.

The second week of health center and village visits was conducted by two RACHA staff accompanied by an individual from the Sampoav Meas OD office, who followed the procedures described above. The external consultant then worked with RACHA’s midwife on interviewing midwives in Sampoav Meas District and on developing a questionnaire to be used later to collect information about each midwife in the District. These interview data could be used to generate a midwife database to assist RACHA with future activities involving midwives and to familiarize RACHA’s midwife with all the midwives working in Sampoav Meas.

Again, an iterative process was followed, beginning with a general outline for interviews, meeting with midwives, asking questions and letting the discussion develop, developing and then refining the questionnaire, etc, until a working version was produced. From initially merely translating questions, RACHA’s midwife took over the process so that by the end of week, she conducted the interviews without assistance. A total of 20 midwives were interviewed. Annex 4 contains a copy of the Midwife Questionnaire.
Annex 3

Client Assessment Questionnaire

Province: Pursat

Operating District: Sampoav Meas

Health Center/Hospital:

Date:

1. When did you first start coming to this facility?
   Year:
   Recently: A while ago: Long-time:

2. How many children do you have?

3. About how many times did you come to this facility for services for you or your children in the past year?

4. About how many times have health center staff come to your home to give you or your children services in the past year?

5. Why did you come to the clinic today? (Circle reasons)
   a) Child sick  b) Mother sick  c) Pregnancy check-up
e) Follow-up visit  f) Child injury  g) Mother injury

6. How long did you have to wait to get services today?
   a) More than 30 minutes?
   b) More than 1 hour?
   c) Was this too long to wait?

7. Approximately how far away from the health center is your home?
   a) Kilometers:
   b) Time walking:
   c) Time by bicycle:
   d) Time by moto:

8. Did you get what you came for?

9. How much did the services you received here today cost you?

10. Did they have the medicines or other items you need for treatment?

11. Do the think that the cost of services you received today is fair? Too expensive?

12. Why did you come here today instead of visiting a Kru Khmer for treatment?

13. Do many of your neighbors come here? If not, why not?

14. Were the staff who helped you today polite and friendly?

15. a) Did they explain what the cause of your problem is and what the treatment is?
    b) Do you understand what they said to you?

16. a) Did they explain what you should do at home?
b) Do you understand what they said to you?
17. Do you think the facility is clean enough?
18. How would you rate the quality of services you usually receive at this facility?
   Poor/Fair/Good?
19. For you, what is good service?
20. a) Do you think services have improved/gotten worse/are about the same since you
    first started coming here?
   b) What has changed to make things better/worse?
21. What do you like most about this clinic?
21. Is there anything that you think could be done to improve services here?
22. Do you plan to use this health center again?
23. Would you recommend coming to this facility to your family members or to friends?
Annex 4

Midwife Questionnaire

Province: Pursat

Operating District: Sampoav Meas

Health center/Hospital:

Date:

1. Midwife’s name

2. What is your level of training? Secondary Primary Both

3. What year did complete your training? Primary:_______ Secondary:_______

4. How old are you? Age________

5. How many years have you worked as a midwife?
   In government_______ In private practice_______

6. How many deliveries do you usually attend in a month?
   In government_______ In private practice_______

7. How many deliveries have you attended during your entire career as a midwife?
   No._______

8. Do you have a private practice? Yes No

9. What services do you offer in your private practice?

   • Deliveries
   • Birth Spacing
   • OB/GYN
   • Child illness
   • Mother illness
   • Injections
   • Abortion care
   • Other (specify)

10. How much do you charge for a home delivery?

   • For those who can afford to pay________
   • For poor people________
11. Do these delivery charges include injections?
   - If yes, what do you give them:
     - Vitamin B complex_____
     - Oxytocin_____
     - Other (specify)_____
   - If no, how much do you charge for injections?
     - Vitamin B_____
     - Oxytocin_____
     - Other_____

12. How much do TBAs charge for a delivery in your area?
   - Riels_____
   - Live chicken_____
   - Rice_____
   - Cloth_____
   - Bananas_____
   - Kerosene_____
   - Wine_____

13. a) Do you ever work with TBAs?
b) If yes, how do you work with them?
   - TBAs ask for assistance_____
   - TBAs make referrals_____
   - Midwife provides advice/guidance to TBAs_____
   - Other (specify)_____

14. a) Do you tell your clients about using birth spacing?
b) How many follow your advice? (X out 10 clients)
c) Do you have any information about birth spacing that you can give to your clients?

15. a) For clients who do not want more children, do you tell them about sterilization?
b) Do any follow your advice? (X out of 10)
c) Do you have any information about sterilization that you can give to your clients?

16. a) Have you received training for IUD insertion/removal?
   - Yes, for training_____
   - Yes, informal training_____
   - No training_____
b) Would you be interested in receiving IUD training?
17. a) Since completing your midwifery training, have you received any training on birth spacing? b) If yes,
   • what was the topic________
   • when did you attend the training________
   • who provided it________
18. In addition to your government job and your private practice, do you do anything else to earn money?
19. a) When did you last attend a training/workshop for midwives? b) What was the subject of this training?
   c) Who provided the training?
20. What types of training would be most important or useful to you?
21. Are you a member of the Cambodian Midwives Association (CMA)?
22. a) Have you attended any of CMA’s training programs? b) If yes, when and what was the subject? Date_____ Subject________
23. a) Do you think women and their husbands understand the importance of midwives for helping to have a safe birth? Women______ Husbands_______ b) Do you think this understanding is great now than it was 5 years ago?
24. Do you expect to continue your government job for more than the next 5 years?
25. Why is your government job important to you?
   • Gives access to training/skills development____
   • Gives creditability to me in my private practice_____
   • Helps me meet new clients for my private practice____
   • Other (specify)_______
26. What would you like to see improve in your career over the next 5-10 years?
   • Acquire new/better skills____
   • My private practice expands______
   • Government salary increases_______
   • Other (specify)_______