Health care seeking behaviour and impact of health financing policy on household financial protection in post conflict Cambodia: A life history approach

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The ReBUILD Research Programme Consortium is an international research partnership funded by the UK Department for International Development.

ReBUILD is working for improved access to effective health care for the poor and for reduced health costs burdens in post-conflict and post-crisis countries. We are doing this through the production of high quality, policy-relevant research evidence on health systems financing and human resources for health, and working to promote use of this evidence in policy and practice.

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Contents

EXECUTIVE SUMMARY

Introduction

The almost complete destruction of the country's health and education systems was the consequence of nearly three decades of conflict which was characterised by extremes of violence; and starvation, forced displacement of people on a massive scale, and forced labour on collective farms. The exact extent of loss of life remains unknown with the most carefully constructed estimate at 2.2-2.8 million deaths over the ten year period 1970-1980 (Heuveline 1998), while other studies claim that up to 3.3 million people were killed under the Khmer Rouge regime alone (Macrae 2001). The country emerged from nearly thirty years of war as one of the world's poorest countries, with a real GDP per capita of around USD200 and poverty rates of 45–50% (World Bank, 2006). Whilst the country has made considerable economic and human development achievements over the past 10 years, it remains today a low income country with a GDP per capita of approximately $1,000, and an official poverty rate of approximately 20% (World Bank 2014).

Throughout the many years of war, the population had limited access to formally provided public health care. To rebuild its health system from 1993, Cambodia introduced reforms across the health sector to address the considerable challenges. In health financing, the establishment of the National Health Financing Charter in 1996 led to the introduction of user fees (UF), followed by the creation of community-based health insurance (CBHI) in 1998 and health equity funds (HEF) in 2000 (Annear et al 2008).

Study aim and methods

This study sought to understand the impact of the pattern of health care seeking from the 1950s to the present, across political regimes from the pre-to-post conflict periods on the economic situation of Cambodian households that are poor in the current period. , It included questions about the factors that influenced their health care seeking decisions; how poor households coped with different health care costs; and the impact of health and health related financial shocks on their livelihoods. All out-of-pocket health-related expenditure, including official user fees, informal payments, and payments to private and indigenous practitioners were considered in order to investigate their impact on health care seeking, as well as the economic and social impacts beyond health in poor households.

This report focuses on the results of in-depth interviews with 24 individuals 40 years and older, in six Operational Districts, four in Phnom Penh and two in Takeo Province. A life history tool was used to collect information on episodes of illnesses, deaths and births from the participants through the time periods described above.

Findings

Findings from this study suggest that a rudimentary Western medical system have begun to emerge in the pre-conflict period but it was largely inaccessible. Cambodian people relied significantly on self-care, traditional birth attendants and indigenous practitioners in the pre-conflict period and continued to do so during periods of high and low-intensity conflict. The lack of health provision, whether public or private, state or NGO delivered, combined with high levels of insecurity in many areas outside Phnom Penh, created a significant dependence on informal sources of health care until the early 2000s. Even though utilisation of public facilities has increased since then, other factors continue to influence their use, including quality of services, dual practice of health workers, their attitudes and ethics towards users, equality in service delivery, and unofficial payments.

Impoverishment associated with health is a regular feature of the respondents' accounts and extends across all periods; and impoverishment associated with health care seeking is a regular feature of accounts, particularly since 2000. It was found that people who used public facilities report still having to use their savings, sell assets or get a loan to pay for health care. This is despite the emergence of pro-poor health financing schemes, such as the Health Equity Fund (HEF), which aims to protect vulnerable groups such as the elderly and women headed households. The impact of such schemes still depends on the poverty level in each household, chronicity and severity in the type of illness in each case, and the implementation of the schemes.

Conclusion

Enhancing the quality of public health provision and improving the performance and attitudes of health workers towards patients would have a significant impact on the impoverishing effects of health care costs by encouraging greater utilisation of relatively affordable publicly provided care. By expanding the coverage of the HEF and community-based health insurance (CBHI), particularly increasing the scope of the HEF to cover chronic illness and increasing public awareness of the various health financing avenues that are available to them, the government could enhance the impact of these pro-poor policies.

1. Introduction

Seeking health care expresses a fundamental need for help. Perceptions of need, how that need is met and the potential pathways taken by individuals, engages people's agency in determining what is possible and is highly dependent on the context in which they function. Using a 'life history' approach enables a deeper understanding of how agency operates - particularly in difficult contexts - and how changes in health needs, perceptions of available options, increasing stability and the plurality of providers all influence the changing patterns of seeking health care.

This study sought to understand the behaviour pathways followed by Cambodian households in seeking health care from the 1950s to the present, the factors that influenced their decisions, and how poor households coped with health care costs over this period of time. All out-of-pocket health-related expenditure, including official user fees, informal payments, and payments to private and indigenous practitioners were included in order to investigate their impact on health care seeking, as well as the social impacts beyond health in poor and near-poor households.

Interestingly, no study to date has undertaken to explore the pattern of health care seeking behaviour across political regimes from the pre-to-post conflict periods and how health seeking behaviour (HSB) patterns have shifted through time. Grundy and Annear, (2010), in reviewing HSB studies in Cambodia, noted that "few HSB studies have been conducted in Cambodia, especially since 2005" (ibid: 10) and that most of them "focused largely on disease-specific conditions with narrow research questions" (ibid: 10). This study adds value to existing research by focusing on longitudinal HSB using the life history method. The findings of this study will allow further understanding about how historical periods of conflict and post conflict have affected the health care seeking behaviour of Cambodian people.

The study also sought the perceptions of individuals about whether pro-poor health financing policies such as user fees (UFs), Health Equity Funds (HEF), and Community-based health insurance (CBHI), introduced in the post conflict period, contributed to household financial protection for the poor and near-poor. There are other well-known studies that have also investigated the impact of such initiatives. For example, Barber et al. (2004) explored the impact of user fees on out-of-pocket spending; Ir (2004, 2008), Van Damme et al (2004) and van Pelt (2006) examined the impact of the HEF on household health expenditure; van Pelt (2006, 2008), Men and van Pelt (2006), Ir (2008), the Ministry of Health (MoH) (2009) focused on impoverishment and indebtedness and Ozawa and Walker (2011) examined Community-based health insurance. The focus of this research was, again, on the impact of health expenditure and health financing policies across historical periods.

Historical background

Following independence in 1953 and the establishment of the Kingdom of Cambodia, the country experienced nearly three decades of conflict from 1970-1998. Four distinct periods of conflict can be identified during this time. The first followed the coup d'état in 1970 against Prince Sihanouk that brought about the Lon Nol regime and the Khmer Republic (1970-1975). This was followed by the Khmer Rouge period known as Democratic Kampuchea (1975-1979); the Vietnamese-supported People's Republic of Kampuchea (PRK) (1979-1989), renamed the State of Cambodia (1989-1993); and between 1993-1998, following the return to the Kingdom of Cambodia [see Figure 1].

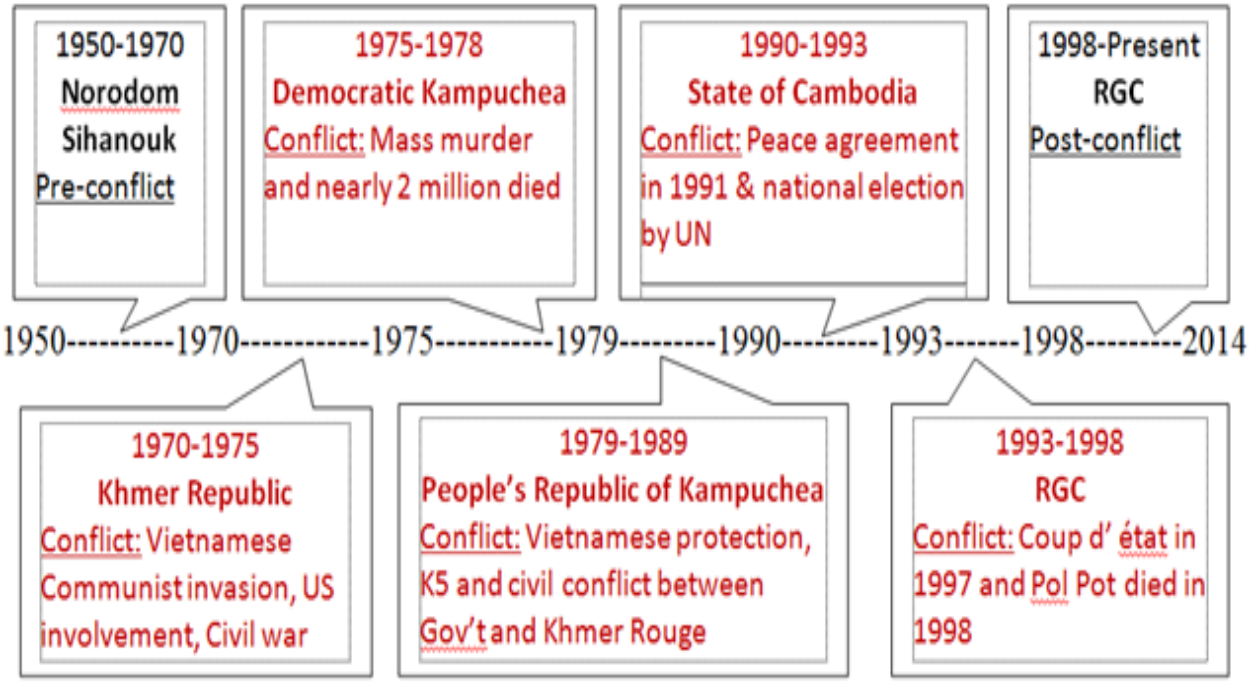


Figure 1

Cambodia was drawn into a regional war when, between 1969-1973, "sustained, large-scale B-52 bombings" were carried out by the United States' air force targeting the supply lines and sanctuaries that the Vietnamese communists had established on Cambodian territory (Blum, 1986: 151). Several of those who related their life histories in the study remembered the insecurity created by the bombing, which caused massive displacement and reduced access to health care facilities dramatically. The Khmer Rouge period from 1975 to 1978 was epitomised by a grotesque social engineering experiment in which between one and three million people died (Macrae, 2001) - around 20% of the population - from forced labour, torture, execution, malnutrition and disease (Curtis, 1993). Intervention by the Vietnamese in 1979 overthrew the Khmer Rouge, halting the genocide and installing new leaders in the newly named People's

Republic of Kampuchea. However, this action had enduring ramifications: up to 300,000 Cambodians, including the Khmer Rouge leadership and fighters, went into exile along the Thai border, residing in camps for another decade. It also meant that the Khmer Rouge could re-group to fight the new state and its Vietnamese supporters (Mysliwiec, 1988). The Khmer Rouge formed an alliance with two other opposition groups, including one founded by Sihanouk – the Coalition Government of Democratic Kampuchea - and, with support from the Western powers and China, occupied the country's seat at the United Nations as the official representative (Macrae, 2001). In 1989, with the end of the Cold War, Vietnamese troops withdrew from Cambodia but the civil war continued until the Paris Peace Accords (PPA) of 1991 and the national election in 1993 (Chandler, 2007). However, the Khmer Rouge continued with armed resistance against the newly-elected Government of the Kingdom of Cambodia until 1998, with the death of Pol Pot.

Prolonged periods of armed conflict and violence, starvation, forced displacement of people on a massive scale, forced labour on collective farms and the almost complete destruction of the country's health and education systems were the consequences of these decades of conflict (Chandler, 1996). The exact number of lives lost remains unknown but Heuveline (1998) has estimated that up to 2.2-2.8 million people died in the ten-year period from 1970-1980.

Health system recovery

During the years following 1993, Cambodia began to rebuild its health system by introducing health sector reforms to address the considerable challenges left by 25 years of destruction and neglect. In health financing, the establishment of the National Health Financing Charter in 1996 led to the introduction of user fees (UF), followed by the creation of Community-based health insurance (CBHI) in 1998 and Health Equity Funds (HEF) in 2000 (Annear et.al.2008). User fees were introduced to reduce informal payments that were often arbitrary and unpredictable, and aimed to reduce out-of-pocket expenditure (Hardeman et.al. 2004). While fee exemptions were available at facility level, their implementation was weak, particularly as the exemption system was unfunded (Annear et.al. 2008). The Health Equity Fund introduced a more robust means of funding exemptions, although, as noted by Grundy et.al. (2009), "HEFs are not a health financing mechanism but a means of providing subsidies to the poor," to cover the costs of "referral hospital (and in some cases health centre) medical services, transport costs from health centre to hospital, food for patients and carers and other ancillary items like funeral costs in some cases" (Annear, 2010: 12). The criteria used to identify potential HEF beneficiaries included their "health care-seeking behaviour, out-of-pocket expenditure, ability to pay, effect on coping strategies and debts for health care" (Annear, 2010: 15); beneficiaries were often "enrolled through pre-identification, post-identification or a combination of the two" (ibid:14).

User fees were used in the majority of public health facilities from 1996 onwards; in 2013, USD $30.4 million were received from fees. CBHI, on the other hand, was implemented mostly by

NGOs in 19 Operational Districts (ODs) across ten provinces[1] including Phnom Penh as of 2013. The population covered by CBHI increased from 79,873 in 2007 to 445,648 in 2013 (MoH, 2013). Health Equity Funds have been used in 49 ODs in 20 provinces and the estimated coverage has increased from around 71% of the target population in 2011 to 93% in 2013 (MoH, 2013).

All these processes were referred to routinely by the participants in the present study.

2. Objectives

This study aims to explore the health care seeking behaviour of Cambodian people during the pre-conflict period (1950-1970), several conflict periods (1970-1998), to the post conflict period (1998-2013), and the impact of health financing schemes introduced in the latter period. The two major objectives were:

- To explore the access pathways followed by Cambodian people in childbirth and illness treatment from the pre-conflict to post-conflict periods;
- To identify the impact of out-of-pocket expenditure, official user fees and pro-poor health financing policies such as CBHI and the HEF on household financial protection for the poor and near-poor.

3. Methods

A qualitative approach was employed, using a life history method to collect information on episodes of illnesses, deaths and births from participants through time. Life history with the use of lifelines provides a subjective understanding of the life trajectory and pathways of individuals, including perceived shifts and the factors that may have triggered these shifts, and is suitable for health policy research, especially when exploring past learning for informing future practices (Gramling and Carr, 2004). Life history is not just about describing individual lives; rather it seeks to disclose context, phenomenon, events, agency, structure or even institutions (Berg, 2009; Ojermark, 2006). When the individual life history is joined with other life histories, it explains not just individual, but collective experiences of practices in a society or historical influences on change, which is important in understanding social change.

3.1 Study sites

This study was conducted in the capital city of Phnom Penh and Takeo province in the South West of the country. Phnom Penh and Takeo were selected because they represented urban and rural

[1] Officially there are 24 provinces, one municipality (Phnom Penh) and 81 Operational Districts (MoH 2014)

locations in Cambodia where user fees, the Health Equity Fund and Community-based health insurance had been piloted and implemented, beginning in 1996.

In Phnom Penh, four Operational Districts were chosen for this study: Sen Sok, West, North and South. The selection of the four ODs was based on the high poverty level in the areas where poor and near-poor urban people were residing and where UF, HEF and CBHI were operating. User fees began in Phnom Penh (and other provinces) after the establishment of the 1996 National Health Financing Charter. On the other hand, the Health Equity Fund was piloted in Phnom Penh in 2000 (Annear et al 2008). Community-based health insurance was scaled up and expanded to Phnom Penh in 2005 by the French non-governmental organisation (NGO) Groupe de Recherches et d'Echanges Technologiques (GRET).

In Takeo, two ODs were selected, Ang Roka and Kirivong. The selection was based on their long experience in operating the three schemes. User fees were introduced in Takeo in 1996. The Health Equity Fund began in this province, mainly in Kirivong in 2003 (Jacobs and Price, 2006) whereas Community-based health insurance was piloted by French NGO GRET in 1998.

3.2 Selection of participants

Twenty-four participants were purposively recruited equally from Phnom Penh and Takeo, from the identified ODs for life history interviews. The selection had to reflect the mix of single or mixed scheme users of UF, HEF, CBHI and private health care. The recruitment process was conducted carefully based on three criteria. First, only people who were poor as confirmed by local authorities and local people were selected for the HEF participants. Secondly, the participants had to be the heads of households, male or female who were 40 years old or above. Lastly, participants should have health treatment experiences that they were able to remember sufficiently for the purpose of this study.

The process of identifying the participants not only relied on the HEF ID cards of households, but also on the assistance of village/Sangkat chiefs, health workers and/or NGO field-level staff. These people could identify or help verify those who had the most difficulty in managing to meet their basic needs and living costs and those who had experienced crises or shocks. Visits by researchers to participants' households prior to the actual interviews were also conducted to validate their poverty condition and to build rapport.

3.3 In-depth interview

Each life history interview lasted between two-and-a-half to four hours. The in-depth interview was conducted to capture information from birth up to the present day. Where reference to major illnesses, death or birth incidents were mentioned by interviewees, probes were used by

researchers to gain breadth and depth of the answers around the topic, especially on spending, coping strategies or the long-term impact of illness on the current situation (Ritchie and Lewis, 2003).

During interviews, researchers drew a lifeline indicating important life events of individual participants according to the information provided by interviewees. The drawing of lifelines was useful to help organise life events in chronological order and to establish links between individual events and the historical events for analysis.

To maintain the depth, nuance and the interviewee's own language for understanding the meaning (Ritchie and Lewis, 2003), all interviews were audio recorded. Verbal consent for the interview and the audio recording was given by participants, who were free to decline.

3.4 Data analysis

All audio files of the interviews were transcribed in Khmer and later translated into English. Khmer transcription was reviewed before translation followed by the English transcripts being reviewed as a final check.

On the basis of the interviewees' past experiences of health behaviour, health expenditure and poverty, a coding framework was developed to explore the pattern of change since the 1950s; it was structured in chronological order in an Excel spreadsheet classified by the political regimes of Cambodia and divided by births, deaths, and episodes of illness. This was then divided into sub-themes such as: type of illness, when, who, why, what costs etc.

'Path matrices' were used to display patterns of analytical results on health-seeking behaviour across the different regimes using colour grids to differentiate patterns. One matrix represented each important theme. The researcher then reviewed the accounts of data to explain the role of historical factors, different health policy interventions or other factors influencing the pattern at each point in time.

4. Findings

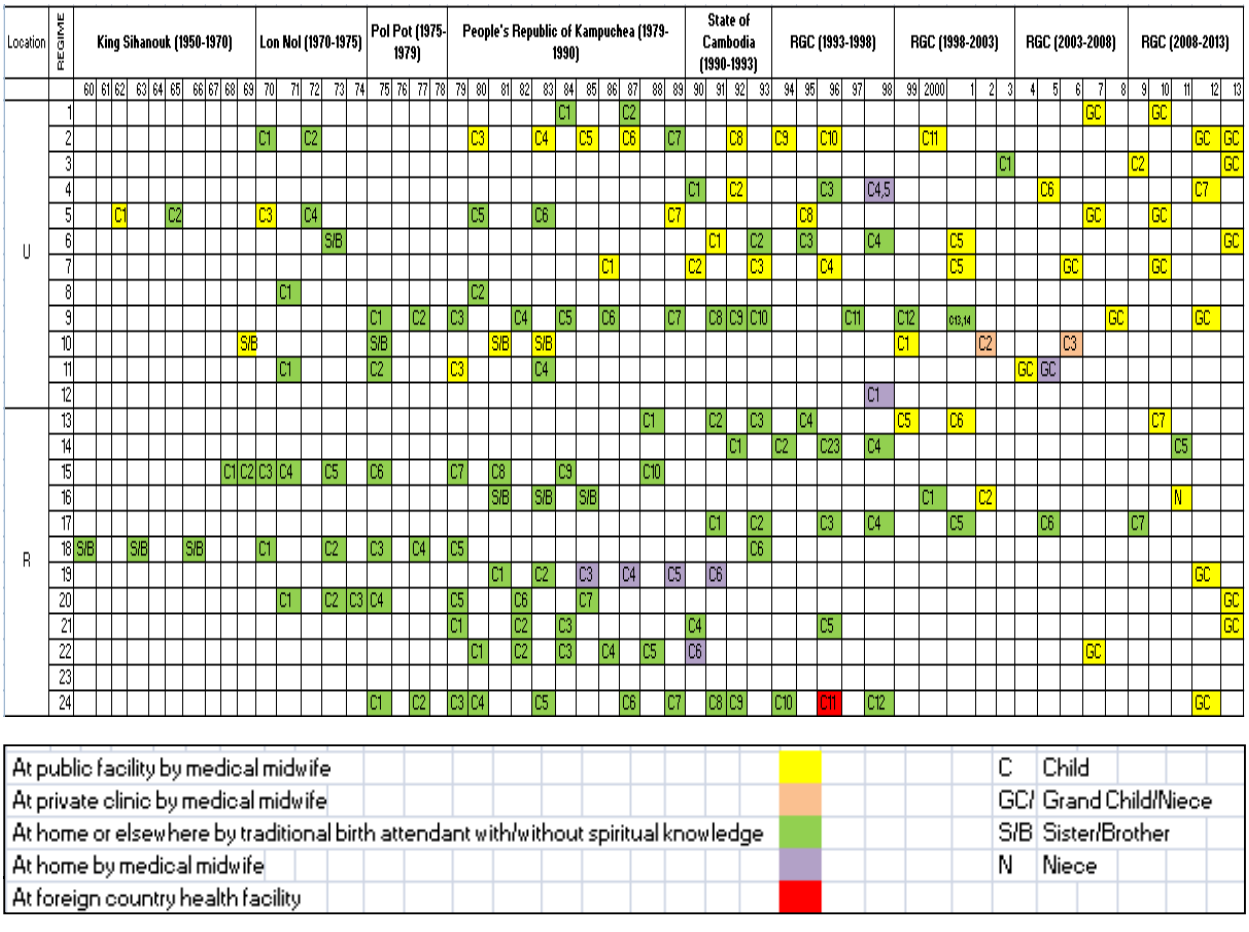
4.1 Behaviour pathway

4.1.1 Birth delivery

Five forms of birth delivery sought by participants were: delivery at home with assistance from traditional birth attendants (TBAs), delivery at home with assistance from medical midwives,

delivery at delivery at private clinics, delivery at public facilities and delivery at a foreign country health facility. Life history analysis suggests that the behaviour pathway of participants gradually shifted from using TBAs to public facilities. TBAs have been relied upon consistently in the periods before, during, and in the transition after the war. In the latter period, demand for medically trained midwives to assist deliveries at home also became more evident when the health system was being reconstructed and public facilities were not yet easily available. Crossing borders to seek better services in a neighbouring country for a complicated case was also reported in this study by a participant who lived close to the border after roads and transportation started to become available in the mid-1990s, or when domestic public facilities were unavailable during the transition of health system reconstruction. Delivery services at private clinics also emerged in the post-war period to accommodate those who could afford to pay. Increased use of public facilities was also noted during this time.

Table 1: Behaviour pathway in childbirth



1950-1975:

Between the 1950s and mid-1970s, women and families seeking help with birth delivery depended on the assistance of traditional birth attendants (TBAs). Utilisation of public facilities was rare and more likely to occur among people who resided in urban areas. Traditional birth attendants could be persons in the village or in neighbouring villages, kinsmen or non-kinsmen, often with extensive experience in delivery.

Perceived risks associated with giving birth were reflected in the Khmer terms for birth delivery, that is '*Chhlong Tonle',* which is translated as 'crossing the river', and refers to the high risks that women could face. People often relied on TBAs who were recommended by their family, friends or fellow villagers whose capacity to assist they trusted; thus they often used the same TBAs throughout their delivery history except in exceptional cases when they could not find them or the TBAs were not available.

After giving birth, women were often recommended to drink a particular traditional medicine and to stay warm above a fire stove for a period of time and to avoid doing heavy work. During this time women had to be on a diet. There were particular foods they were recommended to eat and certain foods they should avoid.

> *A: …Traditional birth attendants were very common and more preferable. People spread word from mouth to mouth about how to stay safe during pregnancy and in labour, especially about selecting Khmer herbal medicine and the practice of getting warmth from fire set for a duration of two or three months [after giving birth].* (M, 56, Takeo_24).

Several reasons were cited for using TBAs. The most frequent reason given was inaccessibility to public facilities due to the combination of a lack of hospitals, distance to them and the lack of transportation. Some recalled uncertainty about where hospitals were or whether they provided delivery services or not. Inaccessibility to public facilities meant people had to use any service available within the community, that is, to rely on TBAs.

> *A: …Pregnant women were rarely brought to hospital to deliver baby because it was too far and they may give birth on the way. Another choice was to carry them with a hammock, and nothing else.* (M, 74, Phnom Penh_7).

Following traditional practice by local people, their belief that TBAs could assure safe delivery had been passed from one generation to the next. Participants claimed the common practice of using TBAs by their parents or other villagers set an example for them to follow.

> *A: …Also people in the past do not really believe in medical healthcare for birth delivery; they usually believe in traditional midwife. As I witnessed (during a delivery), a traditional midwife used threads wrapping up the umbilical cord of the baby very tightly for about*

two or three rounds, and then used scissors for cutting clothes to cut it off. (M, 74, Phnom Penh_7).

Some participants compared this period to the current situation and claimed a lack of health information sharing about where people should go for birth delivery has remained a reason why people continue to choose delivery at home with TBAs. People said they were not aware of the importance of delivering at a hospital, so they had also ended up following traditional practices.

Interviews showed, however, that even when people lived close to a hospital, they still used TBAs in this period as they perceived this to be safe if there did not seem to be any complications, for example having bleeding or prolonged labour pain.

Q: When you had your fourth child, you were in Kampong Cham Town and you lived near the hospital, but why didn't you bring your wife there? A: There was a TBA living near my house, and my wife was not difficult in giving birth. (M, 74, Phnom Penh_7).

During the 1970s, the war also explained why people chose delivery at home with TBAs. After

the coup-d'état by General Lon Nol in 1970, the destabilisation arising from American bombing and the civil war with the communist Khmer Rouge produced massive displacement of people in some parts of Cambodia, therefore, accessing public facilities was not possible. A participant recalled insecurity in 1973 resulting from American bombing.

*A: It was my fifth child (who was a girl) born in the year of the ox [1973]. It was around 8-9 am in the morning that I delivered her and my husband tried to cover the fire to prevent the smoke from getting out because we were so scared of bombing. If they saw the smoke, they will drop the bomb on our house. It was very difficult during that time until I was recovered. I got warmed up both at the day time and at the night time because I was afraid that my child would cry because of the cold weather. (*F, 63, Takeo_18*).*

Another participant shared a memory of her mother who was in labour, but had to flee to a safe place from a house-fire started by Khmer Rouge troops during the fight against Lon Nol. She emphasised that the civil war was a contributing factor in her mother using TBAs.

A: She [her mother] was expecting to give birth soon…The Khmer Rouge soldiers set some houses in the village on fire. It was during fighting between Khmer Rouge and Lon Nol soldiers. Back then some people who were able to moved to live in a camp called Tuol Trach organised by the Americans. You were not born yet at that time, but you can ask your mother about whether the Americans built camps for us during Lon Nol regime. There were long blue tents in the camp for people to live, but the Khmer Rouge soldiers still sneaked in and burnt it, leaving some people to die in the fire. So, some people went back

to live with their relatives in the province, and those who did not have relatives asked other families to live with, even in a swine warehouse. After Lon Nol regime was overthrown, I went back to my home village and then Pol Pot regime began….(F, 63, Takeo_18*).*

1975-1978:

Between 1975-1978, when the Khmer Rouge regime controlled Cambodia, birth delivery was solely reliant on the assistance of TBAs. During this time, deliveries at hospitals were not reported by the participants, who explained that the non-existence of health facilities or the lack of delivery services was a reason for their use of TBAs. Some participants explained that even access to TBAs during this period became difficult because attendants were often assigned to work in different locations. Other participants explained that, because they were often moved to work in new places or were overworked until almost delivery, they could not find a TBA on time.

*A: I was moved [to a new place] three days before I gave birth to my fifth child. My husband went to [the TBA] for help when I was about to give birth. I looked after about ten kids when I was moved to that region. (*F, 63, Takeo_13*).*

1980s-2000:

Between the 1980s and 1990s, new patterns of birth delivery services started to emerge in the life history accounts, including delivery at home with medical midwives, delivery at foreign country services and delivery at public facilities. The life history analysis shows, however, that people were still highly dependent on TBAs after the fall of the Khmer Rouge in 1979 through to the late 1990s.

The use of TBAs at the time was related to several factors. Soon after the Khmer Rouge regime was overthrown, people described the lack or destruction of local health infrastructure. Some mentioned the reopening of state medical centres or hospitals in some districts or provinces in the 1980s, but recounted either the absence of delivery services or the unresponsiveness of the health system. The latter was due to poor facilities, their insufficient operation and management, the lack of medical supplies and midwives as well as the absence of health workers on duty. People reported the absence of delivery services in hospitals continued until the mid-1990s in some areas, which was the reason that they were not interested in going to hospital for delivery. Consequently, people had to rely on TBAs who were available and close at hand to offer immediate assistance.

A: At that time, there was no hospital still. However, traditional birth attendants were available in the village since the Pol Pot regime had collapsed, and so people who were traditional birth attendants returned to live in the village. (F, 53, Phnom Penh_11).

A: It was because there was no hospital here at that time. Hospital was available at district when my wife had the third or the fourth children, […]Even though there were hospital/medical centres, midwives were not available either, so people always delivered at home with traditional birth attendant. (M, 54, Takeo_14).

A: As I told you all my seven children were delivered by traditional midwives. From 1979-1983 there were no doctors. You can think about that? There were also no proper doctors from 1979-1990. There were some physicians at commune or Sangkat, but not enough medicines were available. (M, 67, Takeo_21).

The civil war between the remnants of Khmer Rouge and the government troops continued until 1998 in some areas of the country. In our transcripts, participants talked about the deployment of Vietnamese troops at the border where the remnants of Khmer Rouge remained. For security reasons, participants claimed they did not dare to travel outside the village to access public facilities.

The issue of landmines in some areas also reduced the accessibility of public hospitals.

A: There were hospitals only in Borvel and ThmorKol district towns and there was no hospital in SampovLun district where I was living. During that time there were still some remnants of Khmer Rouge since it wasn't completely peaceful yet. Those remnants of Khmer Rouge didn't hurt civilians because they were afraid of the government's troops. Sometimes they came to ask for rice…Because the distance was far, we were worried that I might deliver the baby on the way, and if it was so, we couldn't find any traditional birth attendants on time... Also, there were landmines along the way as well. So I tried to labour at home but I didn't know what time I delivered my child because I was unconscious. (F, 55, Takeo_15).

A: Vietnamese troops also lived there. However, people were afraid of Vietnamese troops. We didn't dare to go out at night. Likewise, at the day time, we needed a few people to accompany us or Vietnamese troops could harm us. Prey Kdouch village was far from town. However, I moved to live in Prey Kdouch because I wanted to grab land. At that time, my husband went to cut wood and I stayed at home with my children. My children were still young. (F, 63, Takeo_18).

The reliance on traditional practices and TBAs by local people persisted even at that time. Participants related this to the lack of information sharing and awareness raising by local authorities and other stakeholders about the importance of delivery at a hospital.

In the late 1990s, participants reported the establishment of hospitals in some areas which demonstrates that the health system was being rebuilt. However, limited coverage of health facilities, especially at commune level, was also a challenge for people who lived far from district towns to access public services. The cost of delivery at the hospital, combined with household poverty and a distrust of health workers' motivations, also influenced their decision-making.

> *A:…There was a referral hospital at district as well which was just established about 2-3 km from home. Also, I didn't have a motor bike. At that time we didn't have a health centre in commune yet […].* (F, 41, Phnom Penh_6).

> *A: I sometimes thought of going to hospital, but I also thought of having no money […] I witnessed some doctors did not take care of patients if they didn't have money. Those doctors did not even look at the face of those poor patients. However, if patients have money, they will serve quickly. My sister experienced that. Her water broke in the evening and until morning she was sent to the hospital. She could not give birth, so doctors need to use vacuum to assist her. However, doctors started vacuuming only after we gave money to them. Because I witnessed this, I decided not to go to hospital because I did not have money like my sister.* (F, 41, Phnom Penh_6).

Whilst the services of TBAs continued to be popular among people in the 1980s-1990s, the hiring of private medical midwives to perform deliveries at home also emerged during this period. People mentioned the incidence of hiring former midwives who survived the Khmer Rouge regime to assist them at home between the 1980s-1990s. Others recalled hiring newly-trained midwives during the late 1990s. The hiring of private midwives came after people became more aware of the risks of delivery, and so they demanded reliable services as they faced inaccessibility to public facilities.

> *A: We started knowing who used to be midwives and asked them for assisting the delivery of our babies. Those former midwives have their own equipment to assist us during the delivery unlike the traditional birth attendants.* (M, 53, Takeo_14).

During the mid-1990s, analysis showed that local people who lived near the border also moved to seek services from a neighbouring country when their economic condition was getting better. This was also due to the road and transportation systems starting to become available and the fact that they could not rely on a domestic health facility that was underdeveloped to deal with complicated cases. A participant who lived in Kirivong district, Takeo province that was close to Vietnam recited her experience of having her 11th child.

A: Before I went to Vietnam, I saw a neighbour who died after she delivered baby at home and was bleeding. After I saw this case, I wanted to go to hospital, and did not dare to deliver it at home. That neighbour died just two days before I went to Vietnam… A village physician suggested I go to Vietnam and another physician knew Vietnamese, so he accompanied me to Moat Chruk. Ton Lop hospital [Kirivong referral hospital] didn't look as modern as today. The hospital is just upgraded probably in 1997. (F, 57, Takeo_20).

Using public facilities was also evident, especially among people who lived in the urban areas between the 1980s-1990s. These participants reported that they witnessed Vietnamese midwives providing services in the 1980s. Our transcripts indicated that people who served in the military could have free access, for example, one participant recalled how she managed to get free services by using her nephew's status:

A: My nephew told me during my pregnancy that when I was in labour, I should inform him and he would take me to military hospital so that I did not need to pay. I was even given food, scarf and towel. When I was in labour, he took me to the hospital by a motor at midnight. I rested there for three days…I had my name as a wife of my nephew. He had a soldier certificate…. (F, 52, Phnom Penh_1).

While availability of and transport to public hospitals was still a problem for urban residents in the 1980s, it was better than in the rural areas. Participants reported knowing more than one urban hospital and the means of transportation used to access the services.

Individuals also appeared more aware of health information in urban areas. Everyday interactions enabled people to share information with their neighbours and friends about birth delivery, which also contributed to people deciding to go to hospital.

A: My neighbours, some elderly people, and the Vietnamese that lived near me advised me to go to hospital. They said "you should go to hospital; Vietnamese people never use traditional birth attendant because they were afraid of danger and old facilities (unsterilized equipment) used by the traditional birth attendant. I listened to them, so I went to hospital and I could deliver baby safely. It's near our house. I went to ChakAngre Hospital. It was 3am when I delivered my first child. When I was in labour, I rushed to hospital where they provided 24 hours service. All the medical staff were Vietnamese, and we had very few Khmer medic from the brutal regime. I rested there for five days because I delivered my baby healthily. (F, 60, Phnom Penh_2).

With the helpful attitudes and less cash orientation by TBAs, poor participants routinely decided to rely on them for childbirth.

<u>2000s-present:</u>

From 2000 to the present, the behaviour pathway showed the continued use of three types of delivery services: delivery at home with TBAs, delivery at home with medical midwives and delivery at a public facility; interviews also indicated the emerging use of private clinics for birth delivery. Their use was mainly determined by the slowly improving economic conditions and the desire for better quality. However, for most respondents, private clinics were still out of reach; for example, one participant claimed that without support from her brother who worked in an international organisation, she could not afford to deliver her child at a private clinic:

> *A: My brother suggested me to go to that clinic. He said if any other expense incurred, he would pay it for me. I didn't know why he suggested this clinic, but all five children of my brother were delivered there. His workplace bought him an insurance there. My brother works for the International Red Cross.* (F, 47, Phnom Penh_12).

The reliance on TBAs declined gradually during this period. From the interviews, it appeared that those participants and the generations that followed them who could afford the cost had switched to public facilities, while those who were unable to pay still relied on traditional birth attendants.

> *A: …Most families would go to hospital now. However, there are still some families- one among 100 families, who are too poor to afford to go to hospital, so they still keep using service from the traditional birth attendant. However, my family has money, so we go to hospital. Like I said, the hospital asked us first if we had money or not*. (M, 57, Takeo_24).

> *A: I did not have money to go to hospital... one bed cost 40,000 riels and we need to spend on eating as well. The hospital gave food to us, but we cannot eat.* (F, 44, Takeo_22).

The quality of service in combination with enough health equipment and drug supply was also a key factor underlying the increased use of public services. People mentioned that they switched from TBAs to public hospitals for critical conditions or a complicated birth delivery.

Our transcripts showed that in some areas the new pro-poor health policy that encouraged people to access delivery services with no charge influenced their decision to go to a public facility. People talked about having free deliveries due to the use of the HEF and CBHI.

> *A: The delivery of the second baby was smooth. She only went to the health centre. ….She didn't spend any pocket money for the delivery service because her family also shared the ID poor card with me.* (F, 52, Phnom Penh_1).

However, in other areas, even with the ID poor card, some people still could not access public health facilities because of the high level of poverty in the household and the poorly perceived behaviour of health workers. Poor people could not afford the indirect costs including the

unofficial payments to midwives. They were discouraged by the unfriendly behaviour of health workers toward their low economic status.

> *A: Although the doctor did not ask money from me, I did not have money to buy food to eat for myself as well as the caretaker. I did not have any means to travel too. I literally had nothing…They would take 30,000 riels and fruits just like I told you previously. They asked for the money because they touch our blood and help us deliver the baby. It's normal. I saw the example of my neighbour. She went to Trapang Ondoeuk health centre, but they (the young midwife) asked her for 30,000 riels, two kilos of fruits and two cans of fruit juice. They said it's for the service that they touched her blood. Those midwives are young, around 17 or 18 years old. They said they did not ask for other prices, but they only asked money for touching my blood. If I did not have money, I could not go.* (F, 40, Takeo_17).

> *A: For me, I don't want to go to hospital. I was also ashamed and shy of nurses and doctors. Health workers had bad words, so I didn't want to go to hospital. Although I met a good doctor when I gave birth to my previous son, I was afraid that next doctors could be bad and blame me. When they blamed me, I was angry.* (F, 41, Takeo_23).

People's heightened health awareness and change in perception, particularly among the younger generation, also contributed to their greater use of public facilities. The perception shift was a result of information sharing and outreach programmes by the government, NGOs, media, community groups, local authorities and others.

> *A: Now we have media to raise awareness of people about pregnancy that women should go to health centre for check-up when expecting or when they miss period. Health care system before was far different from now. Now there was advertisement about children's disease, tuberculosis and diarrhoea. They advertise everything […] as I am [I] a village representative for health network […] I walk door to door and inform people […] or we invited 10 people for a short meeting. We have 10 packs of washing power to give to those 10 participants and 5000 riels for each person, and so people like to participate. When they listen they understand a lot about pregnancy test, tuberculosis, etc. There were many serious health incidences in the previous regime. That was because [people] didn't understand about their health. They didn't understand about any diseases. They didn't know. Unlike us now, we understand a lot.* (F, 52, Phnom Penh_1).

> *A: Now young people prefer to deliver baby at hospital and there are no traditional birth attendants... Delivery in the hospital is safe because there are a lot of medicines and equipment. I know about this because I went to hospital to take care of my relatives and I observed it. I heard doctors talked about that to the patients. Doctor asked her to return*

home after staying in the hospital for 24 hours and midwife came to our house to give her injections. Midwife didn't allow her to take Khmer traditional medicines so she drank only warm water. Now people trust medical midwives because they have enough equipment and medicine to help. In the previous time, people trusted traditional birth attendants. People's belief and perception on health care have changed according to circumstances. (F, 55, Takeo_15).

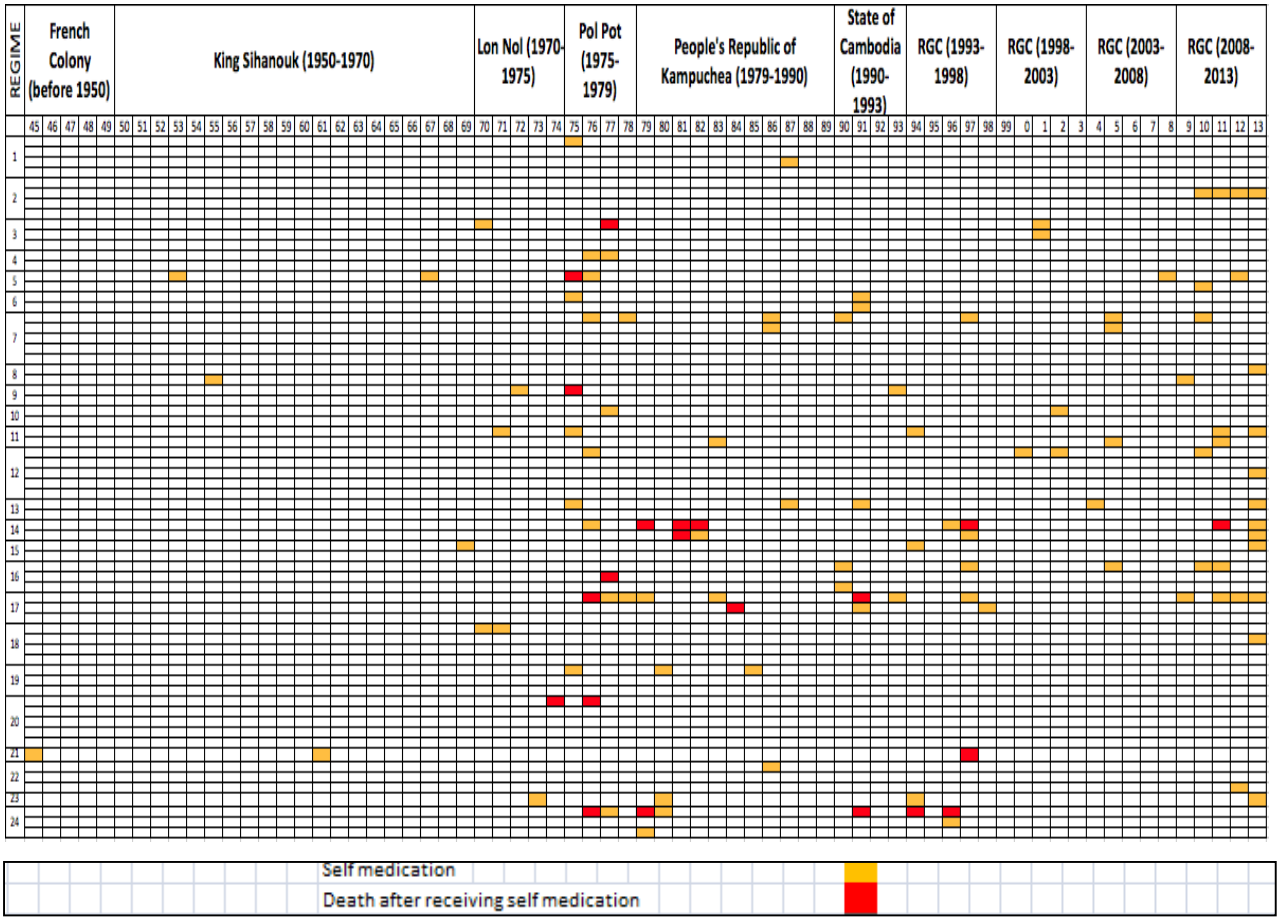
4.1.2 Illness/injury

A range of different forms of health care sought by participants and their family members were found in this study which included: self-medication, the use of indigenous practitioners, the use of local village medics, the use of private health clinics and the use of a public health facility and/or NGO health facility. People either chose a single service or a range of services to treat one illness. The access pathway of Cambodian people to seek health care from these different sectors changed in the periods before, during and after the war. Several factors influenced this access pathway.

4.1.2.1 Self-medication

The practice of self-medication was a popular method used by participants to treat illness or injury throughout their life story. As the life histories showed, self-medication had been used by participants in all historical periods before the war (before the 1970s), and during the war (1970s-1990s), and has carried on in the post-war period between the late 1990s to the present when the public health system and private clinics were developed. The reliance on self-medication to deal with serious illnesses was frequently practiced during the war period from the 1970s to the later 1990s. Although this practice still continued to the present, it was not as frequent as it was during the war time.

Table 2: Behaviour pathway in self-medication



Self-medication was often used as a method for treating typical local illnesses such as fever, headache, dizziness, cough or diarrhoea. Self-medication was also believed to cure some specific illnesses in women such as post-partum relapse, or in children such as measles. Some participants believed that public facilities or private medics could not cure post-partum relapse. They believed that self-medication, using a specific method of making a home remedy based on experience and knowledge from older generations or Khmer traditional healers, was more effective and could deal with the illness in a timely way. Self-medication still persists and is practiced by people in the present time.

> *A: They did not have medical service for postpartum relapse. Even nowadays if you have postpartum relapse, you need to get herbs from traditional Khmer healers. Khmer healers have porcupine stomach preserved with wine. They boiled skin of custard apple for us to drink. It was effective though.* (F, 46, Phnom Penh_9).

A: When I had postpartum relapse due to eating a kind of insect, I burned its wing and boiled it with water to drink. We must do it immediately. If we could not figure out what caused the relapse, we could have diarrhoea until we die. (F, 45, Phnom Penh_8).

The typical methods of self-medication identified in this study can be categorised into three main types: 1) imbibing or applying traditional medicine made of home ingredients, wild animals, roots or specific herbs; 2) using methods such as scraping a coin on the body, massaging or warming with fire stoves or stones; 3) buying medicine from private drug stores or pharmacies.

Generally, the Cambodian people were not familiar with all types of self-medication; their degree of knowledge depended on whatever was the common practice within the community or their family, and this varied by household and location. The elders were often the ones who had the most expertise. Such knowledge was often transferred from one person to another or from one generation to the next. Different families might have alternative ways to treat a particular illness which could vary in what ingredients they used, the methods they applied or how they used it.

Even though people might have their own approaches to self-treatment, they were willing to share with others when they were asked for help. Sharing their knowledge with their neighbours or villagers was found in all periods of Cambodian history and represented a reciprocal relationship.

1950-1975:

Within this period, the life history interviews provide limited information on how people sought health care treatment. Our data show the three types of self-medication mentioned above. Participants reported the practice of buying medicine from pharmacies, the use of local ingredients to make home remedies and treatment through warming by stones. In the urban areas, participants reported combining self-medication with using a public health facility while, in the rural areas, self-medication was often used alone or in combination with private medics or traditional healers. The main reasons for using self-medication during this period were to cure minor illnesses and to deal with emergency needs since public health facilities were not easily accessible nor widely available, especially in the rural areas.

A: We did not really go to hospital for just normal fever unless we fainted. In some cases, people still did not go to hospital until they died. It was too far, and it is not like today that we have referral hospital or commune health centres. In the past, our seniors just used herbs and leaves to treat us, and it's not like today that we have a lot of medicine available. (M, 74, Phnom Penh_7).

Besides the absence of health facilities in rural areas, the war between the Khmer Rouge and Lon Nol's forces also was a major factor in determining the treatment options available. Our transcripts showed that when the war began, public facilities were not functioning in some areas, and that traditional healers and other people also fled, therefore self-medication was the only means for people to deal with illness or injury within their community.

A; I had an abscess, and it was very painful. I walked, but since I was little, I often sat on a person's shoulder. Sometime, I sat on an ox-cart with my younger brother. My mum also helped carry him since he was even younger than me. My thigh was painful and become atrophied on one side, so I could not walk in a straight position. There was no hospital at that time because it was war time. There were no health staff either because they also ran away like us. Under that regime, from Prey Veng or Svay Rieng provinces, I often heard bombing. (M, 51, Phnom Penh_3).

<u>1975-1978:</u>

During the Khmer Rouge period, participants reported using self-medication as there were no other services to complement, not only for minor illnesses, but also to treat serious conditions. People said they could not trust and rely on the public health service under Pol Pot's government. In some areas, people reported that public health facilities did not accept patients unless they were at a critical stage, or that people did not dare to report their illness because they were afraid of being criticised or punished by the Khmer Rouge government if it was not deemed serious enough. Self-medication, therefore, was a response to the lack of health facilities, as well as the poor quality and unresponsiveness of the health system.

> *A: My older sister died at the age of 25 years because she had haemorrhage due to hard work. She worked too hard and she was not used to such hard work. She did her medical degree in Phnom Penh, had passed her medical doctor examination already and was about to become a doctor. During the Pol Pot regime, she was forced to dig canals and build a dam. She never did such hard work. It was too hard for a woman like her… She coughed blood, and she still tried to work hard. We could not be weak under that regime. If anyone showed weaknesses, he/she would be considered as pretending like a rabbit's trick. They warned that people who 'pretended' to have a disease often got killed, like their slogan - "no benefits by keeping such persons, and no loss by killing them". She still worked very hard until she fell down in place. We requested them to bring her home… No hospitals in this regime. Actually there was a Khmer Rouge so-called hospital where they gave two types of pill and the drug looked like a "rabbit pellet" to treat all kinds of diseases. It does not cure diseases actually….*(M, 51, Phnom Penh_3).
>
> *A: I had mouth disease due to poison. My mouth became putrid like a 7-day corpse. It was swollen…. When I blew a lamp in front of me, I was not able to put the light off. It was*

terrible. People felt disgusted with me because I looked like a zombie….At that time it was a common disease. The Angkar pushed the patients to health centre, but they all died later…my father did not allow me to go. He asked me to stay at home and followed my faith regardless of death…my father was asked to join self-criticism sessions even four times a day. The Khmer Rouge blamed my father for not taking me to the health centre. At that time my father bargained for me to stay at home … my father was a Khmer traditional healer, but he dared not to reveal his skill otherwise he would be executed because the Khmer Rouge did not allow to have a Khmer traditional healer, but only its so-called health centre….(F, 40, Takeo_17).

Accessing traditional healers was reported to be forbidden in some areas within this period. At the same time people did not have full freedom to share health information for self-medication between each other either. Participants also complained about difficulties in finding ingredients to make their own remedies during this time.

A: My father had a swollen leg because of starvation! We ate only rice porridge... We ate porridge for months. We had rice only during the dry season, and in the rainy season, we ate porridge… People told him [how to cure it], and we just followed them. He used Khmer traditional medicine. He tried to find it by himself as all the children were at work. For that kind of swelling, he asked for palm juice from a neighbour who had a palm tree nearby the house and he added rice bran into it and ate it. He did not recover yet, but Pol Pot soldiers destroyed the palm tree [after hearing about my father's treatment]. They didn't allow us to collect its juice.... (F, 45, Takeo_16).

The death toll was high during this period, not only due to starvation, hard labour or execution, former Lon Nol soldiers or government officials, but also because of illness for which people did not receive proper treatment and relied on self-medication. Some people did not even have the chance to self-treat their own illnesses properly.

1980s-1990s:

After the fall of the Khmer Rouge regime, self-medication was still popular among local people to treat minor illnesses or specific conditions such as post-partum relapse.

During the early 1980s, self-medication was also used to treat serious illnesses along with the services of traditional healers. In conflict-affected areas, where Khmer Rouge soldiers were active, accessing traditional healers remained difficult as many people including the healers themselves still fled from violence, so self-medication was often the only option available to local people, particularly given the lack of transportation and poor road conditions.

Our transcripts showed some self-medication could result in recovery, but most ended up in failure and loss of lives. A participant recalled how her father saved the life of her younger brother by treating the child himself.

> *A: My little brother was poisoned by eating a root that he believed was a sweet potato. The root was this thumb size and looked white like a sweet potato, so he ate it. I thought he died, but luckily he was saved by my foster father who used palm sugar to treat him. My foster father let him eat two spoons of palm sugar, and then he recovered.* (F, 41, Takeo_23).

Another woman described how she lost her father and three siblings between 1979-1981 from using self-medication.

> *A: His leg was swollen. All of his body got swollen like a rice sack. I did not know what kind of disease he had. Probably my father had water in the lung. Q: Did your mother find something for your father? A: We were running for our life, and how could we find something for him. We did not even have food to eat…At that time, people were fleeing for their lives, so they didn't care about others. We could not find any physicians to treat him. Some corpses were even abandoned on the ground randomly. He died… [next] One [a brother] climbed up to pick coconut, and then fell down. And broke the backbone. Q: Did you take him to a hospital? A: No, we only used herbal medicine. He was the only boy among the 13 siblings. He took herbal medicines a lot too, but later he just died…My older sister who died after my older brother died of measles. My mother told me so. I did not know her disease. I just saw that my mother let her drink kanin wood skin, but she was not recovered. Q: Was there a traditional healer to make medicines for them? A: No, it was my mother who learned from my father. She just dug and looked for some grass, and pounded together. Sometimes she simmered wood skin for long time for them to drink... the last one to die was also from fever she was going to the forest to find crabs and shellfish, and then the forest spirit cursed on her in return. She got fever after return. She took herbal medicines.* (F, 40, Takeo_17).

Hence, the death toll in the early 1980s was high from the prevailing conditions of the war during which there were often no alternatives to self-medication. Later in the decade, the practice was used more frequently in combination with the services of traditional healers and village medics. The use of public health facilities increased but these were not used as frequently as the other types of health care. The high cost of treatment from village medics was also a reason why participants continued to use self-medication. From the transcripts, some people initially sought treatment from a private medic, but then dropped the service to self-treat instead once they found that they could not afford it.

A:…My husband had malaria. The private physician at Sla Ku who often came to my village diagnosed him. The private physician gave him injections and some medicine to take. We didn't have much money, so my husband had to get the traditional medicine to take in addition to the modern treatment. Not that he took both of them at the same time. He took the traditional medicine after he had completed taking modern medicine. He got recovered about a half-month later. (F, 45, Takeo_16).

The cost of self-medication was cheap because people often sought help from their family members, friends or community for no charge and they often used local ingredients available at home or within the neighbourhood to make their own remedy. Sometimes, people received traditional medicine from friends or relatives free of charge. The cost of buying medicines from drug stores or pharmacies was also reported to be low-priced as people tended to buy it based on the amount they could afford.

A: I ate meatball soup with a kind of cabbage. The meatball was made from a kind of fish. My sister-in-law cooked for me. After having it, I started to feel a stiff jaw, but I still went to teach. The stiffness has spread from my jaw to other parts of my face. I told a teacher who was teaching next to my class. She said I might suffer from food allergy. Then, she took motorbike back to her house nearby and brought porcupine intestine wine for me. I felt better just immediately after drinking the wine. (F, 47, Phnom Penh_12).

<u>2000s-present:</u>

Self-medication in this period was still carried on by people, along with traditional healers, private medics, private clinics and public facilities. The data showed self-treatment evolving from a reliance on home/traditional remedies to the purchase of medicines from drug stores or pharmacies to deal with illnesses. Other forms of self-medication to treat typical minor conditions - and specifically post-partum relapse - continued.

Buying medicine was commonly done in the early stages of treatment when people believed their illness was not serious. From our transcripts, people preferred to buy medicine from pharmacies or drug stores because it took less time than going to public facilities. Some people believed medicines bought from drug stores or pharmacies were more effective than those bought from public facilities.

A: He always bought medicine to take because it seems that medicine from Ang Roka referral hospital did not make him feel better. (F, 63, Takeo_13).

Buying medicine as palliative relief to ease pain before seeking other services such as public health care was also reported. Taking pain relief medicine to prolong the period before seeking

treatment was also a popular strategy to deal with some chronic illnesses e.g. gall or kidney stones, back pain etc. when people could not afford to pay treatment costs at the same time.

> *A: He had been difficult to urinate. He had a piece of stone in bladder. … He went to Kirivong referral hospital. Then health staff told him that there was no medicine to treat this disease. They told him that his disease required the surgical treatment. At that time, we did not have anyone to take care of our children, and nothing to eat, and if he got a surgery, he need to be hospitalised for one week or two weeks, and so we would have no money. So, if he was not feeling well, and if he got pain, he bought medicines at the drug stores.* (F, 44, Takeo_22).

> *A: He got pain in his back since Pol Pot time. It was because at the time he was forced to carry big baskets of soil and one day he fell over and rolled down. Since then, he got this pain. He keeps telling me that he will have x-ray when he has enough money. He wants to know what was wrong with his waist. Anyway, we don't have money... Normally, he goes to pharmacy to buy some pain killers. Anyway, the pain comes back after he stops taking those pain killers.* (F, 41, Phnom Penh_6).

People also reported they stopped using other health care services and turned to self-medication when they could not afford the treatment costs anymore or could not bear the bad words from health workers. A woman decided to bring her son back home to receive self-treatment because she was afraid of being blamed by health workers.

> *A: My son was crushed by motor. Half of his face was bruised, swelled, and was full of blood…I sent him to Kirivong referral hospital… because I was afraid that doctors would blame us, I took him back home.* (F, 41, Takeo_23).

Another woman gave up receiving services from a village medic because she could not pay the cost:

> *A: I felt better when I got this treatment but I didn't have money to continue, therefore I stopped. I drink Khmer traditional medicine.* (F, 62, Takeo_19).

Self-medication was also used for serious injuries or illnesses during this period. Our transcripts showed that poor people who earned just enough to live on and were not able to cope with treatment costs still rejected going to public facilities, even with severe injuries or illnesses that required immediate help. Instead, they preferred to self-treat at their own risk. A man described how his son recovered from severe cut by the treatment techniques of his wife:

> *A: He stood to cut a tree, but he didn't put the chain saw in a proper position. By accident, this chain saw cut his knee…If you saw in your eyes, you were probably unconscious too.*

My son refused to go to the hospital. He was afraid of needles. It was a combination of many factors. He was afraid of needles and we did not have money. If we went to hospital, we would need to spend a lot of money. We didn't have enough money. ..she [my wife] pounded the leaves of Kantreang Khet[2] with salt, and applied on the wound for a few days. Next, she used water limestone with pork fat, applied on the wound for two weeks. Then, he was cured. She also let him take some antibiotic drugs bought on credit, and she paid it later. (M, 51, Phnom Penh_3).

Even with the Health Equity Fund, some poor people still could not access public facilities because they could not afford other costs such as care taking, transportation and the loss of income from missed work. A woman recalled why she refused to send her sick young baby to health facilities, but used traditional medicine even though she had an ID poor card.

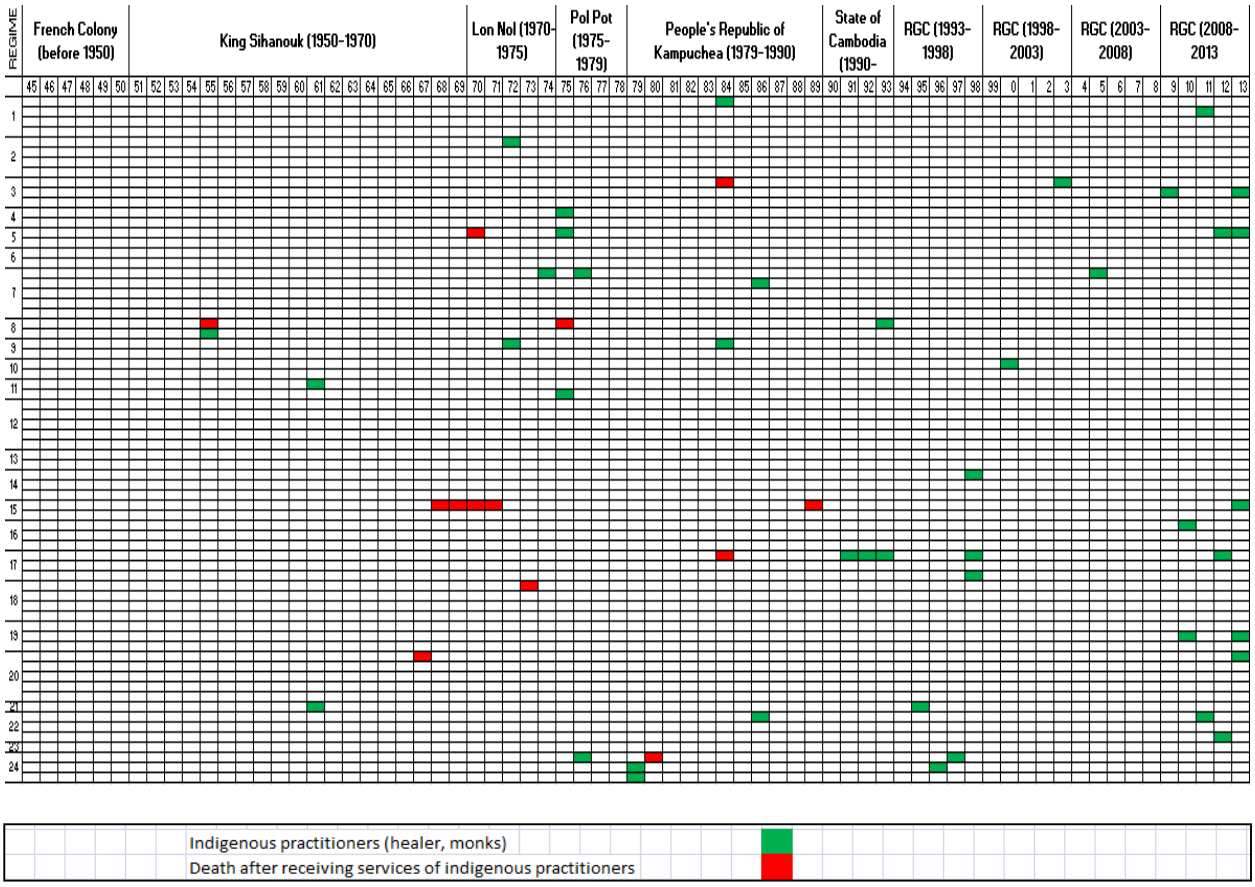
A: I did not have any breast milk for her, so she did not have it at all. So, I just cooked porridge and feed her with the porridge soup since she was born. The doctor said that the baby lacked nutrition without enough and proper food. I did not have breast milk since she was born. She died in three months. She got diarrhoea. The baby stomach was swollen. The porridge soup that I kept for her since the morning probably turn bad already when I fed it to her at lunch time again. I kept the porridge soup for her for two meal times. Q: Why didn't you take the baby to health centre? A: I did not have any money at all even one riel, and how could I go to health centre? Q: But, you had the ID poor card/certificate? A: Yes, I had it, but I did not have money for the transportation and who would lend me the money… At that time, I had a thought that if I spent time to go to health centre, my other children did not have food to eat at home. At that time, I did not have rice even a palm of rice. I did not lie to you. I survive on daily basis. When my children and I went to look for bamboo shoot to exchange for three or four cans of rice today, then we could only live today. So we needed to go to look for it every day otherwise we would not have anything to eat. Sometimes I could also have 5000 riels from the selling, but I also needed to buy rice and gave to my children each for 300 riels or 400 riels. I never dare to spend any money for myself. During the illness of my youngest child, I did not have rice and I did not have money at all, so I just let it be, let the fate decide. If I took the small baby to hospital, the other children would die too. No mother would want their baby or children to die, but I could not do anything. (F, 40, Takeo_17).

4.1.2.2 Indigenous practitioners or '*Kru Khmer*'

[2] Kantreang Khet is the Khmer name referring to a kind of plant that is self-grown in a bush or nearby people's homes. This kind of plant provides a lot of benefits, one of which is to be used as a traditional medicine.

'Kru Khmer' is the general Cambodian term to refer to people who perform health treatment through indigenous methods. The use of '*Kru Khmer'* or indigenous practitioners to cure illnesses was found across Cambodian history during the periods before, during and after the war. People sought treatment from indigenous practitioners for curing both physical and mental illnesses and for treating some types of injury, i.e. bone fractures, or for common conditions, i.e. post-partum relapse. Based on our transcripts, indigenous practitioners were local people who lived in or outside villages who had much knowledge and experience in treating illness. Some of them were monks or traditional birth attendants.

Table 3: Behaviour pathway in seeking services of indigenous practitioners



Different types of indigenous practitioners were found in this study depending on the methods they used. Some traditional practitioners cured illnesses with the use of only traditional medicine. These healers knew recipes for curing specific illnesses or injuries through the combination of roots, herbs, bark, wild animals or other elements. Patients were advised how to use the traditional medicine - whether they should boil it, apply it to the skin, or soak in wine for daily consumption. Another group of indigenous practitioners cured sickness or injury through performing chanting. They chanted specific mantra and blew at patients. Some healers chewed

betel leaf and areca nut and then spat at their patients. Others burned some spots on a person's skin, or massaged the affected part of the body, presumably to kill diseases.

> *A:…the traditional healer used his fingers to press on my stomach. He cited a typical ritual, and he said he twisted the neck of the turtle in my stomach. During my last treatment, a traditional healer cited a kind of superstitious ritual, and he chewed betel. He then placed the chewed betel on his palm, which pressed on my stomach. He pressed stronger and asked if I felt hurt. I responded immediately that I felt very hurt, and he then twisted and screwed on the spot very strong. He did this to me for three days in the morning consecutively, and since then I got recovered fully until today.* (F, 46, Phnom Penh_9).

Some traditional healers were believed to connect to a spirit. Here patients and their families were required to organise a ritual ceremony based on the advice of a healer in which they had to prepare specific food, spiritual music or other ritual materials to offer to the spirit to request their help to cure the illness.

Traditional practitioners also included Buddhist monks, who provided treatment through traditional medicine or other methods including water spraying.

KruTeay or fortune tellers were also mentioned by our participants, who referred to those who could predict the future. For illness treatment, they could identify the causes and so could inform on what needed to be done to improve the situation. In these cases, patients could be advised to change the position of houses, doors or windows, or to organise a certain ritual ceremony.

1950s-1960s:

The life histories did not provide sufficient data to fully explain health treatment by indigenous practitioners during this period. However, from the data, we found that the utilisation of indigenous practitioners was generally accepted for both minor and serious illnesses. This was largely determined by the lack of public facilities and limited health workers available in rural areas; indigenous practitioners were often the only available service in the village, so people had to rely on them.

> *A: In that time there were not many doctors. Only traditional healers were available, so she [older sister] relied on a traditional healer and used Khmer medicine. There were hospitals, but they were not as many as today. For example, my house was here, but a physician was living at Kirivong district town (3km). We could not contact him on time. In that time, physicians could visit villages, but they could not come often.* (M, 67, Takeo_21).

People in that period also had strong beliefs based in traditional medicine. They believed that the cause of some illnesses, for example epilepsy, oral thrush, spasms in children and some types of

adult disease were related to spirits; only indigenous practitioners who knew how to arrange ceremonies or connect with those spirits could cure illnesses. Some participants related this to the lack of information and awareness raising among local people about health issues.

> *A:…at that time people did not really go to hospital in Kampong Cham town because they did not feel confident in the hospital treatment. People instead believed in superstition like the spiritual keeper or ghost of the forest or surrounding (Arak Nak Ta). People often worshiped with classical spiritual music, and offered pig head, cows, chicken, coconut and so on to the spirit…There was no information sharing about the hospital. Many people believed in the superstition. Whenever they got fever, they would pray to the spirit or they use traditional medicine. They squeezed the kapok leaf to drink, and their temperature became stable as normal.* (M, 74, Phnom Penh_7).

> *A: He (second child) had a boil on his buttock and he always slept on his side… I also took him to a traditional healer. I was told to put the same traditional medicines on the boil but my child always cried, slept on one side, refused to drink breast milk and the hole at his buttock became bigger. He wasn't cured and died. I didn't take him to the hospital because I thought that he was not serious. I only treated him with traditional medicines and some people said it was because of his previous mother spirit "Maday Deum"… Previous mother spirit "Maday Deum" caused all kinds of serious diseases to baby, for example, epilepsy or oral thrush and makes the baby not eat or drink. His previous mother, in his last life, did that in order to make him die and then took him back. Some babies got spasms because of this.* (F, 63, Takeo_18).

Relying on indigenous practitioners for treatment was also considered a local practice for people because they often saw their family members, relatives or community members seeking out indigenous practitioners, setting an example for them to carry on.

> *Q: So it was a habit that you did not bring your child to the hospital? A: Yes it was. I delivered a baby at home and when my children got sick I took them to traditional healers. Q: Who told you to take your children to this or that traditional healer? A: Interviewee: My mother told me to do that and I followed her.* (F, 63, Takeo_18).

Participants talked about poverty in that period. Because they could not afford to pay the cost of other health care services, people chose to use traditional healers. A participant recalled that having no money was a reason why she did not take her child to hospital, but to indigenous practitioners.

> *A: She was treated by the Khmer healer…I didn't go to hospital. I only took her to traditional healers. I had no money to bring her to hospital.* (F, 63, Takeo_18).

1970-1975:

During this period, people continued to rely on the services of indigenous practitioners. The reasons remained the same: the lack of health facilities in the rural areas, local belief in superstition related to illnesses and the lack of media and information sharing on health issues. This was now compounded by the war.

> *A: There was no medical doctor at that time. The traditional healer is still alive now. At that time, we were often in fear and there were no doctors. Whenever we heard the sound of military airplanes, we brought plates, pots and cutlery and went into a safety tunnel. If the rice is cooked on time, we brought it along to eat in the safety tunnel, but if it isn't, we just left and run away. The ground tunnels weren't built with high roofs or the military airplanes would see and drop the bombs. At that time, if we got sick, we could find only traditional healers and we were not sure whether or not we could recover. At that time, we couldn't find physicians. My father heard that the traditional healer could cure it, so he went to find him.* (F, 53, Phnom Penh_11).

1975-1979:

The practice of seeking indigenous practitioners also existed during the Khmer Rouge regime. Our participants mentioned the persistence of local beliefs in the health care services of indigenous practitioners. The poor quality of public health facilities and lack of responsiveness to provide treatment to local people during the Khmer Rouge period also supported their decision to use these services. In our transcripts, we found cases of Angkar[3] referring a patient back home or to indigenous practitioners because it had failed to treat them.

> *A:…He was an ordinary person, but he knew how to treat it. The Angkar assigned that person to treat any children that suffered from the disease since they found out that he knew how to treat it.* (M, 74, Phnom Penh_7).

> *A: When I suffered greatly from my stomach disease, it was unbearable and I almost died. I got into the Pol Pot healthcare centre… but they did not know how to treat it. They said they could not do anything. I was afraid of dying because I was young. I cried and hugged my parents… My father met a village healer who claimed that he knew how to treat this disease. He came to ask my father for smoking tobacco. My father learned that he knew how to treat my illness, so my father asked his favour.* (F, 46, Phnom Penh_9).

Despite the willingness of some *Angkar* to refer people to indigenous practitioners, our transcripts also confirmed contradictory views from the Khmer Rouge regime towards them -

[3] Angkar is a name given to the government of Khmer Rouge regime

some were executed because of their knowledge to treat people while others were moved to work in different places. Some practitioners who were still based within a village did not dare to come out and show their identity. Hence, finding a traditional practitioner in this period was often difficult.

> *A: At that time my father was a Khmer traditional healer, but he dared not to reveal his skill otherwise he would be executed because the Khmer Rouge did not allow to have a Khmer traditional healer, but only its so-called health centre.* (F, 40, Takeo_17).

1980s-1990s:

During this period, the services of indigenous practitioners remained popular; they were either sought for their help alone or in combination with others such as village medics or public facilities. The low cost of treatment by traditional practitioners and their availability in rural areas was one factor that encouraged people to choose them. Using indigenous practitioners meant that people could often pay whatever they could afford. Some healers required only a certain type of gifts.

> *A: My family just thanked him and gave some rice and one or two riels to him.* (M, 67, Takeo_21).

> *A: He did not ask for money, but just a handful of bananas.* (F, 46, Phnom Penh_9).

The inexpensive cost of treatment and the flexibility that people could pay in-kind, e.g. with rice or bananas did not fully explain why traditional practitioners were so widely called upon. We also found that, even when the cost of treatment was high, people still used the service. This was because community groups at large had a strong belief in traditional treatment which influenced individual decisions to use their services. In our transcripts, participants mentioned the involvement of family members, relatives, neighbours or villagers who advised or encouraged people to use the services of indigenous practitioners.

> *A: The Khmer traditional healer prepared a ceremony to pray to spirit (neak ta) to break the magic spell. I spend a lot on Khmer traditional healers. Maybe 30,000-40,000 riels for each ceremony… prepared rice, chicken and classical music such as drum and tro to worship angry spirits. ..It [the money] came from my saving from selling wood. I sold another cow during his treatment and a plot of rice field.* (F, 63, Takeo_18).

> *A: ...His swelling becomes more serious. The swelling became critical after I gave birth to the fourth child… I'm afraid he was cursed. I looked for traditional healers. I heard it from word of mouth. I just believed in those words of mouth. My mother-in-law said that it's not a disease that caused immediate swelling like this, and it must be someone who cursed him with black magic. So, I just tried to treat him in that way.* (F, 40, Takeo_17).

People believed that illnesses were caused by the spirit of nature, spirit of ancestors or a black magic spell. A person could be ill because he/she disrespected other spirits or other people who then took revenge through giving a curse back on the person. Some illnesses were believed to be connected to the person's previous life and only indigenous practitioners were able to address it. It was also thought that traditional practitioners were appropriate to treat typical illnesses such as measles for children or postpartum relapse for women.

With this belief, some people persisted in using these services even after their first treatment failed. People thought that some indigenous practitioners would be more effective than others, so they sought services from a range of them.

> *Q: How many traditional healers did you take him to? A: There were three Khmer traditional healers, and all of them said that my husband was cursed Q: You knew that your husband did not get recovered after the treatment received from the first and second healers. But why did you still look for the third one? A: I just followed his mother who told me to change from one healer to another. She said something like "let's go to another one," because she heard that one was very good.* (F, 40, Takeo_17).

The use of indigenous practitioners was again determined by the lack of health facilities in the rural areas between the 1980s-1990s. Participants mentioned the absence of health centres at the commune level. Hospitals only existed at the provincial towns. The distance to the hospital and the ongoing war with the remnant groups of Khmer Rouge hindered local people from accessing public hospitals.

> *A: After delivering the baby, I had been seriously sick for three months. My father-in-law asked a traditional birth attendant to clean up my uterus again. In fact, my husband and my father-in-law wanted to take me to hospital twice, once when I was in labour and the other when I got sick after the delivery. Because hospital was far and war with remnants of Khmer Rouge was still occurring, he invited a Khmer traditional birth attendant to clean my uterus instead.* (F, 55, Takeo_15).

People who lived in the urban areas reported the existence of health facilities and having access to such services in the mid-1980s, but then complained about the lack of medicine, shortage of health workers, poor facilities and ineffective services to diagnose or cure illnesses. Participants changed to traditional practitioners as another option to continue the treatment when they could not rely on a public health facility anymore.

> *A: My brother stayed in Phnom Penh. He was hospitalised at PreakKosamak hospital. Doctors told us that my brother had intestine adherent because he had difficulties to defecate. His stools were very little, flat and sticky. [at the hospital]..there were few medical volunteers, like my aunt to work there…At that time, there were no drugs at*

PrekKosamak hospital; they gave us only one or two pills. If he was sick in the late 1990s, he would have been cured. At that time, our health care system was weak. (M, 51, Phnom Penh_3).

Even though public facilities started to become available in some rural areas in the late 1990s, some people still did not use these services. The belief in the use of traditional practitioners was still carried on until the late 1990s.

2000s-present:

Seeking services from indigenous practitioners was still pursued by local people from the year 2000 to the present even though public health facilities and private health care have become more widely available. Rather than using the service of indigenous practitioners alone, however, we have found that people have tended to combine various services. Several cases indicated that indigenous practitioners were often sought after seeking other services. Only a few cases were found where people sought to use traditional practitioners first, particularly if the condition was not serious. We also found that people switched services depending on their trust in the quality of their treatment and the influence of others.

In this period, people tended to rely on a range of services, especially public facilities, except for some conditions for which they turned to indigenous practitioners. This was usually when their illnesses were considered untreatable by public doctors or when people lost trust in the capacity of public facilities to cure the disease. If this occurred, people decided to use traditional healers as an alternative solution or combined public, private and indigenous health care, hoping to get the best of all.

A: I suffered from the hepatitis again but I went to traditional healer in my Sangkat instead…Actually, last time, I went to hospital, the medical staff there told me that my hepatitis has developed to ascites. The medical staff at Municipal hospital and at a private hospital said the same thing, that is why I decided to find treatment from traditional healers. (M, 74, Phnom Penh_7).

A: He had high fever and could hardly speak. He suffered from high fever and blood pressure until he couldn't identify anyone even his children. He had severe headache and blood pressure. First, I sent him to private clinics and then to the Khmer-Russian Friendship hospital… later on I changed to Municipal hospital. I used to send him to see Khmer traditional healers. I sent him there whenever I heard any rumour that they could treat such a disease. (F, 47, Phnom Penh_12).

In contrast to the past, we also found that marketing by some indigenous practitioners emerged strongly in this period; they were strategic and attractive to local people. Unlike the older practice

of in-kind or little payment, the cost of treatment with indigenous practitioners became more expensive. Participants said their marketing practices were often conducted through the media and tended to make promises to cure chronic or severe illnesses, thus attracting the interest of patients who had experienced failed treatment with public or private health care services even though they had to face the high cost of it.

> *A: She had a fever and felt tired and she was sent to Angroka referral hospital when she was serious but we just took the medicines and came back home. We didn't pay the hospital because we had a membership of CBHI. Later, I heard the announcement from radio about Khmer traditional medicine that it could cure such disease. I bought it for 300 dollars and my daughter felt better after taking it.* (M, 54, Takeo_14).

Some indigenous practitioners combined the traditional treatment with modern health care, which cost patients a lot of money. Some patients described effective results while others admitted to no effect at all. A participant described how he used his savings to pay for the treatment and pawned his property to cope with it.

> *A: I suffered from the hepatitis… I went to a traditional healer in my Sangkat. I just gave him a small sum of money to show my gratitude. But, I have spent a lot with the Kandieng traditional healer… I spent around two or three thousand dollars. Actually, the medicine is not expensive, only around 20,000 riels (USD $5), but I had to spend a lot on x-ray and echo test. Also, I had spent more than 130,000 riels (USD $32.5) for blood test. The healer required me to go for blood test. I borrowed money from ACLEDA bank by using my house title as collateral. I'm really worried about the money I have to pay back. My youngest child is still studying and only one single child earns money.* (M, 74, Phnom Penh_7).

People still preferred the services of indigenous practitioners over biomedical treatment to treat some typical illnesses such as post-partum relapse, measles, bone fracture, etc. Such perception and belief were still carried on by many Cambodian people in the current period and influenced their decision to continue or to switch from using public facilities to indigenous practitioners.

> *A: To treat bone fracture in the hospital, my aunt told me that first a surgery was conducted to put metal to reinforce bone and then we have to do a surgery to take out that metal. This will take a lot of time, up to six months to one year. So, I think that fracture like that could be treated by traditional healers and it took less time than at hospital, about more than a month. The pain disappeared after one week, and she would spend another month to get a complete recovery and then she could start to work…I also trusted treatment by traditional healers that it would take shorter time to cure it.* (M, 51, Phnom Penh_3).

This idea was compounded by the fact that the cost of treatment at public facilities and private health care was too high for some poor people.

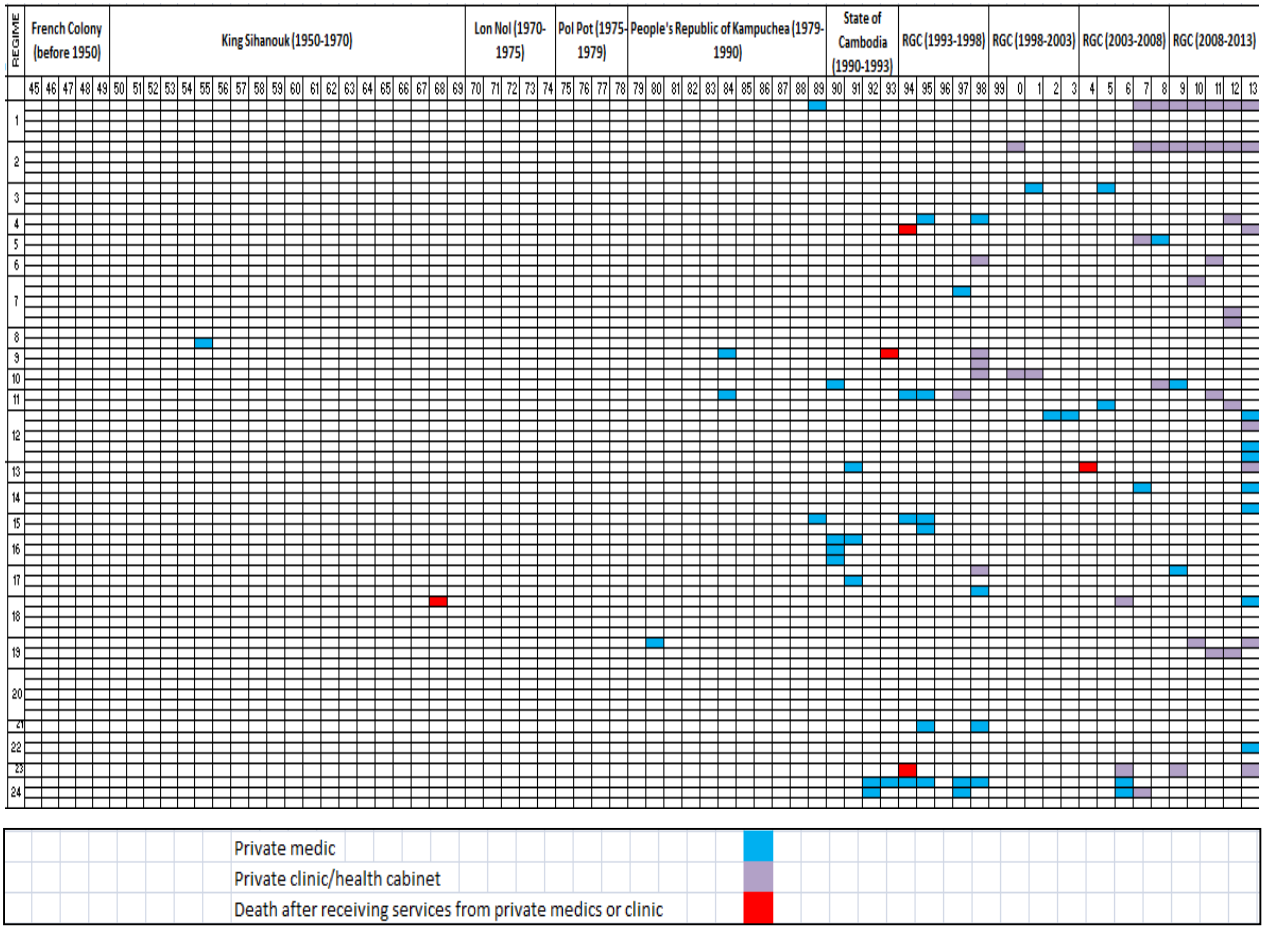
> *A: If she got treatment at the hospital, it would take from six months to one year…Because we had nobody to take care of her for such a long treatment, we decided to send her for treatment with Khmer traditional healers. If we stayed longer in the hospital, we would have nothing to eat. We had no income, and our children couldn't do anything. The traditional healer used shorter time, and I could do some works while my wife got treated by traditional healers at home. If she was hospitalised, I couldn't do anything and I had to take care of her at hospital. At home other people or neighbours nearby could help me to take care of her... No one could help us if we were staying in the hospital.* (M, 51, Phnom Penh_3).

4.1.2.3 Private health care

Private health care included the services from private medics and private health clinics or cabinets. The life histories showed private health care existed in the period before the war (1950s-1960s), but during the war under the Lon Nol and Khmer Rouge regimes (1970s), private practice gradually disappeared. The service re-emerged during the 1980s and expanded in the 1990s through the popular practice of private medics or 'village medics'. After the war ended during the late 1990s and peace building and recovery began, new private health care services in the form of health clinics or 'cabinets'[4] also emerged. Since then, the use of private health care has not exclusively relied on private medics or village medics. The use of such clinics or cabinets remains popular in the present day along with the services of private medics.

[4] Health cabinets refers to out-patient healthcare services provided by private sectors, especially for minor treatment or consultation

Table 4: Behaviour pathway in seeking private health care



1950s-1960s:

Only a few participants mentioned the use of private health care in this period. Limited information from life history interviews did not allow us to describe the full practice of private health care. However, we learned that private care in the regime was often provided by health workers who worked in public facilities, with many using their break times to earn extra money through providing private treatment to villagers. Because these private medics offered services by going door-to-door from one village to another, local people often called them *Pet Phum* or 'village medics.'

> *A:…in Sihanouk's time, not French time, some physicians could work outside when they finished their time in the public hospital*…. (M, 74, Phnom Penh_7).

The forms of treatment included giving medicines to patients, giving injections or IV drips. Village medics bought medicines from drug stores at the market and then used those medicines to cure

the illnesses of people in the village. Their equipment was different from the current period. A participant described his experience of seeing the old equipment of village medics at the time.

> *A: I didn't go to hospital. I just invited a physician in the village to give injections. Physicians at that time used hypodermic syringes. After using, they sterilized the hypodermic syringes with hot water and then they reused them.* (M, 68, Phnom Penh_10).

The use of private medics was rare and was reported to be expensive, so people tended to reserve their use for serious cases that self-medication or indigenous practitioners could not deal with; in fact it was mostly the family members of private medics who received the service. People relied on these practitioners rather than going to hospitals because of the considerable distance to the public facilities and the lack of transportation to get there. Using village medics was more convenient because they could come to people's houses.

1980s-1990s:

The use of private health care disappeared during the Lon Nol and Khmer Rouge regimes, but then re-emerged in the 1980s in both rural and urban areas; people reported the greater use of private services during the 1990s. Towards the end of the decade, there emerged the service of private clinics and cabinets to provide treatment in combination with the village medics. The seeking of private health care in foreign countries was also identified.

People described village medics as mobile, driving a bike or a motorbike with a bag of medicine and equipment. With their appearance and frequent visits to villages, people could recognise village medics easily.

Local people directly contacted village medics from the same village; if they lived in a different area, the everyday visits to villages allowed local people to access treatment. Village medics had their own transportation, so they often visited villages even though there were no patients available. People could invite them to provide treatment at their houses or, in serious cases, people could bring patients directly to the medic's home.

During this period, village medics were often: 1) those who remained in the country from the Sihanouk Period and who survived the Khmer Rouge regime and offered private health care services; 2) those who returned to their home towns from the refugee camps at the Cambodia-Thai border after their closure in 1993 and set up the business; and 3) those who worked at public facilities, but then provided private treatment to villagers for extra money.

The popular use of village medics was due to their convenient services particularly as they travelled from one village to another and offered assistance at the doors of local people. People

reported that hospitals were far away - often at the provincial towns - and they did not have transportation or could not afford the transport costs. Therefore, they sought services nearby.

> *A: The private physician at Sla Ku who often came to my village diagnosed him. The private physician gave him injections and some medicine to take… There was no hospital, only one in the province…It was very difficult at that time, there was no motorbike like today, and we had to walk.* (F, 45, Takeo_16).

Even though this period also showed the popular use of indigenous practitioners' services, we found that people had also noticed that better services were available from private medics to effectively treat some severe illnesses such as malaria. People reported quick results from private health care services which built their trust in the village medics. This influenced the perception of local people; they shared and advised each other to use the service. The practice then became popular within the community to cure illnesses along with the services of indigenous practitioners. A participant described her decision to use the village medic:

> *A: Most villagers here got malaria and that physician was very skilful at treating malaria. I didn't go to hospital because there was a private physician in the village*….(F, 63, Takeo_18).

Participants also reported that when the war still continued in some areas, village medics were the ones who could reach patients in those conflict zones because they lived close by..

> *A:…the eighth child got sick and was unconscious for three days. He got malaria. He was sick at home once returning from forest. He didn't know anything while he was unconscious. He looked like a dead person. My daughters and I cried because we didn't expect that he could survive. I called a private physician for help… The village chief and the physician... dared not to go back home at night because they were afraid of Vietnamese troops on the way home. They returned home in the morning.* (F, 63, Takeo_18).

Village medics were responsive to local demand as long as people could guarantee the payment.

> *A: She started with chill, not yet trembling. My father then encouraged to call a physician and not to wait because it could become serious and then cost a lot of money for treatment. Then, I went to invite the physician to treat her urgently…When I arrived in his home, he was eating food. He stopped eating and went straight to my home. It was easy to call him because we didn't make any difficulty to him (owing him any treatment costs).* (F, 44, Takeo_22).

The cost of private medics was more expensive than the cost of indigenous practitioners with high charges for medicine. As a rule, patients had to pay the fees as demanded by village medics

or they would not receive future treatment. No clear standard tariff was reported, and the amount due depended on the decision of the medic. Having no money to pay the cost, some people had to sell property. Some participants decided to drop out of the service when they could no longer afford it.

Even though the treatment costs were high, our participants described that some village medics in rural areas were flexible in the payment process. They often allowed patients to owe or pay in instalments. As such local people often chose the service even though they could not afford to pay immediately.

> *A: I often asked a village private physician to give her IV drip… If we invited the private physician to treat her at home, we could owe the physician first and pay him later.* (F, 46, Phnom Penh_4).

> *A: I also pay to the private physician, but I could owe him some. I could pay him back little by little.* (F, 63, Phnom Penh_18).

In the urban areas, on the other hand, during the 1980s and 1990s, people who were close to and could access public hospitals confirmed that the poor quality of public health care, the lack of health workers on duty and the behaviour of some health workers all encouraged patients to receive private treatment at home. Participants recalled that the public health facilities in the district were not yet upgraded and failed to provide sufficient services to patients. They also reported some health workers were not interested in providing assistance at public facilities and encouraged patients seek private treatment.

> *A:…the medical physician asked me to send my daughter to receive treatment at his home. At that time, the hospital had only one building with three rooms. That physician bought medicine from district town to cure my daughter. He gave modern medicine to her to take and gave her injection.* (F, 57, Takeo_20).

In the late 1990s when public facilities were upgraded, poor people still kept using the services of private medics because they could not afford treatment at the hospitals, including the costs of transportation, care taking, food and loss of income. Seeking services from private medics at home proved cheaper than going to public facilities.

> *A: If I took him to hospital, no-one cooked for other little children. I had many young children at home who needed me to look after. So, I asked a private physician to give him an injection and provided him some medicines to take.* (F, 60, Phnom Penh_2).

The concept of going to hospital for illness treatment in the late 1990s was not yet popular among local people either. There was a lack of outreach programmes by the government to share

information on the services provided by public facilities. The existing information sharing did not deeply reach local people at village level.

It was found that some village medics were aware of the government programmes and could inform and advise people to attend public facilities when necessary.

> *A: After I got recovered from diarrhoea, I began getting into drinking a lot of wine with my friend who was also poor. He got TB, and I was transmitted with the disease… I felt tired and I could not eat. I could only drink wine. I coughed a lot for years. However, I was still able to work like ploughing. Later, I heard there was a private physician from the district hospitals to come to give people injections outside. So, I chased the news and met the physician… However, the physician dared not to give me injections, and asked me how long I had cough. I told him that I had coughed for long time already. He then said he could not give me injection. He added: he did not just want to get money from me, but my disease needs treatment at hospital… At that time I also knew that there was a hospital in Kirivong district. However, I did not think of going there. He then asked me to meet him at the referral hospital. So, I went to the district hospital following his recommendation.* (F, 57, Takeo_24).

In the late 1990s, private clinics and cabinets were established, especially in urban areas. Participants reported seeing more clinics or health cabinets available around their neighbourhoods or communities. Some people who lived near the border also reported knowing of private clinics in neighbouring countries, and often used these in an emergency because they were close to them.

Not all private health care services were effective in curing illnesses. Participants described both effective and ineffective services from village medics. Our participants reported knowing or having used more than one medic. Some reported using only those who were recommended by their neighbours or who were known to provide effective treatment. There were cases of some illnesses (e.g. malaria) that could not be cured by village medics completely. A participant described how she kept on spending money on village medics trying to cure her husband who had malaria for several years.

> *A: My husband took Quinine to cure his disease, malaria. He does not recover from malaria completely. He got fever every four or five months or sometime seven or eight months. It's unpredictable. When he got sick, we needed to spend 80,000 riels to 100,000 riels to call a private physician to treat him. Because I couldn't earn much, sometimes I borrowed money from private lenders like 100,000 riels to pay the treatment. When I couldn't pay this debt, I borrowed money from micro-finance to pay back the private lenders. I also sold another plot of land for consumption since my husband was often sick and couldn't work.*

The physicians gave him medicine to take as well, but it was not effective. (F, 57, Takeo_20).

2000s-present:

The use of private health care since the year 2000 remains popular among local people. People continue to either invite private medics to their houses for treatment in an emergency or to consult with them at their health cabinets or clinics. In the last decade, health clinics and cabinets have mushroomed all over the country, particularly as many health workers in public facilities run their own clinics as personal businesses in addition to their public job. Competition in price and services between private health care was also evident. For business marketing, some clinics even provide free services to customers. A participant talked about free ultrasounds provided by new startup clinics in urban areas.

A: I had appendicitis. I had surgery. At the beginning, I felt hurt, and I felt a hard lump. I went to a private clinic and had a free eco-test. Then, the physician told me that I had appendicitis, and it was very serious. The doctor advised me to have surgery now otherwise it's too dangerous for the next one or two months. (F, 59, Phnom Penh_5).

In the early 2000s, it was widely reported that health workers from public facilities were taking medicines from hospitals to sell from their own homes or encouraging patients to buy or receive additional treatment at their private clinics for high prices.

A: Health staff are always thinking about additional money even though they have salary and receive other benefits. Other benefits include medicines they took from hospital to sell at their home. They are not honest. Q: You believed in this way? A: Yes,… I brought my daughter to hospital. We did not have money and she was required to have an intravenous infusion of fluid. A health staff told me that he did not have infusion fluid in stock, and asked me to buy it at his home. I went to buy the fluid at his home that was sold by his wife. One sack of infusion fluid costs $12. I think the doctor took the infusion fluid from hospital and let his wife sell it. Q: Why do you know that the seller is his wife? A: I asked her, is it your home or you rent it? She responded that she bought this land, and she paid for such amount of dollars. I continued to ask her the price of the infusion fluids she bought and how much she sold it. She said that "my husband is a doctor; he takes home each time two or three sacks of infusion fluids". I was surprised by her answer. (F, 44, Takeo_22).

However, not all private health care services could assure good quality of treatment for patients. Our participants stressed the quality difference between urban and rural areas. They also mentioned the lack of quality control in some private cabinets or clinics; some medics performed treatment with the help of their family members who lacked medical skills; where others did not perform their tasks properly.

A: I got the accident because of the road condition. During that time, most of rural roads were covered with gravel. One day I had to ride to my hometown where I didn't really know about the condition of the road. While riding in a fairly fast speed on that gravel path, I couldn't control my motorbike and it veered off the path. My mouth and nose was seriously injured and needed to be stitched. I went for treatment immediately after the accident. The medical service in countryside was very poor in term of hygiene. The medical staff there carelessly stitched my wound leaving some scraps of grass inside the wound. Just one night after that, when I came back to Phnom Penh, my wound was swollen… Next, I went to Dr Sai who open a private clinic, the doctor's wife seemed to know very little about medical treatment. The doctor asked his wife to clean my wound. She just made some wipe on my wound by using the cotton. Then, Dr Sai applied some injections on me…Last, I went to a private clinic in BouengKengkong. (M, 74, Phnom Penh_7).

A: Even we spent all money with the private clinic, my son still didn't get better; there were some tiny pieces of metal left inside his stitched wound. After that, my son kept crying and the wound was swollen because there were some tiny pieces of the metal left inside his stitched wound. (F, 45, Phnom Penh_8).

The lack of price control over private health care services was also identified. Our participants reported great differences in treatment costs between the private health clinics.

For the second miscarriage, first, I went to Bayon clinic, but they demanded a lot of money for the medical service. So, I went to KbalThnol clinic. It's cheaper than Bayon clinic. (F, 47, Phnom Penh_12).

The popular use of private health care in this period rested on several factors. Our participants explained that the service of private health care was for emergencies. They were everywhere and often close to their homes. However, when the illness or injury was severe and required surgery, people would use public facilities.

A: There was a time when my husband was cutting firewood, the blade of the axe accidentally slipped out of its handle and cut through my child's skin around his testicle. He was bleeding heavily. I brought him to a private clinic near Chroy Changva bridge to get his wound stitched…It was an emergency case as he kept bleeding heavily, so I had to bring him to the private clinic nearby. Then I brought him to Kuntheak Bopha hospital. I just gave the staff there some background story related to the wound, and they sent my son to the emergency room without having to draw the waiting number. (F, 45, Phnom Penh_8).

Unlike the past when distance and unavailability were often the barriers to accessing public facilities so that people chose village medics, our participants cited that their decision to use

private health care in the present day was related to the speed of service. They also perceived achieving more effective results than from using some NGOs or public health facilities. Besides the perception of quick and effective treatment, people often chose private health care to avoid spending too much time waiting for treatment at public facilities that would mean taking time off work. People who held Community-based health insurance also reported using private health care sometimes because of the quicker service.

> *A: I thought private clinics could cure my daughter's illness fast, and so I could return to work early although I needed to spend much money…my work was very important. At that time, earning US$10 a day was really a lot.* (F, 60, Phnom Penh_2).

> *A: My third child who got divorced and lived with me was also sick. He had typhoid and gastric disease. My son also went to state hospital (Sen Chey health centre) three or four times already. However their medicines were not effective, that is why we decided to take him to private physicians and he felt better. Q: Around this area, I know that there are Sihanouk Hospital Centre for Hope's and Licado's physician teams [NGO] who came to provide services to vulnerable people, and why did you still go to private physicians? A: Because the medicines we received from them were not effective at all for the disease.* (F, 59_Phnom Penh_5).

> *A: I remember I went to seek treatment from Dr Lun. Dr Lun didn't name his clinic. He just provided medical treatment to people living nearby him. I heard about him from my brother. At that time, SKY[5] service [CBHI] was available, but I didn't have time to seek treatment from public hospital covered by SKY insurance all the time. I had to work and I didn't dare to take leave frequently. If I went to public hospital, I had to spend at least one morning. However, for private treatment, I could go there at night time and I didn't have to wait.* (F, 47, Phnom Penh_12).

> *A: I held CBHI…I didn't get any relief by getting medicine from Angroka referral hospital. Plus, the service was rather slow at Angroka referral hospital. I used private clinic service around three times.* (F, 63, Takeo_13).

Our participants also mentioned the high costs of treatment at public facilities as a factor in their decision to choose private health care. Poor people did not go public because they could not afford the costs of treatment, transportation, care taking and food.

> *A: I took him to the house of the medical midwife who helped me in birth delivery as her house was nearby. She gave IV to my son. After having IV, my son got better in the evening*

[5] SKY is the abbreviation for 'Sokhapheap Krousar Yeung' meaning 'Health for our Families'. It is an innovative micro health insurance scheme implemented by the French NGO, the Groupe de Recherche et d'Echanges Technologiques (GRET).

but he felt sick again in the next morning. So, I sent him back to that medical midwife again. The medical midwife then pressed on my son's arm and found blood coming out slightly through his sweat pores. She told me that my son got dengue fever... She advised me to take him to Calmette Hospital in Phnom Penh. I didn't send him to Calmette hospital. I didn't go to Calmette because I didn't have money even to cover transportation. The medical midwife told me that she had no capacity to cure my son. That was why I took my son to see the physician who came from Thai refugee camp. I knew him through neighbours nearby. They said he is good at treatment. (F, 41, Phnom Penh_6).

A: As I have mentioned before, I could not leave my children at home alone. If I stayed and received treatment at home [with private medics], at least I could guard the house and helped do light work, such as cooking for children. If I went to the hospital, I would be required to rest at the hospital. (F, 57, Takeo_20).

Fee exemptions for poor people were not always accepted. Poor respondents described their experiences of health workers demanding payment at public facilities which discouraged them from attending when they had no cash in hand.

Q: Didn't you think that the public hospital could help cover the cost of treatment for the poor people? They may exempt all the fees because you are poor? A: No. I don't think so. It must be cash on hand before they start treatment. I witnessed it myself. The public hospital will provide services to only people who have money. I heard villagers who brought their relatives to public hospital complained that physicians there ignored patients until they paid money. They complained that physicians would diagnose patients or send the patients for x-ray and so on only when the patients paid money. They said after paying, the services were quick. That was why I decided to invite private physician to treat my mother at home and I borrowed money from others to pay the treatment cost. (F, 41, Phnom Penh_6).

The private health care treatment costs were considered high. People who went to private clinics were required to pay immediately after receiving the service; there were no reports of repaying the charges over a period of time. to the private clinics.

In the case of private medics, payments were often flexible as in the past. Some participants reported they would go to consult, take medicine from private medics or receive an intravenous drip (IV) and pay the cost later. Those private medics showed their understanding as they lived in the same village or they believed in the capacity of patients' families to pay back the cost. In contrast, going to public facilities required people to have cash in hand; they could not owe money otherwise they could not receive the service.

A: When my son was sick, my youngest sister can't get money within that short time to send him to health centre. The public hospital (referring to health centre) needs cash on hand. Private physicians could let us owe the cost of treatment…[Similarly]my mother got lung and heart related disease and she received treatment from private medics. I wanted [to take her to public hospital], but my mother told me that she did not want to go because we didn't have money in hand. I couldn't borrow money from others immediately to send my mother to hospital. At that time the private physician allowed me to owe him the treatment cost, but he asked if I could pay him in one week. I said 'let's see sir!' And he understood and said nothing. We knew each other since I often seek his treatment. Differently, we can't do this with public hospital. They need cash on hand (I can't owe treatment cost with public hospital) and I didn't have it. (F, 59, Phnom Penh_5).

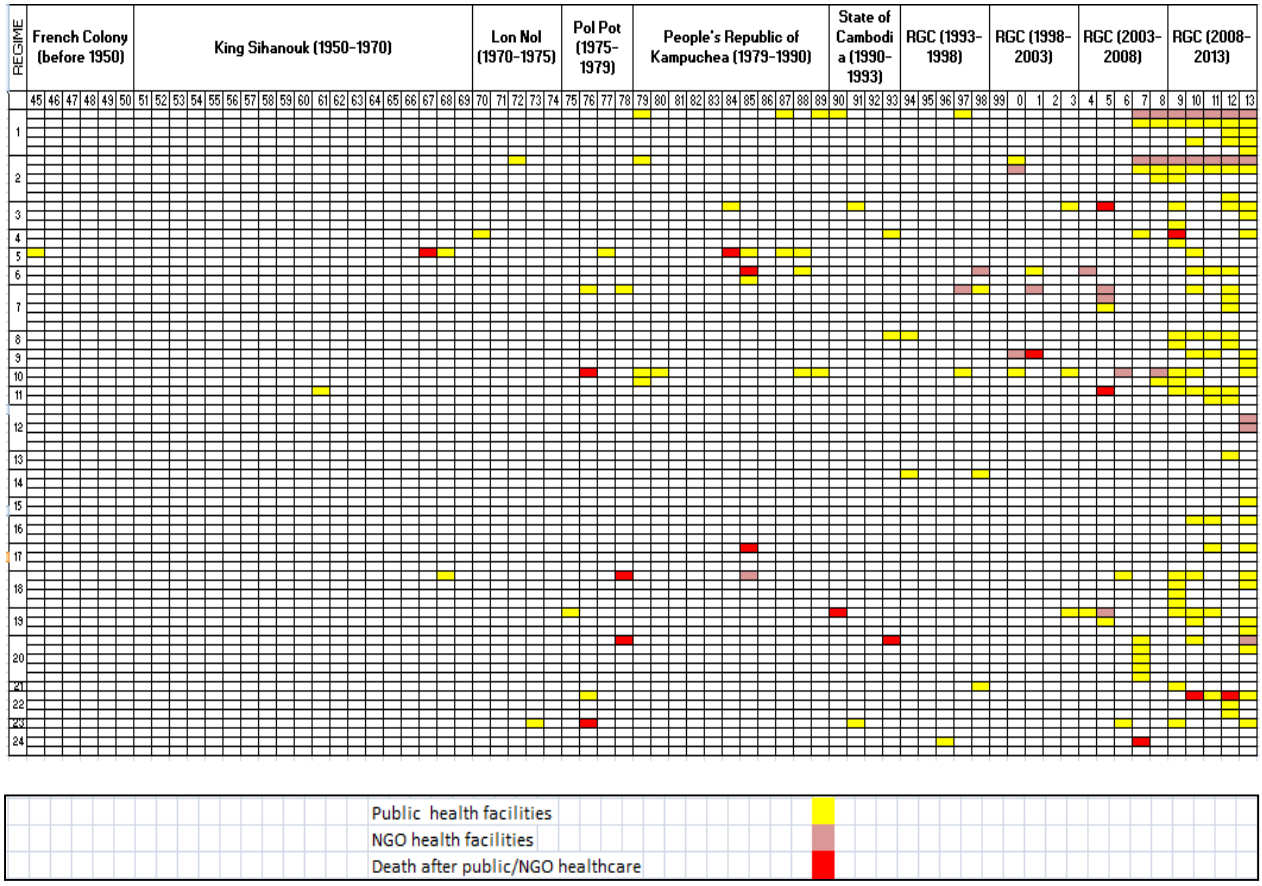
We also found that poor people with HEF who had chronic illnesses such as diabetes still relied on the services of private health care even though HEF sought to cover medical bills for them. This was because the HEF did not sufficiently cover the costs of treating long-term conditions. Those patients had to spend money from their own pockets to seek additional services from private health care which had an effect on their household economy.

A: Sometimes, I need the specific serum for the diabetes but the hospital or health centre do not have it, so I have to go to a private clinic. Besides using the serum, I need some money to buy food. My husband didn't make much money and I often get sick….(F, 52, Phnom Penh_1).

4.1.2.4 Public and NGO health care

Public health care included services for both civilians and the military. Civilian care comprised health posts, health centres, referral hospitals, provinical referral hospitals and national hospitals. Life histories showed uneven results on the existence of public health care across political regimes. Our participants recalled both the absence and the presence of public health care in the period before and during the war. In the late 1990s, more people confirmed the accessibility of public health care, but the popular use of the service was not achieved until the mid-2000s. Non-governmental organisational health care also existed during the war period and continued to the late 1990s.

Table 5: Behaviour pathway in seeking public health care



a. Public health care

1945- 1970:

This period covered the French colony and King Sihanouk period. Very little information was provided by our participants for this era. Only one participant could provide his expeirence in receiving public health care during the colonial period, which he described as difficult to access. He mentioned the lack of services at the commune level, only at the province and some district towns. He also mentioned difficult roads and limited transporation means for local people to access public facilities. At the time, the only means of transport people had was either by foot, ox-carts, bicycle taxis, or boats. He recalled the availability of red liquid medicine[6], which was the product of China and France, to apply on minor wounds, or the suturing of large wounds. He said

[6] Likely to be mercurochrome – a very common antiseptic used worldwide but removed from public circulation as the active ingredient was mercury.

there was no charge for services, but confirmed the poor behaviour of health workers towards patients which was influenced by their French masters.

> *A: Oh there was physician in district like in Kroach Chhmar District and Suong District as well, but it was not available in commune. People went to hospital on foot, through wheel cart, canoe or bicycle taxi... I used my own boat... It was far. If I chose to travel on streets or paths, it would take much time because we did not have motor or car or I could be carried on shoulders. It is not like nowadays that transportation is numerous and that we have motor taxi. Thus, it was faster to en route through canoe, and I did not need to pay anything because it was my own boat... During the treatment, I could not even scream a bit because they intimidated me by cutting of my leg. They were Khmer physicians who were under French's surveillance. They had no ethic and were rude, not like nowadays. They wanted to follow their French master. But, I don't know about other patients. They bandaged my wound, which did not take much time. I must return in a week sharply. If I was late, I would be perceived as disrespectful to their job. I saw some Khmer physicians terribly cursed and blamed on other patients.* (M, 74, Phnom Penh_7).

During King Sihanouk's period, our participants stressed the improvement in health care services due to the greater attention paid by the government to the health sector. French medicine was also available, but medical technology was not yet advanced.

> *A:...during the king-father's regime, health care service was improved. French-made medicine was widely used and it was very effective. We hardly saw any Vietnamese or Chinese medicine. Our king-father paid great attention on health care service. Anyway, as we were in an early stage of being independent from the colonialism, we didn't have any advance medical technology yet still.* (M, 74, Phnom Penh_7).

Still only a few participants reported their experience in utilising public health care during the King Sihanouk period. They reported the same challenges as during the French colony concerning the absence of public health facilities at rural level and the lack of transportation. A participant described how she managed to access a public facility at the district town:

> *A: We did not have any means of transportation at that time. So, my father put me on his neck and walked to the hospital and we arrived at midnight. We were walking because my father could not ride a bicycle, and my foot was very painful. So, he put me on his neck and walked from our home. It took very long time to arrive at hospital until midnight and we left home at 5pm. It was about eight kilometers. We did not have any motor or car at that time. At that time, it's safe to walk at night.* (F, 59, Phnom Penh_5).

Only people who resided in the urban areas who lived close to health facilities could access the services. Many people still believed in and sought help from indigenous practitioners.*1970-1974:*

The existence of public health care was also reported during the Lon Nol period, but remained in the urban areas. Among our participants, only a few reported having used the service because they lived nearby.

The use of public health care with biomedical treatment was still unpopular among people at the time. One participant recalled that even though she lived in a town which was close to the hospital, she did not intend to bring her child there until she received advice from her neighbour.

> *A:...I sent him to ChamkaChek hospital. My neighbouring lady advised me (at that time, my mother was not at home) that "Phally, you should take him to hospital immediately otherwise he would die for sure. Honey [her husband], please help take him to hospital; Phally does not know anything [how serious this illness is]". Her husband then took my son to hospital. She added that "you should look for my example, I never skipped over hospitals when my children got sick, unlike you."* (F, 60, Phnom Penh_2).

The start of the Lon Nol period marked the limited access of local people to the public health care. Our participants reported the political unrest after the end of the Sihanouk period and civil war in the country with the communist Khmer Rouge which affected the health sector. They reported the neglect of patients by health workers and the limited hospital space to accommodate them.

> *A: They were rude and ignorant. They did not want to treat us and kept us waiting outside. They called us to get in or out at will. Sometimes they asked us to sleep against the wall. After 1970 once the King Father was toppled, situation seemed to be chaotic, and everyone was working with low spirit, and they used the impolite words.* (M, 74, Phnom Penh_7).

1975-1978:

During the Khmer Rouge period, public health care was also available, and was reported to exist from the villages up to the commune and district level. A participant explained that health care levels were determined by the number of patients' beds.

> *A: I was advised by head of the group to take my child to another higher-level hospital at the commune level. There was no lab or equipment still to treat her when she got to hospital. The difference between the village health centre and the higher-level hospital at commune was that the higher-level hospital had more beds for patients to rest and that's it. The whole pagoda's area had been converted and used as the commune hospital.* (F, 63, Takeo_13).

Accessing public health care during the Khmer Rouge regime could not be done at people's own free will, but had to be under the order or permission of Angkar. People could go to health facilities only: 1) when they were in a critical condition, and; 2) when they were referred by Angkar. Patients did not dare to request health care treatment themselves. They had to wait until their illness was noticed by their group leader who then decided if the condition was serious enough to require public health care. If the group leader perceived the condition not to be serious, patients still continued working and there was no treatment provided. People reported that during this era, the government preferred work over the health care of their own people. We found many cases of patients who were sent to public facilites only when they were uncouncious or when they could not eat or could not walk.

> *A: It started in the midnight and in the morning when I was working. I felt shivering and I couldn't do anything. I was falling down on the ground and got unconscious. I was unconscious one day and a night. I was sent to a (Pol Pot) so-called hospital.* (M, 54, Takeo_14).

> *A: They did not look after us well. They did not take us to hospital unless we were seriously sick, for example, we could not walk. We should try to work even though we were sick.* (F, 57, Takeo_20).

> *They did not permit us to stay in [public health centre] if our illness was not serious because they did not want to waste their rice to feed us. They would ask us to return and work. In my case, when I got serious fever, they said it was not and asked me to return to work. My temperature was high inside me, but they just checked my external temperature by placing their hand on my forehead.* (F, 46, Phnom Penh_9).

If patients were referred to health care by Angkar, they had to go. The rejection of the order was also considered to be disrespectful, therefore patients would receive punishment. Refering patients from one level to another level of treatment also required order and permission, and without it the referral could not take place.

Even though public health care existed, participants often complained about the poor quality of treatment and the lack of health care services under the regime. People claimed improper health facilities during the Khmer Rouge period. Pagodas or citizens' houses were often transformed into health centres or sometimes the government provided a hut made of leaves where patients had only beds made of bamboo trees upon which to rest, with no other medical equipment available. In some areas, people complained that there was no central health care based in the village, but only medical teams who moved from place to place following farming groups.

> *A: There were beds made of bamboo trees like this size for one person only. They called it "Angkar medical centre."* (M, 74, Phnom Penh_7).

A: Pol Pot healthcare centre was only like a big hut with leaf roof with some beds, and there were no other medical facilities at all. (F, 46, Phnom Penh_9).

Some participants recalled health workers wearing white coats while others claimed no uniforms. People expressed doubts in the medical skills of those workers since they did not provide consultations, make a diagnosis or explain the type of illness to patients or their family members. A man described how his child experienced treatment at Khmer Rouge's health centre and died afterwards. He was not clear what illness his child had except for the assumption of his wife who claimed that the child had dengue fever.

A: My wife brought him to Angkar health centre, but it was no use. They have only a small black drug like a rabbit pellet. He maybe got dengue fever because of dark red spot on his skin. We were not sure about his disease because our knowledge was poor. My wife told me about that because I was working at rice fields at that time... they [health workers] didn't tell me what my child's disease was. They just gave the medicines and I didn't know what kind of medicine. As I already told you they just gave the same medicine to even young or old patients. (M, 67, Takeo_21).

Drugs were also available at the time, but people complained about their ineffectiveness and of a preparation that looked unfamiliar to them which they often called 'rabbit pellets'. Those drugs were claimed to be dangerous in some cases.

A: There was one occasion when a lot of people got poisoned to death due to the rabbit pellets. We carried the corpses away from the work site for the whole morning. Those people got poisoned from the rabbit pellets, and I think they put too much weed in the rabbit pellets. There were many fainted people as well. (M, 74, Phnom Penh_7).

Khmer Rouge tended to combine traditional treatment with biomedical treatment. This was reflected in the types of drugs they provided to patients. Only two types of drug were often available even though a few claimed a variety of drugs in other areas. The first one was locally made which was a kind of traditional medicine, that people often called a 'rabbit pellet' because of its round shape and black colour, presumably made from tree roots; people were often told to take this drug for any type of illness. The second one was a white, round-shaped drug similar to the smedicine that was recently imported from China, which people reported to be more effective than the first one, but there was limited supply of it.

Besides pills, participants also mentioned the existence of drug injections and IV drips. However, people showed doubts in the type of drugs used. One participant described a liquid medicine that looked like a coloured one that health workers used for injections or for patients to drink. Other

participants also mentioned that coconut water[7] was used as intravenous fluid for an IV drip or for injection.

> *A: The Khmer Rouge rarely gave out that Chinese pill, but only rabbit pellet and vitamin from a red liquid bottle look like being colourised. So, they gave us a cap of that red liquid to drink and even for injection. When we got fever, they used coconut juice as serum.* (M, 74, Phnom Penh_7).

> *A: In Pol Pot regime, although I was not sick, I was required to get injection with coconut juice. All kids were required to have injections. Pol Pot soldiers would kill parents if they did not allow their children to get this injection. They let kids to be in a queue to get coconut juice injection. This injection was so painful and I was sick of swelling nearly a half-month after the injection.* (F, 41, Takeo_23).

Different information was reported on the food available at public health facilities during the Khmer Rouge regime. In some areas, participants reported more food options for patients compared to the non-patients. However, in many cases participants still claimed there was insufficient food supplied to patients and that this often contributed to their poor condition and slow recovery from illness.

Health care services during this period did not respond to local demand. A participant reported occasions that he requested a drug, but never received it.

> *A: I told you the truth. I never received medicines from them when I asked for their treatment like headache. When I told a Khmer Rouge's soldier, he said he would get the medicine for me and so I just slept and wait. I never received until today.* (M, 74, Phnom Penh_7).

Another participant reported receiving no treatment from public health care. Patients were left untreated until they died.

> *A: I had mouth disease due to poison... At that time it's a common disease. The Angkar pushed the patients to health centre, but they all died later... The health centre just ignored the patients, unlike today hospitals* (F, 40, Takeo_17).

Another participant believed that public health care was not capable of treating severe illnesses.

> *A: When I suffered greatly from my stomach disease, it was unbearable and I almost died. I got into the Pol Pot healthcare centre... but they did not know how to treat it. They said they could not do anything* (F, 46, Phnom Penh_9).

[7] Some have recognised this as a treatment where resources are scarce (Campbell-Falck et.al. 2000).

Nepotism was also reported in health care during this period. A participant asserted that good medicine and treatment was often given to those who were in the network or family of higher officers.

> *A: If anyone had a Chinese medicine round pill, that person was lucky because it was effective. However, the Khmer Rouge rarely gave out that Chinese pills, but only rabbit pellet...If you had network in the party, you may have a better treatment and medicine.* (M, 74, Phnom Penh_7).

With the poor quality and unreliable services, some patients avoided using public health care, but relied on self-medication or indigenous practitioners.

1979- 1990s:

This period marked the re-emergence of biomedical health care in the county. Soon after the fall of Khmer Rouge, some public facilities, especially those in Phnom Penh and the provinical towns started to re-open. Some participants reported the existence of health offices in some districts, but health workers were often unavailable or they did not work full-time, especially in areas where conflicts still existed due to the ongoing fighting between the remnants of Khmer Rouge and the Vietnamese troops.

> *A: There was no hospital here. There was only a hospital in Takeo provincial town. There was a healthcare building here but physicians were not yet available. At that time, I did not yet come to live in this place because battles often occurred here between Khmer Rouge and Vietnamese troops. Khmer Rouge troops always came here at night and had a battle with Vietnamese troops. They were shooting at each other and the bullets dropped everywhere. The banana trees were cut by the bullets. Its sound frightened chicken and ducks and they run everywhere in the village. Fortunately, Khmer Rouge troops didn't shoot at villagers' homes; they just shot at Vietnamese troops*. (M, 54, Takeo_14).

Our transcripts also showed that in the early 1980s the government started to rebuild the public health system by mobilising medical students or formal medical staff who had survived the Khmer Rouge regime to work within the health sector.

> *A: My aunt and my elder sister (who died during Pol Pot), studied medicine together. After liberation from Pol Pot's regime, my aunt returned back to live in Phnom Penh in 1981, and then my aunt applied to work as a health worker, and she passed the exam tests to work in Preah Kosamak hospital.* (M, 51, Phnom Penh_3).

Public health care at the time was still in a poor condition. Our participants reported the shortage of health workers by seeing the presence of Vietnamese medical teams in hospitals to assist with

health care. They also stressed the shortage of medicine and the lack of medical equipment. Some hospitals had just been renovated and could not accommodate patient demand.

> *A: At that time, there were no drugs at Preh Kosamak hospital; they gave us only one or two pills. If he was sick in late 1990s, he would have been cured. At that time, our health care system was weak.* (M, 51, Phnom Penh_3).

> *Q: How many Vietnamese physicians were there at the military hospital? A: There were four female and three male physicians. However, they had only injections and medicines, but not many medical facilities. At that time, there were a lot of Vietnamese physicians....*(F, 45, Phnom Penh_8).

> *A: At that time, the Vietnamese had re-established the Calmete hospital and I stayed in the hospital. There were Vietnamese medical staffs and several Khmer health workers... My wife got to know almost every medical staffs there. She cooked with the staffs there. The hospital was just renovated and reopened and there was only one hall for the patients.* (M, 74, Phnom Penh_7).

The access to public health care at the time was limited as facilities were available only in the provincial towns and some districts. For those who lived in the rural areas, the distance and lack of transportation to the towns were often barriers to their access.

With severe illnesses or injuries, some people tried any means to bring patients to public health care in the urban areas. The cost of treatment for such severe illnesses or injuries was reported as being expensive and as a result, people had to sell their assets to cope with the cost.

> *A: He sold two cows for the full treatment. At that time, a yoke of cow was only 3,000 riels. 3,000 riels was a big money back then because this amount was equal to a half bag of cash. Our currency at that time started from one dime note, the smallest currency, 10 riels, 20 riels, and 50 riels note as the biggest. It was in People's Republic of Kampuchea regime in 1985.* (F, 57, Takeo_20).

We found inconsistency regarding the cost of treatment at public facilities during that time. Some participants reported no charge at all whereas others had fees to pay. Because hospitals were public facilities, some participants did not think they needed to pay. Others relied on people they knew or had relatives working in the hospital, so they avoided paying. It appears that personal networks were important for people to be able to gain access under this regime.

> *Q: Did you pay for services at Preah Kosamak hospital at that time? A: At that time, there was no charge for the hospital fees. My aunt was working at that hospital, and we spent*

only for eating. You did not need to pay for the hospital fees. Why? A: It was probably because my aunt was working at that hospital.(M, 51, Phnom Penh_3).

A: During the communist regime...if we didn't know any doctors we may be in a big trouble. If we knew someone there, then we could ask them to look after us with less money spent. (F, 46, Phnom Penh_4).

Q: Why did you send your sister to the Khmer-Russian Friendship hospital? Why not Mean Chey hospital? A: We had an uncle working there. My sister used to stay in Mean Chey hospital too. They also paid careful attention on her. My brother too used to stay there while he got a bad diarrhoea. Then, my mother thought that we should send my daughter to Khmer-Russian Friendship hospital as her brother is working there. Q: She may think that the staffs would pay more attention when we have network there. A: Yes. It was just her idea. (F, 47, Phnom Penh_12).

Our transcripts also revealed that medicine was not sufficiently supplied to patients at the time, however it may have been more readily available through a network. A participant recalled:

A: I remember that my brother was in need for IV therapy, but the staffs there said they didn't have it. However, at that time, the hospital's supervisor came and ordered the staffs to find another bag of IV solution. Eventually, they managed to find one. (F, 47, Phnom Penh_12).

People did not need to pay for health care if they worked for the government because the latter covered all of the costs.

A: As I'm a government official, my treatment fees were covered by the government. (M, 74, Phnom Penh_7).

Besides receiving free health care, government officials also received good support from their employer for the duration of their treatment.

A: They even provided me more stuff like I told you previously. All the treatment fee was covered by the government. I also got supply of juices, milk and so on from the government. The government estimates the quantity of milk or juice I would presumably consume per day, and they would deliver those stuff to me once every half or one month. (M, 74, Phnom Penh_7).

The poor quality of public health care continued until the early 1990s and many people had no interest in going to public facilities during this period. While some participants reported a positive view of public health care, a few perceived it as unsafe and even to be the cause of death to some people using the service at the time.

A: One of my older cousins was sick and sent to Takeo provincial hospital and when he died I took ox cart to take his body home... He had a pain at his neck or stomach-ache I am not sure. He had a surgery at the hospital and then he died immediately after that. He seems normal before he went to the hospital. Also, there was an elderly who lived in the same village. He also had a pain at his neck. He also died after the surgery at the hospital. He was normal and ate Khmer traditional cake at Pchum Ben festival before he went to hospital. He said he had a pain at his neck and he was told to check it at the hospital. He died and was taken back home a day after my cousin. (M, 54, Takeo_14).

Some participants expressed doubts about the capacity of health workers to diagnose illness during this period.

A: I used to have serious abdominal pain. I was sent to the provincial hospital in Battambang province. The doctor told me that there might be some kind of stone which was developed in my abdomen, but I didn't understand and even made some argument with him. My wife was afraid if I needed to have a surgery because we didn't have money. Doctor instructed me to rest in the hospital for two or three days for diagnosis before they started the operation. First, doctor told me that there might be some kind of stone. Later doctors performed diagnosis and said that I had liver abscess. I didn't accept the result because I have got this illness since I was a child. So, my wife asked permission from the hospital to discharge me. (M, 68, Phnom Penh_10).

Some people preferred the quality of care from indigenous practitioners over the services provided by public health care. A participant expressed regret for sending her grandmother to a public hospital in 1993/94. She perceived that her grandmother would have recovered if she sought treatment from indigenous practitioners.

A: She was sick. Q: What kind of her pain? A: She felt painful with her stomach. It was a sharp pain. We took her to the hospital. She died at the hospital. Q: Which hospital did you take her to? A: There was a hospital here already, but it's not yet become a referral hospital yet. It was just a district hospital. It was later changed from district hospital to referral hospital. At that time, we didn't think about traditional healer. We didn't know the hospital hadn't had medicines like that. As I thought traditional healer was really good to heal stomach ache and she would be fine if I brought her there. Q: How was the hospital's service at that time? A: Its service wasn't good. As I said that hospital was just created and there were not enough medicines. It had only a building but no medicines. We were also poor and busy for our own family livelihoods. And we didn't know how to find good doctors who could treat her sickness. If we took her to traditional healer, she would be fine. (M, 67, Takeo_21).

We also found that people and communities living near the border with Vietnam sometimes sought public health care there. Even local authorities encouraged their own people to access foreign services rather than going to domestic facilities, especially for critical conditions.

> *A: I went to a hospital in Vietnam for treatment. The doctors there said that traditional birth attendant didn't remove all my blood, so that is why I was sick. Q: Who introduced you to go to hospital in Vietnam? A: Village chief introduced me to go there. In that period, if someone was seriously sick, they would go there. Q: Didn't people go to district hospital? A: No. People usually went to Vietnam. We had to pay for treatment. If someone is sick, they usually go to NhaBang, Vietnam, but if they are seriously sick, they will be referred further to Nahak Tri, which is a bigger hospital.* (F, 41, Takeo_23).

Besides civilian care, military health care provision for soldiers was also highlighted in our life histories. After the fall of Khmer Rouge, the fighting against remnant groups still continued. In some places where the war was still ongoing, people reported the functioning of military health care facilities rather than civilian hospitals. Those military hospitals served as places to provide treatment for injured soldiers who continued to fight the Khmer Rouge. Such facilities also helped to provide treatment for civilians.

> *A: Back then, there was a hospital in the provincial town also, but we could reach only district. I took her to district military hospital and let her stay there for one week or 10 days and then I picked her home.* (F, 45, Phnom Penh_8).

In the mid-1980s, some participants recalled the K5 period[8] when people were conscripted to go to clear forests. Some remembered how they or their relatives entered the military to fight against the remnants of Khmer Rouge. Others expressed being lucky to be able to escape from the conscription.

> *A: After the 1979 liberation, still there were Pol Pot's remnants. He went to the battlefield at the border at Samlot, PreahVihear province and Pailin province. Like my brother, he was conscripted by the government. They [the government] arrested men including teachers at districts or villages to become soldiers. My brother has lost his leg since then. Q: Was it K5 period? A: Yes, that's right! It was K5 period.* (F, 52, Phnom Penh_1).

> *A: In 1984, I got mobilised to join K5 where people were forced to cut trees by Vietnamese, but I did not go. They were sent to clear the forest in order to prevent enemies from hiding in the forest. Some of them were asked to bring bullets and gun in order to shoot Khmer Rouge at Thailand's border. That war was not finished until the Khmer Rouge's integration*

[8] K5 period lasted between 1985-1989. K5 is the plan of the People's Republic of Kampuchea to seal Khmer Rouge guerrilla infiltration routes into the central Cambodia. Letter "K" is the first letter from the word '*Karpier',* meaning 'defence' and number '5' referred to the five points in the defence plan.

by Prime Minister Hun Sen, which hence built peace. Some people who went to K5 escaped and took refuge in Thailand. All strong men were sent to K5. As I remember, some died and some could survive... I didn't go to K5. I escaped to Phnom Penh. I worked as a labourer and sold my labour carrying water for others, or running a bike-taxi for surviving. I returned home to meet my family and siblings in 1989. If I went to K5, I would die there. Most of them died at K5, for example, the husband of that lady over there also died in K5. (M, 67, Takeo_21).

Besides K5, others mentioned their voluntary involvement in the military in the late 1980s or early 1990s. At that time, there was critical fighting in the northern part of the country, for example in Pailin and Somlot, Battambang province. As a result of the war, people reported deaths, injuries and cases of malaria. Some of the people who served in the military recalled the provision of health care.

A: I got sick when I was a soldier. I got malaria for six months, and I was hospitalised in Or Svay [military hospital] for two months, in Yeay Chhi hospital in Battambang for two months, and then in hospital 1st 79 in Phnom Penh for more than two months... I got malaria after the Paris Peace Agreement in 1991. I had malaria when I was based at Bor La (in Pailin). (M, 51, Phnom Penh_3).

Military health care was divided into three levels: district, province and national. The difference between these three levels depended on the technical capacity to assist patients. The district level offered emergency help to patients and sometimes provided a mobile medical team to accompany soldiers to the battlefield to administer emergency first aid to patients in need. For critical treatment, patients were referred to the province level, which was considered regional and offered a higher level of treatment. The national level was the highest and was located at the capital city.

A: Or Svay is a front-line hospital for emergencies. For instance, if we got injured with bullet, Or Svay hospital would provide assistance to stop bleeding and bandage it. It was for emergencies and often near the battlefields. Once injury was bandaged and patients got injection or intravenous infusion, they would be referred to the higher-level hospital. Yeay Chhi Hospital is located in Battambang province, on the border of Sanke River. It is a regional military hospital...I received intravenous fluids for two or three times, and later on, I received drugs to take for three times per day. In the morning, health staff gave me drugs to take. They measured my blood pressure, but once I got better they stopped measuring it. Q: How did the treatment at 1/79 hospital differ from the treatment at Yeay Chhi hospital? A: It was different. When I was in Yeay Chhi hospital, I received only two types of drugs for taking per time, whereas in 1/79 hospital, I received four or five different

types of drugs. However, at 1/79 hospital, I did not receive any intravenous fluid infusion, except injection. (M, 51, Phnom Penh_3).

Our participants described difficulties in accessing services from military health care during the war time, particularly the absence of transportation means to refer patients to hospitals.

A: There were military cars, but they wanted us to walk. They called an ambulance through radio phone (walkie talkie) to pick us up. They told us that the ambulance would come to collect us on the way soon. They suggested us to start walking. We all walked and looked for the ambulance to come. We walked from the morning until three or four pm. We walked through the forests until we arrived at the hospital. The ambulance had never come. (M, 51, Phnom Penh_3).

Because of the ongoing fighting, there was always an attempt to send soldiers back to the front line even though they had not recovered. Some patients had to find their own way to seek additional treatment.

A: My disease was not cured as I remained chill and tremble. At that time, Yeay Chhi hospital had prepared two letters for me and my friends: one letter to discharge me back to the front line, and the other to refer me to 1/79 hospital in Phnom Penh. I knew people in the hospital, who came from the same district. When I met them I built relationship with them and they helped prepare these letters for me. After I went out through the hospital gate, we showed a letter that we got referred back to the front line (discharge letter) to the Military Check Point. Once we were out of the gate, I took a car to Phnom Penh with the letter that referred me to 1/79 hospital (national military hospital) in Phnom Penh. Q: Why did you need to make two letters? A: Soldiers were not allowed to return to Phnom Penh. They needed to go to the front line. For this reason, we needed to make two letters.... (M, 51, Phnom Penh_3).

In 1993, we also found that some civilian hospitals also helped provide treatment to injured soldiers. A participant complained about the inadequate supply of medicine to those soldiers.

A: They had already sent him to Kompong Thom provincial hospital. Actually, they wanted to refer him to Preh Katomealea military hospital in Phnom Penh. But because his condition was serious, they thought that he could die on the way, so they kept him in that hospital. We were hopeless. He lost a lot of blood. She [his mother] sold buffalos to get money for his treatment. It (the hospital) was not like the military hospital. We needed to buy food and medicines. He was in so much pain that he woke up crying. There was no pain relief at the hospital. That was why we needed to buy the medicine from outside. (F, 46, Phnom Penh_4).

Military health care was provided completely free of charge, however we found that patients still needed to buy additional medicine and food. We also discovered the significance of networking with senior military officials in accessing military health care. Patients needed to have this network in order to receive good care or to get referred to a higher level of treatment; without a network, patients did not receive enough attention.

> *A: At first, when they want to transfer me to Yeay Chi hospital, the doctors at Russian hospital didn't let me leave. They said my disease was not malaria and they could cure me. During that time, if we don't have close relation with the senior police officials, the military doctors wouldn't send us to a better hospital; they would just keep us there and pay little attention on us. Some patients were even sick to dead. For me, I often tried to please my commander.* (F, 45, Phnom Penh_8).

Late 1990s –present:

Since the late 1990s, access to public health care has gradually improved, particularly from mid-2000s to the present. During the late 1990s, people reported that they began to see referral hospitals in their districts. The establishment of health centres was reported later from the 2000s to the present. People reported the gradual emergence of health centres from place to place. The last period of our study in 2013 still marked the new establishment of health centres in some of our study sites.

> *A: A health centre was just established a month ago near here and it also provides maternal services like delivery as well. People ride bike there to get medicine. It is about two km away from my house....*(F, 57, Takeo_20).

In the late 1990s and early 2000s, we found that participants, especially those who lived in rural areas, sought services from public health care only after they sought other services such as private health care or indigenous practitioners. This decision indicated that local people had a low regard and distrust in the public health facilities, whilst some were not aware which services were available to them. After they had experienced the failure of other services or the suggestions made by others, then they sought care at public facilities.

From the mid-2000s to the present, our life histories showed that the utilisation of public health care increased. Our respondents' first choice was often to seek public health care before other services. Public health centres were more likely to be available closer to their homes at the commune level than before. The health centres provided primary assistance to patients and were part of a referral system to hospitals if more complicated treatment was needed.

> *A: Unfortunately, they couldn't administer the IV into his arm. Then the ambulance took him to the [Porchentong referral hospital]. They dared not to keep him at the health centre*

because he had high fever and convulsion. The physicians inserted capsules into his anus. It is extremely difficult to deal with his illness each time. (F, 52, Phnom Penh_1).

In the urban areas, people reported knowing of a range of public facilities across different levels. They switched from one facility to another. People emphasised the options and the specialisation of the hospitals where they could go for treatment.

Q: Why didn't you go to another hospital? A: I know that the National Paediatric Hospital and KunthaBopha Hospital are more expert at children disease. (F, 59, Phnom Penh_5).

A: I still have another serious tumour. Later I was transferred from the Khmer-Russian Friendship hospital to the Cancer Department at Calmette hospital where it has the specialised doctor. (M, 68, Phnom Penh_10).

People expressed that their perspective on public health care had changed in this period and they became more willing to use public health care, partially influenced by the outreach programmes provided by the government, local media, NGOs and local authorities.

Q: How did you know that there was a health centre in TropangOndoeuk and Angroka referral hospital? A: I heard from the village chief that there was a state health centre in Tropang Ondoeuk already, so if anyone gets sick, just go there. (F, 40, Takeo_17).

A: Red Cross youth groups come to provide some trainings on health care, traffic or issues related to drinking water. In the past, there was an organisation called Khemara used to come here and conducted trainings on sanitation issues. For example, during rainy season, they taught us about the dengue fever or diarrhoea protection. (F, 45, Phnom Penh_8).

Positive experiences of receiving effective treatment from public facilities also contributed to people's growing trust and continous use of the services.

A: Her eldest daughter had lump in uterus. She also went to Teuk Thla health centre in 2012. When she could not bear with the pain, she decided to go to the Khmer-Soviet Friendship Hospital to have ultrasound. Q: Why did she choose to go to the Khmer-Soviet Friendship Hospital? A: Because I used to go there for my surgery, so we were familiar with it. (F, 59, Phnom Penh_5).

A: After I had some experiences with the hospital, I only took my children to the hospital when they got sick. It was when my eldest daughter was sick (of dengue fever), I sent her to hospital, and the medical staffs there were very diligent to take care of her, so I believe in going to hospital. I also learned of how to deal with those diseases through experiences. (F, 46, Phnom Penh_9).

As public services became more available, private and indigenous practitioners began to advise people to go to public facilities with serious illnesses.

> *A: I had appendicitis. The doctor at the private clinic recommended me to go to the Khmer-Soviet Friendship Hospital.* (F, 59, Phnom Penh_5).

> *A: Later, the traditional healer refused to come because he said that the boil was beyond his treatment capacity. He asked me to take my son to go to hospital.* (F, 46, Phnom Penh_9).

Other changes were apparent as illustrated by the following quotes. For some, their use of public health care was influenced by the lower fees compared to private clinics.

> *Q: How about the third miscarriage? Did you go to any hospital? A: I went to Mean Chey hospital in Chhbar Ampov. Q: Why did you choose Mean Chey hospital rather than Kbal Thnol? A: I didn't have money to go to a private clinic. It's much cheaper than that of Kbal Thnol clinic.* (F, 47, Phnom Penh_12).

However, the affordability of public services varied and depended on the poverty level of each household at the time. We found several cases where people spent a lot of money at public facilities. Sometimes, they had to borrow money from others to meet the cost.

> *A: As I mentioned earlier, there were reasons why people go to the hospital and not going to the hospitals. Some people did not have enough money, so they did not go to the hospital. They just bought medicines from pharmacy instead. If they went to hospital, they needed to register for the bed which cost 30,000 riels and also the cost for injection... So, they needed to spend a lot.* (M, 57, Takeo_24).

> *A: I spent 500,000 riels. My relatives begged a doctor that my daughter had just died and I had no money. They asked the doctor to reduce the cost, but the doctor didn't agree. The doctor said he was cheated by this trick before... I borrowed 500,000 riels and I had to pay 50,000 riels per month for interest rate. I re-paid this debt all now.* (F, 55, Takeo_15).

We also noted a major shift in the utilisation of public health care following the introduction of the HEF and CBHI, both of which helped to encourage people to seek treatment from public facilities.

> *A: Mr Thy, a CBHI representative in our community, also suggested us to send him to hospital. I joined CBHI service a few months before my husband got cyst in his bladder. I send him directly to Takeo provincial hospital instead of Ang Roka referral hospital as his condition required surgery.* (F, 63, Takeo_13).

However, as will be shown later, the implementation of HEF and CBHI was not straightforward. For chronic diseases such as diabetes, for example, HEF and CBHI did not cover the full range of treatment, so patients would turn to other providers, such as NGOs, as discussed in the following section.

Even though some participants responded that they held the HEF, they said they simply could not manage going to referral hospitals, but used instead health centres that were close to their homes. The poverty level in their households contributed to this. These people explained that they could not afford to spend the required amount of time at the hospital, because they had small children to look after whilst all of the other adults had to spend time out of the house earning money.

> *A: It is very difficult if I am required to stay at hospital. I don't have anyone to accompany me at hospital in case I need to stay there and neither had someone to look after my grandsons at home. Small kids are not allowed to bring to hospital as they could get infected with diseases. At the health centre, we can bring kids because there are not many patients there. Some patients go there to ask for medicines. Q: Is it also because the health centre is close to your house? A: Yes. It is near my house. It is easy to bring meals.* (F, 52, Phnom Penh_1).

Despite the development of and growing availability of the public health care system in the country, a number of challenges were identified. Firstly, our participants mentioned that some public health workers could also be found working as private medics or running their own health clinics or cabinets. Such dual practice was reported from the late 1990s and continues to the present day, and it has had an effect on their performance at the public facilities. A participant complained about the late arrival of a health worker who was busy running his own clinic.

> *A: He fell from this house and broke his arm. My husband and I brought him to the health centre and then he was referred to the Municipal hospital. There was an argument between my husband and a doctor. We got an appointment to meet a doctor at 2pm, but by 2pm while the arm of my grandson got swollen gradually, he did not do anything. That doctor was busy running his own clinic.* (F, 52, Phnom Penh_1).

Secondly, our participants complained about the poor attitudes of some health workers demonstrated through the use of bad words towards patients, especially the poor. Whilst they recognised that tiredness of health workers might influence their attitudes, considering their low pay from the government and the workload that they had, they did not find such repeated behaviour acceptable, because it was viewed as discrimination against poor people.

During the last few years, our transcripts showed the government made an effort to improve the attitudes of health workers through evaluation, but the practice still continued in some public facilities.

> *A: A few years ago, I was interviewed about the health care. Two people (a man and a woman) came to ask me about the services of Kirivong referral hospital and the communication between the health staff and patients. I told them that health staff warmly welcome us, except one health staff who used bad words, and all patients hate her. I told them frankly...That woman used to scold me when I went to request drugs. She said "you often come and come, get sick and sick, and request drugs with free of charge". I didn't respond. No one wanted to be sick.* (F, 44, Takeo_22).

Another participant described her experience of being scolded by health workers.

> *A: As a poor person, I need to be patient with their words (healthcare staff's words) because we do not have money. It's not like rich person who gets better treatment. However, I don't need to pay for the medicines. I used to have bad experience at the municipal hospital when I was scolded repeatedly for small mistakes. However, I tolerated as long as I can recover. It's also the same at the Khmer-Soviet Friendship Hospital. At that time I took care of my daughter who just delivered the baby at the hospital. My grandchild was crying, and then a medical staff complained that we just let the baby cry and that we were stupid for not being annoyed by the crying sound. I whispered to my daughter that we needed to endure it as long as we got recovered.* (F, 60, Phnom Penh_2).

Thirdly, it emerged from our transcripts that inequality existed in health care services between the rich and the poor. Regarding the rich, our participants referred to those who could pay user fees directly to health workers after receiving the services. The poor were identified as those who held HEF or who could not afford the cost and requested fee exemption. Our participants described that the poor received a lower quality of care, including slow services, a lack of attention or the limited supply of medicine. Poor people often received services only after the wealthy and were often scolded by health workers, who sometimes ignored patients who held HEF, or requested money first before treatment was carried out.

> *Q: Have you noticed any difference in health care access between the rich and the poor? A: I noticed there is a difference in health care access. The rich can afford the service, and so health workers provide services to them immediately. However, for us as clients of NGOs, if we go to Khmer-Russian Friendship hospital, there is a possibility that we can get scolded, for example, "you have been working and earning since 1979, you still have no money to treat your own disease; you always depend on NGOs. Why don't you save some for your own treatment?" That is why I always think if I go and stay at hospital, it would*

be difficult because I do not have any money. I also get scared of hospital. I'm not kidding. I always tell people to go to hospital, but for myself I get scared of hospital. I'm afraid that I am left alone at hospital and do not receive any treatment. If this happens, I prefer to stay sick at home and this would not waste money for transportation. (F, 52, Phnom Penh_1).

Q: When you went for health care treatment at the hospital, have you observed if the medical staffs show the same attention on the poor like the way they did with the rich? A: Not really the same. Usually, they paid more attention on those who had money. We would also receive the treatment, but we had to wait a bit, maybe about 30 minutes or so…. (F, 45, Phnom Penh_8).

A: The medics did not care much about the poor, but they welcomed the rich a lot. They don't even want to look at our face as the poor. Just like I mentioned, when I gave them the certificate (the letter from the village chief that acknowledged my poverty), they just walked away and returned for a while later. They were not diligent at all. They pretended to be busy and walk to somewhere else. They came back to me and took the letter half an hour later. However, if the patient is rich, the medics would go to take them while the patient was just getting out of the motorbike. As for me, I waited for hours before they allowed me to get in. (F, 40, Takeo_17).

A: I saw it in every health centre, not the specific one. Please pity poor people and hurry to treat them first before asking them for money. Some doctors asked for their money first and when they knew those people don't have money, doctors leave them alone without treatment. At this point, poor people were vey pitiful. Poor people also need good care and good deeds from other people. Both rich and good people themselves need good cares and good deeds. We all are Khmer people who believe in Buddhism and we all know how to treat other people in a good ways. If we don't know about this, we are not Khmer people. Some foreigners are very good to care for other people. (M, 67, Takeo_21).

Inequality in health care also affected people who held CBHI. One participant described:

Q: Do you think that those who use CBHI receive the same treatment and care compared to those who do not use it? A: Honestly speaking, those who pay money directly without CBHI received better treatment. As for those who have CBHI coverage, the medics seemed reluctant to provide good care and treatment. They only gave medicines and wait until the condition becomes serious (for example the case of my husband's swollen leg). (F, 46, Phnom Penh_9).

Fourthly, participants also reported cases of some health workers requesting unofficial payments for any services provided. Whilst the good attitudes of some health workers were also reported,

the respondents highlighted cases of serious misconduct by some health workers who tried to take from patients with unwarranted charging.

> *A: I also saw a case that sometime it was difficult to send body from hospital back home. It takes a lot of time to find an ambulance to send the body back home. The hospital, I refers to the Khmer-Soviet Friendship hospital always asks for money. We then contact Mr XXX, responsible for coordinating HEF. Mr XXX then contact others to get an ambulance. Municipal hospital is better. If we inform the head of the hospital, he will intervene quickly. Dr YYY, the head of the Khmer-Soviet Friendship hospital is nice, but he has 500 staff, so he can't manage all of them. He does not know which staff perform bad or perform good. You know those health workers are clever. When they ask for pocket money from HEF users, they do not wear their name tags. If we know their names, we can inform the head of the hospital. Health workers who ask for money are only those who work at the Khmer-Soviet Friendship hospital. For those health workers at the municipal hospital and the health centre, they did not request any money.* (F, 52, Phnom Penh_1).

> *A: My son ran to call for an ambulance to take me to Takeo provincial hospital. On the mid-way to the hospital, they asked for ambulance fee for 40,000 riels. Usually it costs only 20,000 riels but they asked from me 40,000 riels, even though I already became a SKY member [CBHI].* (M, 54, Takeo_14).

Another participant reported that an x-ray operator charged her without giving her the bill, which meant that she could not get reimbusement from the HEF.

> *A: When he had the accident, I brought him to the hospital, but some staffs there didn't come to work yet as they were on their holiday during the New Year. Other medical staffs gave him a shot of drug to relieve his pain. It cost 12,000 riel per shot. Then he was sent to do scanning test on his hand and head. The scanning on the hand cost 45,000 riel and on the head cost 15,000 riel. I received reimbursement for the expense on head scanning only. The equity fund representative in the hospital blamed me for not asking for the payment bill. I told her that it was night time so she went to query the medical staffs who were on standby the previous night to find out why they didn't issue the bill for the patient after scanning test which cost more than 40,000 riel. The staffs didn't acknowledge it and just pointed at one another. If I had the bill, I would have been able to claim the money back.* (F, 45, Phnom Penh_8).

b. Non-governmental Organisational (NGO) health care

Based on our life histories, NGO health care emerged during the 1980s at the refugee camps at the Cambodia-Thai border when people had escaped from ongoing conflicts with remnant groups after the fall of the Khmer Rouge regime. NGO health care then proliferated in the 1990s throughout the country in different forms to help provide health care to poor people and this has continued to the present.

1980s:

In this period, there was only one participant who stayed in a refugee camp at the Cambodian-Thai border who reported on the health care services. She recalled her daughter's illness and described the health facilities and equipment of NGO health care at the camp as being much better than in the Khmer Rouge period. She claimed that the facility had proper beds and enough biomedical drugs for patients. She also recalled the use of IV fluid for patients similar to the present, in a contrast to the Khmer Rouge regime.

> *A: All medicine was French-made. Also, they were using the same IV fluid as we are having in present day. They were not using IV fluid stored in juice bottle like Pol Pot time. About two to three cases of IV fluid were used when my child got sick. They used them on her since she was in coma till she gained back consciousness.* (F, 63, Takeo_13).

The health team at the camp was composed of both Khmer people and foreigners. Khmer citizens were also chosen to get medical training and became local medics to help provide health care in the camp voluntarily. These health workers were accountable to patients and did not use bad words towards them; they performed their tasks and diagnosed illnesses soon after patients were received. For the serious cases, patients were referred to hospitals in Thailand via an ambulance.

> *A: Once arriving in hospital, doctors gave her* [daughter] *a bed when they learnt about her serious condition. They performed some tests, gave IV fluid, and took blood test sample. The French doctors left in the evening and returned back in the morning at 8am...they paid utmost attention on patients. This cannot be compared with Pol Pot generation. During Pol Pot time, no-one was paying attention on patients. French, Thai, and Khmer doctors took turn monitoring patients days and nights. Frankly speaking, I am still thinking doctors at camp are still better than doctors in present day. For instance, doctors inside the camp dare not to use any big words on patients....* (F, 63, Takeo_13).

Besides the quality of the service, NGO health care in the refugee camp was provided free of charge. Food was also provided to patients and caretakers.

1990s-present:

NGO health care gradually developed in the country during the 1990s and continues to the present day. Various forms ranged from hospitals, health clinics or cabinets and mobile health workers. Some NGOs served as information centres and worked within communities to form health groups to raise awareness among local people on hygiene, health protection and health issues.

Most of these NGO health care services were based in Phnom Penh, but they also had sub-offices in some provinces. In our transcripts, the most frequently mentioned service was the Kuntha Bopha Children's Hospital, an NGO that specialised in health issues affecting children and pregnant women. We learned that people came from rural areas as well as the city to receive treatment at this hospital.

> *A: On the third day of her illness, I sent her to KunthaBopha Hospital. The doctor said that she was just fine, but if she got serious, I must bring her to the hospital immediately regardless of any time. I then had a feeling that the doctor was suspecting that my daughter may have dengue fever. At dawn, my daughter was having nose bleeding, so I took her back to KunthaBopha hospital by motor taxi. The doctor said she had dengue fever....*(F, 46, Phnom Penh_9).

The Sihanouk Hospital Centre of Hope also performed health treatment during this period, and focused on general illnesses. Our research team met the medical team during our fieldwork when they were delivering services to local people in the suburb of Phnom Penh. They came in a pick-up car with bags of medicines and some equipment. They had their own local office where people were sitting to wait for the service.

MoPoTsyo Patient Information Centre also worked to provide information to poor people who had chronic diseases, like diabetes, so that they could manage their condition effectively. Our participants described how MoPoTsyo helped to bring local people to receive blood tests for diabetes once their symptoms were recorded. They mentioned the support of MoPoTsyo in forming groups of patients with chronic conditions and then providing them with training so that they could further educate other patients within the community.

> *A:...He was responsible for diabetes. He came to my house [as] I am a health volunteer. During meetings, he observed that I sweat a lot….and [he mentioned] blood level or something. Initially, I didn't believe it. Then he asked me to have blood test and urine test, so that I realised I have diabetes.* (F, 52, Phnom Penh_1).

Some NGOs concerned with human rights also incorporated health care into their activities to help those who were victims of human rights violations and were living in eviction or resettlement sites. In our transcripts, we found that since the early 2000s, when the wave of urbanisation and development began in Phnom Penh, the issues of land conflicts and eviction

among people who lived in the slums became serious. The forced evictions by the government were described by our participants. All of these people had been moved to the suburbs where they did not receive a good place to live and lacked water supply and sanitation. The Promotion and Defence of Human Rights (LICADHO) brought its own medical team to deliver medical care to these people.

> *A: LICADHO's team came here long ago since local villagers were evacuated from Sombok Chap village in 2006 to live in Andong village here. Besides LICADHO, various organisations also came to give donations to us. On the other hand, Sihanouk Hospital Centre of Hope's team just came two years ago. Sihanouk Hospital Centre of Hope's team came down once a week on Monday whereas LICADHO came on Thursday. LICADHO provides medicine to cure cold or to release pain in knee, waist or wound, etc. Sihanouk Hospital Centre of Hope's team, on the other hand, does medical test related to phlegm or health check-up for any diseases.* (F, 41, Phnom Penh_6).

There were also some NGOs that worked to raise awareness among local people on specific health topics in various locations, for example on pregnancy health care, contraception and HIV, as well as general issues such as hygiene or protection and prevention mechanisms. These NGOs worked in their target areas with poor people, for example, within the slums.

> *A: There are organisations such as Khemara coming to share information related to dengue fever prevention; generally, they call villagers to have a meeting. Sometimes they talk about HIV/AIDS.* (F, 53, Phnom Penh_11).

Several factors influenced people's decisions to use NGO health care. First, NGO health care was completely free of charge and that is why local people liked using their services. Besides no charge, people liked using the NGO health care because the quality of their services was good and reliable compared to other public and private health care providers. Our participants generally agreed that Kuntha Bopha Children's Hospital was effective in carrying out treatment. We often heard of participants taking their sick children there after being refused by private clinics or public facilities and they recovered completely. Health workers performed their tasks diligently once they received patients and had enough equipment to diagnose illnesses. Some private clinics and public health facilities also acknowledged the quality of care by Kuntha Bopha Children's Hospital and they also suggested that patients go there in serious cases.

> *A: At the beginning, my husband took her to the Red Cross hospital and then further to the municipal hospital. However, we were refused and we got recommended to send her to Kuntha Bopha Children's Hospital….*(F, 60, Phnom Penh_2).

> *A: I took him to Kuntha Bopha Hospital. The doctor x-rayed his legs and saw a lot of pus inside. The doctor said that those pus would eat my child's bone in five more days and that*

the leg would need to be cut off. The leg got swollen incredibly big and tight. It looked white and later red with a lot of pus. The doctor blamed me for believing in the treatment of Khmer traditional healer. It was only five days that the abscess would spread on the bone. At 5pm, they began surgery operation. They made two holes to get rid out of those pus. My child could not walk when he had abscess. We rested at the hospital for one night first, and he had surgery on the next day. My son was administered with IV to help him gain strength. After the surgery, the doctor gave him injections to restore his leg's flesh and muscle. (F, 46, Phnom Penh_9).

The reputation of some NGO hospitals spread quickly. People often went to access their services and then spread the information to others.

Also, because NGO health care was free of charge and good quality, there was a lot of demand, and therefore several facilities had to give priority to the more serious cases. One participant recited that Kuntha Bopha Children's Hospital did not allow patients to rest for long except when their condition was severe. Other participants also mentioned the long queues at Kuntha Bopha Children's Hospital and so they sought an alternative provider if they did not think that the condition was serious.

A: In general, Kantha Bopha Hospital rarely allowed sick children to take rest in the hospital for more than 10 days, but my child was allowed to stay for almost half a month. When we just got there, my child got serious diarrhoea. (F, 60, Phnom Penh_2).

4.2 Financial spending on health care and the impacts of financial reform policies

4.2.1 Birth delivery

Our participants reported different experiences of financial spending for birth delivery with the use of different types of services. It appeared that delivery with assistance from TBAs was generally the most cost-effective. The financial impact of delivery with medically trained midwives and at foreign health facilities could be catastrophic for people, especially for woman-headed households, and affected their savings and the assets needed for livelihood such as land. Delivery at private clinics also cost a lot of money, however people often decided to use this option only after they were assured of financial support from their relatives, so that the cost did not have such an impact. Whether or not the charges (UF) for delivery services at public facilities caused unmanageable spending depended on delivery complexity and the effectiveness of post-poverty identification in determining whether the patient was poor. With a normal delivery, it was unlikely that UFs drove people into poverty. The HEF and CBHI also had a positive impact on decreasing spending for poor people even with complex deliveries, hence reducing the financial

burden on household economies. The attitudes of health workers and informal payment practices needed to be improved and HEF and CBHI operators played important roles in monitoring this process.

Traditional birth attendants (TBAs)

Interviews with participants who experienced birth delivery at home with assistance from TBAs were consistent in reporting that the service was inexpensive. From pre-war to the post-war periods, participants frequently cited that TBAs did not request money or that they simply helped people who lived in the same village or nearby. TBAs were often paid in gifts or in-kind based on what people had. In the past, participants reported that they prepared a set of traditional gifts which included a basket of rice, candles, incense sticks, areca palm, clothes or a little money to offer to TBAs. In other times, local people just gave based on what they had such as fruit or livestock. However, during the Khmer Rouge period, TBAs were reported to receive nothing; in contrast to the most recent period when payments have changed to cash. The payment was not demanded by TBAs, and it depended on how much people wanted to offer in gratitude to the person who assisted them and possibly saved their lives. There were cases of TBAs refusing gifts or money from poor people considering the poverty level within the household. There were no reports of any financial burden from using the service of a TBA.

> *A: I gave her one basket of rice, betel leaves, areca nuts, a pair of candles, incense sticks and a small amount of money. I gave all of this stuff to her as our thankful gifts for her help.* (F, 63, Takeo_18).
>
> *A: I did not offer her anything as I did not have anything either. No currency was used during that generation [Pol Pot regime]. After helping me with the baby delivery, she left for home.* (F, 63, Takeo_13).
>
> *A: Sometimes I owed her for several months. I tried to work more, and paid her 5,000 riels. She did not ask. However, I owed great gratitude to her, so I needed to pay her otherwise I would suffer from bad karma in the next life.* (F, 40, Takeo_17).

Medically trained midwives

Delivery at home with assistance from medically trained midwives was costly; private midwives often demanded specific amounts of money from clients. Charges were high because the service involved not only a payment to the midwife but also for biomedical treatment using medicine, injections and an IV drip.

A: The midwife gave me three injections in each hip. The midwife gave IV drip for me, but I refused. She then removed the IV drip. (F, 46, Phnom Penh_4).

We found cases where midwives reduced the bill for clients who had a financial shortage, but no midwives provided free help to people in the same way as the TBAs. However if clients could not pay the cost immediately, they were allowed to pay in instalments.

Q: Did she charge you any money? A: Yes, but I didn't have money to pay her immediately. I owed her till my son was one year old. I paid her little by little. She didn't remind me unless I missed paying her for some time. She charged from me less than from others because I was poor. She charged from me 100,000 riels in total. (F, 41, Phnom Penh_6).

The study participants often reported saving to pay private midwives; with couples starting to save early in anticipation of these costs. However, in female-headed households, women held the responsibility for saving on their own; so if they could not save enough due to the lack of stable employment, they requested assistance from their parents or relatives. Some families paid the cost in instalments and it took them months to pay off the total. A woman described how she earned money from noodle sales, sharing in livestock-raising and the support of her parents.

Q: By the way, where did you get the money to pay the medical midwife? A: I got it from my saving and my parents helped me some. At that time, I tried to sell Khmer noodle and shared labour with other families in raising cows. (F, 55, Takeo_15).

Another woman described how she paid a medical midwife in instalments when she got little support from her husband:

A: I paid her 10,000 or 20,000 riels per time depending on money I had. I was a farmer earning just enough for consumption. Q: Did your husband know you were pregnant? Why didn't he give you money? A: He knew it. He came home once when I was eight months pregnant. He didn't visit me on the day I delivered my son, but he did a day after. Anyway, a few days later he went back to Phnom Penh. He gave me about 30,000 riels. He told me that he didn't earn much and he could not borrow from his boss. He sent money to us again about $30 when my son was about five months old and no more until we got divorced. (F, 41, Phnom Penh_6).

<u>*Delivery at a neighbouring country health facility*</u>

Delivery at a health facility in a neighbouring country was generally expensive as this included transportation fees, food and other services such as translation. A woman described how she spent money on a complex delivery in Vietnam and as a result she had to get a loan from a relative. Even with no interest, she still sold a plot of land and a cow to pay off the debt.

Q: You spent 500,000 riels. Where did you get that money from? A: I borrowed money from my relatives and they didn't take interest, and I paid them back after I sold a plot of land (a portion of my residential land) and one cow at 200,000 riels. (F, 57, Takeo_20).

Delivery at private clinics

Delivery at private clinics emerged during the post-war period in the early 2000s to respond to the need for better quality and the improved economic conditions. The cost of delivery at private clinics was reported to be higher than at the public facilities. It included treatment costs, bed fees and other services. There was no report of any informal payments at private clinics. Even though the charges were high, this participant reported getting financial assistance from her siblings that assured her decision to use the service and to pay the clinic.

A: I spent 280 dollars which included stitching and hospitalisation. I didn't have to pay any money though the overall fee was high. My siblings gave me 50 dollars each, so I got from them more than the money I had to spend. (F, 47, Phnom Penh_12).

A: As for my husband, when he heard the doctor said that I could not give birth because I lost all of my amniotic fluid and I needed to have C-section, which cost 500,000 riels, he became hopeless because he did not know how to get the money. We had only 70,000 riels for food, and we spent most that money on his relatives who came to visit me. There was a scar on my baby when they pumped the baby out. The doctor only charged the bed for 1300 riels a day. Q: You said that you sold gold for treatment at Pet Chin hospital, how did you get the money to buy gold? A: I earned the money from working at the kiln. At that time my husband and I worked hard, and we could save up by buying gold little by little. I save it just in case I get sick. During dry season, I could earn more and buy more gold. (F, 45, Phnom Penh_8).

Delivery at public facilities and the impact of financial reform policies

Delivery at public facilities was reported during the King Sihanouk and Lon Nol periods by people who resided in the urban areas, but how much people spent on the service was unclear. People could not recall their expenditure during those periods.

A clearer report on spending was described by participants following the Khmer Rouge regime. People who used public facilities in the 1980s and 1990s reported varying payments for delivery – some free and some chargeable. People who worked for the government or whose husband served in the military reported getting free health care from public facilities.

Q: Did you pay for your birth delivery? A: No, because I was a soldier's wife. Ordinary people needed to pay. (F, 59, Phnom Penh_5).

Some civilian people reported receiving free delivery services at public facilities between the 1980s – 1990s. However, other respondents reported paying in cash or in gold.

Q: Did you pay? A: Yes, they were very helpful, but we needed to spend money. I spent almost five huns (a Khmer measurement for gold) of gold for hospital bed, medicine and IV. They asked in cash, but I did not have money, so I just gave them my golden ring. However, it was a state hospital in nature. (F, 60, Phnom Penh_2).

Informal payments were also reported during this period, as one participant described her experiences:

A: I also gave them some small money as gratitude. Q: How much did you gave them? A: At that time I had 50,000 riels, and it was quite a lot during the 1980s. I gave 15,000 riels to three medics. They did not really want it, but they still took it anyway. They were good because they took care of me well. (F, 46, Phnom Penh_9).

During the late 1990s, national health financing reforms introduced user fees (UFs) to charge people who used public facilities. Among our participants, some reported full payment, which included medical services, bed fees, food and other costs; others had their fees exempted; whilst some reported informal fees.

The cost of childbirth with UFs varied depending on the complexity of the delivery and the facility level that people sought. For normal delivery, some participants went to health centres – and we did not uncover many complaints of financial burden from using such services. These participants claimed they used their savings to pay the fees. There was no report of using other major coping strategies to deal with the costs at this level.

For some normal deliveries, participants chose to go to referral hospitals or national hospitals because they preferred higher-level facilities, which they perceived would provide adequate support if there was an emergency. We still found that the payment of fees at this level for normal deliveries caused few burdens to our participants.

For the case of complex delivery, however, most people were advised to go to hospital when a complicated birth was anticipated, and so the costs could be high. Our transcripts showed some participants coped with this by selling assets such as gold or land after their savings ran out. Others sought loans when they could not rely on the sale of property.

A: First, I asked a traditional birth attendant to help me deliver my baby. My water broke and kept pouring out of me. The traditional birth attendant just told me to try to push my

baby out when, actually, it was not the right time yet. The water didn't stop pouring for two days, and I had still not delivered my baby yet, just only bleeding… My boss took me to hospital. I was so lucky to have this boss to help me. He was very helpful and friendly. Now he stayed in foreign country… I spent around three CHIs of gold for the treatment [one CHI is 3.749g]. The medical service cost 1300 riels a night, and I also needed to pay for emergency service and the bed to sleep at the hospital for one week. In total, it cost me three CHIs of gold. One CHI of gold was 25000 riels. I spent a lot on medicines, especially the medicines to open my uterus. It was just a small pill, but it cost 9000 riels. If I did not take it, my uterus would not open because I lost my amniotic fluid. At that time I did not care about my timidity anymore as long as I could give birth. (F, 45, Phnom Penh_8).

A: I sold a plot of farm land. At that time, I had three plots, and I sold one. But the money was not enough, so I borrowed some from a money lender, yet I don't remember how much. (F, 45, Takeo_16).

Meeting the treatment costs for a complicated delivery had the potential to cause impoverishment for some families. To pay back a loan, other family members, besides the breadwinner, also had to contribute to earning income. People sold other available assets to pay back the lenders. For example, one participant recalled her experience of paying for a caesarean section at Takeo provincial hospital. She had to get a loan and combine it with her savings. As a consequence, her children had to work to pay off the debt through piecework along with the sale of livestock:

Q: Where did you get the money from? A: It was from … borrowing from the relatives as they were also private money lenders. The interest rate was cheap, 3%. And I had my own pocket money of 50,000-60,000 riel for the traveling expenses. Q: And how did you pay back the money? A: We tried to earn it by making knives, selling chickens, ducks and pigs. We could pay back the loan three months later. (F, 45, Takeo_16).

On the other hand, we also interviewed people who received fee exemption through post-poverty identification processes at public facilities. Some participants were granted full exemption and others partial, under a system that appeared to be entirely arbitrary.

A: After spending three days staying in hospital, we had to leave, and the cashier demanded us to pay 210,000 riel. But we had only 150,000 riel, and we told her this. The cashier kept silent, and asked us to sit at nearby area to wait after other people finished their payment. Once the others finished the payment, the cashier called us in and asked us to pay the amount we could afford. After paying, we were allowed to leave. (F, 53, Phnom Penh_11).

Fee exemptions helped to reduce hardship for poor people who lived at subsistence level. In the life history interviews, for example, two families made their living through collecting firewood. They were faced with delivery complications that required emergency intervention at referral hospitals. Fee exemptions helped them to deal with the financial burden resulting from the medical costs, however, this did not cover transportation or lost income.

We found that support from their community, family and friends helped people to deal with the costs of healthcare. Some health workers also exceeded their duty in making a donation to people beyond the remit of the health financing policy. Food-sharing with neighbours played a very important role in helping to maintain the household economy of poor families, and meant that they could survive for a period of time after the shock of having to pay medical bills before they started labour work.

> *A: My neighbours took me to the hospital. At that time someone lent me a motorbike filled with gasoline and the cousin of my husband took me to hospital… At first I decided to deliver at home, and I was not afraid of death. But my neighbours advised that if I died, my daughter would become an orphan. So, I decided to go to the hospital. All my neighbours encouraged me to go to the hospital, and they gave me one pillow to sit on, and put me on a motorbike, and one of my neighbours (a woman) went with me and sat behind to protect me….We locked our house. We did not have anything to be stolen. When I came back, people in the village donated me some money, some rice, some food to me, so we can eat for one month. We had no money at that time… The foreign doctors gave us some money, some baby's clothes, and some new books, because they felt pity for us as we were poor. A health staff gave few sarons to me when I discharged from the hospital after staying there for 27 days. One health staff asked me if I had some money. He gave me 10,000 riels to take motor-taxi back home, and he informed a motor-taxi driver not to drive very fast. When I arrived home, they charged me only 3,000 riels.* (M, 68, Phnom Penh_10).

In some cases, local people were granted waivers once they were identified as poor through post-identification after arriving at health facilities, and this helped them significantly. In other cases, however, the staff were unwilling to do this.

> *A: I did not have money. Although I told them that I was poor, they would not help me. It cost 30,000 riels for the birth delivery service. They would ask for this amount of money for sure. We also needed to buy one kilogram of rambutans and langsiums, and fruit juice for midwife.* (F, 40, Takeo_17).

However, fee exemption through the post poverty identification system was not consistently implemented. For some of the respondents, even though they were eventually granted fee

exemption, the process was arbitrary, often at the discretion of administrative or junior workers and sometimes only achieved following the intervention of more senior staff or international health workers.

> *A: When my child moved, I got bleeding, and then I was referred to the hospital. All my neighbours encouraged me to go to the hospital, and they gave me one pillow to sit on, and put me on a motorbike… If there was no intervention from the French doctors, I would have spent lots of money. And they still conducted the interview with me to identify if I'm really poor or not. They asked a lot of questions "how many cows, pigs, chickens do you have?..." I responded that I have nothing. When a French doctor came, they took me to the surgical ward, and all health staff wore masks, and I could see their eyes, their green blouse, and white gloves. They put oxygen for me, and told me to take deep slow breath. I could see what they did; they pulled out a knife from its cover…I received blood transfusion. My husband's blood was not compatible with mine; it was compatible with the blood of the one who drove me to the hospital. He was not my relative. However, he wasn't strong enough to donate blood to me. At that time, they asked me money to buy blood, but a French doctor told them not to charge it from me, but he would pay it for me…The French doctors were very generous. There were two of them, male and female. They gave me a bottle of formula milk to feed my baby because I didn't have breast milk yet…Without the French doctors, I would not receive the surgery on time. Health staff would continue to interview me....*(F, 44, Takeo_22).

> *A: I got labour..., I got much pain; I was in pain for about two days before delivering her whereas for other sons, I was in pain for only few hours. My villagers forced me to go to hospital. Personally, I didn't want to go to hospital. I was afraid of the bad words from nurses. Because neighbours advised me to go to hospital, I agreed and went there… One nurse came to ask me to pay for delivery, but one doctor came to help me. He pitied me because I am poor. The nurse still insisted that I needed to pay. The nurse who forced me to pay even though I begged her that I didn't have money even one riel [was a bad one]. She still didn't agree and forced me to pay even though I said I did not have money. However, there was a male doctor who helped me. Moreover, that male doctor still insisted that I was so poor, so I should not pay. "How could you take money from her since she had no money even one riel?" he also added. He said he would use his salary to cover my expenses if the nurse still insisted. Finally they agreed.* (F, 41, Takeo_23).

Participants also complained about the slow process of post poverty identification which affected pregnant women who had hurried to the facility for emergency help. A participant described a long interview process by health workers that delayed treatment.

A: When I arrived at the referral hospital, a hospital staff interviewed me, "how many cows do you have? How many hectares of rice field do you have? How many chickens do you have? How big is your house?..." Someone told her that I did not have anything. I had no rice field, no home, no chicken, no ducks. The hospital staff pretended not to hear this answer, and she did not pay much attention to me. Fortunately foreign doctors came and talked with health staff and he ordered to the health staff to take me to the surgical ward. They took off my clothes, and they let me wear blouse. Since the French doctors visited me, other health staff gave much more attention to me. Before the French doctors came, they paid less attention to me. You know, I had arrived at the hospital for more than an hour and the health staff just let me wait outside. My caretaker insisted "please treat her faster, she was getting cold of the sole of foot, and palm". I had lots of haemorrhage. Then, my caregiver went to invite them for three times, and finally they came to visit me. They put my legs on a delivery chair, and they told me that you were not able to deliver normally; we need to do caesarean section. I asked them that how can I do? And then they sent me for an interview. They asked me about: how many pigs, cows, chicken…I have. I replied that I did not have anything. They kept interviewing me although I was bleeding heavily. (F, 44, Takeo_22).

Informal fees continued to be charged even after user fees (UFs) were introduced. Informal fees were often paid in cash and/or in-kind with or without a prior request from health workers. A participant reported how she was asked for informal payment by midwives.

A: They asked me for money when I delivered my eighth child. It was not like I did not want to give it to her, but she repeatedly demanded it like three times. (F, 60, Phnom Penh_2).

Another participant claimed that she was willing to give an informal payment to health workers even though they did not demand it because she perceived this as a way to show her gratitude for their assistance.

Q: Did you ever experience health workers requests for pocket money? A: No. When my daughter delivered a baby, I put 30,000 riels into a pocket of a health worker. He came to return the money to me. I handed it back to him and said I would not tell anyone. I pitied him since he took care of my daughter all night and did not sleep. (F, 52, Phnom Penh_1).

Community-based health insurance (CBHI), introduced in 1998, was shown to be effective in helping people to cover the cost of birth delivery, even in complex cases. People reported that no payment was demanded for the delivery services, although they spent on food and other

personal materials. One participant reported the need for careful support from CBHI operators to help to monitor and ensure an effective service by health workers for CBHI users.

> *Q: When your eldest daughter delivered her second child at the Soviet hospital, did they treat her well? A: Yes, they were diligent. I kept instant contact through phone call with the manager of health insurance who also called the doctor directly. When my daughter was in labour, she felt her stomach very tight. She used to have prenatal check-up regularly, so the doctor grasped her pregnancy condition. So, I asked her husband to sign up immediately for C-section, and it took only half an hour.* (F, 46, Phnom Penh_9).

The Health Equity Fund (HEF), introduced in the year 2000, differed from the exemption process that had relied on the arbitrary post-identification of poverty by establishing people's livelihoods before they received health care. The new system meant that ID cards were issued to be presented on arrival at health facilities. The Health Equity Fund was very helpful in helping poor people to access delivery services at public facilities. People holding HEF ID cards often went to seek treatment at public facilities because the HEF covered the medical expenses for them. Through the scheme, patients also received compensation for transportation and for their caretakers, and users showed their satisfaction at the reduced impact of delivery on their household spending.

> *Q: With the ID poor card, she didn't have to pay any money for her second child's delivery, right? A: No. The ID poor card is really useful to the poor like us in term of health care treatment. We are very happy to receive such assistance from the government.*(M, 74, Phnom Penh_7).

The HEF also helped reduce the practice of informal payments to health workers. One participant reported:

> *A: They asked me for money... I told the lady medic to wait until 2pm. I then called Mr. XXX (coordinator of Health Equity Fund) to visit me around the set hour. At 2pm, the lady actually came, and I then said to Mr. XXX: "Can I borrow your money for 20,000 riels?". Then, he asked why I needed to borrow this, and I told him that "I needed to give it to the medical lady who asked me three times already". Mr. XXX said that a Health Equity Fund user was not required to pay, and then the medical lady said that she did not ask for the money. I said to her: "this morning at 10am, you asked me for the money, and I told you that I did not have money. But, right now why you refused to take it?"* (F, 60 Phnom Penh_2).

However, our participants still reported some cases of informal payments to health workers by HEF holders. They also reported the neglectful attitudes and behaviour of some staff members who did not show enough support to patients who held HEF ID cards.

There were only two participants who reported getting a small loan for birth delivery even though they were HEF holders. The loan was to help to cover additional spending including buying food and materials for a new-born baby and to cover spending for caretakers and visitors. Some people said they had a certain diet after delivery, for example, drinking juice rather than eating food, so they needed to purchase this. Some other families reported that there were no other adults available to help take care of patients in hospital, so that the husband had to take a break from work to be a caretaker. This resulted in a loss of income, so the family had to take out a small loan to cover living costs during this short break.

> *A: I bought some juice. I could only take liquid. I dared not spend that much. Q: Did you borrow any money for delivery? A: Yes, I did. Q: How much did you borrow? A: My husband made advancement from his work place. Then, he asked them to deduct 10,000-20,000 riels from his wage every time it was released. My husband made advancement of $50. Q: How did you spend with the $50? A: I needed to buy medicines, nappies and a hot water container. My husband also helped to take care of me at the hospital. Q: Did it interrupt his work? A: Yes, it did.* (F, 46, Phnom Penh_4).

> *A: What did you spend with the 200,000 riel that you had borrowed? A: Several of my relatives accompanied me and my daughter to the hospital with their motorbikes so I had to refill the gasoline for them. You should know that just two litres of gasoline would cost 10,000 riel already. I just paid the gasoline fee and bought them a bottle of water each because we went to the hospital at night around 8 o'clock. I spent 200,000 riel in total on gasoline fees and other small expenses for my relatives and neighbours that accompanied me here and on food and other stuffs such as torn fabrics, towels, tissues, and wet wipes etc. for the baby because we stayed at the hospital for eight days. I also had to buy nappies for my daughter to wear until her blood stopped dropping. Three nappies cost 5000 riel already. Q: What did you use the wet wipes for? A: To clean the baby's body. The wet wipes have a pleasant smell. We don't need to soak it before using it. I bought one package of the wet wipes only, but I had to buy five or six packages of baby nappies which cost 4000 riel per package. I also spent on other items including medical oil, powder and so on.* (F, 45, Phnom Penh_8).

4.2.2 Illnesses

The life histories confirmed that spending on health care contributed to the financial burdens of poor households. Self-medication appeared to be inexpensive in its nature, but when it manifested through the frequent purchase of drugs, this was also costly to poor households.

It was apparently unclear whether indigenous practitioners caused any financial burdens to households during the pre-war period. After the Khmer Rouge regime however when public health care was not easily accessible and people had few other options, they reported that the costs of treatment by indigenous practitioners did have an impact and contributed to poverty in some households. We found that people could slip into poverty quite easily at this time, particularly when they kept on switching from one practitioner to another to find the best treatment. In the most recent period when a wider range of health care services were available, people remained willing to spend significant amounts on indigenous practitioners when they had illnesses for which health facilities could not guarantee treatment.

Private health care was reported as expensive since the pre-war period, driving people into poverty both in the short and the long term. Some households came to rely on common pool resources when they lost all of their key livelihood assets. Households became increasingly vulnerable when their breadwinners became sick or when they faced subsequent illnesses among their family members; which meant that it often took even more time for them to achieve financial recovery. The latest time period indicated that poor households were not only affected by the high cost of private health care, but also by private money lenders, who tended to charge high interest rates that often put people into the poverty trap. The reliance on private health care by low-income patients who had chronic illnesses also impacted not only on the patients themselves, but also on their family members. Reducing food intake was reported to help deal with the cost of private health care, especially in the context of high-level poverty.

Non-governmental organisational (NGO) care was reported to be pro-poor and effectively assisted patients in accessing services. Compared to other types of service, we found people who used NGO providers did not complain much about financial burdens or report any coping strategies to deal with the cost of treatment.

During the 1980s and 1990s, after the Khmer Rouge regime, people reported a mix of expenditure and free access to public health care. Government officials or people with contacts in the health sector were often able to get free services, including from military facilities usually reserved for soldiers, but many reported that they were charged for treatment.

The impact of user fees on household economies varied across the participants. Some claimed that the cost of treatment through user fees was lower than private health care, but we still found people who complained about financial burdens, especially for treating severe illnesses. Informal fee payments, which emerged more prominently in this period, also contributed to the total expenditure at public facilities. Fee exemptions helped to reduce health spending in poor households if the process of poverty identification was pro-poor.

The Health Equity Fund also contributed to improving access to health care for poor people, both at the health centres and referral hospitals, thereby helping to reduce health spending for households. However, to what extent these people could avoid financial burden depended on their poverty level.

Community-based health insurance was also perceived as effective in reducing financial burdens on near-poor households, especially those who had an unstable income or whose livelihoods were dependent on others.

Self-medication

The level of spending on self-medication depended on what methods people chose: home-based remedies, traditional medicine, or self-prescribed drug purchases. From the pre-war to the post-war periods, using home-based remedies or traditional medicine did not cost any money to patients because people often used home ingredients available in their neighbourhoods to make remedies to treat illnesses. Some people went to find wild animals, roots or specific herbs themselves from the common pool resources that were free of charge. The practice of self-medication was also performed among families, kin-groups or communities in which people were willing to share or exchange medicine or methods with each other as needs arose. This was part of social networking for living and survival in Khmer villages.

The practice of self-medication through purchasing medicine from private drug stores or pharmacies from the 1990s to self-treat illnesses did cost some money to people. However, most participants still claimed that the spending did not cause much burden to their economy because: 1) people purchased items based on their available budget, for example they chose cheaper medicine, or they advised sellers to give medicine at the amount they could afford, and; 2) there was no other related cost involved such as transportation, as people tended to buy medicine from nearby drug stores. A participant reported she could have spent more if she chose the best quality medicine, but usually she chose one that was mid-range.

> *A: I need to take medicines every day otherwise I felt sick again. I bought medicine from pharmacy. One small package of medicine cost me 3,000 riels and a better one for 5,000 riels. However, I just take the cheaper one for 3,000 riels.* (F, 59, Phnom Penh_5).

Even though self-medication through purchasing drugs was not expensive, a few participants complained about the cumulative costs of frequent purchasing. For example, if our participants reported having back pain or bladder pain, they often went to purchase painkillers from drug stores that provided short-term relief. However, when their discomfort returned, they had to purchase the drug again. People reported they often used their wages or savings to pay for those medicines.

A: So, if he was not feeling well, and if he got pain, we bought medicines at the drug stores. Then he got better after taking those medicines for few days. However, he got pain again when he worked hard. If he does not work hard, it is no pain. Q: How much did he spend for buying medicine? A: Each time, he spent 8,000 riels, 9,000 riels or 10,000 riels. (F, 44, Takeo_22).

For some families, especially woman-headed households that had a low income, the frequent purchasing of medicine from drug stores did not allow them save any money. They sometimes had to borrow from their boss to buy medication, and the amount would be deducted from their wages. One participant reported:

A: It costs about 10,000 to 16,000 riels at most depending on the sickness. If it is serious they will give good medicine but I have to spend more as well. Q: Where did you get money from? A: The money was from my salary and sometimes I borrowed from my boss. When I spent too much I didn't have money to send to my parents in province. It is hard for me to bring up my son alone. I often sent money to them every month or every two months from 40,000 to 50,000 riels for my son's health care and food. (F, 41, Phnom Penh_6).

Indigenous practitioners or "Kru Khmer"

Across political regimes, people reported various experiences of spending on treatment with indigenous practitioners ranging from no cost at all to significant amounts. During the pre-war period, we heard people claim their reliance on the services of indigenous practitioners who did not demand anything in return, so that patients could just make a gift based on what they had, for example, giving rice or livestock.

A: My father went to find a traditional healer who lived in the next village to treat me… Q: Did you spend any money for the treatment? A: We did not have money. My father gave the traditional healer rice instead of money even though he didn't ask for anything. (F, 53, Phnom Penh_11).

However, when indigenous practitioners failed to cure illnesses, we also heard that patients did not attempt to repay them.

A: I found three Khmer traditional healers to cure the baby, but they still could not help. I was in grief and regret over its death. I didn't offer them any money and they too didn't ask for it. (F, 63, Phnom Penh_13).

A few cases confirmed they were charged by indigenous practitioners, but claimed the amount was less than that of other treatment services such as public facilities. There were no reports of people getting a loan or selling assets to deal with the cost of such services at the time.

Q: Did your father spend money on the Khmer healer during Lon Nol regime? A: Yes, we did spend some money, but I did not know the exact amount. I guess it cost less than going to hospital. (F, 46, Phnom Penh_9).

During the Khmer Rouge regime, treatment with indigenous practitioners was completely free. Even though a few people reported that they still managed to offer gifts, this was unusual under the regime. High poverty and individual deprivation meant that people could not afford to give things to practitioners in return.

Between the 1980s and 1990s, the use of indigenous practitioners became increasingly popular, and the service was still considered inexpensive. In many cases, they simply requested simple gifts or a little money in gratitude or as part of their treatment rules.

Q: Did the traditional healer who treated your eye disease ask you for money? A: He did not ask for money, but just a handful of bananas. Normally, we needed to provide the offering when we got recovered. He did not ask for any money, and I just gave him any available offerings I could afford such as bananas or just little money. He said that he did not take the offerings for himself, but for his master. (F, 46, Phnom Penh_9).

Q: At that time, how did you pay the Khmer traditional healer? A: I just bought a bunch of incense sticks, banana, and candles for him. For money, I just give him a few riels! (F, 57, Takeo_20).

However, we also found that in some cases the treatments did cause a financial burden to families where indigenous practitioners demanded high fees for treatment. One participant claimed he had to sell one cow to buy traditional medicine.

A: I tried traditional medicine for three months, but it was not cured. Actually, I spent more than one million riels on traditional medicines. I sold one cow. I took his traditional medicine for three months. I bought a pack of the traditional medicine every 10 days that cost 25,000 riels. I soaked that medicine in 2.5 litres of alcohol and drank it for 10 days and then I soaked another pack in 2.5 litres and drank it again. I drank one glass during my dinner. (F, 44, Takeo_22).

Some treatments also involved offering gifts to indigenous practitioners and preparing ritual ceremonies including music, fruit, foods and other materials to worship spirits.

A: I sold my land for 170,000 riels, and it cost 50,000 riels for that healer. I needed to buy one kilo of beef and fruits for him in addition. (F, 40, Takeo_17).

Patients also slipped into poverty when they moved from one indigenous practitioner to another, as they were required to spend a lot of money on each treatment process including

transportation, and this used up all of the savings they had. Some patients sold their assets, took a loan or requested additional financial assistance from relatives to continue to meet these costs. In the end, they ran out of cash even to support their households whilst their key property assets needed to support livelihoods were also gone.

> *A: When a traditional healer asked to buy this drug or that drug, or asked to make offering to this or that spirit, we just followed him. Still my brother was not cured. Q: How long did he receive treatment for at the hometown before he died? A: He received treatment at our hometown for 10 months before he died. Q: For all treatments at your hometown, who covered the costs? A: It was shared by my mum, my brothers, and my aunts. My mum was the oldest sister and she has six younger sisters. So, when she did not have enough money, she often asked for contribution from her sisters. Q: Did your mum borrow money from others? A: No, she did not. We treated him based on our own resources. We sold rice, chickens, ducks, and cows to treat him. How many cows did your mother sell? A: We sold two buffaloes, and two cows. We remained one cow only.* (M, 51, Phnom Penh_3).

> *A: I spent 50,000 riels for each traditional healer for this kind of fruit arrangements, so I spent 150,000 riels for three traditional healers* (F, 40, Takeo_17).

Some indigenous practitioners allowed patients to owe them money, but patients still needed to pay back. Hence, some patients sold their assets urgently at a low price to deal with the fees demanded.

> *A: I tried traditional medicine a year later with that healer. He allowed me to use his medicine first, and pay him later. Because I couldn't earn money, I sold a cow to pay him. Q: How much did you sell your cow? A: (Husband responded) We sold it at 700,000 riels. We sold the cow at a cheap price. If we sell it now, it is about more than three million riels. At that time, we could not sell it at the high price. If we did not sell it, we did not have money to pay the healer.* (F, 44, Takeo_22).

The sale of major assets was reported by local people to have a long-term impact on their livelihood possibilities. A participant described the loss of cattle as a result of curing her husband's illness. Since then, she has had no cattle for ploughing.

> *Q: Where did you take him to at first? A: At first I took him to Khmer traditional healers. Q: How many Khmer traditional healers had you met? A: Maybe three or four traditional healers. Q: What did Khmer traditional healer do to him? A: The Khmer traditional healer prepared a ceremony to pray to spirit (neak ta) to break the magic spell. Q: You sold land and cows and you still borrow from your brother-in-law? A: Yes, I spend a lot on Khmer traditional healers. Q: How much did you spend for that? A: Maybe 30,000-40,000 riels for each ceremony. I prepared rice, chicken and classical music such as drum and tro for angry*

spirits. Q: How can you have that money? A: It came from my saving money from selling wood. Did you sell anything else for his treatment? A: I sold another cow during his treatment and a plot of rice field. At that time the land was cheap. Now, I don't have any cows left. (F, 63, Takeo_18).

Another participant also complained about the loss of land derived from treatment with indigenous practitioners. She had used the land for her residence and planted vegetables to exchange for rice. After the loss of land, she had to rely heavily on common pool resources.

Q: Before you sold your land, how did you make use of the land? A: I planted banana, potatoes, papaya, and cucumber to exchange for rice. Q: And your house was also in that land? A: Yes, the house occupied half of the land on the west, and the other half was used to plant yam to exchange for rice. Q: So, when you sold the land, you came to build this hut here? A: Yes, this is just a small portion of rice field. I sold the big land and bought this small one. Q: How did it impact on your livelihood when you sold the big land? A: I lost everything. I did not have food to eat and I had no money at all. When I had that land, I could plant vegetables to sell for 4000 or 5000 riels to buy MSG, salt and fish paste and so on. After I lost the land, I had nothing and I only hunt for bamboo shoot, crab and snails. (F, 40, Takeo_17).

From 2000 to the present, people continued to use indigenous practitioners, but now in combination with other health care services. In this later period, the service was used to cure minor illnesses at lower costs, as well as to treat illnesses that public facilities failed to cure. People again switched from one indigenous practitioner to another and so they spent a lot on the treatment.

This last period also represented a change in how some indigenous practitioners approached their healing by combining traditional treatment with biomedical treatment. This practice resulted in high costs to patients. A participant described how he spent money during this period:

A: I have spent a lot with the Kandieng traditional healer. Around two or three thousand dollars. And I had to go for x-ray and echo. I just went to buy the medicine from him. Actually, the medicine is not expensive, only around 20,000 riel (USD$5), but I had to spend a lot on x-ray and echo test. Also, I had spent more than 130,000 riel (USD$32.5) for blood test. Q: The healer required you to go for blood test? A: Yes, once receiving x-ray and echo test result, I had to bring it to the healer to see whether I had hepatitis A, B or C, and then, he would arrange the medicine for me. I had to go for various tests many times, not just once. (M, 74, Phnom Penh_7).

Again, because of high spending, patients had to get a loan from banks or microcredit to pay for treatment. As a result, patients became stressed about repaying the debt. A participant described the pressure that he felt over being in debt and how his children helped him to pay it off.

> *Q: You said that you spent around two or three thousand dollars for the treatment with Kandieng traditional healer. May I know where you got the money from? A: I borrowed money from ACLEDA bank by using my house title as collateral. I'm really worried about the money I have to pay back. My youngest child is still studying and only one single child earns money. Q: You have still not yet completed the repayment to ACLEDA? A: Not yet. I just felt ill and was in debt maybe six to seven months ago since the last Pchum Ben ceremony. Q: How much you have to pay ACLEDA per month? A: More than 100 dollars, but we can pay more than that or repay all the debt at once if we are able to afford it. However, we can't afford it. We sometimes do not have enough money to buy rice. Q: So now, who helps pay the debt and its interest? A: My eldest son. He works in a factory. My second son also helps some, but his income is not stable.* (M, 74, Phnom Penh_7).

The responsibility for paying back the debt was held among the family members living under the same roof as well as by the patients themselves. We found that when a father got sick, his children had to work harder to save some money to contribute to the cost of the treatment while at the same time they also earned to support their own family.

> *Q: How about your children? Are they very helpful to you when you are sick? A: They helped me with the money to their capability to pay back to ACLEDA and support their own family. They have to work from dawn to dusk and also have to think about their children.* (M, 74, Phnom Penh_7).

Private health care

From the 1950s to 1960s, a few participants had experience of using private health care, which was reported as being expensive. People reported they had to deal with the cost through various mechanisms including spending their savings or even selling their livestock.

> *A: My mother, she spent everything she had in order to cure me. It was very expensive at that time to get medical treatment.* (M, 68, Phnom Penh_10).

> *A: After I was run out of my eye drops, I did not have anything more because my family was below poverty. Sometimes my parents tried to catch chicken and sold it for my medicine. We were miserably poor.* (M, 57, Takeo_24).

In the 1980s, private health care came in the form of village medics and towards the end of the 1990s, new services emerged, such as private clinics and cabinets. People needed to pay for the treatment provided by village medics, whose prices were reported as often being higher than indigenous practitioners and usually paid in cash. There was no report that village medics provided free health care to patients. Bargaining on treatment costs was also reported, but village medics tended to defend their own prices. If people pleaded poverty, village medics could allow them to owe the cost or to pay in instalments rather than deducting the price. Some people also perceived that it was impossible for patients to bargain over medical fees.

> *Q: Could you bargain with the IV bag which cost 60,000 riels? A: No, it's a fixed price. The medicines for dengue fever are very expensive. We can bargain with anything like beef, but we can't bargain with medicine prices.* (F, 40, Takeo_17).

Village medics often charged for medicine, injection or IV. Patients did not need to pay for bed fees, transportation or food because village medics were willing to provide treatment at patients' houses and they were responsible for their own transportation. How the village medics set their prices was unclear, but it appeared to be based on their own individual, arbitrary decisions.

> *A: My second child got sick. His stomach became swollen and tense. The physician gave him three injections costing 30,000 riels (10,000 riels for one injection) and medicines.* (F, 59, Phnom Penh_5).

The charge by village medics in some areas was higher than elsewhere. A participant claimed:

> *A: The medic treated and gave my father an injection for three days and he charged us for 200,000 riels. It was a lot of money for us. In Stung Chhay, the costs of health care was more expensive than in other places. For example, if the cost of drugs in Stung Chhay was 1,500 riels, in other places with the same drugs, it cost only 500 riels. So, three days' treatment costs 200,000 riels.* (F, 44, Takeo_22).

Those people who used the services of village medics often coped with treatment fees by relying on financial assistance from other family members or relatives to deal with the costs in addition to their own savings.

> *Q: How did you get 30,000 riels for his treatment? A: It's my daughter's money. I could earn small money just enough to buy food to survive on daily basis. So, we did not have any saving. Everything is upon the eldest sister.* (F, 59, Phnom Penh_5).

However, people often relied on their own assets to pay village medics if they had any. Those assets included gold, land, livestock or rice.

Q: How much did you spend on the private physician? A: I sold one pig and I also spent some money from selling the buffalo to pay the treatment with the private physician. (F, 53, Phnom Penh_11).

Q: You spent 100,000 riels for your husband's treatment with the village medic at the village, so where did you get the money from? A: I have some saving. I also sold gold jewellery and rice. (F, 62, Takeo_19).

Q: Where did you get 200,000 riels to pay for the treatment cost? A: 200,000 riels was from selling one buffalo. We remained only one buffalo. (F, 44, Takeo_22).

As a result of selling assets, people reported a longer-lasting impact on their livelihoods. One participant recalled that, because her family sold the cattle for pay for treatment, the entire family had to work transplanting rice seedlings for other farmers in exchange for using their livestock to plough their own land.

A: My children and I exchanged labour with others to transplant their rice seedlings and in return they helped plough my rice fields. To plough the whole rice field, we had to help transplant their rice seedlings for about four or five days. I sold a pig and got 3,000 riels and then sold another buffalo at 10,000 riels. (F, 53, Phnom Penh_11).

Another participant recited that her family relied on cattle as a means of transport. After the sale of their cattle to treat illnesses, her family needed to hire livestock from other people to transport their products at a high cost. It took them a while to save enough money to purchase new cattle.

A: It was very hard for us to save money to buy another. So, we rent another buffalo to drive the cart that costs about 10,000 riels per day. But we had to take care of their buffalo. If the buffalo was lost, we had to pay for the full price of the buffalo. We rent one buffalo for 10,000 riels per day, and we had to feed him too. It took quite long time to save money to buy another one. (F, 44, Takeo_22).

Once people ran out of savings or assets, they also started looking to take out loans to pay for treatment:

A: Once, my wife and children could not get the money for my treatment, and then we borrowed from our neighbours to pay the physician. They did not take any interest from us. We tried so hard to earn a living. (F, 57, Takeo_24).

People also described support from their close relatives who helped their household economy during times of hardship whilst receiving treatment from village medics.

A: My father-in-law felt pity on me, so he asked my wife to go to his plantation on the mountain to pick papaya and wax melon so that we could sell it to pay off our debt. (F, 57, Takeo_24).

Some village medics allowed patients to owe for the cost of the treatment, but they often put pressure on patients by coming to their homes to demand payment. Patients did not want to owe money to village medics because they did not wish to cast doubt over their capacity to pay, which could impact on the availability of assistance in the future. Therefore, some patients would try any means including selling their assets even at the lowest prices in order to pay the bills on time.

Q: How much did you get from selling one buffalo? A: Around one million riels. We sold it at a cheap price. Because we owed money to the private medic, we could not wait any longer to sell it with the higher price. We had to pay the money to the private medic as soon as possible because he often came to ask for the money. It was embarrassing that he came to ask it almost every day, so we had to sell the buffalo regardless any price. We didn't want the private physician to feel unhappy with us or he wouldn't come to treat us next time. At that time, we sold the buffalo at one million riels cheaper than the original price we bought. (F, 44, Takeo_22).

With no assets to sell, some people in rural areas had to rely on common pool resources to pay the village medics. One participant described:

A: He asks every day. I told him that when I have money, I would pay him. Sometimes I give them 2000 or 3000 riels from selling bamboo shoots. Q: What do you do to pay them back so far? A: I look for bamboo shoots. When I could find a lot like one big bag, I could sell it for more than 10,000 riels or 20,000 riels. So I paid them some and kept some, and the next day I continued hunting. Sometimes I paid them just 2000 or 3000 riels, and they did not mind to take it like that. Sometimes they took my bamboo shoots and crabs and snails instead. (F, 40, Takeo_17).

People also highlighted that when the sick person was their breadwinner, the family was more vulnerable. When the breadwinners were unwell, the families could not generate income to live on, and had to rely on their savings or money borrowed from others to pay for the treatment and support the family the same time.

Q: And during the time he was sick, he didn't work? A: No, I had to borrow my relative to eat. Where did you get the money from? A: From cutting the trees. We had a little money left, and it was gone. (F, 45, Takeo_16).

A: When my father got sick, we couldn't go to forest to find Romeat vine. Q: So, while your father got sick, nobody went to the forest to cut Romeat vine? A: No, we are women, and we are afraid to go there. As a woman like me, I don't know the direction and where to go, so it's easy to get lost. We always went with him. Even though we went there several times, we still didn't remember the path. I often got lost when I went into deep forests and silence. We woke up very early in the morning by riding a buffalo's cart, and the path was not smooth. We came across a river, and the buffalos could swim. We found Romeat vine with the size of our carpal bone of our ankle, or some were as big or small. If we found one cluster, it was enough to fill up one cart. Q: When your father got malaria, the whole family couldn't go to forest? A: All of us couldn't go without him. My younger brother even got more scared than me. Only my father was our backbone of the family whereas the rest of family members were very afraid of tiger. (F, 44, Takeo_22).

Financial burdens also increased when subsequent illnesses occurred among other family members. For example, one participant described how four members of the family fell ill with malaria. This often happened in highly malarious areas. To cope with the cost of treatment, the family had to sell livelihood assets. The subsequent illnesses also meant that the family could not achieve financial recovery quickly enough following the first illness. They had to struggle and work hard to save enough money to recover their position.

A: After that, my father had malaria, and we sold one buffalo to treat him. After my father was cured, my mum was sick again. Q: After your mother was cured, did you have other people who got sick? A: Then, I was sick myself. Q: What was disease did you have? A: I got malaria too. Q: Your younger brother got sick subsequently after you? A: Yes, we bought drugs for him to take. He took drugs for two or three times, and he was cured... Because of such frequent sickness, we couldn't save enough money to buy another buffalo… (F, 44, Takeo_22).

From 2000 to the present, people still reported using private health care. Many participants reported that the spending was high, mainly on medicine, injections, or IV. In private clinics, the cost also included bed fees and other medical operations. During this period, people continued to use similar coping strategies as noted above to deal with these costs such as relying on their savings, selling assets, getting a loan or using financial assistance from relatives. However, the types of assets being sold have altered in response to the changing national economy, to include televisions and motorbikes rather than buffalo or other livestock.

For example, a participant reported selling a TV to deal with treatment fees:

A: He was given two injections which cost 38,000 riels. Q: Where did you get the money from? A: I sold my TV for $50. I spent the rest on food. (F, 46, Phnom Penh_4).

The same participant also sold the motorbike that she had just bought with her savings and a loan. She needed to do this to pay for the treatment at half of the total price she originally paid.

A: At first I made a loan to buy a new motorbike so that my husband can go to work in Phnom Penh. I also had $100 from savings. So, we got $300 to buy the motorbike. I sold the motorbike and I was so regretful, but my husband said that if we are still alive, we can make money later. The most important thing is to survive. How much did you get from selling the motorbike? A: $170. (F, 46, Phnom Penh_4).

In the recent period, village medics still let patients owe cost of treatment.

A: He had typhoid and gastric disease. He went to many private physicians. The first physician cost around 210,000 riels, the second around $10, the third around 200,000 riels, and the last time 180,000 riels. I have not paid it off yet. (F, 59, Phnom Penh_5).

Poorer people complained that the sale of their livelihood assets - such as land - to deal with the urgent need to pay the village medics affected their standard of living.

A: I sent him to a village physician who came from Thai refugee camp. Q: For how long your son was sick and how did you earn for a living? A: My son stayed sick for five days. He had IV from morning to afternoon. My son had IV till the temperature came to normal and the physician found out that he was fine. At the time I didn't earn any money because it was during flood season. I didn't have money. I sold a plot of land (10X50m). He asked me several times before I could pay him. I asked him to wait until I sold my land. Q: What did you do on this land before you sold it? A: I rent this land to famers that has cow, so I got one third of the total yields they could get. We can also grow bean and potato. We also can grow rice in rainy season. (F, 41, Phnom Penh_6).

Our participants reported both effective and ineffective results from treatment with private health care. Some participants sought recurrent treatment with the same or a different facility for several years, sometimes switching between private and indigenous practitioners. Such recurrent use often drew people into poverty since they could not save enough money for the family. Some people had to get a loan to deal with the persistent treatment.

A: My husband was sick. He often falls sick. He does not recover from malaria completely yet. Sometime he got sick and rested at home for six-eight months or one year and I often invited a private medic to give him injections and put IV for him. When he got sick, we needed to spend 80,000 riels to 100,000 riels. Now, he has no hair! Because I couldn't earn

much, sometimes I borrowed money from private lenders like 100,000riels to pay the treatment. (F, 57, Takeo_20).

Unfortunately, in the more recent period, loans from private money-lenders come with high interest rates, which poor people still preferred over microcredit with lower interest rates because the process was less complicated and collateral was not required. Some private lenders showed understanding to debtors. A participant described:

A: I borrowed 150,000 riels from a lender. I didn't put any collateral because the lender felt sympathy on my family since they saw my parents are old and gentle. I paid them back little by little and now I still owed them 70,000 riels. Q: How much did you pay for the interest? A: I paid about 60,000 riels already as an interest. Later I begged them not to pay the interest anymore because I didn't have money, so they agreed because they felt pity on me. (F, 41, Phnom Penh_6).

In some areas, private lenders provided urgent loans to the poor in the community, but borrowers needed to bear the high interest rates. These loan sharks also earned profits from selling things at high prices, but people could pay in instalments.

A: I dared not to tell you her name. She lives in Trapaing Anchanh. All people living around here borrow money from that someone. Her husband is a court official. Her house looks like a royal palace. She used to live at the Building. Her husband is a retired court official. They earn money via many sources. They sell stuff in which we can pay in instalments. In total, she makes a lot of money from us. That's how they make quick profit. We don't have big amount of money to buy stuff we need. So, we need to buy her stuff and pay in instalments every day. (F, 46, Phnom Penh_4).

People reported that the interest rates of private lenders could range from 10-40% per month. With the low wages they received at work, poor people could not pay off the debt in the short term, especially with high rates of interest. One woman who bought a motorbike indicated that she had paid 40%, although this could also be lower:

Q: Let's go back a little bit when your husband got swollen leg, and you said that it cost you USD $280. Did you borrow from someone? A: I borrowed it from someone, and the interest rate was 10%. (F, 46, Phnom Penh_9).

Some people owed the debt for several years. Because they could not pay it off, they tried to avoid meeting their lenders. A participant complained that she did not dare to visit her son in her hometown because she was afraid of meeting her lender who would insist that she pay the rest of the money she owed for her son's treatment.

A: Lately, I do not dare to go to my province because I don't have money to pay them back. My lenders didn't ask my parents to pay because they saw my parents are old. They will ask me if they meet me. Anyway, they told me that if I don't pay soon, they will start to take interest again. (F, 41, Phnom Penh_6).

We also found challenges in health spending among households whose family members had chronic illnesses such as diabetes. Our participants who had diabetes claimed that, even though they received support from the HEF and NGO health care, they occasionally used private health care, sometimes for several years. Even though they held the HEF, those poor people could not rely on public health care for certain treatments, such as specific IV drips that health centres did not have.

A: That IV was for diabetes (health centre does not have diabetes IV), and it cost 40,000 riels for one IV plastic bag. (F, 60, Phnom Penh_2).

The cost of the IV for diabetes appeared to add burdens to poor households, especially when their state of poverty was already severe. We found some diabetes patients could not go to work due to their old age and the severity of their condition. Those patients had to rely on their family members for financial support. The impact of spending on diabetes treatment caused stress to the family members, not only related to the costs of treatment, but also everyday food consumption and other necessary household spending. Their low wages did not allow them to support both the health treatment and everyday expenditure, therefore, they had to work overtime or during weekends to earn extra money. They sometimes had to borrow food from others as their wages had been spent on health care, or they had to borrow money from colleagues to pay off the health care costs or for essential household spending.

A participant who had diabetes described the poverty issues within her family and how her daughter overcame to support the entire household and her treatment.

A: Now I have eight people of four females and four males, living under the same roof. The females include my two daughters: 26-years-old Laen, working at garment factory, and 13-years-old Socheata, one-year-old granddaughter, and me. The males include my 85-years-old father (half-body paralyzed), a 28 year-old son, and eight-year and six-month-old grandsons. My grandsons' and granddaughter's fathers died of a traffic accident hit by a car, and their mothers (my two daughters) run away, and I don't know where they are now. Q: Who is the breadwinner? A: It's my daughter Laen. However, my father does not rely on us, as he has his retirement stipend about 150 thousand riels a month. He used to be a lifting machine operator at Sihanoukville seaport. He has suffered from high blood pressure and half-body paralysis due to his falling since six or seven years ago. He cannot get up from his bed. My son who is living with me is a construction worker, and he can

only feed himself. Q: What is Laen's job? A: She is a garment factory worker. Q: What is her salary? A: She can get $100 per month including overtime, but it is very difficult to afford the powder milk for the two babies. Each consumes six cans of powder milk; one can cost $5, so it costs us $60 a month. I really want to stop milk feeding my one-year-old granddaughter [to reduce the spending for powder milk].Q: Do you have any other income? A: No. I also receive $10 or $20 from my children when they visit me once in about five-six month a year. If they don't visit me, I get nothing. These medicines (for diabetes) are from an organisation… Sometimes I called physicians to administer IV for me at home or need to buy medicine for itchy skin. Q: How did you get the money? A: I got it from my daughter. When she got salary from the garment factory, I called physicians to administer IV for me. Sometimes she borrowed money for me. Now we still owe money to some people. My daughter is in debt about 40 dollars for my IV… The debtor does not really force us to pay because the debtor comes to our house and witnesses our misery. In addition, we pay interest for them 20 dollars of 100 dollars that we borrow. The debtor is also a garment factory worker but has money. The debtor can take the interest money from my daughter's salary. My daughter got off from work at 5pm, but she works extra time for another two hours. The extra time bonus from 5pm to 6pm is included in the monthly salary, but the extra time bonus from 6pm to 7pm is included in the weekly payment that is about 40,000 or 50,000 riels. She uses this money to buy 10kg of rice. Q: How many days did your daughter work at the garment factory? A: She works every day, no rest even Saturday or Sunday. The factory manager asked my daughter if she wanted to take rest at weekend, but my children refused because we are too poor. If she worked on Sunday, she could get five bucks extra, so she wants to work. (F, 60, Phnom Penh_2).

Sometime these poor households had to reduce the amount and quality of food for consumption. A participant described the type of food that she and her family consumed:

A: Now I have only 1kg left, just enough for this morning. Food can be preserved salty fish or fish paste (Prohok), river shell on wheel carts and fish. Sometimes I borrowed money to buy food and when my daughter gets her salary, I pay them back. This morning we only have rice, but no additional food to eat with. (F, 60, Phnom Penh_2).

She also put an emphasis on the small amount of money that her daughter took to the factory to buy her lunch.

A: She went to garment factory this morning and took only 1500 riels ($0.4USD) with her [for her own lunch]. (F, 60, Phnom Penh_2).

Non-governmental Organisational health care

Participants who received NGO health care reported that the treatment, bed fees, medicine, injections, IV and other services were free of charge. Even in long-term situations, patients were still not charged by hospital. The only spending they made was for transportation and food. No informal fees were reported to have been paid to NGO health workers either. Rather, we heard that poor patients often received donations and support from staff members and the hospitals. They helped by giving food to poor patients who could not afford to buy it during their hospitalisation. One participant described:

> *A: At that time, hospital provided support to me. Doctors often came to check patients' cabinet, and when they found nothing beside a package of rice, they helped me. Firstly, they asked me how many children I had, and further asked how my hardship was. They gave me 1,500 riel per day for food because I just gave childbirth. At that time, 1,500 riel could buy one kilogram of fruit. Hospital did not only help me but also other poor patients.* (F, 53, Phnom Penh_11).

Some health workers even donated money and food to patients who were recovered and discharged home.

> *A: When my son was released from the hospital, the staff gave me 90,000 riel as transport fee, 10 loaves of bread and a few packs of noodles to eat along the way back home.* (F, 45, Phnom Penh_8).

Our participants who sent their children to NGO facilities and had a brief stay in hospital did not complain about spending at all. Others who had a longer stay in hospital cited some spending on food, but they did not mention any serious coping strategies to deal with it. They often used their savings to meet the cost.

There was only one participant who mentioned getting a loan from her boss to buy blood for her son. As such, she and her family members took about six months to earn enough to repay this loan.

> *A: At that time, we didn't spend much on food. Yet, we spent a lot on buying blood for transfusion as my son had lost a lot of blood and he looked deadly pale. We solely spent the money on buying blood… We borrowed 400,000 riel from the brick kiln owner. Q: When could you manage to pay back that 400,000 riel? A: six months after my son recovered. I kept paying back 50,000 riel to my boss every time I got my wage. In some occasions that I could get more salary than usual, I would pay him back 100,000 riel. He didn't charge any interest on my debt.* (F, 45, Phnom Penh_8).

Public health care

A few participants could recall their illnesses and trying to access public health care during the pre-war period during the French colony and King Sihanouk. One participant, for example, claimed that the treatment during the French colony was free of charge, but often patients had to spend a lot on transportation due to the distance to the facilities. Sometimes people chose to travel by boats or canoes rather than by road if this was quicker. People in that period lacked transportation and the condition of roads was not good, therefore, they often had few options for travelling.

> *A: I went to a French hospital in Kampong Cham Province through a canoe rather than a machine boat, which was not available at that time. As I remember, I did not pay anything because I used my own boat. Q: Why did you choose canoe? A: It was far. If I chose to travel on streets or paths, it would take much time because we did not have motor or car or I could be carried on shoulders. It is not like nowadays that transportation is numerous and that we have motor taxi. Thus, it was faster to en-route through canoe, and I did not need to pay anything because it was my own boat*. (M, 74, Phnom Penh_7).

More people could recall information about public health care during the King Sihanouk period. They noted a variation in whether public hospitals charged: some reported no charge whilst others recalled paying. Informal payments were not commonly found, but some participant highlighted that, while health workers in this period were not willing to request informal payments, if patients insisted, they would be accepted. Where charges for treatment were reported, nothing was added about coping strategies to deal with the burden.

> *A: I got a cut on my foot and all these parts from my waist down were injured as I fell from my bicycle. There was only one hospital in O'Rang'Ov district. The physician just put the red liquid medicine and bandaged for me. Q: Did you pay? A: Yes, but I did not know how much we paid. At that time, we needed to pay.* (F, 59, Phnom Penh_5).

> *A: He was about five or six years old. He was diagnosed by a physician. My first child got sick as he had fever. Q: Didn't they ask for any service fee? A: No! If we bribe, they will take it! But they didn't dare to ask for service fees. He was sick for one week. The hospital provided porridge and rice for the sick kid, but it was not like at home.* (M, 74, Phnom Penh_7).

During Lon Nol period, not many people reported using public health care. A participant who did send her child to a public facility recalled that there was no charge as she claimed there was fee exemption for poor people. Similar to the previous period, health workers did not request informal fees from patients, although patients felt that by giving money to the staff this would encourage them to do their best for them. Some health workers did not accept these payments

as they pitied poor patients. We did not hear any complaints that people struggled to cope with the treatment costs during this period.

> *Q: Did you send him to hospital? A: I sent him to ChamkaChek Hospital. Q: When we arrived there, he was rushed to emergency room where I was not allowed to get in. Q: Did you pay money? A: No, because I went to a place that had free treatment. Q: At that time, was there also bribery? Did the medical staff ask for money? A: It was not like that. The medical staff did not ask for money, but we gave them to encourage for their best service when our children got seriously sick. Q: Did they take it? A: Yes, they took it. However, in my case, they did not take it and they said "I took it for what since you don't even have money to buy food."* (F, 60, Phnom Penh_2).

During the Khmer Rouge period (1975-1979), access to public health care was completely free of charge. However, the challenge in this period was not about the cost of health treatment, but rather the availability, quality and responsiveness of the health system to the needs of people. Public health care in this period differed from the other eras in that it tended to combine biomedical health care with indigenous practices. Public health care was not considered effective in treating illnesses, which meant that, even though the service was free, people were not interested and even avoided these facilities; instead they relied on self-medication or indigenous practitioners.

After the Khmer Rouge regime, the health system was gradually reconstructed and biomedical treatment re-emerged. Our participants mentioned two types of public facilities available between the 1980s to early 1990s: civilian and military hospitals. During this period, experiences of paying for health care varied among those who used civilian health care services: some claimed treatment was provided free, some said that there was no charge if you were a government official and others explained they had relatives working in the hospital who arranged a fee waiver. These people said they just needed to pay for their food and transportation.

> *Q: At hospital in Kampong Thom town, there was no medicine like today? A: No, it was very different from now. I didn't want to stay. It was not like today. Q: So you needed to pay money? A: Yes, that is right. Health care was not free.* (F, 52, Phnom Penh_1).

Another participant recalled a serious accident that happened to his uncle in 1985. The treatment cost from the provincial hospital was high and required the family to sell cows.

> *A: My uncle fell from a tamarind tree cutting wide his thigh. The stitches were done in many layers, and the doctor needed to cut some flesh from his buttock to fill his deep wound. He sold two cows for the full treatment. At that time, a yoke of cow was only 3,000 riels. 3,000 riels was a big money back then because this amount was equal to a half bag of cash. Our currency at that time started from one dime note, the smallest currency, 10*

riels, 20 riels, and 50 riels note as the biggest. It was in People's Republic of Kampuchea regime in 1985. (F, 45, Phnom Penh_8).

Some people reported finding coping strategies through the sale of gold.

A: I had lump in uterus about 1.8kg. Teacher Lorn, he brought me to Takeo provincial hospital because he knew a doctor there. He gave me a ride to the hospital. I spent one Damleoung of gold for the whole treatment including food. (F, 62, Takeo_19).

Paying informal fees to health workers did not appear to be common from our transcripts in this period.

Q: Did the medical staffs demand any extra money from you? A: No. At that time, the hospital was strictly controlled. Dr. XXX was in charge of the hospital. I know him and even used to visit his house. (M, 74, Phnom Penh_7).

Q: Some people said that during that time some medical staffs have asked for unofficial fee. How about your family case? A: My mother didn't say anything about it. I think they didn't ask for any money. (F, 47, Phnom Penh_12).

Some people who stayed close to the border during this period when public health care was not easily accessible sought health care from neighbouring countries. Their costs were found to be high, including not only the treatment, but also transportation, food and other services. As a result, patients had to get a loan from relatives and sell their assets.

A: I went to a hospital in Vietnam for treatment. The doctors there said that that traditional birth attendant didn't remove all my blood, so that is why I was sick. Q: Did you pay money? A: Yes, I borrowed some money from my foster parents' relatives to pay it and sell properties. Q: How many nights did you stay to be treated in Vietnam? A: Three nights. When I rested at the hospital, my relatives needed to go to buy serum in another hospital (Nha Bang). The hospital I was resting didn't sell serum for me. Thereby, I had to spend on travel to buy serum. One sac of serum cost about 70,000-100,000 riels. I borrowed some money from my foster parents' relatives to pay it and sell properties. Q: What did you sell? A: Two cows, two pigs and a paddy field. (F, 41, Takeo_23).

The sale of assets had a long-term impact on households. A participant recalled that after the sale of cows and pigs, her family needed to rely on common pool resources such as catching fish for survival.

Q: What did you do after you didn't have cows and pigs anymore? A: After I didn't have cows and pigs anymore, I catch fish to sell. (F, 41, Takeo_23).

Military health care was reported by our participants after the Khmer Rouge regime to provide services to soldiers who fought against the remnant groups. Military care was provided free, including bed fees and other services. However, in some areas where military facilities did not yet exist, injured soldiers were referred to civilian hospitals where patients needed to spend their own money to buy extra medicine. A participant described that her family had to sell a buffalo in order to cure her husband who was injured during fighting in 1993.

> *A: Before the incident, my husband fought at Po Chi Ork area. He fought against the Khmer Rouge. My husband's team prevented the Khmer Rouge from taking over the Kampong Thom province. At that time, he tried to remove land mines which were deployed by the Khmer Rouge soldiers. He was in the front row with his colleagues. He successfully removed the first layer and he didn't realise that there was another row. Then it exploded. His colleagues fought and brought him to hospital. He lost almost all his blood. He stayed at Kampong Thom provincial hospital. He was in so much pain that he woke up crying. There was no pain relief at the hospital. That was why we needed to buy the medicine from outside. His mother sold a buffalo (to cure him).* (F, 46, Phnom Penh_4).

> Military health care also helped provide services to civilians, but this was not free. However, according to a participant, it was still cheaper to bring patients to the military hospitals because they were based at the district town. One respondent's grandmother was often referred to the military hospital when she got ill rather than to the civilian hospital located in the provincial town. Even though her grandmother was referred to the military hospital that was supposed to be cheap, she still needed to sell gold in order to pay for the treatment.

> *A: At that time, it's much cheaper to go to military hospital rather than provincial hospital. I could not afford to take my grandmother to provincial hospital. Q: Did they ask for money? A: Yes, every time I went there, I spend 70 riels. My grandmother did not get recovered although I spent money…: I sent her to a [military] district hospital around five times. At that time with 0.13 ounce of gold you could buy only 60 cans of rice.* (F, 45, Phnom Penh_8).

Since the late 1990s, participants described the emergence of renovated public health facilities such as referral hospitals and later the existence of health centres at the commune level and the charging of official user fees (UFs). Participants described different financial burdens derived from treatment through UFs. The cost of treatment for minor illnesses at the health centres or referral hospitals was not high; participants did not describe any financial burdens from receiving care at these levels.

A: I still have pain in my chest. Mostly I go to get medicine at Samdach Ov Referral Hospital. I go to get medicine one-two time per month or sometimes I do not go; it is according to my sickness. When I arrive at hospital, they ask me how my pain is; I tell them, and they record; then they give me medicine. I have to pay (only) 2,000 riel. (F, 53, Phnom Penh_11).

Some people went first to the health centre but were then referred to hospital when their condition was found to be serious. The cost of treatment for severe illnesses at the referral hospital varied by the type of service. Some participants claimed that the total cost of treatment at this level was somehow cheaper than private health care and they just used their savings to cover the cost of treatment. A participant compared the cost of treating Chikungunya fever at the referral hospital with the fees charged by private facilities.

A: My father and my sister used to seek treatment from a private medic. If we are urgent we can go to private clinic, but if we don't have much money we can go to public hospital although it took more time for treatment. I took my grandson to Angroka referral hospital (to treat Chikungunya fever). Q: How much did you spend for your grandson? A: I paid 40,000 riels for four bags of serum and two nights stayed in the hospital. For the case of my father and sister, they sought treatment from a private medic and it cost 120,000-130,000 riels for the medicines. (F, 55, Takeo_15).

Some participants complained that the high cost of treatment for critical illnesses at public hospitals resulted in financial burdens to their families. In addition to the cost of treatment, which was already high, they had to bear other costs such as transportation and food. Their family members also had to cope with loss of income from missed work to accompany them at the hospital.

A: The surgical fee was 200,000 riels. After surgery, I was asked to stay at hospital for one week. The total spending was around 1,000,000 riels for food and hospitalisation. This also covered the round trip fee which was 100,000 riels… My first and fourth children were staying in Battambong. They were hired to harvest corn and bean. When I was sick, they stopped working, but their husband still did the work. (F, 63, Takeo_13).

Informal fee payment was also reported by some participants even though others suggested the absence of this practice during their treatment experience. Whether the informal fee contributed heavily to the high cost of illnesses was not yet confirmed as we heard that people generally paid the amount that they could afford.

To deal with the costs, people relied on their savings, as well as financial assistance from other family members and relatives. Some began by using their savings but, when this was not enough, they had to sell their assets such as gold, cattle or land. Some people had to get a loan and were

concerned about how to earn the money to pay it back. Others revealed that they had already paid off what was owed with the support of their children.

> *A: I had appendicitis. I had surgery. At that time, I went to Khmer-Soviet Friendship Hospital. I spent $600 in total for medicines and injections. Q: How did you get $600? A: My daughter borrowed $500 from a relative in our hometown and another $100 was from daughter's salary in the garment factory. My second son also contributed $50. I owed someone in the hometown more than $3000 for both sickness and buying this house. Q: Did they ask for interest of $500? A: No. But, now they called me on phone to ask for the money. I have no money to pay them yet because my scavenger business is in bad luck now.* (F, 59, Phnom Penh_5).

> *Q: Where did you get 200,000 riels from? A: My first and fourth children helped cover the surgical fee for me. I covered the cost for food.* (F, 63, Takeo_13).

As above, the cost of treatment drove people into poverty when households faced successive illnesses among family members. A participant described that, within a year, three members of her family fell ill, resulting in the loss of her two daughters. To deal with the cost, she lost all of her savings, one plot of rice field, a pair of cows and remained in debt for a few years. This occurred despite financial assistance from her relatives and other family members.

Fee exemptions were also reported by some participants, who regularly reported inconsistency in the poverty identification process for fee exemption. Several people highlighted their different experiences in seeking fee exemptions below, with differing outcomes. The first two participants described how fee exemption, despite the absence of the HEF ID cards, nevertheless helped to reduce their total spending on treatment.

> *A: I felt pain in my uterus. I went to Kilometre Number 9 health centre, and then I was referred to the Municipal hospital. The health worker cleaned my uterus and gave me medicine. At that time I slept at the hospital for eight days. The treatment fee was free. Q: Why you did not pay? Did you have the poor ID card? A: I did not have the poor ID card yet, but I told the health worker that I was merely a labour worker at a brick kiln. The health worker felt sympathetic with me, so she decided to help me… I also owed the transportation fee to the motor-taxi driver. He knew that I didn't have money so he let me pay him back when I have. Q: Did you pay anything during the stay in hospital? A: I only spent on food. I bought my own food.* (F, 45, Phnom Penh_8).

> *A: Before they provided me any treatment, they interviewed me to see if I really didn't have money. If they demanded money from me, I would surely go back home without any treatment. The medical staffs who were on stand-by and the doctor at Kilo 9 health centre*

helped process the document for me because I told them that I didn't have money without showing them the Equity Fund card. (F, 45, Phnom Penh_8).

On the other hand, a third participant claimed that even though she tried to insist that the health worker reduce the amount of her bill or exempt her fees, they believed that she was lying to them about her poverty level. The poverty identification process did not work effectively to assist her in identifying her circumstances. As a result, she had to get a loan to pay the costs.

A: One week after my first daughter died, I had an eye problem; a bird bit it. I spent 500,000 riels. My relatives begged a doctor that my daughter had just died and I had no money. They asked the doctor to reduce the cost, but the doctor didn't agree. The doctor said he was cheated by this trick before. (F, 55, Takeo_15).

We also interviewed participants who were HEF holders. Some of them were people who had chronic or severe illnesses such as diabetes and others were poor people who also experienced general illnesses. As noted earlier, the HEF facilitated a more robust implementation of fee exemption, so that people described a lesser financial burden on their households. The impacts of the HEF on financial spending in poor households presented in various forms. Some participants revealed the positive impact of the HEF in improving access to health centres for poor people. Many HEF holders at least experienced going to health centres where they could receive primary health care. The treatment cost was generally not high, and people explained that the HEF to some extent reduced health spending at this level: they did not need to go to village medics or buy medicine from drug stores when they felt sick. For some families, several people got sick successively, and so the HEF helped to provide free treatment for them. A participant described that in 2013, three members of her family fell ill and they received free health care at the health centre covered by the HEF.

A: In 2013, I suffered from the pieces of bomb inside body. Q: So generally you only go to the health centre? A: That's right. I hardly go to referral hospital. In the same year, he (my late husband) has headache. Sometimes he is just like a normal person. Sometimes he is very difficult to deal with. He used to stay at the health centre for one day. [We] didn't spend any money at that time. He only got an IV drip and felt better. Q: In 2013, were any family members of yours seriously sick? A: Yes, it was my daughter. She had fever. We had to give her serum and medication at the health centre. She used to be thin like you but she gained some weight after she had got the serum and medication. It [the weight gain] is all due to the contraception pills. (F, 52, Phnom Penh_1).

Besides accessing health centres, the HEF also helped improve the access of poor people to higher level health facilities such as referral hospitals. When their illnesses were found to be serious, people who visited the health centres could be referred.

For a family that held the HEF, the exemption covered everybody. Without this support, poor people admitted that their family members could not survive and they could not afford to pay for treatment. The HEF also helped to cover the costs of caretakers and transportation for patients.

> *Q: Did the HEF card help you and your family? A: Yes, this card helps a lot. Without it, we died, and we did not know what to do when we are sick. Q: Although they gave little money to the caregiver, did it help you a lot? A: Of course, it is very helpful. It covers the health service fees. If someone said that this card is unhelpful, I strongly disagreed. I can live until today because of this card. My wife was admitted to the hospital for three to four times already and I myself also got hospitalised. Without this card, we had no money to pay for medical care; this card helps me access medical care and treatment. For this reason, I appreciated the value of this card very much. HEF is very valuable for my life. For those who had money or those who had never had a severe illness and never went to hospital, they might think that this card is useless. Some who have money could afford hospitals, so they might think this card isn't valuable. However, for us as poor people, we are able to access the hospital again and again because of this card, so we know its value. I could say that without this card, I would die. We did not have money to pay for health care services. Each time its costs ranged from 300,000 riels to 400,000 riels or sometimes up to 1,000,000 riels. We saw the receipts of payment that were covered by the HEF.* (M, 51, Phnom Penh_3).

Even though the HEF supported poor people in many ways, we found there were still challenges related to its operation, particularly as there were varying interpretations of what the HEF covered. For some, the HEF did not cover certain specific treatments for chronic illnesses such diabetes; and such patients were referred to NGOs for further support.

> *A: When I got there [Municipal hospital], the medical staff there said that they could not treat me because I have diabetes. They directed me to NGO.* (F, 60, Phnom Penh_2).

However, another participant, who had diabetes, said she was sent to the referral hospital and stayed there for over a month. The HEF helped to cover the costs for her.

> *A:…When I knew that I have diabetes, I slept at the hospital for 42 days. I got fainted at home, and Mr. XXX called the ambulance of the Municipal hospital to take me. I rested at the hospital for 42 days. I was so weak and dizzy. I could not even sit, and I just slept the whole time with IV. Mr. XXX, supervisor of the Municipal hospital, administered IV for diabetes to me so that I could be a bit stronger. It was not for treatment. He said that this disease has fluctuating symptom. When I was at the hospital, my legs got swollen. Now it became smaller, and I loosened my skin, and then it became dry and cracked.* (F, 60, Phnom Penh_2).

With HEF support, some people reported having no financial burdens at all as a result of their illness, unlike during earlier periods.

However, others claimed that they still needed to spend a lot of money and incur debt even though they held the HEF. The fees for caretakers, for example, were not enough to cover the actual expenditure. Participants who stayed in hospital had to spend extra money to buy food, and also complained about the shortage of medicine provided, requiring them to buy extra out of their own pockets. Furthermore, transportation covered by the HEF was often insufficient as it applied to one round trip only. According to our participants, if they had young children at home they would need to travel back and forth several times to visit them, and had to meet the costs themselves.

> *A: I often called the ambulance to refer him to the Municipal Hospital. I have the hotline number of ambulance to call whenever we needed. Q: Didn't the HEF cover the cost for care taker? A: It did, but it is not enough. We needed to buy him extra drinks. If we stay at the hospital, there will be no-one help look after the children. They were doing their study. We also don't have transportation to go back and forth from home to hospital. Q: Why did you borrow money if you already had HEF? A: The treatment cost was free, but I needed money to buy food and stuff. A nurse asked whether I had money. They took some money to buy a kind of medicine with the cost of 16,000 riels. I also spent on transportation. I needed to travel to visit my children at home. My children were still little at that time.* (F, 46, Phnom Penh_4).

In another life history, a participant explained how support from HEF operators helped her to bring her husband's body back home even though she had no money at all.

> *Q: How long did he stay at the Khmer-Russian Friendship hospital? A: Just a few days. Once he died at the hospital, they asked me to find a tuk to bring his body home. I didn't know where to find the tuk and I didn't have money. I stood and cried near my husband's body and then I called the HEF operator that I didn't have any means to take my husband's body home. The HEF operator was surprised and she contacted the ambulance of Porchentong referral hospital to pick up me and my husband's body from the hospital.* (F, 46, Phnom Penh_4).

Despite the positive changes brought about by the HEF, the behaviour of health workers was still a barrier that hindered poor patients in accessing public health care, even though there were efforts to improve the situation.

> *A: I would like to thank the health equity fund but I wish to see changes. I think that we can't stay at the hospital even we have the card. I need further supports. I wish to see nurses and doctors put more interest on their patients. I don't want to hear them complain*

about us who used the HEF. I just kept silent whenever I heard nurses said such words. I worried that they would mistreat us. I also hope that HEF still operates to continue to help the poor. Personally, I have a disabled husband and I have too many children. I need further support especially to get my house back. (F, 46, Phnom Penh_4).

Another participant felt unhappy with the bad words from a health worker. From this experience, she was not willing to bring her child back to the health facility.

The nurse said that I didn't have hygiene, and did not look after my child well. I was so poor, so I had to go out to earn money. When I arrived home, I didn't take my child to take a bath. I saw he got sick, so I sent him to the health centre immediately. The nurse blamed me because my son was not clean. Later, I didn't want to go to that health centre because I was afraid to get blamed about hygiene. I tell you the truth! Even though I was sick, I bought medicine from pharmacy, but I didn't dare to go to the health centre to allow those nurses to blame me. It hurt me. I was angry, but I didn't react to them. I was silent, but I was angry. [She said that to me] because I am poor. (F, 41, Takeo_23).

Poverty issues varied by household. In some cases, even though the household was poor, some family members could afford to bring patients to health facilities for treatment. However, we also found cases where family members were reluctant to bring their relatives to hospital, especially when their condition did not seem to require urgent treatment. This was because the poverty conditions within their household were high and they could not afford to miss work, or because they had to take care of their young family members when the others went out to earn money.

A: Regarding my condition now, I need to stay at the hospital because I am too weak and I cannot eat. However, I can't go to hospital because I still have two small babies to take care of. If I went to hospital, I did not need to spend money. I am even given medicines, food and money, five thousand riels a day for caretaker. However, I cannot just leave. (F, 60, Phnom Penh_2).

Q: Now, you had a HEF card, why did not you bring your husband to the hospital?
A: If we go to the hospital, we did not have money to eat. If my husband goes to the hospital, I also go with him, so there is nobody to take care of our children, and how can we have money for spending. (F, 44, Takeo_22).

Participants who held the HEF also complained about the slow process of reimbursement.

A: I'd like to suggest for a better health care service such as speeding up the reimbursement process of the companion and transportation fee. (F, 45, Phnom Penh_8).

Most importantly, participants also expressed concerns about the unfair process of identifying poor people for pre-ID card distribution. A participant described the issues surrounding card distribution in his village:

Q: When did you have a HEF card/ID poor card? A: (Husband responded) I had it about two years ago. Local authorities did not want to give it to me. Rather, they preferred to give this card to their party. Some card holders had homes or several hectares of rice fields. I would call those who distributed this card corrupted people. They didn't see us who did not have rice field as poor people. Rather they consider those who have a motorbike Honda Dream 2013 as poor and they gave this card to them. I shouted all these words to them, and then they decided to provide this card to my family. (F, 44, Takeo_22).

Several participants also protested that some poor people in their communities had still not received their pre-ID card. Those people got sick and because they were poor and did not have the pre-ID card, they were not willing to go to health facilities. They suggested that the government should expand the coverage of the HEF.

A: I beg you, after you go back, please inform that operating NGO to give another HEF card to a woman named XXX. She is in need for such a card. (M, 51, Phnom Penh_3).

They also talked about the low awareness of some HEF holders, who did not realise the importance of the card and so they did not use it effectively. This was partly because poor people were not informed of its importance sufficiently during the distribution.

A: I would like them to organise a meeting with us to explain about the meaning and importance of this card. This card is very essential for our life. I can understand it because I can read, but for some people, they don't understand its importance, and they think that this card is useless. I don't want anyone make such judgement on this card… I would suggest that NGO to invite all HEF card holders for a meeting and explain them about the benefits, meaning and usefulness of this card. It is all from me. Q: So far, didn't they explain anything to you? A: No, they simply tell that "if you have any illness, you just bring this card with you to the hospital; the health staff won't charge money from you". Some people may not understand it. For example, some people went to hospital, but the hospital didn't accept them because they were little sick. When they come back, they think that this card was useless. But the real value of this card is very important for our life. I meant that its value is equal to the value of our lives. It can buy our lives. This is my own opinion. For

some people, they may need additional education about this card. (M, 51, Phnom Penh_3).

Q: How did you get the ID poor card/certificate? A: The village chief gave me. There was an announcement on a loud speaker to inform poor people to register for the certificate. Then, I went there to get one. Q: Did they give you instruction on how to use it? A: They never explained anything, but they just gave me the certificate. They just said if I was sick, I could show this certificate to medical staff at the hospital. They did not say anything else. (F, 40, Takeo_17).

Interviews with people who held Community-based health insurance also showed how this helped to reduce health spending for their households. We found that people often used CBHI when they were in a critical condition. A participant described how her husband was treated several times at the hospital with support from CBHI.

A: He got cyst in his bladder. He had difficulty with urination. He urinated a little and sometimes could not urinate at all. So, I took him to Takeo provincial hospital. After surgery, he stayed at hospital for more than two months before he was allowed to leave hospital. After around one year, he suffered the same illness and doctor dare not to give him another surgery as he was old. So, they connect a tube to his bladder for urination… Q: Did you have to pay medical fee? A: No. CBHI covered everything such as accommodation and surgical fee. I spent only on food. (F, 63, Takeo_13).

Another participant described subsequent illnesses among their family members and as a result CBHI helped to cover the medical costs incurred.

A: I used to go for treatment of my urinary bladder problem at the Khmer-Russian Friendship hospital. Q: When was it? A: In 2009. I didn't have to pay any money because I had SKY health insurance... My third child used to stay in Khmer-Russian Friendship hospital when he had dengue fever (in 2010). Q: Did you use SKY insurance service at that time? A: Yes. I become SKY insurance member since 2007. The insurance covered the cost for me... Now I got an ovarian cyst which has just been removed by the recent surgery. Q: Did you have to pay any money? A: No. I used SKY insurance. (F, 47, Phnom Penh_12).

Community-based health insurance also helped deal with the financial constraints faced by households where family members suffered from chronic illnesses such as cancer. A husband described how CBHI helped cover the cost of several major treatments undergone by his wife who had stomach cancer.

A: She had stomach cancer. Doctor said she could live only for six months after the surgery. But so far it has been three years already. Hmm, for now she doesn't take medicine, so

she often has pain. Q: Is it serious pain? A: Yes. She had surgery after she stayed for three months in hospital. The surgery was conducted in 2010. Q: Did you pay for the surgery? A: No. CBHI covered it for me. Q: After that what kind of illness did your wife have? A: (his wife mention) Later I was transferred from the Khmer-Russian Friendship hospital to Cancer Department at Calmette hospital where it has the specialised doctor. I stayed in the hospital for almost two weeks. Mr. XXX who is the representative from Khemara Organisation went with me. (M, 68, Phnom Penh_10).

Even though CBHI covered medical treatment, we found that patients still needed to bear other costs such as food and transportation. Some types of treatment required patients to be hospitalised for months, hence the spending on food was a huge financial burden to their families. To deal with this, our participants claimed that they still needed to use their savings or sell their assets. One respondent described additional costs that she needed to bear in addition to medical fees and the coping strategies she used to deal with it.

A: I spent only on food. It costs me around 1,000,000 riel just only staying at hospital for more than two months. I bought some food at hospital. Guess what, a fish about this size cost 1000 riel. Hospital provided food only for patients… Q: Where did you get 1,000,000 riel from? A: The money came from my son. He got it from selling paddy rice and he brought the money to us. We used to have many rice fields and yielded a good result also. Later, we distributed some of them all to my children (children of my husband's ex-wife). We still remain little only and all of them belong to my husband. I do not own a single rice field. (F, 63, Takeo_13).

We also found that community sharing also helped people to deal with the costs.

A: The rest of money came from Sang Ka Hak. Sang Ka Hak is a practice where people in the community contribute things to less fortunate members in the village. These can be food, money, etc... It was organised in each village to help sick families. When a member in one family got sick, villagers set up ceremony. Each member from every household in the village brought money to the sick family's home. There was an archar (Buddhist priest) who waited to collect money and gave them wishes. The donation was from 5.000 to 10.000 riel. So, the patient could use the money to receive treatment. During that day, the host arranged a small treat such as tea and some snack to welcome guests. The organiser was either a priest or village chief. Once the date was set, they would broadcast the news publicly through loudspeaker. If you did not have money, you could contribute paddy rice instead. Sang Ka Hak can be organised for any desperate persons in the village. It could be organised for elders who got sick, low income family, or children regardless they were sick or not. Villagers were not forced to join this ceremony. This was based on their own

free will. It is just people cannot escape sickness, so we should help each other. (F, 63, Takeo_13).

The implementation of CBHI still faced some problems in its operation. A participant who bought CBHI complained that despite this, he was charged for the ambulance, which was priced even higher than usual by the hospital:

A: My son ran to call for an ambulance to take me to Takeo provincial hospital. On the mid-way to the hospital, they asked for ambulance fee for 40,000 riels. Usually it costs only 20,000 riels but they asked from me 40,000 riels, even though I already became a SKY member. Q: Why didn't you show them that you have a CBHI membership? A: I already showed them but they still took that money from me. (M, 54, Takeo_14).

Some participants complained that patients still needed to buy extra medicine using their own money.

A: I was given 20,000 riels when I returned home. But we get this money only when we stayed at hospital. If you didn't stay so you can't get this amount of money. They gave us medicine but we need to buy it by ourselves if it was insufficient. (M, 68, Phnom Penh_10).

The behaviour of health workers towards CBHI users varied according to our participants. Some claimed that certain health workers did not take good care of CBHI users; others said that they experienced good treatment. The intervention from CBHI operators was important to help to mentor staff performance.

A: If doctors don't cure us, the staff of NGO that operate CBHI will do something. I saw the change after buying CBHI. We can go to hospital for treatment. We spent only for food because my wife can't eat food which was provided by hospital. I always bought food outside. In the morning she ate rice soup that is why I need to spend money a lot. Sometimes the neighbours pity me and then they give me some money to buy food. (M, 68, Phnom Penh_10).

People who bought CBHI were those who were near-poor. These people had unstable incomes and so they could not make sufficient savings to deal with health shocks within their families. Paying the insurance premium was suitable for them and could help protect them from financial burdens during future illnesses.

Q: How did you come up with the idea of joining the Community-based health insurance? A: I think that we would get sick at any time, and my family budget is very low and unstable. After receiving rice production, I also had some money left, so I thought I should use this little money to buy health insurance, just in case my family or I get sick.

So, I took some money from selling my rice production around 57,700 riels to buy health insurance for four people for one year. I'm afraid that when I got sick, I did not have money. So, I needed to buy it when I had money otherwise I could not rely on anyone or any help. (M, 57, Takeo_24).

Community-based health insurance was also suitable for some families who had limited income or whose livelihoods depended on other people such as children or relatives. Buying insurance would help to reduce financial shocks not only to the families, but also to those who served as their source of financial support.

Despite the fact that people still needed to spend their own pocket money to cover some costs, we found our participants still believed that without CBHI, they would be in more debt or even have lost their assets.

Q: *Suppose that you didn't buy SKY insurance, do you think you would be in heavy debt or would have a lot of problems dealing with your children's treatment? A: Sure, I would have owed a lot of money to my relatives and other people. Even with the SKY insurance, I still had to borrow some money from my relatives.* (F, 47, Phnom Penh_12).

Q: Why do you continue buying CBHI? A: It is a long-term investment. I do not know when I fall sick. Let's take my husband's case as an example. I would have paid a lot on medical fee if I did not buy CBHI. Buying insurance is like getting a loan. You just have to pay the interest monthly. (F, 63, Takeo_13).

5. Conclusions

Findings from this study suggested that Cambodian people who used to rely mostly on traditional birth attendants and indigenous practitioners in the past, have increasingly shifted to using the modern health care methods and facilities provided through public and private health care services, especially since the late 1990s and early 2000s. Factors that influenced the change in health care seeking behaviour can be grouped into three: i) the development of health care systems, offering both public and private services; ii) socio-political factors that improved security and the accessibility of modern health care; and iii) individual factors such as awareness and household economic conditions.

The findings also showed dynamics of Cambodia health system recovery after conflict and the interplay of several players in building the health system. The Khmer Rouge period from 1975-1979 reversed the existing development by destroying available health infrastructure, and executing health workers. The camp provision at the Thai border during and immediately after the Khmer Rouge period from the 1970s to 1980s provided what health care could be accessed by some Cambodians, and started to rebuild human resources for health. The entering of

Vietnamese midwives and medical teams into the country to provide medical assistance to Cambodian health workers during 1980s was reported, but it was not clear to what extent their assistance contributed to strengthening the Cambodian health system. The emergence of NGO health care services in the early 1990s was the consequence of the international humanitarian efforts to help improve access to health care, but the scope of their work was still small. The post-conflict period from 2000s onwards saw the emergence of private providers that spread over the country quickly, health system reform and the operation of pro-poor health financing schemes driven by international agencies. These developments were supported by parallel economic development.

We also found that while the public health care system was in the transitional phase of rebuilding, TBAs, indigenous practitioners and village medics were the main sources of services. However, their scope and quality were limited. Support from NGO health care helped to increase health coverage in this period.

Cambodian people still pursue traditional medicine in combination with other services up to the current period. Local beliefs rooted in pre-modern times remain alongside quite sophisticated understandings of modern medicine and many report use of such services to good effect. The satisfaction with traditional medicine was also reported during the Khmer Rouge period and its aftermath.

In the recent period this industry had used sophisticated marketing strategies through public media to maintain business. The practice of treatment through traditional medicine and indigenous practitioners has become increasingly expensive over time, especially when practitioners started to combine traditional treatment with western methods. The payment has changed from in-kind to cash payment.

Some participants mentioned the roles of indigenous practitioners in curing mental illnesses. The interview accounts did not provide adequate information about the health care seeking behaviour related to this type of illness.

Private providers started to flourish in the early 2000s, but their quality was varied. In some cases, the costs of service delivery by private providers did not match their quality of care, and in the absence of effective regulation, this had impacts on poor households both in terms of financial and continuing health problems.

Despite increasing use of public facilities by Cambodian people after 2000, there were other factors that still inhibited people that required attention from utilizing public facilities. In addition to quality of services, the problems related to dual practice of health workers, their attitudes and ethics towards users, equality in service delivery, and unofficial payments, needed to be addressed.

In terms of health spending, even though the price of public healthcare was reported to be lower than of private services, this price was also variable according to condition or illness. It is not clear that greater utilization of public health facilities has allowed people to spend less on healthcare. Rather, it was found that people who used public facilities still reported a lot of cases where they had to use their savings, sell assets or get a loan to pay for healthcare.

In general, the accounts suggest growing commercialisation of medical care of all types post-2000 and most accounts of impoverishment through health costs were relatively recent. Impoverishment associated with health is a regular feature of the respondents' accounts and extends across all periods; and impoverishment associated with health care seeking is a regular feature of accounts, particularly since 2000.

However, also after 2000, the emergence of pro-poor health financing schemes contributed to easing financial burdens for some households, especially protecting some vulnerable groups such as the elderly and women headed households. However, due to their incomplete roles and the dynamics of household poverty, the impact of the Health Equity Fund and Community-based health insurance still depended on the poverty level in each household, chronicity and severity in the type of illness in each case and the implementation of the schemes.

The role of informal moneylenders, referring to those who provide loans with high interest rates, in several cases contributed to impoverishment of respondents. There were no indications from respondents that government or communities considered this a problem that required regulation. This was beyond the scope of the study, but the findings raise alarm about the operation of informal moneylenders in Cambodian communities.

The study suggests that the government can improve the pro-poorness of the country's health financing by expanding the coverage of CBHI and the HEF, increasing the scope of the HEF to cover chronic illness, expanding the benefit package of CBHI and the HEF, and increasing the general public awareness of the various health financing avenues that are available to them.

Continuing efforts to strengthen the health system by enhancing the quality of public health care and improving the performance and attitudes of health workers towards patients appear likely to have a significant impact on the impoverishing effects of health care costs by developing a more affordable and effective alternative to those providers who appear to have the most impoverishing impacts. Additionally, monitoring the practice of informal money-lending and considering the opportunities for regulation and the potential to improve the accessibility of alternative micro-financing mechanisms also appears a fruitful avenue towards policy development

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