Towards safe abortion access: an exploratory study of medical abortion in Cambodia

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Abstract: In 2010, following its approval by the Ministry of Health, the medical abortion combination pack Medabon (containing mifepristone and misoprostol) was made available at pharmacies and in a restricted number of health facilities in Cambodia. The qualitative study presented in this paper was conducted in 2012 as a follow-up to longer-term ethnographical research related to reproductive health and fertility regulation between 2008 and 2012. Observations were carried out at several clinic and pharmacy sites and in-depth interviews were conducted with a purposive sample of 20 women who attended two MSI Cambodia centres and 10 women identified through social networks; six men (women’s male partners); eight health care providers at the two MSI centres and four pill sellers at private or informal pharmacies (who also provided health care services in private clinics). Although the level of training among the drug sellers and providers varied, their knowledge about medical abortion regimens, correct usage and common side effects was good. Overall, women were satisfied with the services provided. Medical abortion was not always a women-only process in this study as some male partners were also involved in the care process. The study illustrates positive steps forward being taken in making abortion safe and preventing and reducing unsafe abortion practices in Cambodia.

In Cambodia, total fertility rates have decreased considerably over the last 30 years, from 6 in 1980, to 3.3 in 2004, and 2.9 in 2010, respectively. Despite various improvements, however, there is still a lack of access to the range of contraceptive methods in public health facilities, particularly long-acting methods such as intra-uterine devices, implants and permanent methods. Many Cambodian women also perceive hormonal birth control methods, e.g. oral or injectable contraceptives, as the cause of a number of physical problems, which leads them to switch from one method to another, or to stop using a method altogether. As a result, unintended pregnancies frequently occur and Cambodian women may seek medical or surgical termination of pregnancy, often under unsafe conditions.

In Cambodia, the abortion law was reformed in 1997 to allow abortion on request up till the 12th week of pregnancy and in certain circumstances during the second trimester. This law was adopted to contribute to reducing the high maternal mortality ratio at the time, estimated at 900/100,000 live births. A significant number of maternal deaths were believed to be caused by complications of unsafe abortion. After the reform of the abortion law, implementation of safe abortion services was slow and initiatives to improve access to safe abortion are only recent. Lack of awareness of the law and lack of available safe abortion services means many women continue to induce their own abortions through non-registered abortion medications or seek unsafe services that result in complications requiring post-abortion care.

Several public health studies have documented these problems in Cambodia and advocated for improved access to safe abortion services.
A few studies have also documented Cambodian women’s experiences in accessing “traditional” non-surgical abortifacient methods.\textsuperscript{8–10} In rural areas, women would swallow herbal preparations such as a mixture of rice wine with pepper and garlic, while others consumed a concoction of rice wine and herbs sold by the \textit{Grû Khmer} (traditional healer) and a pill called Tiger\textsuperscript{11}.\textsuperscript{2} More recently, research has highlighted that Cambodian women also use pharmaceutical products, typically unregistered combinations of mifepristone and misoprostol, described locally as “Chinese pills”, as they are predominantly manufactured in China.\textsuperscript{4,14}

Due to the Millennium Development Goals, Cambodia has taken a great deal of action in the area of maternal health, specifically to “reduce by three quarters the maternal mortality rate by 2015”. As a result, this ratio fell from 472 per 100,000 live births in 2000–2005 to 206 in 2006–2010.\textsuperscript{13} Contributing to this success was the introduction in 2007 of the national Comprehensive Abortion Care (CAC) training curriculum which, since 2009, following advocacy efforts highlighting high maternal mortality from unsafe abortions, has included medical abortion. Services were introduced at the main public hospitals in Phnom Penh, the capital city, as well as some provincial hospitals, international non-governmental organization (NGO) clinical centres, some registered private clinics and registered pharmacies.

Given these circumstances, we wondered why, how and to what extent cultural values, gender norms, social organization of health care as well as individual experiences and attitudes regarding unwanted pregnancies shaped medical abortion practices in Cambodia. An exploratory qualitative study was conducted to examine the implementation and the effects of the distribution of Medabon at selected health care facilities. A follow-up qualitative study was conducted at one site in Takmao (Kandal province) and at seven sites in the capital city of Phnom Penh: two NGO clinical centres run by Marie Stopes International Cambodia (MSI Cambodia), one private clinic and four local pharmacies.

At the beginning of 2013, MSI Cambodia operated seven centres in seven provinces in Cambodia. All centres, including the two involved in this research, provide a comprehensive range of sexual and reproductive health services for set fees. In 2012, each of the centres served over 500 patients per month, with about 10% of them coming for abortion services, both medical abortion and manual vacuum aspiration (MVA).

In depth-interviews were conducted with a purposive sample of 30 women (ten at each of the two MSI Cambodia centres and ten women identified through social networks); six men (some of the women’s male partners); eight health care providers at the two MSI Cambodia centres and four pill sellers at private or informal pharmacies (who also provide health care services in private clinics). Women were selected among patients attending reproductive health services at each of the health care facilities. A restricted number of male partners were identified by the women selected for interview. All available providers directly involved and dispensing Medabon at selected health care facilities were interviewed. Pill sellers were purposively selected in Phnom Penh.

In-depth interviews with pill sellers and Medabon providers and users were conducted at study sites.

Methods

The qualitative study presented in this paper was conducted as a follow-up to a longer term ethnographical research related to reproductive health and fertility regulation issues carried out between 2008 and 2012.\textsuperscript{2,12,13} In this previous research, over 200 interviews and 20 focus group discussions were held with women, some of their male partners, health care providers working in private or public settings and at home, pharmacists working in registered and unregistered pharmacies, and social workers. In addition, observations of counselling sessions and reproductive health medical procedures were carried out. At the end of 2012, additional in-depth interviews and observations were conducted. We also completed our ongoing investigation of unregistered medical abortion products. These are commonly referred to in Cambodia as the “Chinese pill”, and are popular but unregistered abortifacient pills. Our research found that women were resorting to unregistered medications to avoid unsafe and possibly ineffective surgical abortion practices, and also because they didn’t have access to safe abortion services in public facilities and private clinics were too expensive.\textsuperscript{2,3}
Interviews with women and their partners were conducted at their homes. The interviews used a semi-structured questionnaire format, with both closed and open-ended questions, to ensure key standard information was obtained. Researchers were given freedom to follow any interesting threads. To be eligible, interview participants needed to be aged 18 years or older and willing to participate following informed consent, and were using or had used medical abortion pills within the last six months. Male partners of interviewed women were eligible as well as providers who were dispensing medical abortion pills. We also conducted various observations (e.g. organization of care, counselling provided to women) related to the provision of medical abortion services at each of the study sites.

All qualitative information collected through interviews and observations was recorded in Khmer and translated into English. Content analysis was then conducted. The techniques used for content analysis included encoding information, analysis of words (word repetition, key-indigenous terms and categories) and identification of emerging themes and sub-themes. An inductive research approach was applied.

The study protocol was approved by the National Ethical Committee for Health Research (NECHR) in Cambodia, the Institutional Review Board at the Institute of Tropical Medicine, Antwerp, and the Ethical Committee at the University of Antwerp in Belgium.

Findings

Medical abortion pills: different products, various sellers and unstable prices

The MSI centres were providing only Medabon. The private pharmacists and pill sellers interviewed were dispensing both Medabon and unregistered Chinese pills.

Medabon* was approved by the Cambodian Ministry of Health in 2009. It contains 200 mg mifepristone and 800 μg misoprostol (4 tabs x 200 μg), which is the WHO-approved regimen†

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*Medabon was developed by the Concept Foundation under an agreement with the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. It is licensed to and produced by Sun Pharmaceutical Industries Ltd, Mumbai, India.


Since December 2010, Medabon has been sold in Cambodia by the NGO Population Services International (PSI) and distributed by the local firm Mega Lifesciences (Mega) in 21 of Cambodia’s 23 provinces (excluding Banteay Meanchey and Mondolkiri provinces). Originally, the price of Medabon was fixed by PSI. At the time of research, it was sold to Mega by PSI through its social marketing programme for US $2.70 per pack. Mega then sold each pack at US$3.50 to health care providers, who were recommended to sell it for US $4.50. In 2012, we observed that Medabon was sold at US $10—$15 per pack in pharmacies. The MSI centres were supplied with Medabon pills by MSI Cambodia’s head office in Phnom Penh. At MSI’s centres, Medabon was sold for US $20 as part of a comprehensive abortion service package which included medical consultation, counselling, pain relief, written and pictorial information about the medical abortion procedure, post-abortion care and post-abortion family planning.

The Chinese pills do not follow WHO regimens but they are widely available on the market in Cambodia. The name “Chinese pill” refers to a combination of mifepristone and misoprostol, in varying dosages, made by a number of Chinese companies.\(^4,14\) The type of Chinese pill purchased during this study was a product made by the firm Beijing Zizhu.

The instructions inserted in the product box were written in Chinese and not understood by the researchers and probably not by Cambodian users either. According to the instructions on the company’s website, mifepristone (6 tablets X 25 mg = 150 mg) should be taken in combination with misoprostol (3 tablets X 200 μg = 600 μg) to terminate a pregnancy of less than 49 days after the last menstrual period and is not to be used beyond 50 days of pregnancy. Various other kinds of Chinese pills are also available in Cambodia.\(^4,14\) To date, no scientific information is available to quantify the extent of sales or the effectiveness of “Chinese pills”. However, this market appears to be quite developed. The majority of women we talked to knew these pills and many had already used them. In addition, they were sold in most pharmacies we visited.\(^14\)

A wide range of pill sellers provide medical abortion

Considering the already documented heterogeneity of drug providers in Cambodia, in registered
We decided to interview various kinds of pill sellers. We also interviewed two medical doctors in their private pharmacies and two providers selling Medabon in their small private clinic/pharmacy in Phnom Penh. The level of knowledge related to Medabon use, dosage, side effects and complications varied widely among these providers.

One of the women pill sellers interviewed, who referred to herself as a wholesaler selling medical abortion drugs in her shop, reported never attending any training. The two medical doctors interviewed said they had received some training but did not provide any information on how or where they were trained.

Despite varying levels of training, all the pill sellers that stocked Medabon knew that it combined mifepristone, to be taken orally on the first day, and misoprostol, to be inserted into the vagina on the second day. They also knew that Medabon is permitted for use within the first 63 days of pregnancy and were able to identify potential common side effects, such as nausea, headache, chills/shivering, fever, vomiting and diarrhoea, including pain after inserting the four pills into the vagina. Thus, they would sell pain relief medications such as paracetamol or other drugs such as Kinal (containing paracetamol, aspirine and caffeine) or Sara (containing acetaminophen) when clients purchased Medabon. They also mentioned that women using medical abortion had to return to see a doctor if the bleeding continued after one week.

All the pill sellers interviewed reported that they felt Medabon was 97–98% effective and very safe, and much cheaper than manual vacuum aspiration or MVA. They also emphasised that incorrect usage of Medabon may lead to incomplete abortion. Three of the four pill sellers reported they would provide consultations with the woman before selling her the medication.

"Most pregnant women who come to my clinic rarely ask directly about Medabon. First they consult with me and explain the reason why they have decided to not continue the pregnancy. Sometimes if I observe that they are not so clear in explaining their case, I do not sell them the pills. I do a urine test or I ask them to do an ultrasound examination." (Dr A, 36 years old, male medical doctor working for an NGO and selling medical abortion pills in his own small pharmacy).

When the reason for purchasing Medabon was not clear, this pill seller suspected the client might be purchasing the product for someone else or wanting to use it beyond the recommended number of weeks of pregnancy. Another pill seller helped clients to calculate the gestation of the pregnancy by asking questions related to their previous menstrual period. Two pill sellers also emphasized that they would not sell Medabon if after questioning the woman, they suspected she was more than two months pregnant. Three of the pill sellers said they would provide follow-up consultations to their clients. Besides selling medical abortion pills and giving post-abortion follow-up, two pill sellers also reported giving advice on post-abortion contraceptive methods and selling the women various contraceptive methods, including oral contraceptives, a Depo Provera injection or condoms. They would also give advice on natural methods, such as the calendar method or withdrawal.

Medical abortion provision at two MSI Cambodia centres

Eight women health care providers working at MSI Cambodia were interviewed for this study. Their roles included providing counselling, safe abortion services (MVA and medical abortion), contraception and sexually transmitted disease (STI) services. All providers had completed the 8-day Comprehensive Abortion Care training provided by the National Maternal and Child Health Centre under the Ministry of Health* before commencing service provision at MSI Cambodia. This training included both theory and practicum on MVA and Medabon medical abortion use. All providers reported no previous experience of providing abortion services before working with MSI Cambodia.

All MSI Cambodia providers gave counselling and a medical consultation to women in order to assess their general health status, the diagnosis and the length of the pregnancy. A good example of a standard medical abortion consultation at MSI Cambodia centres was described like this:

"If the client decides to choose medical abortion, I tell them more details about Medabon usage, normal effects, side effects, and contraceptive methods. First, I ask them to sign the consent form that says they accept abortion, in order to avoid any problems [compulsory under Cambodian..."

law. Then, I bring a glass of water and one tablet. I tell them that this is the first pill, mifepristone, which aims to stop pregnancy development and that they cannot reverse their decision after having taken it. I tell them to check the time as they will have to remember to use the other pills at the same time on the second day. On the second day, four misoprostol pills (second set of pills) are inserted into the vagina... The woman must lie down for 30 minutes to make the medicine effective.” (Midwife, Mrs B)

We observed that all MSI Cambodia health care providers used the pictorial guides contained in the Medabon box to explain to clients the various details on how to insert misoprostol tablets in the vagina: to wash their hands properly, to lie down on the bed, raising their knees and pushing the pills as far as they can into the vagina.

All health care providers interviewed could clearly report the advantages and disadvantages of medical and surgical abortion. According to the Medabon user instructions, Medabon is 97–98% effective. However, based on the providers’ experiences with incomplete abortions, their perception was that it was effective in 93%–95% of cases. They understood that medical abortion did not harm the uterus. Also, they believed that surgical abortion was much more painful than medical abortion, and from their point of view, medical abortion was just a means to induce menstruation.

Few health care providers had informed their relatives about their professional activities due to fears of stigma. For example, another told us:

“At the beginning when I started working at the MSI Cambodia centre, my relatives as well as my husband did not know that I provided abortion services. They just knew that I provided women’s reproductive health services including for STIs, family planning, and counselling.” (Midwife, Mrs C)

Six of the seven health care providers expressed a tension between their professional obligations and their personal or religious concerns about providing abortion services. All acknowledged that despite these feelings, they felt that they were making an important contribution, bringing necessary services to support Cambodian women’s reproductive health.

**Women’s experiences with medical abortion**

Despite the increased availability of medical abortion in Cambodia, 2012 data for the two MSI Cambodia centres show that of the total number of women who accessed abortion services, only 40% were for medical abortion. Some of the possible reasons for this lower rate in comparison to MVA include: preference for MVA as it is quicker and bleeding afterwards is similar to a normal period; distance of the woman from the centre and difficulties returning for follow-up; pregnancy of more than nine weeks, meaning use of medical abortion is excluded; and unwillingness to experience prolonged bleeding common with medical abortion use. MSI Cambodia centres report a 97.3% success rate for medical abortion among clients, with the most common failures related to retained products of conception (incomplete abortion) and in very rare cases, continuing pregnancy or infection.

A total of 30 women were interviewed, with 25 having used Medabon and five using the Chinese pill. Of the 25 who used Medabon, 20 received the preparation at one of the two MSI Cambodia centres and the other five bought the pack from pharmacists, drug sellers or midwives.

The women who received Medabon at the MSI centres reported hearing about the service through neighbours, friends, relatives, NGOs or MSI Cambodia’s Pregnancy Options and Advice Hotline, whose phone number is displayed on MSI Cambodia’s socially marketed pregnancy test kits. These women were more knowledgeable on issues related to medical and surgical abortion than those who received services at pharmacies.

All women could describe the advantages and disadvantages of both abortion methods. Most of the women described Medabon as *Thnam Soul* (the pill inserted into the vagina) in Khmer language. They also knew that the Medabon pack contained two kinds of pills. Only one woman could clearly describe that the medications are mifepristone and misoprostol. All women interviewed reported resting after self-insertion of the four misoprostol tablets, except for one female construction worker in Phnom Penh who said she was afraid her salary would be reduced if she took time off work. Like the other women interviewed, she felt some discomfort with bleeding and abdominal pain but she felt she had no other choice but to withstand it.

Most of the women who reported using Medabon either at MSI Cambodia centres or from pharmacies and who had successful abortions, reported experiencing heavy bleeding 30 minutes to four hours after inserting the
four misoprostol pills. All reported that they clearly saw that this blood contained the expelled embryo/fetus. They reported heavy bleeding for about two days then spotting for one to two weeks. One woman who worked in a garment factory on the outskirts of Phnom Penh, recalled this experience using Medabon:

“After that my skirt was soaked and I had heavy bleeding and cramping. There was a lot of blood, with Doum Khoun (literally: the remaining piece of the child – the expelled fetus), Phlork Trey (literally: a long white piece that looks like a fish – the amniotic membrane), and Sok (placenta). At this time, it made me exhausted, pale, and I could not eat. On the second day, bleeding still continued, it soaked two thick sanitary pads per day. This blood was a kind of urine. Then the bleeding was like my menstrual period and it lasted for one week.” (Mrs. D, aged 20 years, married two months)

Although women were told that the physical effects of using Medabon would be similar to what they would normally experience during their menstruation, all of them perceived it differently. From their point of view, medical abortion was associated with bleeding for a period of one month. Seven of them also described experiencing weakness, tiredness, headaches, and irregular menstruation following the medical abortion, with less blood flow.

In terms of medical abortion success rates among our interviewees: 17 of 25 women interviewed reported having a complete abortion using Medabon. With the Chinese pill, two of five women reported having a successful abortion. The eight women who used Medabon unsuccessfully subsequently had an MVA. This is not a representative sample, however, and no conclusions can be drawn from these numbers.

Women’s partners: some successes for male involvement

To complement women’s interviews, the male partners of six medical abortion users were also interviewed. All of them were married, two of them had children. They were employed as a teacher, company staff, NGO staff, construction worker, and college student. The average age was 31 (range 23–40 years). Two of the men reported that they or their partners had never used any form of contraception.

All men reported that they had discussed with their wife before a final decision was made to have an abortion. Five of the men were aware of their wife’s pregnancy at 4–5 weeks while one man was only aware when his wife was already eight weeks pregnant. Similar to the women, men reported knowing about the availability of abortion services from their neighbours, relatives or friends. They learned also that one NGO provided reproductive health services through information in newspapers or when listening to medical news on the radio. Five of the male partners also explained that the effect of the pills was similar to menstruation and less painful than surgical abortion. According to them, surgical abortion was seen as more effective than medical abortion. However, surgical abortion was described as more harmful, potentially affecting the uterus and negatively impacting fertility.

Three of the women’s husbands knew that their wife had received services at an MSI Cambodia centre. They also knew that their wife called the Medabon a combination pack, and that the first pill was taken at MSI Cambodia orally and the four pills were inserted into vagina on the second day at home. The three other men accompanied their partners to buy the “Chinese pill” at pharmacies and small private clinics. They knew that this medication should be taken for three days. The choice of pill providers was made according to information they received, and availability of medical abortion.

The women’s partners also recalled how their wives experienced the medical abortion. Four of the six men accompanied their partners during the medical abortion process. Four of them helped their wives if they could.

“My wife told me how to insert the tablets. So I washed my hands and cut my nails. She raised her knees and then I helped her to insert the four pills into her vagina, one immediately after the other and pushed them in as far as I could.” (Mr. E, aged 29 years, no children, married two years)

Three men took their wives for post-abortion care follow-up; two were informed that the medical abortion had been unsuccessful.

Discussion and recommendations

As reported by previous studies that examined the role of pharmacists in expanding access to
safe and effective medical abortion in developing countries, this small-scale study also documents the provision of medical abortion products by various health care providers in Cambodia and raises two issues for public health programming. First, we observed that women who do not have access to medical abortion in health institutions can get Medabon through registered pharmacies where, at least in those we visited, the sale of medical abortion pills is combined with both counselling and patient follow-up. Although women attending NGO sites seemed more informed about the use of medical abortion drugs and potential complications signs, overall, women were satisfied with services provided both in the private and informal sectors as well as at NGO centres. Training for pharmacists and other pharmacy-type pill sellers on correct prescribing of registered medical abortion pills (including Medabon\textsuperscript{16}), should be considered, based on our findings, under the aegis of public health programmes to decrease maternal morbidity and mortality related to unsafe abortion in Cambodia.

The evidence-base and safety of the medical abortion regimen is well documented.\textsuperscript{17} Similarly, the acceptability of Medabon was good among the women we interviewed. Furthermore, as previous studies conducted, for example, in Sweden,\textsuperscript{18} have shown, vaginal self-administration at home was never presented as a problem by our informants. However, given that some of the women interviewed had to have MVA after taking medical abortion pills, training in counselling women about this possibility, and that in the very few cases where they may need to consult emergency services, e.g. in cases of severe bleeding, could be strengthened.

Regarding health care providers offering medical abortion in MSI Cambodia centres, we found a high level of knowledge of medical abortion products and processes, and concern to provide accurate information. Some providers also expressed some tension between their personal convictions and the benefits for public health more broadly and for women. Values clarification exercises and regular meetings discussing daily work issues, including staff frustrations or personal feelings as well as the issue of unintended pregnancies, the negative public health impact of unsafe abortion on maternal health vs the benefits of safe abortion in terms of choice and maternal morbidity and mortality, might provide some support to providers.

Interestingly, our study results reveal that having a medical abortion is not necessarily a women-only business. The discourses of the interviewed men highlight sensitive concern for their wives’ or partners’ welfare and their supportive roles in the process, including with the vaginal insertion of the misoprostol pills. These findings should be viewed cautiously, however. Women mostly manage family planning on their own in Cambodia, and do not always inform their husbands about their decision to have an abortion or how they obtained an abortion.\textsuperscript{2,13}

To our knowledge, this is the first study documenting the distribution and the implementation of medical abortion drugs in various settings in Cambodia. However, as a small study it has some limitations. First, it was conducted in a restricted number of sites, with a limited number of participants, and is not representative. Second, as the use of Medabon at public health facilities was still recent at the time, the Ministry of Health did not permit us to include public health facilities in the study. Even so, our findings raise some issues for public health programming as they illustrate positive steps forward being taken in making abortions safer and preventing unsafe abortion practices in Cambodia with the support of women, their partners and providers in several clinical and community settings.

Acknowledgements
This research was made possible through three project/study grants: (1) “Transmission of HIV, HBV and HCV in health care settings: the cultural dimension of hygiene in health settings in Cambodia” (ANRS 12102 and Sidaction); (2) “Women reproductive health and care issues in the ANRS 12095 CIPRA KH001 CAMELIA Clinical Trial: an anthropological approach” (ANRS 12268 and Sidaction); and (3) “Women, men and the abortion pill: an anthropological approach to reproductive health issues in Cambodia” (European Society for Contraception and Reproductive Health), which raises specific issues on Medabon. We would like to thank the MSI Cambodia team in Phnom Penh who authorized the authors to conduct data collection in two MSI clinical centres and the MSI headquarters for their comments and suggestions on a previous version of this article. The information and views in this article are those of the authors and do not necessarily reflect the opinions of MSI.
Résumé
En 2010, après son approbation par le Ministère de la Santé, le produit pour l’avortement médicamenteux Medabon, conditionnement qui contient mifepristone et le misoprostol, a été commercialisé dans les pharmacies et dans un nombre restreint de centres de santé au Cambodge. L’étude qualitative présentée dans cet article s’est déroulée en 2012, comme prolongement d’une recherche ethnographique à plus long terme relative à la santé génésique et à la régulation de la fécondité entre 2008 et 2012. Les observations ont été réalisées dans plusieurs dispensaires et pharmacies. Des entretiens approfondis ont été menés avec un échantillon raisonné de 20 femmes qui s’étaient rendues

Resumen
En el año 2010, después de ser aprobado por el Ministerio de Salud, el paquete combinación para el aborto con medicamentos Medabon (que contiene mifepristona y misoprostol) se hizo disponible en farmacias y en un número limitado de unidades de salud en Camboya. El estudio cualitativo presentado en este artículo fue realizado en 2012 como seguimiento a investigaciones etnográficas más extensas relacionadas con la salud reproductiva y la regulación de la fertilidad del 2008 al 2012. Se realizaron observaciones en varias clínicas y farmacias, así como entrevistas a profundidad con una muestra intencional de 20 mujeres

References
dans deux centres MSI Cambodge et dix femmes identifiées par les réseaux sociaux ; six hommes (des partenaires des femmes) ; huit prestataires de soins de santé dans les deux centres MSI et quatre vendeurs de comprimés dans des pharmacies privées ou informelles (qui assuraient également des soins de santé dans des dispensaires privés). Le niveau de formation des vendeurs de comprimés et des prestataires était divers, mais leur connaissance des schémas d’avortement médicamenteux, de leur utilisation correcte et des effets secondaires fréquents était bonne. Dans l’ensemble, les femmes étaient satisfaits des services fournis. L’avortement médicamenteux n’était pas toujours une « affaire de femmes » dans cette étude puisque certains partenaires masculins participaient également au processus. L’étude illustre les progrès accomplis pour rendre les avortements plus sûrs, tout en prévenant et réduisant les pratiques abortives à risque au Cambodge.

que asistieron a dos centros de MSI Camboya y 10 mujeres identificadas por medio de redes sociales; seis hombres (parejas de mujeres); ocho profesionales de la salud en los dos centros de MSI y cuatro vendedores de píldoras en farmacias privadas o informales (que también prestaban servicios de salud en clínicas privadas). Aunque el nivel de capacitación entre los vendedores de medicamentos y profesionales de la salud varió, tenían buenos conocimientos acerca de los regímenes de aborto con medicamentos, uso correcto y efectos secundarios comunes. En general, las mujeres estaban satisfechas con los servicios que recibieron. En este estudio, el aborto con medicamentos no siempre fue un proceso solo para mujeres, ya que algunas parejas de sexo masculino también participaron en el proceso de brindar cuidados. El estudio ilustra los pasos positivos hacia adelante que se están realizando para lograr que el aborto sea más seguro y para prevenir y reducir las prácticas de aborto inseguro en Camboya.