



**Health Unlimited**

Action Research to Advocacy Initiative (ARAI)

**Project Update**

May 2006

# Indigenous Women Working Towards Improved Maternal Health

Ratanakiri Province, Cambodia



A Health Unlimited  
project supported by:





**The Action Research to Advocacy Initiative at Health Unlimited is funded by Christian Aid and Exchange:**

Christian Aid works in more than 50 countries, helping people regardless of religion or race to improve their own lives and tackle the causes of poverty and injustice [www.christianaid.org.uk](http://www.christianaid.org.uk)

Exchange is a networking and learning programme on health communication. Exchange has been integrated into the Communication, networking and learning programme at Healthlink Worldwide [www.healthlink.org.uk](http://www.healthlink.org.uk)



# Table of Contents

List of Acronyms	4
About Health Unlimited	5
Contributors	6
Introduction	8
Phase 1:	
<i>Report Summary - Crossing the River and Getting to the Other Side</i>	9
1. Background	9
2. The Policy Environment	11
3. Research Results: The Indigenous Perspective	12
4. Research Results: The Health Provider Perspective	20
5. Research Results Summary	22
Phase 2:	
<i>Enabling Advocacy - Stakeholder advocacy workshops</i>	23
1. Health Unlimited and Advocacy	23
2. Introduction	24
3. Planning and Preliminaries for workshops with villagers and service providers	25
4. Workshop 1: Multi-stakeholder research presentation workshop	27
5. Workshop 2: Advocacy Capacity Building Workshop for Indigenous Women	30
6. Workshop 3: Advocacy Capacity Building Workshop for Health Centre Staff	37
7. Workshop 4: Health Centre Staff and Indigenous Women Advocacy Planning	40
8. Workshop 5: Multi-stakeholder Advocacy Campaign Presentation	45
9. Lessons learnt	46
10. Concluding Comments and Next Steps	51
Bibliography	52



# List of Acronyms

<b>ANC</b>	Ante Natal Care
<b>ARAI</b>	Action Research to Advocacy Initiative
<b>HC</b>	Health Centre
<b>MRD</b>	Ministry of Rural Development
<b>NGO</b>	Non-Governmental Organization
<b>OD</b>	Operational District
<b>PHD</b>	Provincial Health Department
<b>STI</b>	Sexually Transmitted Infection
<b>TBA</b>	Traditional Birth Attendant
<b>VHV</b>	Village Health Volunteer



# About Health Unlimited

Health Unlimited is an International NGO<sup>1</sup> established in 1984, whose vision is a world in which the poorest and most marginalised enjoy their right to health. We work in difficult environments to secure access to effective primary health care and information for marginalised people affected by conflict, instability or discrimination. Health Unlimited has over 30 projects in 15 countries in Africa, Asia and Latin America, and works in partnership with communities, service providers, policy makers and donors.

Over the past 20 years, Health Unlimited has built up a strong track record in the delivery of culturally-appropriate, community-led projects in maternal and child health, HIV/AIDS, sexual and reproductive health, TB and malaria, supporting the development of basic health care services, and health communications.

Health Unlimited has significant experience and expertise in:

- Delivery of community health services in **areas affected by conflict** and **fragile states**
- Partnership with **indigenous and ethnic minority communities** in raising awareness and facilitating access to primary health care
- Cooperation with government ministries and service providers
- Health communications programmes using radio, theatre, print and other media to provide information and encourage discussion of public health issues.

## Health Unlimited in Ratanakiri

The Health Unlimited programme in Ratanakiri Province, Cambodia has been running for 14 years and employs over 65 local staff (including staff from indigenous groups), funded by various donors. The programme supports more than 100,000 poor and vulnerable indigenous people throughout the province on issues including:

- Maternal and child health
- Support and supervision of health centre staff in the provision of outreach services
- HIV/AIDS, STIs and sexual and reproductive health
- Support to Village Health Support Groups and Health Centre Management Committees
- Malaria
- Water and sanitation

1. UK Registered Charity Number 290535



# Contributors

Firstly, many thanks to our funders Christian Aid and Exchange for their continued support for our work in Ratanakiri.

This project update includes a summary of the research report: *Crossing the River and Getting to the Other Side*, which was written for Health Unlimited by Eleanor Brown (Phase 1). Special thanks go to the indigenous communities, health centre staff and Health Unlimited employees who have participated in the research phase and in the continued development of advocacy objectives and activities.

We would also like to thank the Ministry of Rural Development, the Operational District and HealthNet International, and the Provincial Health Department for their continued cooperation and participation in Action Research to Advocacy Initiative (ARAI) project activities.

This report has been compiled by Health Unlimited Advocacy Coordinator Ebony Riddell with the support of Health Unlimited staff in Ratanakiri and London. Special mentions are deserved by Noun Sopheak and Cindy Godden for all their hard work and contributions to the advocacy workshops.

We encourage those interested in reading the full research report to contact the Health Unlimited Cambodia Country Office in Phnom Penh, Cambodia ([hucco@everyday.com.kh](mailto:hucco@everyday.com.kh)) or Health Unlimited Advocacy Coordinator in London, Ebony Riddell ([e.riddell@healthunlimited.org](mailto:e.riddell@healthunlimited.org))



**Action research** combines research with social action. It aims to raise consciousness and increase awareness, while undertaking qualitative analysis.

(Mikkelsen, 2005)





# Introduction

The **Action Research to Advocacy Initiative** (ARAI) forms part of a process to establish a common advocacy agenda across Health Unlimited projects worldwide. After consultation with Health Unlimited country managers in Summer 2004, it was agreed to focus on access to maternal health care services as a common issue across many of our programmes. Indigenous communities in Ratanakiri, Cambodia, where Health Unlimited has worked for 14 years, were selected to initiate the ARAI. The project aims to tackle the barriers indigenous communities face in accessing maternal health services through the development and implementation of an inclusive advocacy strategy.

The first stage was to identify the key issues. In early 2005, Health Unlimited commissioned Eleanor Brown to conduct user-centred research into the experiences of indigenous women in Ratanakiri province in accessing modern maternal healthcare. The aim was to analyse the range of barriers and facilitators that impact on access to publicly provided maternal health services from the different perspectives of demand and supply.

The study investigated the experience of three main indigenous communities in Ratanakiri: the Tampuan, the Jarai and the Kreung in the following districts: Voien Sai, Kachon, Andong Meas, Oyadao, Bokeo and O'Chum.

The resulting research report, *Crossing the River and Getting to the Other Side*, summarised in Phase 1 of this update, used an action research methodology to identify local problems and gain consensus on needs, solutions and recommendations. The results of the research were used as the basis for workshops involving all stakeholders in the development of the shared advocacy strategy for the promotion of indigenous health rights described in this report.

The second stage consisted of a series of stakeholder advocacy workshops for indigenous communities, health centre staff and government officials between November 2005 and March 2006. The research results were presented and discussed, stakeholders identified priority issues, explored key concepts and developed an advocacy action plan. These workshops were preceded by training for Health Unlimited staff, many of whom are indigenous themselves, so as to support the communities in their advocacy efforts.

This update includes:

- A summary of the research report, *Crossing the River and Getting to the Other Side*
- Details of the process of the various single and multi-stakeholder workshops
- Key lessons learnt



# Report Summary:

## *Crossing the River and Getting to the Other Side*<sup>2</sup>

### 1 Background

Ratanakiri is a remote and isolated province in the North-East of Cambodia, bordered by Vietnam to the east and Laos to the north. Indigenous people comprise 65 percent of the population. There are at least eight different indigenous groups in Ratanakiri, practising swidden (shifting) agriculture and with animist beliefs. Marginalised by physical remoteness, language and cultural barriers, indigenous people have little access to services or essential information. Studies indicate that 98 percent of the indigenous population are not functionally literate in Khmer (official language of Cambodia).

Indigenous people are facing degradation of natural resources, diminishing food production, rapid deforestation, internal migration and land loss/confiscation. These factors impact negatively on their already precarious health and nutritional status. In addition, most people live in remote villages with limited access to affordable transport.

The Ratanakiri Health Situation Analysis 2001, conducted for Health Unlimited, found that indigenous people of Ratanakiri have significantly poorer health status than other Cambodians, with child morbidity and mortality being the highest in Cambodia (Hardy, 2001). Indigenous communities face an especially high rate of child mortality: 66 percent of the women interviewed in the study were found to have lost at least one child. Although there are no official statistics, experience from Health Unlimited's work in the province indicates that maternal mortality in Ratanakiri is also high.

Public health services in Ratanakiri are provided by the Operational District and comprise one referral hospital in Ban Lung (the provincial capital), 10 health centres, and 17 health posts. Eight of the nine administrative districts have one health centre and the other has two. Most health centres are staffed by primary nurses though a small number have staff with secondary nurse/midwife qualifications. The study found that salaries are paid irregularly, with equipment and supplies at minimum levels and standards.

**Indigenous families reported heavy infant mortality, with 23.1 percent (one in four) of all children born having died before their fifth birthday**

(Hardy, 2001)

2. The full report "Crossing the River and Getting to the Other Side" was prepared for Health Unlimited by Eleanor Brown in June 2005.

# Phase 1: Research Report Summary: *Crossing the River and Getting to the Other Side*

## 1.1: Maternal Health

Several surveys have found that indigenous women face multiple risk factors during their reproductive lives. These include:

**High Levels of Malnutrition** - Health Unlimited's Nutrition Survey (2002) found that 18 percent of mothers were underweight, and that 38 percent were less than 145cm in height. These women would be considered at high risk of complications during delivery and birth, regardless of their obstetric or gynaecological history.

**High Rates of Anaemia** - High rates of anaemia increase the risks of complications during pregnancy and birth. In the Cambodian Demographic and Health Survey (2000), 63 percent of women of child bearing age in Ratanakiri and Mondulakiri were anaemic (National Institute of Statistics, 2001).

**High Levels of Malaria** - Malaria is endemic in most hilly and forested areas of Cambodia. Due to their immuno-suppressed status pregnant women are at a higher risk of malaria and consequently miscarriages, stillbirths and complications during birth.

**Young Age at First Birth** - Young women in Ratanakiri/Mondulakiri have the highest national rates of pregnancy, with 20 percent giving birth between the ages of 15 and 19 years, compared to a national average of 8 percent (National Institute of Statistics, 2001). Anecdotal evidence suggests that for some, their reproductive lives start when they are as young as 12. Bearing children before a woman's body has fully matured can lead to dangerous complications during pregnancy and birth.

**Short Birth Intervals** - An interval of less than 24 months between births has a significant negative impact on the health of the child and the mother. However, more than 30 percent of women in Ratanakiri/Mondulakiri give birth to a child within 24 months of their previous child (National Institute of Statistics, 2001).

**High Fertility Rate** - In Cambodia, the fertility rate is highest in Ratanakiri/Mondulakiri, with just over 6 births per woman, compared to a national average of four births per woman (National Institute of Statistics, 2001). The risk of complications during pregnancy and birth increases with both age and with more than four births.

**STIs and HIV/AIDS** - The prevalence of STIs and HIV/AIDS in Ratanakiri is unknown, but it is considered to be a rising threat. According to the Cambodian Demographic and Health Survey, less than 25 percent of women in Ratanakiri/Mondulakiri know that condom use can prevent HIV transmission and unmarried women in these provinces are much more likely to have sexual partners than in other provinces (National Institute of Statistics, 2001). In-migration to the province is likely to contribute to the expected increase in HIV transmission, as Khmer traders travelling from urban centres to villages are a potential bridge population, and negative racial stereotypes of indigenous women being sexually available have heightened their vulnerability to exploitation.

## 2 The Policy Environment

Cambodia's Ministry of Health has developed a National Safe Motherhood Policy (2001-2005) which clearly outlines the maternal and neonatal health services that should be available at primary and tertiary care levels. Although the Safe Motherhood Policy was incorporated into the Health Sector Strategic Plan (2001-2005), Cambodia still faces challenges in implementing it. Problems arising from lack of qualified staff and basic infrastructure are compounded by corruption, resulting in poor standards of service and underutilisation. This has adversely affected progress towards reaching targets set by the Millennium Development Goals for reducing maternal and child mortality.

Several issues were found to have a direct effect on the quality and support for health services in Ratanakiri:

### **Contracting of Health Services in the Province**

The Ministry of Health aims to achieve nationwide coverage of basic services, focusing on high population areas. Contracting has begun in provinces that have the most severe health problems in an attempt to overcome failures in the system and build the capacity of staff and resources. In 2004, the government contracted the Ratanakiri Operational Health District to the international NGO, Healthnet International. This is scheduled to end in 2007.

### **Low Government Funding Allocation**

In terms of maternal, infant and child health, minority populations have a demonstrably greater need than the national average. Proportionately higher investment in physical and human infrastructure is needed to overcome transport and language barriers and achieve the same health outcomes. Government funding for maternal health services is low throughout Cambodia. The Asian Development Bank Referral Technical Assistance Project identified a 73 percent funding gap to achieve the recommended minimum expenditure (US\$2.60 per capita) for maternal health services nationwide.

### **Urban Concentration of Services**

Within Ratanakiri, maternal health services are concentrated at the referral hospital in Ban Lung. The Ministry of Health planned to decentralise services and offer emergency obstetric care at health centres throughout Cambodia, but there is little evidence to suggest that this is occurring in Ratanakiri.

### **Low Donor Support**

A variety of donors support the implementation of the National Safe Motherhood Policy, with capacity building programmes resulting in more efficient services. In Ratanakiri, however, donor assistance is low due to the province's low population density.

**The goal of the National Safe Motherhood Five Year Plan Cambodia is:**

**To improve the quality of life of Cambodian women and children by improving pregnancy outcomes and reducing maternal and infant morbidity and mortality**



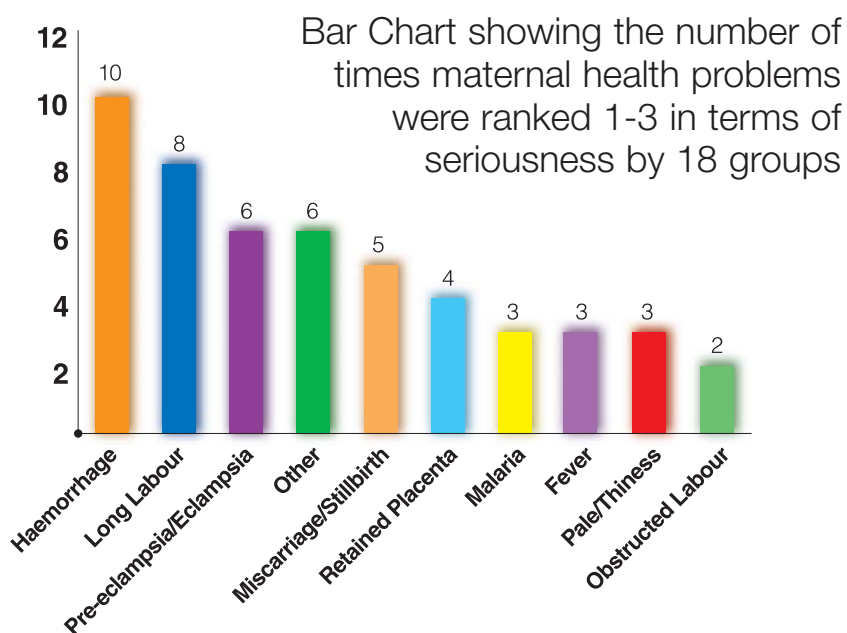
# Report Summary:

*Crossing the River and Getting to the Other Side*

## 3 Research Results: The Indigenous Perspective

### 3.1. Prioritised Health Problems

In conducting the research, indigenous men and women were asked separately to prioritise maternal health problems in terms of their seriousness.



**Figure 1:**  
**Prioritization of maternal health problems**

Surprisingly, there were few differences between villages or ethnic groups in their rankings. The most persistently prioritised health problems were:

- Haemorrhage after delivery
- Long Labour
- Pre-eclampsia/eclampsia
- Miscarriage/Stillbirth
- Retained placenta
- Malaria



## Phase 1: Research

# Report Summary:

## *Crossing the River and Getting to the Other Side*

Although these rankings do not show how often these problems were faced by pregnant women in indigenous communities, most require skilled attendance at the health centre or even the referral hospital. However, close to 99 percent of women interviewed said they had given birth in the village, with limited or no assistance except from a local Traditional Birth Assistant (TBA) or family members.

- In several cases, men's groups listed more maternal health problems than the women, citing symptoms such as tiredness, inability to sleep or joint pain that are common complaints during pregnancy, but are not necessarily dangerous
- Maternal health problems given low priority were symptoms such as swollen hands and legs, or jaundice ("yellow disease"). However, these should be considered as danger signs for both the mother and baby. For example, jaundice is likely to be a sign of malaria, which is endemic in many communities and can cause miscarriages and stillbirth.
- Health problems indicative of malnutrition during pregnancy were also given a low ranking - "night blindness during pregnancy" was considered so negligible that it was unranked by one of the groups.

**Traditional Birth Assistants (TBAs)** usually learn their skills from the experience of older TBAs in the village. They are often told in a dream or selected by their community to perform the role. TBAs assist in the delivery, but also provide advice on what foods are taboo. Donor programmes have supported training for TBAs to encourage healthy eating and dissuade against the common practice of pressing on the woman's abdomen to push the baby out during delivery.

*Health Unlimited  
conducting training  
for Traditional Birth  
Attendants*





# Phase 1: Research Report Summary: *Crossing the River and Getting to the Other Side*

## 3.2. Access to Services

The study revealed that problems in accessing ‘modern’ health care, in both health centres and the referral hospital, are persistent and deep. Barriers to accessing TBAs, however, are almost non-existent. Once again, there was little difference in the issues identified by different villages or ethnic groups.

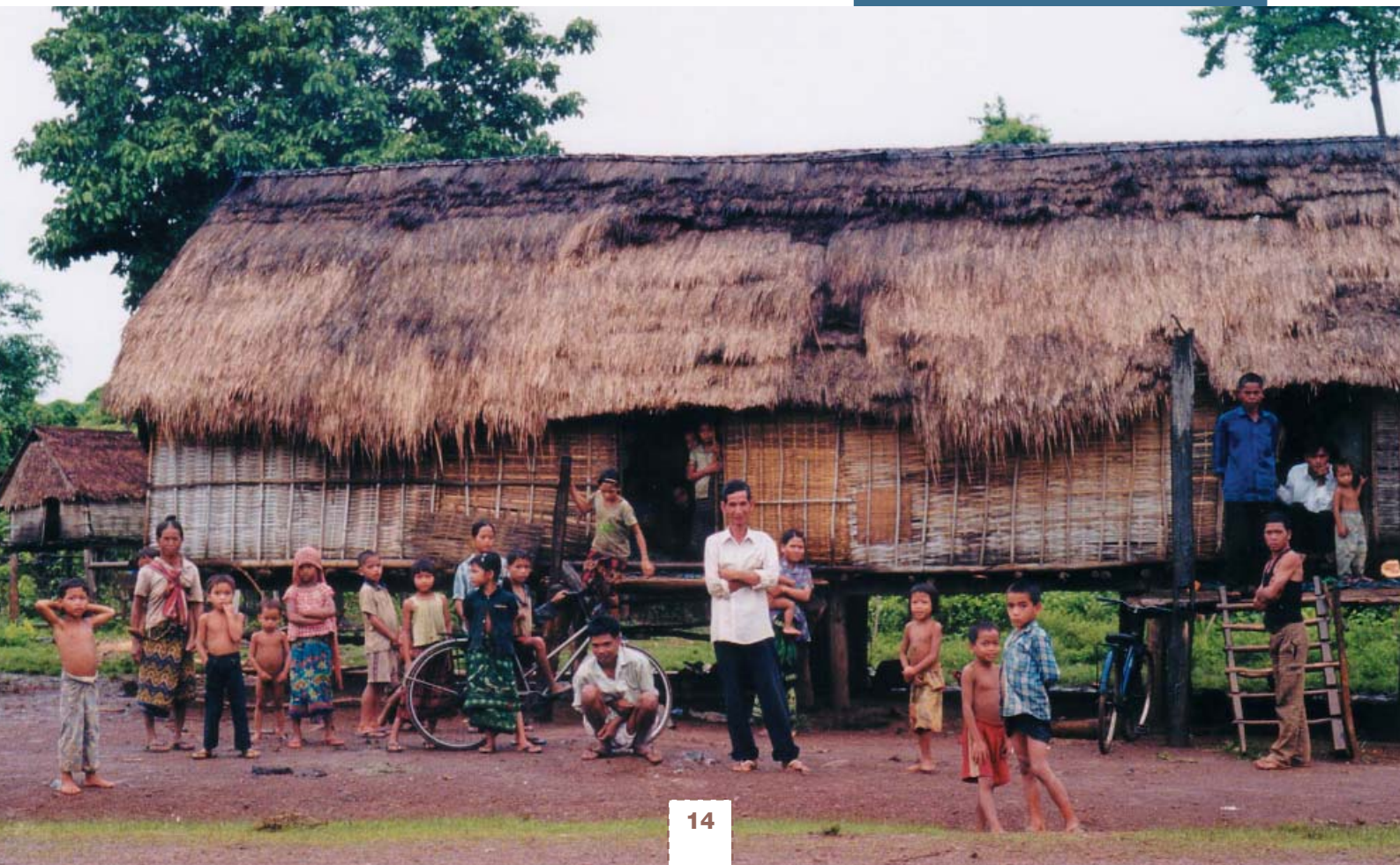
### Money

Lack of money was cited as the most important factor preventing women from accessing health care in the referral hospital and health centres. Access to cash is likely to be a deep problem in indigenous communities, where most people barely reach subsistence level, and have little opportunity to enter into the cash economy.

### Transportation/Distance

The second highest ranking problem was distance from health centres and transportation. All the villages included in the research were approximately 10 km from the nearest health centre. In the absence of appropriate and affordable transport, women are likely to find it hard to reach the health centre, especially when they need to be transported lying down. Although the referral hospital has an ambulance, the system of referral is lengthy and expensive.

*Long House, Kong Yuh Village,  
Ratanakiri province*



## Phase 1: Research

# Report Summary:

## *Crossing the River and Getting to the Other Side*

### **Availability of Care**

A major barrier to accessing treatment is that care is not guaranteed for the patient even if they have managed to make the journey to the health centre/referral hospital. Several factors quoted were “the doctor won’t treat if you don’t have money - they blame you instead”, “when you arrive, there are no staff working” and “no medicine”. These factors clearly describe some of the systemic failures of the health system in Ratanakiri. The research revealed that health staff often refuse to treat patients who have no money, or require them to buy drugs in private pharmacies (often run by health staff or their families). They also do not work regular hours and will not accept patients outside of those working hours.

### **Discrimination**

Discrimination was strongly apparent, with some indigenous people specifically talking about experiencing “strong” discrimination from health staff, and of health staff blaming and/or ignoring them when they went to seek health care. Even when staff are themselves indigenous, many take on the dominant ideology of their Khmer counterparts in typifying indigenous people as “backward, uneducated and stubborn”.

### **Social Support**

Forms of social support such as “lack of family to accompany” the patient were seen as a barrier to seeking care outside of the village. Lack of available labour substitution when the patient and their family leave the village means that families may be affected if there is no one to look after their livestock. This also limits the amount of recovery time when patients do return to the village.

### **Traditional Beliefs**

Indigenous communities have strong beliefs regarding illness and spiritual causation, and in cases of severe illness have to perform a ritual sacrifice to ancestor spirits before they leave the village. This often leads to a delay in accessing care, especially in obstetric emergencies.

### **Language**

The inability to speak Khmer was identified by three of the groups as a barrier. Women are significantly less likely to be able to speak Khmer, often relying on their husbands or a male relative to accompany them.

**In one Kreung village,  
no one in the history of  
the village had ever  
accessed health care in  
the referral hospital**



# Report Summary:

## *Crossing the River and Getting to the Other Side*

### 3.3. Factors in Decision Making

The research revealed there were many factors in decision-making that determined an indigenous woman's access to 'modern' maternal health services:

#### Confidence in the Health Service

From the villagers' perspective, there seems to be relatively little advantage to accessing health care in the 'modern' health system, as opposed to the care provided by TBAs. Though indigenous men and women appeared to have more confidence in the referral hospital than in the health centres, they had the highest confidence in the TBAs. Confidence in the capacity of the health staff in health centres had the lowest ranking.

The study found that treatment seeking of a whole village is often based on the experiences of a few individuals. Positive experiences can therefore lead to wide changes in the use of modern health services.

#### Traditional Beliefs

There are strong links between spiritual beliefs and the decision to seek treatment. A clear pattern was noted. The TBA would initially be sought for treatment and advice. If she could not cure the illness, the fortune teller would be called out to find out which spirit was causing it and what sacrifice would be required. Only when the sacrifice had been performed would the woman be allowed to leave the village. If the woman was close to death, the village would be less likely to let her leave as, if she died outside the village, they would be fined by each village they passed through as they carried her body back. Other traditional practices such as "roasting" are seen to be important to the woman and infant's recovery, many of which cannot be performed in health centres/referral hospital. <sup>3</sup>

#### The Role of the TBAs

Traditional Birth Attendants are the first line of health care within the village and are important as an 'advocate' in referring women outside if problems arise. TBAs are often called on when the woman starts to deliver or when she starts to have problems. The TBA may give advice before or after birth about cultural traditions, e.g. "don't eat eggs and sit at the door" and in the case of trained TBAs, encourage the mother to eat healthy foods. None of the TBAs surveyed described going to check routinely on women after delivery. Post-miscarriage care is provided in the village by TBAs. In several villages there was no cooperation between the TBAs and the health centre.

<sup>3</sup> **Roasting**, known in Khmer as "Ang Pleung" (literally translated as "roasting" or "grilling") is the practice of putting a small fire under the bed of the woman once she has given birth. The process is strongly valued in some communities as it is thought that raising the temperature may help to fight post-birth infections. However, the medical side-effects of roasting are unknown.



## Phase 1: Research

# Report Summary:

## *Crossing the River and Getting to the Other Side*

### **Who Makes Decisions and When**

The decision-making process for seeking health outside the village is highly communal and extensive, particularly for women who are delivering. No single person was said to be the final decision-maker. Instead, a minimum of two people were involved, most often the husband and a male from the woman's family. However, women do have more freedom to call on the TBAs. TBAs generally provide advice to the family if the situation appears serious, but are not involved in making the decision to seek treatment.

### **Perceptions of Ante Natal Care (ANC)**

Seeking ANC was often a response to problems during pregnancy (such as lack of foetal movement) rather than planned access. ANC is supposed to be provided in the villages by health centre midwives, but there are persistent problems in getting midwives to go to villages on a regular basis. The study indicated that only 20 percent of women had accessed ANC in the health centres and only 10 percent of women were able to access ANC from visiting midwives (Mackay, 2002).

### **Transportation**

No formal transportation system exists and there appears to be little social cooperation to make it available. Respondents mentioned that if they wanted to transport a woman outside the village, they would need to negotiate with motorbike owners and then look to see how much money was actually available.

### **The Referral System**

The 10 health centres in the province have access to two cars to transport patients to the referral hospital, but it is a very lengthy process sometimes taking up to a day, and the patient or a relative/villager needs to reach the health centre before they can be transported. At the time the research was conducted the fees for the ambulance were R30 000 (approximately US\$7.50) for one trip, which is expensive given the low incomes in indigenous communities.

# Phase 1: Research Report Summary: *Crossing the River and Getting to the Other Side*

## 3.4. Culturally Appropriate Health Care

Changing health services so that they become more appropriate to the culture of indigenous communities would be a significant step forward, especially if women at high risk of complications could make greater use of the health centres and so have better access to the referral hospital.

Communities had very clear ideas about how to make services culturally appropriate and which changes could significantly increase the use of health centres by women.

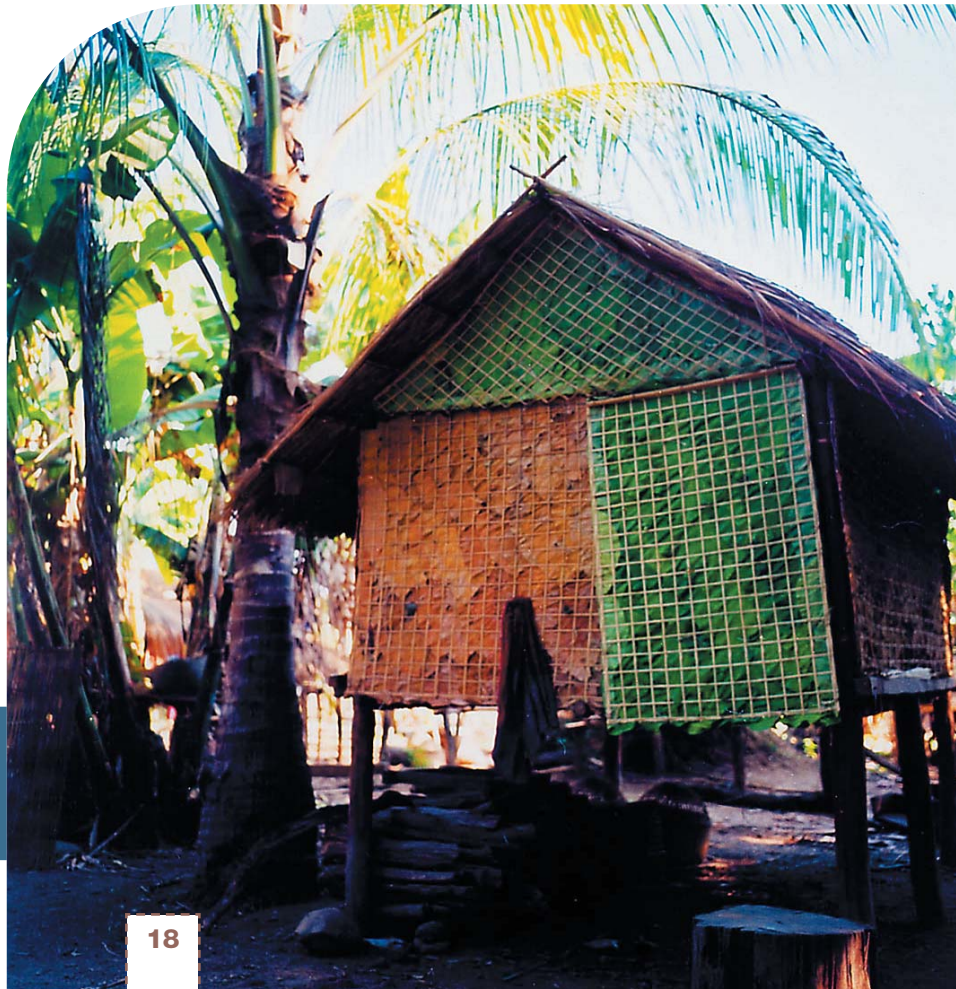
### a. Availability of a TBA in the Health Centre

Participants said that TBAs should be available to provide health care to the women in the health centre and specified that male staff should not be involved. There are good examples from other areas of Cambodia of dual care being provided by health centre midwives and TBAs, which have led to dramatic increases in the number of women giving birth in health centres (RACHA, 2001).

### b. Birthing Huts

Patients in health centres are currently put in a ward with beds arranged in rows. There is no separate place for women to give birth in privacy. In the village, women give birth in a specially made birthing hut separate from the house, which is destroyed a few days after the baby is born. Birthing huts in the health centre would have to be more permanent installations, but the cultural need for privacy is important.

*Traditional Birthing Hut, Koh Pro Brao Village, Ratanakiri Province*





# Report Summary:

## *Crossing the River and Getting to the Other Side*

**c. Roasting**

While some women did not want to do “roasting”, it was clearly strongly valued by people in the communities in order to return women to good health in the post-delivery period. This could be carried out in a birthing hut.

**d. Accommodation for Family Relatives**

Family relatives, especially female relatives, are perceived to be vitally important for looking after the woman delivering. They undertake tasks such as cooking, cleaning, looking after other children and fetching water. Providing accommodation for the family group, including cooking areas, would encourage more women to deliver in the health centre and allow greater recovery time for the woman than if she is accompanied by her husband alone.

**e. Language**

The inability of health staff to speak the local language was highlighted by some participants, though this could be alleviated if a local TBA, able to speak Khmer, were available at the health centre.

**f. Sacrifices**

The belief in sacrifices symbolically reaffirms indigenous peoples’ relationship with the spirit world, even if they are accessing modern health care. Some participants said they would like to be able to make an animal/food sacrifice at the health centres.

# Report Summary:

*Crossing the River and Getting to the Other Side*

## 4 Research Results: The Health Provider Perspective

Ratanakiri province is under-resourced, both in terms of maternal health staff and in support for their professional development. The Safe Motherhood Policy calls for decentralisation of maternal health services, especially in areas such as Ratanakiri, where populations are widely distributed and maternal health statistics are among the worst. While services have begun to be contracted out and this is helping to improve services, little has been done to provide the additional resources to address major problems.

### Referral Hospital

Emergency obstetric care is almost entirely provided at the referral hospital. This includes treatment of post-partum haemorrhage, pre-eclampsia and eclampsia, sepsis and other problems. Although the training level of some staff is relatively high, the actual number of patients per year is exceedingly low. Only 13 caesarean sections were performed in 2003, compared to the 100 caesarean sections for complications such as obstructed labour and malpresentation which would be expected in a population of this size. A caesarean section rate below five percent per 100 live births is considered an indicator of low access to emergency obstetric care. Hence hospital activity for emergency obstetric care is unacceptably low (Fury, 2004).

**“When we want to refer them to the referral hospital, they cry and say they want to go back home to their village to die there.”**

Deputy Health Centre Chief

### Health Centres

At the time of the research, out of a total of six midwives, only one was a primary nurse and the majority of the remaining were secondary nurses. Only one health centre had more than one midwife available, leaving no specialist care when they were undertaking outreach. One health centre did not have a midwife at all.

Health centres do not always have the drugs required; nor does the availability of drugs necessarily correspond to the ability of the staff to administer them. For example, although the drug Oxytocin was generally available, few health centres provided it appropriately, and one midwife who was aware of its correct use indicated that the drug was not available at her health centre.

Health Centres are unable to provide anything approaching adequate emergency obstetric care. Patients referred to the provincial hospital were often sent back to their village if they could not afford the ambulance fees.



# Report Summary:

*Crossing the River and Getting to the Other Side*

**One of the objectives of the National Safe Motherhood Five Year Plan (2001-2005) is:**

To provide at least one competently trained female health provider in basic emergency obstetric care at each health centre

## Attitudes of Health Centre Staff

Attitudes of health centre staff varied widely. Nonetheless, there was a persistent pattern of typifying indigenous communities as being uneducated, with low understanding and dominated by their religious beliefs in seeking treatment. This attitude was similar regardless of the ethnicity of the health staff, even if they were indigenous themselves. These views would be expected to negatively impact on the health services provided to indigenous communities.

In the health centre with the highest utilisation rate of maternal health services, staff had identified that they should attempt to increase their own indigenous language skills. This health centre was significant in that one of the villages under study preferred to travel greater distances to access health care there, rather than in the health centre closer by. Villagers have cited the attitude of health staff as the reason they prefer to travel to the further health centre, as they can usually be assured of receiving quality care on arrival.

Most of the midwives interviewed had a positive attitude towards cooperation with TBAs, especially for referral, updating and managing information and reducing harmful practices. They agreed that cooperation is essential to reducing incidents of maternal deaths.

**“I am so bored of trying to talk to them about health. They don't want to believe us, they just want to do according to their own culture.”**

Health Centre Nurse



# Phase 1: Research Report Summary: *Crossing the River and Getting to the Other Side*

## 5 Research Results Summary

The study has clearly shown that there are many obstacles for indigenous women in accessing maternal health services in Ratanakiri. These include money, lack of transportation, distance, discrimination, language and ritual obligations. Low use of the formal health system is unsurprising, based on the practical realities of women within indigenous communities.

Some local communities have adapted their local belief systems so that both indigenous and 'modern' health care approaches are mutually valued; their beliefs are essentially flexible and can accommodate both.

This stands in contrast to the attitudes of health staff, who see 'modern' health care as the only option. Most were inflexible about the need to incorporate elements of indigenous culture into their health provision and expressed negative views and opinions of indigenous peoples and their cultural beliefs.

For most indigenous families, TBAs were invariably the first health provider contacted for assistance when giving birth. When asked where they would prefer to give birth, only five percent of indigenous women said in the health centre, with 94 percent preferring the village. Communities perceive they have access to an effective traditional maternal health system in the village and think of modern health care only when there is a problem perceived to be beyond the capacity of the village TBA.

In emergencies, it was not always clear if women could access modern health services if they desired to do so.


## 1 Health Unlimited and Advocacy

Health Unlimited's mission is to support the poor and most marginalised in their efforts to achieve better health and wellbeing, and the organisation has a well-established track record in building capacity for improved service delivery to such groups. The organisation is also committed to a rights-based approach to developing community capacity to advocate for better health care provision and hold service providers to account.

### **Health Unlimited's advocacy work encompasses:**

- Giving voice to vulnerable groups
- Raising awareness of the rights and responsibilities of both communities and service providers
- Encouraging dialogue and cooperation between decision-makers, service providers and communities to strengthen participation and foster greater accountability





# Phase 2: Enabling Advocacy

## Stakeholder advocacy workshops

*November 2005 - March 2006*

## 2 Introduction

Following the completion of the research report, it was necessary to share the findings with stakeholders, build their capacity, and create spaces for them to work together to identify ways to tackle the barriers faced by indigenous women in accessing maternal health services. With this aim, a series of workshops were conducted between November 2005 and March 2006 in the regional capital of Ratanakiri, Ban Lung. The same villages and health centres involved in the action research phase of the ARAI project were approached to select participants for the workshops which followed.

In addition to workshops involving all the various stakeholders (multi-stakeholder workshops), individual workshops were conducted with particular stakeholder groups, such as indigenous women, in order to break down the concept of advocacy to a basic level, build confidence and trust, and develop communication skills.

At the beginning of the second phase, Health Unlimited staff members involved in the research participated in a workshop to discuss the research findings and learn about the advocacy elements. This was to enable staff members to adequately inform indigenous communities of the activities that were about to be initiated. Health Unlimited staff then travelled to the six villages involved in the research to explain the results, the purpose and activities of Phase 2, and invite two representatives from each village to attend the first multi-stakeholder workshop. Indigenous participants were therefore aware of the outcomes of the study and project objectives prior to the first multi-stakeholder workshop.

The following process description outlines the initial steps that Health Unlimited has taken so far to enable community advocacy in Ratanakiri.

- Workshop 1: Multi-stakeholder research presentation workshop**
- Workshop 2: Advocacy capacity building workshop for Indigenous Women**
- Workshop 3: Advocacy capacity building workshop for Health Centre Staff**
- Workshop 4: Health centre staff and Indigenous women advocacy campaign planning**
- Workshop 5: Multi-stakeholder advocacy campaign presentation**

### 3 Planning and Preliminaries for stakeholder workshops with villagers and service providers

A considerable amount of preliminary activity is required to facilitate villager and service provider participation in workshops, much more than we had initially anticipated. The planning process involved engaging in formal correspondence with senior ministry officials, awaiting the outcomes of referrals at various administrative levels, consulting with village chiefs, travelling to villages to arrange dates and logistical arrangements and maintaining radio contact with health centres to confirm schedules.

#### 3.1 Participation of Indigenous Women

In order to encourage women to openly and actively participate in ARAI project activities outside the pressures of engendered social roles, the decision was taken to focus on involving solely women villagers in this first phase of workshops. This would allow us to concentrate on building their capacity to act in participatory environments by developing their communications skills, confidence and self-esteem.

After permission had been obtained from the provincial governor, district chiefs and village chiefs (who selected participants), Health Unlimited staff travelled to each of the six villages in order to reassure and confirm details with participants and families. As indigenous communities do not use any formal calendar system, a further visit was necessary a few of days prior to the workshop to inform them of the number of days until the workshop would take place, and that Health Unlimited staff would be along to collect them and take them to the workshop in the provincial capital.

The aim was to ensure the participation of three women from each of the six villages involved in the research. It was necessary that the women were:

- a) willing to volunteer to participate in the workshops, which would involve travelling without other family members
- b) either TBAs, village health volunteers or had some knowledge of maternal health issues
- c) able to speak some Khmer

Health Unlimited decided to invite three indigenous women from each village because travelling outside of the village environment, particularly without male family members, is a significant step for many indigenous women. Furthermore, it was important to ensure that the women were entirely clear about the results of the research and the objectives of the workshops in order to make an informed decision about participating. In the end, many women brought their young children along to Ban Lung for the training workshops, which enhanced the relaxed, inclusive and participatory environment that Health Unlimited wanted to create.



## Stakeholder advocacy workshops

November 2005 - March 2006

### 3.2 Participation of Health Centre staff

In the case of health centre staff, Health Unlimited wrote to the contracting organisation Healthnet International and the Operational District to request the participation of one midwife and one health centre chief from six health centres serving the six villages. In the end, participants included one staff member from each health centre and two from the Referral Hospital, a total of eight. Unfortunately, only two of the participants were midwives as HealthNet International had organised a training course on a new contraceptive method which coincided with the workshop.

In all cases, Health Unlimited provided transportation to and from the villages, accommodation and meals for the indigenous women, and provided allowances for the health staff.



Health centre staff form a statue to depict "advocacy", Ban Lung, Ratanakiri, February 2006



## 4 Workshop 1: Multi-stakeholder research presentation workshop

On Tuesday 22 November 2005, a three-day workshop uniting health centre staff, representatives from indigenous communities and government officials was held in Ban Lung. The objectives were to introduce the research results, identify some of the root causes behind the high levels of maternal mortality and reach consensus in prioritising the main issues of concern.

The first two days of the workshop just brought together indigenous villagers and health centre staff to present the research results. Using a combination of small and larger group exercises, stakeholders analysed the findings within the context of their own experiences and tried to identify some of the underlying root causes for low utilisation of maternal health services by indigenous women.

On the second day participants engaged in some initial advocacy planning by developing their vision of improved health amongst indigenous women and conducting a rudimentary stakeholder analysis session to identify key targets. Community representatives and health centre staff then split into separate groups to explore the behavioural and other changes service users and providers would like to see from each other. The results of the user and service provider group work were used to formulate a draft advocacy strategy, including a common vision, objectives and activities. (See over)

On the final day of the workshop, the draft advocacy strategy was presented to the third vice governor of Ratanakiri, representatives of the Provincial Health Department (PHD), Operational District (OD), Ministry of Rural Development (MRD) and the health service contractor, Health Net International. Government officials expressed their support for the aims and objectives of the workshop and there was overall consensus on the need to work together to achieve lasting solutions to the problems of high maternal mortality and morbidity amongst indigenous women.

### Comments from participants' evaluations


***"This three days workshop is very important because it includes learning about researching and discussing and solving problems of health"***

***"When we come to discuss at this time (it) is very good and helpful for PHD staff and community as well."***

***"Thank you for conducting this workshop. This workshop gave us the opportunity to try and find out the reasons why people don't come to get the health services"***

***"This workshop has short time. It will be better to have five days for this workshop."***

***"I'm very happy to participate in this workshop because this it has made me know and learn things and (helped) my self development."***



# Phase 2: Enabling Advocacy

## Stakeholder advocacy workshops

*November 2005 - March 2006*

Draft strategy developed by indigenous communities and health centre staff during multi-stakeholder workshop 1

### **Vision**

Indigenous women in Ratanakiri Province have increased knowledge of maternal child care, so that they will regularly access health clinics and thereby help to reduce maternal and child mortality rates in the indigenous community.

### **Goal**

To reduce the number of deaths among indigenous women and children in Ratanakiri Province through increasing the number of pregnant women using health centres for their health care support.

### **Short-term Objectives: (Over next two years)**

- Build the capacity and encourage the involvement of TBAs in health care activities for pregnant women
- Increase community participation, including leadership, in promoting better health care for women in Ratanakiri
- Enhance the level of understanding amongst women about the use of drugs to treat complications
- Build trust and improve relations between health care staff and the community so as to minimize levels of discrimination and resentment
- Enhance the level of understanding among the indigenous community and leadership regarding health policies and procedures
- Advocate for staff to be available on standby 24 hours a day and enough good quality medicines in the health centre at all times
- Advocate for free transportation costs for people with severe illness or injury
- Reduce health care costs for serious cases and other related expenditures

## Phase 2: Enabling Advocacy

# Stakeholder advocacy workshops

*November 2005 - March 2006*

### Long-term Objectives: (Over the next five years)

- Build the capacity of the community to carry out health education for all women of child bearing age
- Narrow the gap in the treatment-seeking practices between pregnant women of indigenous culture and other cultures in accessing modern health care
- Train more health centre staff in indigenous languages
- Have culturally-appropriate standards of care at health centres for indigenous peoples

### Key Activities

- Regular strategic planning involving Government, health centre staff and indigenous peoples
- Training for villagers in strategic planning and advocacy, drug usage, basic health and illness and the health care system
- Developing signage that is clearly understood by indigenous people
- Continued and expanded training for TBAs
- Training for health centre staff on discrimination and appropriate behaviour
- Developing schedules for staff to be on-standby 24 hours a day
- Organising an annual provincial health forum in Ratanakiri and exposure trips to other regions
- Advocating to Government to provide free transport, free medical care for the poor, more staff that speak the local language and culturally appropriate facilities.



# Phase 2: Enabling Advocacy

## Stakeholder advocacy workshops

November 2005 - March 2006

### 5 Workshop 2: Advocacy Capacity Building Workshop for Indigenous Women

Following the first multi-stakeholder workshop, the need to particularly encourage women's participation and develop an inclusive methodology to overcome their low levels of literacy and education, and build their confidence and trust was identified. In order to achieve this a workshop exclusively for indigenous women was held to explore the concept of advocacy at a basic level and develop their presentation skills. This took place from 13-16 February 2006.

The workshop was composed of exercises to develop communications skills, explore advocacy and related concepts at a basic level and facilitate the sharing of experience.

*Advocacy capacity building workshop for indigenous women,  
Ban Lung, Ratanakiri Province, February 2006*



### 5.1 Establishing equality and participation

Most sessions started (and closed) with a simple game, such as follow the leader. These were sometimes conducted in the open air and served to energise and relax participants and “get them doing silly things”- an important method for breaking down barriers.

Cambodians are not generally accustomed to participatory workshop environments, and engendered societal roles also impact on this further. It was therefore of added relevance to break down barriers, establish an atmosphere of mutual respect and trust from the outset, and assert the equal right of participants to speak, listen and be heard. In order to address this issue, at the start of both the individual stakeholder workshops (with indigenous women and then health centre staff) participants were given a few moments to think about what they were good at, and then share this information with fellow participants on either side of them. The facilitator then emphasised that all participants were different yet equal and identical simple woven bracelets were distributed to all participants to emphasize these values. In accepting the bracelets, participants agreed to:

- Listen to each other
- Help each other
- Ask each other if they do not understand something
- Explain things to others if they do not understand

Participants then tied each others bracelets. This opening exchange of bracelets proved to be a great equalising activity which helped to put participants at ease and was especially commended during evaluations.

# Phase 2: Enabling Advocacy

## Stakeholder advocacy workshops

November 2005 - March 2006

### 5.2 Enabling Communication

As part of the selection process for the workshop, Health Unlimited had requested that participants be selected on the basis that they spoke Khmer. In the end, three of the 18 participants were not literate in Khmer and other women from their villages were required to provide translation support. This posed an additional challenge to facilitators particularly when explaining new concepts such as “advocacy” and “change”. In the larger group exercises these women participated less, but in the small group exercises they were able to talk to each other in their own languages more.

#### Using pictures

Due to the fact that the majority of participants could not read or write, the ability to depict ideas, concepts and activities through pictures was crucial for both facilitators and participants. Again, some indigenous women were reluctant to do this so drawing exercises were used during the warm-up sessions to break down barriers, relax participants and help them get accustomed to expressing themselves through pictures. For example, one exercise involved two people holding a pen together and drawing various every day objects, such as a tree or animal. Another involved participants drawing a picture of their face with their eyes closed, the results of which caused much merriment!

Facilitators needed to develop additional materials throughout the 3 day session or use props spontaneously in order to explain certain concepts. For example, indigenous women had difficulty grasping what was meant by change, a fundamental element of the advocacy concept! (see box below)

Once there was general understanding, repetition and reiteration of terms such as “change” and “advocacy” in Khmer were used as devices to consolidate comprehension and understanding throughout the workshop with indigenous women. Pictorial representations of concepts were also displayed prominently around the room and repeatedly referred to for the same purpose.

#### Explaining the concept of change

Facilitators used the following image to depict the overall aim of the ARAI project which is to reduce maternal mortality in Ratanakiri. In order to explain what advocacy is and why we do it, it was necessary to explain that we needed to bring about change. The concept of change was illustrated using the following picture:



**Current maternal mortality**

**Reduced maternal mortality**

It was hoped that this visual image would help with conceptualization, but this was not the case. Interestingly, it was not until the same image was portrayed using physical objects (rocks) that some of the women began to grasp the concept of change. These women were asked to describe to the facilitators what they understood and then explained to the other women, in their native languages if necessary.

Further examples to break down the concept of change taken from everyday situations, such as changing your regular route to the local water source, helped to further consolidate understanding.



## Phase 2: Enabling Advocacy

# Stakeholder advocacy workshops

November 2005 - March 2006

### 5.3 Success Stories

The workshop included a presentation by Chanthla, a former TBA now working as a health educator for Health Unlimited who had attended the UN Forum for Indigenous Peoples in New York in 2005. This served as a positive example of an indigenous woman working for an international NGO and fulfilling an important role in the community outside the village. It was felt that further sessions with Chanthla -- acting in somewhat of a mentor role -- would be useful as the participants were unwilling to ask questions at this early stage in the workshop.

Positive examples of indigenous women accessing maternal services at health centres in Stung Treng were also contributed by Health Unlimited staff.

### 5.4 Developing Presentation Skills

The participants responded positively to the participative session on presentation skills. Women were asked to line up facing each other in two equal lines and relay selected information to their partners using a variety of bad presentation techniques such as poor posture, over gesticulation, speaking in a low voice and lack of eye contact. The “listening” group then had to feedback to the facilitator about what they noticed about the presentations. This helped to emphasise the impact of body language and voice on the audience and allow participants to elicit what they should and should not do.

Despite some initial shyness, on the second day of the workshop, nine out of 18 women were able to deliver brief presentations on experiences of women giving birth in their villages using the microphone. Some presented their stories in their own languages. Considering women did not participate at all in the previous workshop this was a significant step forward and marked a critical moment in the development of the communication skills and self-confidence of those involved.

*Indigenous woman taking drinking water home for the day, Kong Yuh village, Ratanakiri province*



## Phase 2: Enabling Advocacy

# Stakeholder advocacy workshops

November 2005 - March 2006

### 5.5 Explaining advocacy and exploring key issues

On the second day of the three day workshop with indigenous women, facilitators began to incorporate various activities to explain advocacy, why it is done, who is involved and the basic form it takes. Initially, group exercises were conducted to identify and depict pictorially which actors are involved in the process of giving birth in Ratanakiri, distinguishing between stakeholders in the villages, and stakeholders working for the government. This enabled participants to understand the user/service provider distinction. Then participants were asked to think about what actors in the service provider group could do to provide better maternal health services.

Once the concept of change had been understood (See box above), it was possible for the women to conceptualise advocacy as actions taken to influence service providers and governments to change the situation in Ratanakiri, by enacting the improvements they had identified, and by providing information to the community.

Further group exercises took place in order for the women to further explore the changes that they wanted to see at village and government level to lower maternal mortality and morbidity. Here are some of the group suggestions:

#### Table showing possible advocacy issues identified by indigenous women participants:

What the government should change	What the indigenous communities should change
Health centre staff to be more welcoming and friendly	Conduct sacrifices quickly so as not to delay referral to health centres
No user fees	Adapt cultural practices so it is not a taboo for patients to die outside the village
Provide free transportation for patients	Skilled TBAs in villages
Provide skilled midwives at health centres	Have village meetings to solve the problems
Construct new roads from villages to health centres	Start using health centres more
Health centre midwives to conduct ante and post natal visits every month	Men should change their habits to reduce women's workloads

Groups then discussed why women preferred to give birth in their villages or at the health centre to further explore the advantages and disadvantages of accessing public health services. At the end of each session, the facilitator would summarise the discussion and reiterate the advocacy messages that the participants had identified using their pictures.

### 5.6 Antenatal care at health centres

A crucial aspect of the project is to raise awareness amongst indigenous communities of the services that are available to them at the health centres and referral hospital, and a session was conducted on the importance of antenatal care and regular visits to the health centre.

The facilitator used photographs to show the various elements of a visit to the health centre, such as checking the woman's blood pressure, measuring her belly and taking her height and weight during the course of repeated check-ups. Participants were also shown a birthing kit and explained how to use it.

#### Reported methods of accessing public health services

Indigenous women worked with fellow villagers during the workshop to discuss how they would get to their local health centre in cases of obstetric emergency. There are two ambulances at the Referral Hospital in Ban Lung, one of which is made available for transporting patients from the health centres to the Referral Hospital. The existing policy does not extend this service to the villages so families are forced to make their own way to the health centres.

The methods of transportation cited included:

- Waiting for a passing sand truck
- Carrying the woman on a hammock
- Travelling by boat
- Transporting the woman on the back of a motorbike

None of these are appropriate forms of transportation for women in cases of obstetric emergency. There is a clear link between the absence of adequate provision and the current high levels of infant and maternal mortality and morbidity. This is a problem that urgently needs to be prioritised by the responsible authorities.

The ARAI project aims to enable indigenous women to engage with decision-makers at village, local and regional levels so as to tackle the inadequacies of the current system of transportation to public health services from villages.



# Phase 2: Enabling Advocacy

## Stakeholder advocacy workshops

November 2005 - March 2006

### 5.7 Tour of health services in Ban Lung

There was heightened anticipation surrounding the proposed tour of the regional capital's health facilities which took place on the final day of the workshop. At least ten of the indigenous women have never been to Ban Lung and many had never visited a health centre.

The tour, which included a visit to a health centre and the Referral Hospital, provided a valuable opportunity for indigenous women to inspect the health facilities, talk to health providers, and obtain a better understanding of the health system. As identified during the research phase of the ARAI project, individual positive experiences of care at health centres can have a multiplier effect and lead to greater utilisation within a particular community. Another important purpose of the visit was to build the confidence of indigenous women to take the personal decision to access health services and/or serve as advocates in their villages.

The Referral Hospital visit included a tour of the ECHO room where fetal echocardiograms (ultrasounds of the foetus' heart) were conducted. The indigenous women were fascinated by the technology and actually saw an ultrasound being conducted on a pregnant woman. Hospital staff explained the purpose of the procedure and its benefits. During feedback sessions, the majority of the women indicated that this was the most interesting part of the visit.

Whilst at the hospital the women were also given information about the Equity Fund scheme currently being implemented in Ratanakiri to subsidise health care for the poor and indigenous groups. Despite Health Unlimited and other NGOs playing an active role in informing indigenous communities about the existence of the subsidy scheme, most of the women were not aware of its existence or how to go about accessing it. Advantageously, the staff member in charge of administering the Equity Fund at the Referral Hospital was fluent in several of the indigenous languages of the region and was therefore able to explain in detail the eligibility criteria and procedures for accessing the fund.

In the obstetrics department of the hospital the women were introduced to eight patients, one of whom had recently suffered a miscarriage. Several of the indigenous women were surprised to note that hospital treatment was available to women in such cases. They were also shown the incubator for premature babies. The special delivery tables with stirrups caused much hilarity!

The women were also taken to the see the beautiful local tourist spot of Yeak Laom lake. In general, indigenous women gave very positive feedback on the tour and this is an activity that we hope to incorporate into forthcoming project activities.

*Indigenous women finding out about the Equity Fund scheme at the referral hospital in Ban Lung, Ratanakiri Province, February 2006*



## **6** Workshop 3: **Advocacy Capacity Building Workshop for Health Centre Staff**

The workshop with health centre midwives and chiefs took place on 22-23 February 2006 in Ban Lung. Unfortunately, due to a training session that coincided with the seminar, only two midwives were able to attend out of a total of eight participants. The other participants were health centre chiefs and other staff.

Facilitators encountered far less communication problems as all participants were literate in Khmer. In addition, explaining the aims of the project and the concept of advocacy was far more straightforward. The group sessions worked well as the participants were familiar and experienced in contributing to workshops, and some good definitions of advocacy were formulated and shared.

Exercises to promote equality and participation that had been used in the workshop with indigenous women were repeated, such as the drawing exercises and the giving of bracelets. There was some insecurity as to whether the exercise would be equally well-received during this workshop but it worked well. Two health centre chiefs were even still wearing the bracelets at the second multi-stakeholder workshop!

Both pictorial and written materials were used during the workshop with health centre staff so as to make the process of the joint workshop with indigenous women that was to follow more integrated. However, although health centre staff were happy to illustrate issues through pictures during this workshop, they reverted to written methods when working in groups with indigenous women in the following multi-stakeholder workshop. This serves as further indication of the barriers to communication created by the perception that as literate, educated public health professionals, they occupy a more elevated strata of society than the indigenous women.

Generally, the workshop took the same form as the previous one, allowing health centre staff to explore the research results and issues around access barriers to public health facilities for indigenous women from the perspective of their own experiences. In group work, health centre staff explored questions such as: “why do women prefer to give birth in their villages?”, “why do indigenous women have more complications during delivery?”, and “what are the barriers faced by indigenous women in seeking ante and post-natal care?” They also made presentations and shared personal stories about their work with pregnant indigenous women.



# Phase 2: Enabling Advocacy

## Stakeholder advocacy workshops

November 2005 - March 2006

### 6.1 Exploring advocacy

As during the previous workshop, participants split into groups to identify the various stakeholders in maternal health services in Ratanakiri. The facilitator raised the problem of high maternal mortality and participants came up with suggestions as to how to reduce it. Again the key word change was used to explain the basic aim of advocacy. There was general understanding of the concept and participants came up with some of their own definitions:

#### **Health Centre staff definitions of advocacy:**

Advocacy is to contribute ideas on how to make change and cooperate with authorities to tackle a problem successfully

Advocacy is supporting community ideas to correct or change the situation to achieve an appropriate objective

### 6.2 Promoting good practice in client relations

There was some concern about how to approach the issue of discrimination which was one of the barriers identified by indigenous people during the research phase of the project. Health centre staff had been first introduced to the issue during the research results presentations at the first multi-stakeholder workshop and at the time it had been the cause of some vigorous denials. Part of the objective of having an individual session with health centre workers was to present the issue in a more generalised and less confrontational way by putting it within the broader context of good client relations.

#### **Role plays**

Role play exercises were used to portray positive and negative examples of greeting and assessing clients on entry at the health centre. Participants were split into two groups and given two different scenarios to plan and then act out. The positive role plays portrayed health staff greeting clients politely, inviting them to sit down, being attentive etc. The negative examples were the opposite: staff were rude, dismissive and

fulfilled other tasks while clients were describing their problems. Health centre staff clearly identified the “good service provider” and this helped to prompt discussions on the importance of ethical client relations and treating people on the basis of respect and equality. In a surprising display of frankness, one or two health centre staff even admitted to recognising themselves during the role play examples! The session went well and, interestingly, one of the midwives indicated that this had been one of her favourite sessions during a later workshop.



*Health centre staff engaged in role play activities during advocacy workshop, Ban Lung, Ratanakiri Province, February 2006*



## Phase 2: Enabling Advocacy

# Stakeholder advocacy workshops

November 2005 - March 2006

### Discrimination

Both health centre staff and chiefs acknowledged that discrimination was a problem that needed to be confronted, yet it remains to be seen whether the relevant authorities will take adequate steps to combat the prevailing stereotypes about indigenous people amongst health sector workers.

Health Unlimited recognises that tackling discrimination is a long-term process, yet hopes to make a contribution to creating opportunities and fostering the necessary political will to combat this issue through the ARAI project.

Our experience in Ratanakiri has shown that there is a severe need for the institution of training and monitoring programmes to ensure that health workers do not act in a discriminatory way towards clients and fellow staff.

## 6.3 Evaluation

The workshop with health centre staff was participatory and informative. It provided an open environment in which staff felt able to discuss difficult issues, such as discrimination, and explore the significant barriers indigenous women face in reaching care. Participants were keen to enable more women to access services in health centres and therefore understood the need for advocacy.

Staff completed evaluations by writing comments on pieces of paper with either a happy or a sad face:

### Health Centre Staff Evaluations



#### Happy Face

I am happy that I have obtained more skills

I have enjoyed learning new skills

I am glad I know a definition of advocacy




#### Sad Face

I am unhappy that some colleagues are absent

It's a shame there was another workshop at the same time

There is no hand-out for participants\*

\*hand-outs were given at the end of the workshop just after the evaluation was conducted.



# Phase 2: Enabling Advocacy

## Stakeholder advocacy workshops

*November 2005 - March 2006*

### **7** Workshop 4: **Health Centre Staff and Indigenous Women Advocacy Campaign Planning**

The fourth workshop in the series brought together a variety of stakeholders to set out an advocacy strategy aimed at reducing maternal mortality and morbidity in Ratanakiri. The workshop took place on 14-16 March 2006 and brought together 19 indigenous women, 14 health centre staff, two representatives from the Ethnic Minorities Department of the MRD, a delegate from Healthnet International, and four Health Unlimited staff members.

A significant amount of preliminary work had been done towards the definition of an advocacy plan during the previous three stakeholder workshops. It was hoped that the individual sessions with indigenous women and health centre staff would help to facilitate greater participation and cooperation amongst different interest groups.

Participants were explained the key objectives of the workshop, which were:

- to develop a one year advocacy plan, and
- to elect a Working Group to take forward to aims of the ARAI project in the short-term

As before, games were used to encourage participation and energise stakeholders before each session. Definitions and methods of advocacy were elicited from participants and examples of positive community advocacy campaigns from Cambodia and other parts of south-east and south Asia were provided by the facilitator. The general structure of the workshop involved group exercises in exploring solutions to the access barriers to maternal health services identified during the ARAI research.

## Phase 2: Enabling Advocacy

# Stakeholder advocacy workshops

November 2005 - March 2006

### 7.1 Setting recommendations and defining priorities

The main activities involved participants being split into groups to discuss recommendations to combat the barriers to indigenous women accessing public maternal health services identified during the research: lack of money, lack of transportation, discrimination, cultural beliefs, and language. Groups then fed back in plenary and more ideas were generated during the general discussion that followed. Here is an example of the results from a vote conducted to select one recommendation to tackle three of these access barriers:

**Tables showing votes for recommendations to combat barriers faced by indigenous women in accessing health centres:**

#### Lack of Money

Recommendation	Vote Result		Total Vote
	Communities	Staff	
Discount user fee	6	0	6
Free of charge for the poor people	1	1	2
Provide Equity Fund	3	11	14
Encourage people to do more agriculture	0	0	0
Provide food for the patients	10	1	11
Health education to the communities	0	1	1

#### Lack of Transportation

Recommendation	Vote Result		Total Vote
	Communities	Staff	
Improve road condition	3	12	15
Provide a boat and motor with trailer	4	0	4
Provide an ambulance from the villages to health centre	5	3	8
Provide a motor cycle, car	7	0	7
Provide a hammock to patients to the HC	0	0	0
Build a bridge across the river	0	1	1



# Phase 2: Enabling Advocacy

## Stakeholder advocacy workshops

November 2005 - March 2006

### Discrimination

Recommendation	Vote Result		Total Vote
	Communities	Staff	
Training for health staff on ethical behaviour	9	0	9
Training in accountability and responsibilities	0	0	0
The communities need to respect the relationship between client and doctor	0	2	2
No discrimination over nationality	11	1	12
Staff to pay more attention to patients	0	0	0
Provide better salaries to health staff	0	4	4

Stakeholders decided that the two major obstacles to accessing maternal health services in the health centres: money and transportation, should serve as the major focus of their advocacy activities. Interestingly, lobbying for culturally-appropriate health facilities at the health centres was not suggested when the groups were asked to define recommendations to promote indigenous utilisation of public maternal health services. This suggests that many indigenous women are well aware of the advantages of delivering and accessing care at the health centres, and would be prepared to do so if adequate transportation was provided and health care was free at the point of delivery. The ARAI research indicated that men and elders, who are key decision-makers when the question of whether to access care in health centres arises, were also supportive of the use of public health services.

## Phase 2: Enabling Advocacy

# Stakeholder advocacy workshops

November 2005 - March 2006

## 7.2 Action Plan and Working Group

The participants then consulted on the general framework in which the working group and action plan would operate over the coming year (number of meetings with other stakeholders, training courses etc.). They also set the issues they wanted to prioritise and elected those that would take this forward. For the results, please see below.

Four indigenous women, two midwives, one health centre chief and one nurse from the referral hospital were selected to serve on the working group by their fellow stakeholder group members. On the final day of the workshop, the terms of reference for the working group members were set.

The final activity involved participants revisiting good presentation techniques and dividing up responsibilities for presenting their action plan to the full set of stakeholders in the final presentation workshop.

### Goal, Objectives and Action Plan for Working Group Advocacy

#### Goal


To reduce maternal and neo-natal mortality amongst indigenous communities in Ratanakiri by increasing the number of pregnant women using public services for maternal health

#### Objectives

To influence the government and other influential stakeholders to respond to the needs and concerns of health centre staff and indigenous communities by:

- Introducing training on ethical and culturally sensitive behaviour for staff at health posts, health centres and the referral hospital
- Introducing a programme to increase cooperation between TBAs and health centre midwives
- Conducting meetings and training sessions to educate indigenous women about the importance of accessing health care during pregnancy, and providing information on the danger signs and risks
- Selecting indigenous women from local communities to train as midwives
- Starting an Equity Fund for poor women to access maternal health care at the health centres and referral hospital which includes the service fee and the provision of transport and accommodation
- Providing food for women and their families when they go to the health centre or referral hospital for treatment or to give birth
- Providing a transportation system (such as a car, or motorbike with trailer) between the villages and health centres, along with a bicycle for TBAs in isolated areas

*continued over →*



# Phase 2: Enabling Advocacy

## Stakeholder advocacy workshops

November 2005 - March 2006

### Action Plan

**Meetings with Stakeholders to discuss** (some or all of the following issues):

- Maternal health education within communities
- Selection of indigenous women to be trained as midwives
- An Equity Fund for the health centres and referral hospital
- Training and dissemination of information on cultural sensitivity and ethical behaviour for health staff
- Transportation system between the health centres and villages
- Selecting translators that speak the appropriate indigenous languages

### Training sessions

Two sessions will be piloted:

- a) Training for health staff on cultural sensitivity and ethical behaviour (who can then be trained as trainers)
- b) Training for TBAs and Village Health Volunteers to provide health education to indigenous women about danger signs during pregnancy and use of public health services

**Conference** (theme to be decided)

**Poster campaign** (on one or more of the following issues)

To encourage women to:

- use public health services for deliveries
- be aware of the danger signs before, during and after delivery
- be aware of the importance of immunisations for mother and child
- be aware of the importance of good nutrition



## 8 Workshop 5: Multi-stakeholder Advocacy Campaign Presentation


The final multi-stakeholder workshop took place on 23 March 2006, and was more of a half-day meeting to allow the indigenous women and health centre staff to present their action plan to the wider group of stakeholders which included government officials. The Provincial Governor, representatives from the PHD, OD and MRD Department for Ethnic Minority Development were joined by Healthnet International, and Health Unlimited and other NGO staff.

The meeting was facilitated by one of the health centre midwives that had taken part in an earlier workshop, in what was the first time she had ever spoken in a public event. The meeting was opened by the new Health Unlimited Ratanakiri project manager and government representatives then made speeches in support of the project and the planned advocacy initiatives and expressed the desire to cooperate. This was followed by a PowerPoint presentation using text and pictures in which several indigenous women - mainly working group members - shared the responsibility of presenting the goal, objectives and action plan for advocacy over the coming year. This was the first time any of them had spoken in front of a large public audience.

The meeting ended with a question and answer session and a few closing speeches.

*Working Group member presenting advocacy objectives during the advocacy campaign presentation workshop, Ban Lung, Ratanakiri Province, March 2006*





# Phase 2: Enabling Advocacy

## Stakeholder advocacy workshops

*November 2005 - March 2006*

## 9 Lessons learnt

A number of important lessons were identified and used to guide and adapt the development of the workshop series.

Evaluations were conducted at the close of each workshop, often in groups. Due to the gender and cultural factors amongst indigenous women previously outlined (lack of confidence, lack of experience, low levels of literacy and education, perceived low social status), evaluation of workshop activities was a real challenge. As is often the case in such situations, the few substantial comments that were given were overwhelmingly positive. It is difficult to ascertain to what extent this is a true reflection of participants' opinion, or merely indicative of an unwillingness to appear critical, which is common in Khmer culture.

### 9.1 Multi-stakeholder workshop 1

The first workshop was useful in terms providing a collaborative environment where:

- stakeholders at various levels from both the supply and demand sides discussed and validated the research results on access barriers to maternal health services for indigenous women
- stakeholders shared information and proposed strategies for addressing the access barriers
- key decision makers at local, district and provincial levels voiced support for the ARAI project and its objectives

However, due to time constraints, the initial multi-stakeholder workshop was held without adequate planning for the varying needs of the participants.

## Phase 2: Enabling Advocacy

# Stakeholder advocacy workshops

*November 2005 - March 2006*

### **Low levels of participation by indigenous community representatives**

The low level of participation in discussion and debate by representatives from the indigenous villages had a number of causal factors. Indigenous women were at a particular disadvantage due to gender and cultural constraints, low literacy levels and issues of social status. Analysis of lessons learnt from the first workshop guided planning for subsequent sessions so that the same mistakes were not made twice.

Although Health Unlimited staff had travelled to the selected villages to explain the results prior to this workshop to ensure the issues were understood, the predominant use of written materials at the workshop meant that some of the indigenous participants were unable to follow the course of events or meaningfully participate. Clearly the issue of literacy and the potentially intimidating experience of speaking in front of senior officials played a significant role.

In particular, indigenous women, who tend to have lesser skills in Khmer, assumed the role of passive participants. It later emerged that many of the women who attended the first multi-stakeholder workshop could understand and speak Khmer despite not participating at all in the activities and discussions. In such cases, there was a clear need to build their confidence and levels of trust. Steps were taken to address this issue in the workshops which followed. One indigenous woman who was completely silent during this workshop later participated actively in the indigenous women's workshop and, being a natural leader, was chosen as one of the Working Group members.

### **Importance of pictorial materials**


After the first multi-stakeholder workshop, we moved from written materials to the use of pictures to enable participants with low literacy skills to participate alongside those with higher levels of education. Additional pictures could be comfortably developed during the workshops to clarify concepts and issues.

### **Discrimination a contentious issue**

The problem of discrimination was identified as part of the research and therefore needed to be shared with stakeholders from the beginning of the workshop phase. Unsurprisingly, research results indicating discrimination as an access barrier for women accessing health centre prompted defensive reactions from some health centre staff members. The topic was the cause of much debate. Nevertheless, it was important to bring the issue out in the open and stimulate discussion about how to combat discriminatory attitudes and practices amongst health staff. This was confirmed by certain indigenous participants, who expressed that they valued the opportunity for the issue to be acknowledged and discussed in the presence of high level officials.

The issue of discrimination was explored further during the individual stakeholder workshop with health centre staff which followed. However, with hindsight it may have been a better idea to explore the issue with health centre staff during an individual workshop, prior to the multi-stakeholder session.





# Phase 2: Enabling Advocacy

## Stakeholder advocacy workshops

*November 2005 - March 2006*

### 9.2 Workshop with Indigenous Women

Significant progress was made in building the confidence, awareness and communication skills of the women and several were identified as natural leaders. There was also widespread validation of the research results amongst the indigenous women that participated in the workshop. Although some pictorial materials were prepared in advance, more needed to be developed as the workshop progressed. Fortunately, this could be done quickly whilst the women were involved in group work.

Although it took far longer than was initially planned, by the close of the workshop the majority of the women had grasped the concept of advocacy and were able to identify issues that should be prioritised in order to improve access to public health services for indigenous women.

#### **Challenges of group work**

The indigenous women tended to want to work with others from their own villages, although facilitators generally encouraged women to work in mixed village groups. However, women did work in same village groups when discussing specific methods of getting to health centres.

The fact that some women did not understand Khmer also impacted on their participation in large group exercises, but in the small group exercises they were able to communicate in their own languages more.

#### **Need for several facilitators when dealing with low literacy groups**

Group work was difficult due to the shyness of some participants. Many of these sessions therefore required constant facilitation throughout, rather than just monitoring. Due to the limited number of facilitators, it was necessary to conduct more sessions in a large group formation or plenary style than had been planned.

Several facilitators or support facilitators are needed when working with low literacy groups, or with participants that need additional support for other reasons. In some sessions, the facilitator/s found themselves doing too much of the talking and relying on large group/ plenary work, rather than small group exercises. This format is obviously not as participatory and inclusive as small group exercises.

#### **Cultural and Gender factors**

During the workshop exercises there was an evident “you know best” mentality amongst the indigenous women when interacting with facilitators which made it very difficult to garner opinions or obtain feedback in evaluations. It was not possible to identify whether this was due to a lack of understanding of what was being requested, or a reflection of the lack of confidence and familiarity with expressing views or opinions. Group games and exercises in communication skills helped to a certain extent, but there are obvious cultural and gender factors which impacted on participation levels.

In cases of poor comprehension, women who had stronger Khmer language skills sometimes acted as supporting facilitators; relaying information and clarifying concepts with the facilitators.

#### **Less is more when it comes to agendas**

Although you don't want to be caught out with insufficient material, it is vital not to fall into the trap of trying to cover too much in the agenda. Particularly in the workshop with indigenous women, it was necessary to allow plenty of time to cover new and potentially complicated concepts (e.g. advocacy). It is best to have a flexible agenda from which items can be left and for which additional exercises are planned if extra time is available at the end.

### 9.3 Indigenous Women and Health Centre Staff Advocacy Planning

This was probably the most ambitious of all the workshops in terms of material that needed to be covered and outcomes delivered.

The representatives from the Ministry of Rural Development, who had also participated in the research phase, helped to facilitate some of the sessions with the indigenous women and health centre staff during this second multi-stakeholder workshop. As well as helping to further enhance the active involvement of senior health officials in the project and cooperation between stakeholders at all levels, there was an additional benefit to this. As group facilitators, officials assumed the role of encouraging other stakeholders to participate in discussion and taking their views into account, rather than dominating the conversation as can sometimes be the case. On the flipside, in some cases this led support facilitators to “take over”.

#### **Mixed-stakeholder Group Work still challenging**

Cambodians are not generally accustomed to participatory workshop environments, and engendered societal roles also impact on this further. Furthermore, work with mixed groups of indigenous women and health centre staff was problematic due to a perceived status gap. The indigenous women were generally timid throughout the various ARAI workshops, even when in isolation from other stakeholders. When grouped together with other stakeholders with higher levels of education, confidence, perceived social status and exposure to training environments, indigenous women understandably felt intimidated. However, it is important to note that the majority of the women have grown significantly in stature and confidence during the workshop process.

It was unfortunate that health centre staff often neglected to communicate with indigenous women during the group sessions, which led to a situation where group recommendations for the advocacy action plan were sometimes set without input from indigenous participants. Again, the low confidence levels and in some cases low literacy levels of the indigenous women meant that it was easy for them to be excluded. Additional facilitators, ideally one per group, were needed to combat this situation. Unfortunately, such support was not available, but facilitators used the plenary sessions to obtain a greater diversity of opinion.

In one case, an indigenous participant was visibly offended after a suggestion made during a group session was ignored. This problem was identified by one of the facilitators and the decision was taken to encourage individuals to express their views during the feedback session, in addition to the planned report back in groups. This was a useful device to ensure that those wishing to express their views had another opportunity to be heard. Further encouragement and support was provided to this participant after the session.

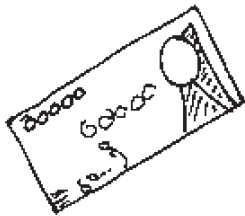
## Phase 2: Enabling Advocacy

# Stakeholder advocacy workshops

November 2005 - March 2006

Barriers for indigenous women in accessing maternal health services in Ratanakiri

(Drawings developed for workshop phase of ARAI project)



Money



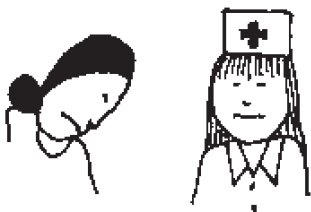
Transportation



Language



Traditional Beliefs/  
Ritual Obligations



Discrimination



Low levels of health education\*

\* The problem of low health education levels as an access barrier was added by indigenous women during the workshop phase.



## 10 Concluding Comments and Next Steps

The workshop series outlined in this report is just the first phase of activities of the action phase of the ARAI project. The ARAI working group of four indigenous women, two midwives, one health centre chief and one nurse will work to take forward the objectives they have identified in cooperation with the Provincial Health Department, Operational District and Healthnet International (see Section 8.2).

The key outcomes of the workshops can be summarised as follows:

- Enabling improved understanding of issues around access to maternal health services
- Contributing to the empowerment of indigenous women through building confidence and self-esteem
- Creating opportunities for indigenous communities to influence their own development by setting their own advocacy agenda and supporting them in their efforts to act upon it
- Facilitating collaboration and open discussion between government officials, health workers and indigenous groups
- Raising awareness amongst indigenous women of public maternal health services

### Future activities

The activities will be aimed at improving village-level and health centre-level capacity to respond to the maternal health needs of indigenous communities. There will be a particular focus on grassroots development. The working group will take forward their action plan (outlined in Section 8.2), as well as pursuing additional priorities and opportunities that arise. The action plan currently involves the following:

- Regular meetings with local and provincial officials to advance advocacy objectives
- Training sessions for health centre staff on cultural sensitivity and ethical behaviour (who can then be trained as trainers) and for TBAs and Village Health Volunteers to provide health education to indigenous women about danger signs during pregnancy and use of public health services
- Conference on health issues in Ratanakiri, bringing together villagers, service providers and government officials (theme and timing to be decided as other activities develop)
- Poster campaign in indigenous villages to raise awareness of issues related to child and maternal health and the health system

We hope to further enhance this action research project by building the confidence of primary stakeholders to speak out, strengthening their literacy skills, and developing their knowledge base and understanding of local power relations. This will allow us to utilise more sophisticated tools and frameworks for advocacy planning and reviewing as the capacities of primary stakeholders develop.

In addition, Health Unlimited will be seeking further funds to continue to support the development of this community-led advocacy project beyond the 2006-2007 financial year.



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## Other Health Unlimited publications

Title	Author	Year
1. <i>Crossing the River and Getting to the Other Side: Access to Maternal Health Services amongst Ethnic Minority Communities in Ratanakiri Province, Cambodia</i>	Eleanor Brown	2005
2. <i>Utz' Wachíl- Health and wellbeing among indigenous people</i>	Compiled/edited by Fiona Bristow	2003
3. <i>Vaccination Survey</i>	Dr Prudence Hamade	2003
4. <i>Indigenous peoples food diary</i>	Dr Prudence Hamade	2003
5. <i>Process of Community Consultation for Health</i>	Eleanor Brown	2003
6. <i>Food Taboos</i>	Dr. Pip Fisher et al	2002
7. <i>A Health and Nutrition Survey</i>	Dr. Pip Fisher et al	2002
8. <i>Ratanakiri Health Situational Analysis</i>	Dr Fiona Hardy	2001
9. <i>Conference paper: Spiritual Health and Natural Resources</i>	Caroline McCausland	2001
10. <i>Of spirits and services: health and healing amongst the hill tribes of Ratanakiri province</i>	Joanna White	1995

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