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Experiences of using a participatory approach in Cambodia: Exposing the needs of sex and good women

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• Introduction

Over the last eighteen months, CARE International in Cambodia, the Cambodian Health Education Development, Reproductive Health Association of Cambodia and Women Development Association have been using participatory tools for sexual health assessment with young garment workers[1]. With additional funding and technical support from FOCUS on Young Adults, the project team adapted and applied participatory methods and tools used by CARE Zambia in their work on adolescent sexual health (Kaul Shah et al. 1999). The process, which is still continuing, has enabled project staff, in conjunction with factory management and local communities, to gain more in depth knowledge with the target population about thoughts and practices regarding sexual health. It has also helped strengthen their participatory facilitation skills, along with many other transferable skills, while undertaking participatory research design, implementation, report writing, presentation and action planning with factory workers and managers. This article reflects on some of the lessons that we have learned through this experience.

[1] Factory workers committed their free time, owners and managers gave their approval to their involvement in the process.

Background

The sexual health needs assessment aimed to identify the sexual health needs of young people undertaking garment work. It was designed so as to learn with these young people about a number of aspects of their lives. These included their general concerns, their knowledge of anatomy and physiology of men and women and their relationships and sexual practices. 77 young people aged 15-23 were involved in the research, of which 75% were female, broadly reflecting the balance of the workforce in the garment factories of Phnom Penh, the Cambodian capital.

• Opening doors

The project arose out of a joint Asia initiative of the United Nations Population Fund and the European Commission. Consultation meetings within Cambodia between the government and NGO staff identified young people as a group that had many unmet sexual health needs. From CARE's previous experience of working with employees of three garment factories, a need for sexual health promotion was identified. Therefore CARE sought to continue opening more factory doors and decided to expand and adapt their experiences, not only targeting factory workers, but also factory management and health staff in an attempt to institutionalise improved factory health services.

Authorisation for this project's work was sought from a number of relevant ministries.

Access to the factories was attempted through the Garment Manufacturers Association of Cambodia (GMAC) and eventually gained through door to door visits. Forty-eight factories were visited in Phnom Penh. Thirty-two agreed to be interviewed. All expressed interest and reported that a project such as this was important, yet whilst our project was seen as 'a good idea' and requests were made by many for medicine, medical personnel and for treatment of Sexually Transmitted Infections (STIs) and gynaecological problems, it was not perceived as needed. Seven out of those factories who expressed a strong interest were selected as project sites. The selection was based upon interest and co-operation, having more than 500 employees and a greater proportion of workers who were female and predominately single.

The seven factories selected originally had, for one reason or another, 'closed their doors' to the project. Some had gone out of business, others had simply 'changed their minds' and thus, none of the original seven were included in the participatory research. A further seven had to be contacted and access re-negotiated. Out of the seven factories selected as project sites, all managers and a total of 1,200 young workers were interviewed. From these seven, three were selected for participatory research. This was based on timing, funds, but most significantly, co-operation and agreement from the factory management. The findings of the research will be channelled into upgrading clinical skills and services in five of the seven factories – the ones which after one year still wanted help from CARE.

Once the factory management had conveyed the discussions about the project to their relevant owners, permission was received to work with CARE. The researchers and management conferred and sought agreement for the days and times when access would cause least disruption to the factory schedule. Factory health staff, a staff representative or a section supervisor were approached through the manager and asked for help in selecting groups of women and men between 15 and 24 years old. The young workers were then eventually approached directly and told about the research. The final selection was controlled by the young workers who self-selected themselves with approval from the supervisor or head of section. The approval was usually dependent on the work commitments and orders that had to be fulfilled. The participatory research was planned for weekends to avoid conflict with work.

Adopting a participatory approach to sexual health in Cambodia

Essential components of participatory research in the area of sexual health are trust, mutual respect and the ability to facilitate open discussions about sexual health matters. In a country recovering from its recent traumatic past, where a whole society learned to distrust their neighbour and children learned to spy on their parents, trust is a precious commodity.

Cambodian society is strongly hierarchical and patriarchal. Powerful social norms govern the sexual attitudes of men and women. Hierarchical power relationships and perceived loyalty were important to survival in the brutal Khmer Rouge regime, and continue to be an important feature in Cambodian society today. The powerful exist by the existence of the weak and vulnerable. And, in terms of this sexual health project, as in most patriarchal societies, women are the more vulnerable group.

The fate of a woman is in the hands of her parents choosing the 'good' man and in the hands of the man being knowledgeable and caring. A traditional proverb 'men are gold, women are cloth' does not refer to the fact that women are useful, versatile and essential, but to the belief that women are irredeemably stained by sexual activity while men can be washed clean. After puberty women find themselves in a difficult position. They have the task to make themselves sexually attractive yet at the same time, be on guard against a fallen reputation. The city presents women with many additional dangers: fears of trickery, deception and violence, of rape and of being drugged, caught and sold into the sex

industry. For young female factory workers, the environment they live in is one in which there are relatively few places to be safe from the attention of men.

Men are perceived to be the ones initiating sexual contact and of having sex with sex workers soon after puberty. It is not uncommon for men, both single and married, to talk openly about visiting brothels where they can pay women for sex. It is commonly assumed that the married woman will remain monogamous to her husband and the virginal woman will defend her 'good' reputation. This is a feat harder than it seems in a garment factory, as all those working in the factory can lose their reputation if one colleague is deemed to have done something 'bad.' 'Bad', (in Khmer the closest translation is the word 'broken', as in a broken machine) is a word most often used to describe women who sell sex. Its use is a little like 'slag' or 'slut' in English, a term with an elastic definition that makes it difficult to defend. Thus, with the exception of the heterosexual male and married woman, people outside this social norm face substantial barriers that prevent access to sexual health and educational services.

Learning participatory methods

Learning a new method of working and new active participatory tools placed the research team in an extremely vulnerable position. There was a strong chance that the activity would not be 'right' the first time. Moreover, it will not be 'right' in front of colleagues. Given Cambodia's recent traumatic past, this vulnerable position may have negative associations and in a society where status is of crucial importance, I assumed that it would be an additionally demanding experience to become a student and a novice again. Yet, as I write I am astonished at how eager the research team has embraced new ideas and how keenly they have explored new participatory techniques. As confidence has grown, a willingness to try new ideas, to act flexibly and to take the initiative has flourished. Before long, the research team was very impressed at the creativity and skills of the young people with whom they were meeting.

Some teething problems cannot be denied. How many books describing participatory approaches say it is difficult for the researcher 'to hand over the chalk?' This proved to be an extreme understatement. The research team raised certain questions around this issue: 'What if the participants do it wrong? The participants need us to help them!'. As a result, the command 'leave the group' became a frequent refrain – a non-participatory solution to a problem undermining participation. This was directed at the research team who required sensitive questioning by advisors in the evenings after the participatory research to facilitate a process of self-analysis and reflective practice prior to developing improved communication skills.

'The best laid plans of mice and women'

All negotiations with the factory management for the participatory research were, and indeed, still are, extremely flexible, and dates, times and access were established, verbal approval given, letters written and authorisation gained. However, there were sometimes problems, such as the arrival of a manager from China for example, which meant that the work of the factory had to take priority and the research team was told to come back the following week.

"No. No PLA today. Today the big boss has come from China and we have a rush order, so please come back next week! The additional note takers can go home; the helpers to arrange the food need to send it back; the drivers can have the day off; the pens, pencils, paper back to the office; postpone the translators; cancel the house rented for the day; cancel the room booked for synthesis reporting. Make a new plan, keep all the money for another rainy day!"

It was important to have a schedule for the participatory research to enable a degree of panning and co-ordination. This schedule however, had to be responsive and flexible to

the needs of a given situation and to the daily routines of all involved.

The majority of the research itinerary went according to plan. This involved three days working with groups from each factory. There were four groups per factory, each with seven participants. Three of these were all female and one was all male. The participatory activities took place in a house close to, but outside, the factory gates. Inside the factory it was impossible to establish any privacy or a relaxed trusting atmosphere. One exception to this was where the research team and the participants were talking about their lives in an office next door to an angry boss. This seemed to limit the discussion somewhat.

The schedule for the research was three full days, starting with discussions on working, living conditions and general concerns. Day two examined general health concerns, women's and men's health concerns, knowledge about men's and women's bodies, contraception and conception. Leaflets about infections of the genito-urinary tract were handed out, along with payment for attending[2]. By day three, the conversations were about sex, relationships and their own personal sexual history. At the end of day three the participants were asked for their evaluation and they received referral slips to a local NGO clinic for a free medical examination. In general the participants reported many favourable comments about the activities; only one man did not like drawing naked bodies. Tools used included mapping, transect walks, listing and ranking, matrix design, Venn diagram, seaonality analysis, thought bubbles, causality analysis, role play, sex census and body mapping (see Figure 1).

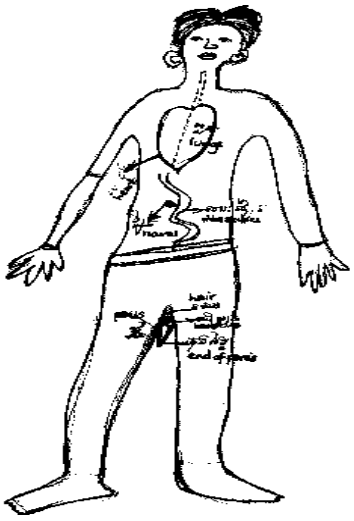

Figure 1. Drawing of male reproductive organs by young men, Factory Y, 5th April 1999

A closed way of opening up

We ran into a problem at the first experience of using participatory methods with a group of young single women. Although the female researchers initially expressed confidence in their ability to talk about sex openly, after all they were midwives, they found themselves unable to ask 'good' women about possible 'bad' behaviour. The tool agreed upon to learn about young women's actual behaviour was adapted for use in Cambodia from CARE Zambia - the Closed Paper method[3].

After discussion with the research team, I stepped in and asked the participants if the researchers could ask them personal questions. The participants agreed without hesitation, but the researchers still remained uncomfortable. In halting Khmer I asked about the young women's sexual relationships. When the scrap bits of paper came in with symbols that represented the replies, the researcher charged with noting down the answers found it difficult to remain quiet and not share the answers with us all.

[2] There were many debates about payments. In this instance, the young workers were missing the opportunity to work overtime. And, as the research shows, they have barely enough money to cover their living expenses. It was decided to respect their time and work with money, as indeed all the researchers were being paid.

[3] The closed paper tool is a method whereby the participants are asked some personal questions and they place a symbol on to a piece of paper in reply. The replies remain anonymous, so a major disadvantage to this method is that there is no discussion.

Her eyes lit up. She went from sitting on the floor to sitting on her feet. The participants remained calm and apparently unperturbed by our flapping.

By the end of this session, the method yielded little in the way of direct information, but it somehow facilitated trust. Many questions poured out from the participants; questions the young women had previously felt unable to ask anyone for fear of gaining a 'bad woman' label. In the following three months of fieldwork, it seems that though this is still a sensitive subject, questions about sex in a personal situation as opposed to a medical setting of midwife and patient can now be asked and responses acknowledged in a supportive style.

Other methods

Methods of body mapping involved drawing around another member of the group and this resulted in much laughter. Role-play turned into team role-play. Often the participants were too shy to speak, but in teams with one person nominated as a spokesperson, other members of their team could whisper questions to ask or suggest replies to make. All were shy but equally, all members participated and enjoyed this approach. At times, hilarity from one group caused a disturbance to another in the adjoining room. Role-play, as with all the methods, was selected to offer the research team and future health providers an insight into the thinking, attitudes and behaviour of the young target population. It was hoped that this would help to identify areas for potential health promotion activities and to enable the young people to practice negotiation through conversation. Often the role-plays resulted in agreement for blood screening or agreement for condom use without a great deal of negotiation (see Box 1). The researchers helped with ideas for a scenario; it is hoped in future participatory activities that the project staff will be more able to empower the participants to take this control and the initiative.

BOX 1
SCRIPT FROM A ROLE PLAY – MEN

Husband wants to use a condom what does he say to his wife?

Moderator:	Who is a volunteer to be a wife? Who is a brave man?
Participant:	I am looking I am not brave!
Moderator:	I like to have the volunteer so that you can explore your own words, can you play as a wife?

Lots of negotiation with the participants before the role-play started

Husband	Now we have 2 children, I am also busy with my job and our life is not so good, I like you to use birth spacing so that you have no problems. I will use a condom what is your idea?
Wife	Up to your decision dear!
Moderator	Any more ideas?
Husband	Don't you think my idea is strange
Wife	Strange or not, this is your business. You may have a bed with other women.
Husband	If you don't mind so I decide to use a condom, I think I shall use, what do you think?
Wife	Up to the man
Husband	Now can we have fuck?
Participant	Don't you think your husband has an infection?
Participant	Do you have infection that's why you want to use the condom?
Participant	Do you have another woman that's why you worry about infection?
Husband	I don't have infection but I want to space the birth. If we have many children it will cause problem to our job. If you have a job with one company and you take leave for delivery your salary will be cut down from $100 to $50 so our life will get down a little.

Cartoon drawings were used to represent relationships and events in a person's life. Drawing was enjoyed and in some groups everyone sat around the paper and added to the story of a girl/boy relationship. The story flowed in a circle with the chatter. Animated discussions took root over how to draw specific parts of the picture, for example, how should the hair of a young woman be drawn; in bunches? Parted? Parted to which side? What colour should the hands be drawn? etc. The drawing had to be *'sa-at'*, a word translated as beautiful, but also meaning clean and smart. The participants were clearly concerned about drawing the picture wrong.

Reports documenting the experiences of such participatory research are very important, but they are difficult to plan correctly. Should they be written on a daily basis? Should they synthesise the research of all the separate research groups? Which language should they be prepared in? At which point should they be translated? Should the final reports be easy to read but include an in depth analysis of young people's complex interpretation of the world around them? What about process reports of how and why and what happened with the use of participatory tools for sexual health with garment workers?

We planned time for reporting but this was too short. Redrawing the visual outputs, reflecting on experiences and translating to English after each session left little room for anything else. Translation was necessary to give appropriate aid with areas that required further probing. Fortunately further funding from FOCUS and CARE allowed us to recruit a consultant who was fluent in Khmer language and skilled in analysis. With support, the research staff analysed and produced their first report. In order to share our experiences of using participatory approaches and to provide a tool which would help with further capacity building, the final report was written in English.

Findings from the process

The project has succeeded in introducing a participatory concept to the project staff. Difficult as it is to measure success, project staff have clearly improved their facilitation skills and gained confidence as advocates for young people. The main concern and pressure throughout has been that of time: time to spend additional project funds was too short as was time for the Cambodian staff to fully understand and adapt a participatory approach before applying it to research. There was also not enough time to analyse the piles of information collected during the study, yet the staff did it and did it well.

A lesson learnt was that the tools needed to be more specific and more time was needed for flexibility. This would enable questions to be asked about what a specific group thought about contraception, what that group's mothers thought; what were the advantages and disadvantages of different methods of contraception rather than just ranking them. The research team had little exposure to experiences of probing; initially activities resembled a question and answer session. Thus while advantages and disadvantages of contraceptives may have been discussed amongst the participants with more experienced facilitation, it was not found to be the case in our first experiences of using participation in research.

Additionally, as it was a needs assessment, bounded by time and resources, specificity of tools would have been more timely and beneficial. Finally, working with 12 groups and using a range of tools, the researchers were able to cross reference and triangulate information learnt. However, due to the flexibility of the researchers approach to a subject, this was a challenging feat at times.

• Future and sustainability

The three factories involved in the participatory research were all invited to send representatives from the management, health staff and factory workers to a presentation with CARE and its local partners. Each factory sent at least two representatives who entered into discussions on the research findings and suggestions for future action. The project staff then visited the factory manager several more times to agree on an action and continued access for CARE and its partners.

At every stage of the process factory management has been and will continue to be actively involved as much as their many work pressures will allow. The factory workers remain interested and enthusiastic to commit whatever time they have free to participatory health activities. In terms of long term sustainability, the future is by no means certain. It is extremely dependent on the growth of the nascent garment industry, the growth and stability of the national and regional economy and the whim of the factory management. The aim is to try and make a demonstrable difference to the smooth running of the factory that would inspire some of the managers and owners to institutionalise improved health services. Managers are supportive with our involvement, one factory manager was proud to a show a potential European garment buyer their renovated health clinic.

Needs identified during the process of the research have resulted in all the factory health staff receiving additional training in STI management and contraceptives, as have the local NGO counterparts. Five factory clinics were renovated and will be intensively supported for six months whereupon the support will be reviewed. Participatory health activities over 2 months per factory with six groups of 15 workers each (4 groups of women and 2 groups of men) will hopefully offer factual information, challenge rumours and lead to a supportive environment for change.

A participatory approach to research is only a beginning of a process. As the project continues, we have time to further develop facilitation and probing skills. Furthermore, we have more time to put into question many of the cultural beliefs that the Cambodian staff continue to accept unquestioningly. Only by coming to terms with the effects of their own cultural beliefs can staff enable the factory workers to gain an insight into the social constructs of gender that perpetuate many a risky relationship. It is believed that components are in place for change. The female workers are in a unique position compared to their grandmothers and mothers; they have the opportunity for independent paid employment, the opportunity for independent living, and an opportunity, however rudimentary, to question social constructs that hinder informed choice. The process of change is beginning.

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NOTES

Julie Forder has been working in Cambodia for several years, the last 18 months as an adviser with CARE. She was previously a nurse, midwife, health visitor and social researcher in North East England.

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REFERENCES

Kaul Shah, M., Zambezi, R., Simasiku, M., (1999) Listening to Young Voices: Facilitating Participatory Appraisals on Reproductive Health with Adolescents. CARE International in Zambia, FOCUS on Young Adults.