Medical Practitioners and Traditional Healers:
A Study of Health Seeking Behavior in Kampong Chhnang, Cambodia

A Qualitative Study in Medical Anthropology
Prepared for

The Health Economics Task Force, Ministry of Health,
The Provincial Health Department, Kampong Chhnang
and
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EXECUTIVE SUMMARY

This study draws a distinction between the indigenous paradigm and the global paradigm as a way to present a discussion of the various kinds of providers known to and utilized by those seeking health care in the case study province. We examined the reasons customers gave for using or avoiding these providers and we noted the approval they expressed for some providers and the complaints they made about other providers. From these expressions, richly documented in the informants' own words, we can discern the contours of a concept of "quality" care that is operating in the judgments and preferences of our informants. These underlying values drive the decision-making that is manifested in health seeking behavior.

The indigenous paradigm takes a holistic, multidimensional view of health, illness and healing. The fundamental premise of the paradigm is that social, psychological, spiritual and physical factors work in combination to yield health and illness. Healing is accordingly understood in terms of interventions that attend to all these factors in combination.

The global paradigm centers on a biological view of health, illness and healing. The premise here is that it is useful to separate naturalistic from supernatural elements, physical from mental elements, biological from sociological elements in considering health, illness and healing. The global paradigm utilizes an impersonal, systematic, scientific approach that favors interventions that are narrowly focused on physical, chemical and biological agents that have a known and predictable effect.

The indigenous paradigm is represented in our case study by providers who come from an oral culture or a manuscript tradition of transmitting age-old wisdom, traditional lore, common and customary practices and local knowledge. This knowledge is conveyed to those with a penchant for it who undergo an apprenticeship to a master teacher within a lineage of initiation to the lore and practice.

The global paradigm is represented by providers who come from a literate culture, in which university training and expertise and technical skill is offered to individuals recruited, selected, trained, tested, qualified and graduated by complex social and ideological mechanisms designed to produce the most suitable candidates.

The indigenous paradigm is culturally situated in the rural areas where virtually free herbal remedies abound and where exchanges, in kind, between farmers is an accepted mode of reciprocity.

The global paradigm is culturally situated in urban areas where expensive imported manufactured pharmaceuticals are available and where the expected form of exchange is cash in commercial transactions for goods and services.

Providers in the Global Paradigm

a. Public Sector Providers.

The government providers appear in many ways to be the antithesis of providers in the indigenous paradigm. The complaints our informants voice about public sector providers, taken as a whole, present a model for health care to which our informants are generally averse. The complaints suggest, by contrast, a standard of quality that we find represented in the recurrent practices associated with providers situated in the indigenous paradigm. These complaints about the government health service facilities can be summarized as perceptions of the customers or health seekers and can be expressed as follows:

Perception 1. The government providers are not easily accessible. Government providers are perceived to be poorly paid with the result that they are often seeking alternative income rather than standing by in a public health service facility.

Perception 2. The government facilities do not have medicines and thus cannot cure patients. Desired medicines are available outside the public sector facility in private sector pharmacies. But the required encounter with private sector pharmacists in addition to the government health service provider is viewed with misgivings.

Perception 3. The government facilities require an immediate lump sum payment, which is difficult for a farmer to make. The failure of government facilities to adapt their payment schedules to the agricultural cycle of their customers and the lack of inexpensive credit for large medical expenses creates hardship for many customers.

Perception 4. The staff of the government facility all seems to need a payment on a regular basis to assure that they attend to the customer. The financial management in government facilities gives customers the sense that the facility is in the business of selling goods and services in commercial transactions, in which profit maximization is uppermost.

Perception 5. The government facilities present an intimidating atmosphere where officials are arrogant and rude to relatively powerless petitioners. The perception that poor sick people are treated with contempt and anger in public health facilities threatens the customers' sense of dignity and autonomy and generates a reluctance to utilize these facilities.

b. Private Sector Providers

The clinic facilities in the private sector (often owned and operated by government providers) present a contrast to the government facilities on a point-by-point basis.

Perception 1. The private facilities are accessible, as they are always open and always have staff standing by.

Perception 2. The private facilities are equipped with staff, equipment and medicines on site.

Perception 3. The private facilities are relatively expensive but they are affordable because they extend credit or delay payment until recovery.

Perception 4. The private facilities are characterized by a home-like atmosphere of caring and attention.

Perception 5. The private clinics compete in the market to attract customers and so they have an incentive to make themselves attractive to health seekers.

Providers in the Indigenous Paradigm

a. The herbalist as a significant provider reflects the importance of self-help and self-medication in Cambodian health seeking behavior. The value in self-medication with herbal remedies is that it preserves the sense of choice and autonomy for the consumer, within a common community lore about natural resources that are free or available at very low cost.

b. The *kru khmer* as a significant provider reflects the importance of feelings of anxiety, fear and dread that are associated with physical illness and affect Cambodian health seeking behavior. The *kru khmer* serves as trusted ally to the health seeker when expert help is thought needed to fend off and appease the anger or vengefulness of supernatural beings. The *kru*'s interventions may accomplish a cure, or may serve as the preparations that are considered necessary to enable other interventions by other providers to be effective.

c. The *yiey mop* as a significant provider reflects the importance of emotional needs for long-term, intimate, warm support during the stressful time of pregnancy, delivery and post-partum recovery. The emotional, physical and herbal interventions of the midwife are aimed at restoring the health and strength of the new mother, often over a six-month period. Families expect that the *yiey mop* may attend each of a woman's pregnancies and then attend the pregnancies of a woman's daughters. The value esteemed here is the life-long relation of trust, compassion and expert care that is generated between the midwife and the families she serves.

d. The aspect of quality care that is highlighted by these traditional healers is that they take the performance of their roles as a sacred duty or a vocation or calling, in the spirit of service to a community. The *kru khmer* and *yiey mop* represent health care providers that attend not only to the physical, psychological and emotional needs of the health seeker, but also to prevailing socio-cultural expectations. This becomes apparent in the character of the payment to these providers. The payments are made in kind and are postponed until recovery. This creates a condition of mutuality and trust between health seeker and provider, which preserves the autonomy and dignity of the health seeker and the esteem of the health provider.

Providers in an Intermediate Category

These are providers we identify on one hand adapt to many of the values and preferences exemplified in the indigenous paradigm, but on the other hand use the techniques and products of the global paradigm.

a. Drug sellers are often an important private provider who makes pharmaceutical products available but dispense the medicines according to the strong customer preference for self-medication and experimentation.

b. Private local *peyt* make house calls and seem generally to be the most favored provider of health care in our case study.

Perception 1. These pets dispense injections on demand. They fulfill the strong preference for autonomy, self-medication, especially with substances that give rapid tonic or "feel-good" effects. They administer modern drugs, which are otherwise difficult for an illiterate villager to choose or obtain. By the act of giving successful injections the *peyt* echoes the highly esteemed work of the *kru khmer*magician who can withdraw sharp objects from the body and shaman who can obtain the blessings of ancestor spirits for a cure.

Perception 2. These pet are very accessible, and are willing to come to the home of the ill person at any time of day or night. They provide attentive, responsive care in a situation where the customer remains in control, in his or her own home surroundings. In this respect, the *peyt* resembles the highly esteemed *yiey mop* in maintaining long-term, respectful relations with the customer.

Perception 3. These peyt accept payment in installments, which makes the treatment very affordable. This provider may defer payment until after the patient's recovery, following the model of *kru khmer*and *yiey mop* in deferring to the judgment of the customer about provider effectiveness.

Perception 4. These peyt present themselves as trusted local neighbors and members of the community who compete with other similar providers to make services available within the customers' frame of reference for quality. The *peyt* attempt to build a practice, a network of long-term relations of trust, and appear to follow a business model of offering a professional service rather than a business model of selling goods, which appears in many government facilities.

Recommendations

1. The recognition and empowerment of providers in the indigenous paradigm would improve their ability to function effectively as referral and screening agents for serious ailments, complementing the modern providers.

2. An increase in understanding of the value of a holistic approach to health, healing and quality of life, which is already acknowledged in the most advanced modern approaches to medicine, should become part of the repertoire of all medical providers in Cambodia.

3. A clarification of the excessively broad concept "*peyt*" should be made through a system of credentialing by testing and retraining and re-qualification, so that customers know exactly what degree of competence they can expect from a provider. Sanctions for malpractice and guarantees of accountability should be a part of any reform effort of this kind.

4. A study of the institutional culture of government facilities could determine why they are not sensitive to competition from private sector providers.

5. A credit scheme that would provide loans for needy patients facing catastrophic illness and huge costs should be considered to avoid driving the poorest patients into landlessness. The success of this initiative would depend on adopting the best and most appropriate practices from the micro credit sector of Cambodian development NGOs.

6. The formation of a health consumers' protection organization should be considered, operated by an independent NGO, which could advocate for higher quality service and receive and mediate complaints about service and charges in both public and private sectors.

7. The formation of a professional association of *peyt* should be considered, including both those working in the private and public sectors. The association could foster interchange between providers and could provide the germ for peer assessment and discipline. Such a professional association at the province level could advocate on behalf of provincial health care providers to MOH and International Organizations and donors. A professional association at the national level could serve as a mechanism to assure the accountability of Ministry of Health officials. These associations would be the likely targets for capacity strengthening efforts.

8. Capacity building in the skills and attitudes of the culturally sensitive public service professional might be considered. Technical in-service training offered to practicing medical personnel might be complemented by training that cultivates an understanding of a medical career as a sacred profession of responsible care giving.

9. If a market approach to medical service is adopted in Cambodia, medical service suppliers should become aware of the need to be responsive to customer preferences and demand. Capacity building for health service policy makers in techniques for assessing customer preferences and customer satisfaction might be considered so that appropriate research can be commissioned and interpreted and so that informed policy decisions could be assured.

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INTRODUCTION

The government of Cambodia has initiated several reforms to produce health services of better quality and lower cost. In order to identify strategies that might increase utilization of public sector health services, it was recognized that information was needed on customer behavior. This information would clarify the choices and decisions underlying the current use of different providers in the medical market.

A qualitative study of consumers' health seeking behavior was contracted to the Center for Advanced Study to investigate the decisions and choices made by families when seeking health care. The terms of reference indicated that the study should explore customer opinions about the quality of services available and obtained and to elicit customer expectations and perceptions of quality and affordability that drives decision and choice making. The research was to use Kampong Chhnang as a case study site. It was considered advisable to investigate any differences in health seeking behavior by location in the province and by socio-economic level and to include both men and women across all adult age categories.

The terms of reference for this study emphasized three related objectives.

1. To examine health seeking behavior of households, in terms of provider choice and expenditures incurred in the purchase of priority services, such as curative care for minor and major illness, antenatal care, delivery, immunization, birth spacing, etc.

We asked where people sought treatment that they needed, what costs were involved and why they chose that provider.

2. To report the opinions of customers regarding their satisfaction, expectations and reactions to services they received from health service providers.

We asked what people felt about the providers and treatments available and what they felt about the treatments they obtained from the providers they consulted.

3. To examine the customers' concept of quality of services.

We asked people to tell us about any virtues and advantages or complaints and misgivings they felt about providers or services. We asked if the interviewees would return to particular providers again and why, or why not.

Progress in implementing reforms in health financing at public sector facilities is at different stages in the case study province. Our study did not attempt to target the catchment communities of particular facilities to assess customer opinion about the reforms or schemes utilized at those specific facilities. Our study provides a more general picture of customer preferences and expectations through out the province.

On the basis of this general picture, planners of health service reform can better determine the options for improving the quality of service in the public sector to meet customer expectations and preferences that our study uncovers. With these insights, policy makers and planners can decide on successful marketing strategies for their reformed services more effectively.

The results of this study, in accord with the terms of reference, provide insights into the socio-cultural dimensions of customer decision making. These insights can inform health service reform planners about the underlying values, beliefs, attitudes and preferences that prevail among the consumer population in the province. These insights will be valuable in identifying realistic options to improve public sector service delivery that lowers cultural barriers to access.

RESEARCH DESIGN

Our study sought sample households on a purposive basis in Kampong Chhnang. We sought informants from the different regions of the province to identify broad ecological factors that could contribute to consumer needs and preferences.

1. We surveyed the flood zone including districts of Chul Kiri, Boribo and Kampong Leng, on the East of the Tonle Sap.

2. We surveyed the hill zone West of the national highway and the railroad line, including the districts of Tuk Phos and Samaki Meanchey.

3. We surveyed communities located along the National Highway, in the urban area in and around Kampong Chhnang town, in rural and urban settings north along the road to Baribo and Rolea Bier and south along the road to Kampong Tralach.

Our sample was designed to include households where house type and possessions suggested that they might fall roughly into poor, medium and rich socio-economic categories. We sought informants from each category to identify economic factors that might contribute to consumer preferences and choices.

We sought out a full spectrum of age groups of both genders in the various ecological and socio-economic settings in order to obtain as wide a representation possible of the consumer public in the case study site for our qualitative purposes. Whenever possible, our researchers sought out pregnant women or mothers with small infants to include in the sample. These informants enabled us to include questions about ante and post natal care and delivery as well as birth spacing knowledge and awareness.

We conducted a total of 122 household interviews with a total of 149 informants. The large majority of informants were Khmer. However, we also included seven Cham families and three Vietnamese families.

Tables that show the distribution of household types in our sample, gender representation in the sample and age distribution of the sample are included in an Annex to the paper.

RESEARCH METHODOLOGY

In this research, semi-structured interviewing was based on an interview guide developed before the fieldwork began. [The guide can also be found in the Annex to

this report]. The interview guide indicated the questions and issues that had to be covered, although the order of the coverage of topics was left to the individual interviewer. The purpose of the interview guides was to have each team of interviewers cover the same issues in more or less the same depth, depending on the knowledge and experience of the interviewee. At the same time, the researchers were urged to follow leads that might expose feelings, preferences, attitudes and complaints, which can only be discussed once rapport, or a situation of mutual trust and respect, has been established.

Our researchers presented themselves as members of an independent NGO devoted to research. We made it clear that we were not connected to the government, or to any International or United Nations organization. We assured every informant of anonymity and tape-recorded the interview only with the express consent of the interviewee. We expressed the aims of the research to our informants as an effort to obtain their experiences and views to provide input to the process of improving and extending the health system.

Our researchers worked in two teams. One team was led by a Cambodian physician, Dr Ouk Piseth working with Ms Chan Kanha, B.A., and Ms In Sokritya, B.A. The second team was led by Mrs. Lim Sidedine, M.A., Professor of Biology at the University of Phnom Penh and included Mr. Heng Kim Van, M.A. and Ms Kin Tepmoly, B.A. These team members have extensive experience on projects involving surveys and interviews in Cambodian villages.

The research was conducted in May and June, when farmers were involved in the intensive work of transplanting rice. A large number of the informants we visited in villages at this time were women or old people. The men we encountered were often sick and unable to work in the fields.

The interviews typically began with a conversation about the most obvious and natural subject at the moment, rice cultivation. Our researchers usually tried to elicit the expected rice yield from the household land holdings in order to verify the socio-economic status of the interviewees. An expected and usual surplus of rice indicated the informant was rich. Just enough food for the family for the year indicated a medium family. An expected and usual shortfall in rice supply for the family indicated the family was poor, for the purposes of our research.

The interviewers then attempted to shift the conversation to the subject of any recent serious illness in the family, or pregnancy and delivery. Following the interview guide, the researchers attempted to gain an understanding of what providers of health care services were known to the household and what services were sought, for what reasons and at what cost.

Uppermost in our interviewing strategy was an interest in probing the reasons some providers were chosen over others and in learning what providers were returned to repeatedly, and what providers were avoided. By understanding the customary and usual health seeking behavior of our informants, we aimed to uncover the values and preferences that underlay those choices.

Some informants who initially agreed to participate in the study withdrew once they understood our detailed aims. Apparently they feared that we were actually government agents, despite our assurances to the contrary. Some informants had to cut the interview short because of some interruption in their attention such as a crying child. Accordingly, the resulting sample is composed of people who were in the

village during the day when we conducted the research, who were willing and able to talk to our researchers for one to one and half hours, and sometimes even longer, to discuss their experiences with health care.

A very few interviews were conducted with individuals who, as became clear during the interview, were not reliable informants. In a very few cases the respondents volunteered the information that they suffered from mental illness. In these and some other cases the informants gave such contradictory and garbled accounts of their experience with health care providers that we were obliged to exclude these interviews from our consideration as we developed our analysis.

It is important to stress that a qualitative study like this cannot answer some questions like "How prevalent is that practice?" or "What is the distribution of that attitude?" Those are questions that can be answered by a second step of research involving a quantitative methodology. But the construction of a useful quantitative survey questionnaire depends on knowing what practices or attitudes are problematic for the purpose at hand. The qualitative research step identifies the significant categories of cultural attitude, values, preference, customary practice and worldview that are present in the population. A subsequent quantitative step utilizing more rigorous sampling procedures could ascertain with precision the actual prevalence or distribution of the attitudes or values in the population, which appear to be important from the perspective of the purposes of the research.

The value of qualitative findings is that they suggest habits, mores and preferences from which the concepts of "quality" of health care held in the culture can be analyzed. This construction of an understanding of concepts of "quality," from the consumers' point of view should, should help service providers fine-tune the delivery of their services to meet customer perceptions and preferences. The recommendations that grow out of this study are intended to inform policy makers as they consider reforms to the health care system in Cambodia to serve the needs of the people, who are largely rural and poor.

Study Findings

INTRODUCTION

The basic distinction that medical anthropologists often make is between traditional and modern approaches to healing. This distinction can serve as a model that we can adapt to organize the presentation of our findings. The modern, or what I call the "global" approach, depends on the use of international standards of manufactured pharmaceuticals and technical skills of trained medical specialists. The traditional, or what I prefer to call the "indigenous" system, depends on herbal remedies and a mixture of natural and supernatural interventions, and is rooted in Cambodian traditional culture.

The practitioners of modern medicine in Cambodia are called *peyt*. International Organizations such as the World Health Organization are actively helping the modern or "global" sector of Cambodian health providers through the Ministry of Health. In Cambodia, prime examples of the traditional or indigenous healers are the *kru khmer*, herbalists and spiritual healers, and the *yiey mop*, midwives.

The interview material we collected suggests that the Cambodian case reflects many of the features medical anthropologists have described in other cultures in regard to the traditional/modern distinction. The global paradigm is defined by an assumption that a systematic, impersonal, naturalistic approach to illness based in the biological sciences should supplant the traditional conflation of physical, mental and supernatural factors in understanding illness and providing treatment. In Cambodia, as elsewhere, the indigenous paradigm is characterized by a holistic view that sees socio-psychological, emotional, spiritual and physical factors of illness and healing as inseparable or intertwined.

The global paradigm depends on medicines and technology produced by global specialists who are involved in a very costly process of research and development, marketing and distribution of their products. The indigenous paradigm depends largely on locally available herbs and other remedies, which are part of local knowledge built up by trial and error over generations. These products of traditional wisdom are available at minimal cost to the patient or to society.

The costliness of modern medicines and the concomitant cost of the training of medical personnel and the construction and maintenance of specialized treatment facilities raise the question how a sound and appropriate health care system can be designed for Cambodia, which enables the poor to obtain essential health services.
These troublesome issues are at the heart of concerns expressed by WHO and the Cambodian Ministry of Health in the terms of reference for this study.

The distinction of indigenous and global paradigms serves our analytical purposes to highlight patterns in health seeking behavior. Understanding these patterns will enable us to grasp the concepts of "quality" of health care that emerge from the material. The concept of "quality" is a factor in decision making and customer preferences that we infer from a mass of interview data. It is our interpretation of the sentiments, beliefs and practices expressed by our informants that they are participating in what we call the indigenous or global paradigm of health care. This tidy distinction is useful for our presentation, but may not occur to a seeker of health care services and providers in Kampong Chhnang. The respondents in our study in Kampong Chhnang are likely to combine any and all remedies available for a treatment. It is we, the outside observers,

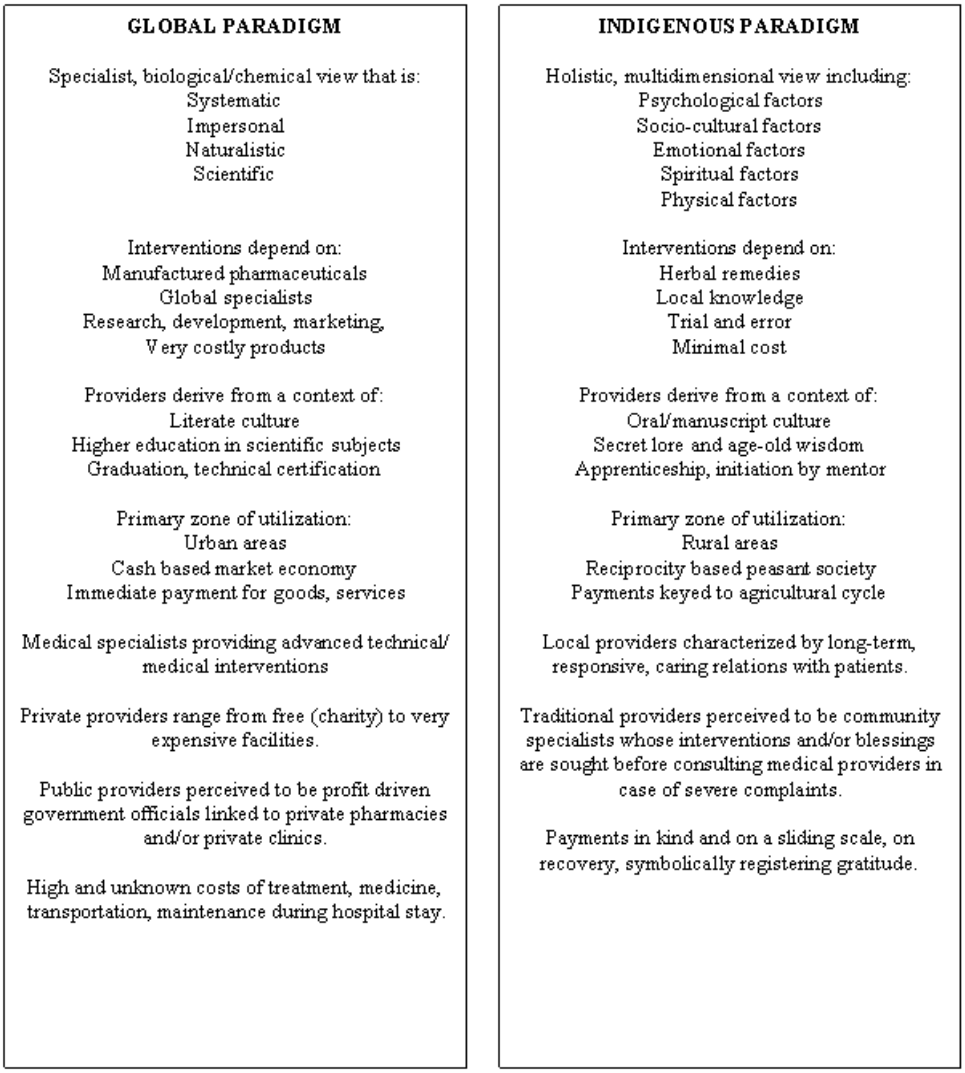
trying to make sense of the patterns we see in the choices of our respondents, who invoke the contrast between traditional and modern healing, or as I have phrased it, between the indigenous and the global paradigms.

Our view will become more nuanced as we discern the contours of "customer preference" in the statements, practices and themes voiced by our informants. We will analyze the concepts of quality implicit in the choices made among providers and in the tendency of customers to return to providers repeatedly and in the statements of satisfaction and complaint voiced by our informants about health care service received.

One narrative strategy would have been to move from village herbalist to provincial hospital physician along a spectrum of increasingly specialized and expensive health care provider roles, which are recognized and named by Cambodians. In this way the derivation of the customers' concept of "quality" would follow from an analysis of socio-cultural dimensions of health seeking behavior within the indigenous paradigm. From the perspective of the Cambodian concept of "quality" care, we would then be able to discuss the complaints voiced about the public sector health services in the global paradigm. These complaints would be intelligible by understanding the point of view of the consumers who use the indigenous paradigm for health care as their frame of reference.

However, since the clients for this report are health program managers in the Ministry of Health, it is probably more reasonable to begin our presentation with the providers in the global paradigm and include an identification of the areas that need to be strengthened. Then we can indicate the virtues and advantages presented by the providers in the indigenous paradigm and conclude with stress on the quality of caring practices that might be transferred to the institutional setting in order to improve trust and confidence in obtaining essential priority health services, which would achieve pubic health goals.

As a guide and summary of the detailed material that follows, we can chart the important differences between the global and indigenous paradigms as follows.



I. GLOBAL PARADIGM

In order to introduce the providers in what we call the global paradigm we will begin with medicine sellers. From there we will move to the *peyt* who provide service in the homes of the family needing health care. Then we will consider the public and private health care facilities available in the case study site. In this presentation the concern uppermost is to provide a sense of the customers' point of view. Our aim is to identify what seekers of health care service consider to be "quality" service. Our focus is on the practices and sentiments that reveal the preferences and aversions of the consumers in regard to health care goods and services that are provided by actors in the private and public sector in the case study area.

A. DRUG SELLERS

An important provider of health service for villagers is the drug seller. These drug sellers often seem to understand the villager's preference for self-medication and low cost and combined treatment with traditional remedies in the case of minor ailments. These drug sellers provide medications to their customers within a mutually understandable framework of self-help experimentation and combination of treatments until an effective remedy is found.

Our informants often spoke of buying packaged or compounded medicines at a nearby shop. Some of these shops were actually variety stores, selling spices and sundry merchandise, including common packaged medicines obtained from larger merchants in town.

[Man, 43, Woman, 39, medium, land zone] *417*
I had a fever and felt cold with gooseflesh. I bought medicine from the drug seller here in the village. It cost 1000 to 2000. The drug seller is a spice seller and has some medicines. They get the medicines from town. The grocery seller goes to Udong to buy cakes and candy. She goes to the pharmacy too and asks the pharmacist to mix medicines for fever, for example. She buys these medicines to sell in our village.

[Man, 50, Cham, medium, water zone] *201*
When my child gets fever I usually buy medicine near my house. It works. We learn from one person and another what medicine to buy from the medicine seller. One or two treatments and we recover. The treatment costs 500 or 700 or 1000. I often get a headache called "receiving head water." Older people say water from the up-lands is filled with animal shit and urine with viruses flowing to lower lands. We use this water and get sick.

The virtue of these medicine sellers is that they are very accessible in the customer's village. They also carry the specific remedies that they have learned their customer's need for the most common complaints of a particular area.

In other cases, our informants mention that they themselves go to the chemist's shop and order the medicines they need for particular ailments.

[Woman, 50, medium, water zone] *173*
When I got sick I got kos khyal *at home from members of my family. Then I bought medicine from a small store near my home. We tell the seller about the kind of disease we have and he compounds the medicine. I am confident in him because his treatment works. If it is a serious disease I would go to the hospital. I went to the commune health center when I had a fever, but their treatment did not work, so I did not go there again. They only have tablets, no injections.*

[Man, 59, rich, water zone] *13*
The drug seller knows how to mix medicine for illness. The patient tells the seller that he is "cold" or "hot" and the seller gives him the medicine. The patient does not say he has a pain in the chest or stomach, just "hot" or "cold."

The virtue of these chemists is that they use the same medical discourse as their customers. The chemist can evidently interpret the description of the complaints in the customer's traditional, humoral terms and can compound a remedy accordingly. The chemist and customer seem to agree that for many common ailments it is not necessary to resort to the elaborate examination, diagnosis and written prescriptions for manufactured pharmaceuticals that would be characteristic of a visit to a *peyt*.

In other cases, our informants report that they prefer to go to a pharmacy, especially those owned and staffed by *peyt*.

[Woman, 66, poor, water zone] *59,*
Some medicine sellers are spice sellers, not peyt. *But I prefer the pharmacy where the wife makes the medicine and the husband is a* peyt. *They know more than the spice seller.*

[Woman, 40; Man, 60, medium, urban zone] *878*
I rarely buy medicines from the Chinese shop. I buy from the pharmacy owned by the peyt *near the health center. The seller keeps the medicine in the sunshine from the East. It*

is not good; medicine cannot keep in the sunshine, that is why I do not believe in her medicines.

[Woman, 20, poor, water zone] *58*
We can recover with the medicine we buy at the pharmacy. But if we don't recover, we go to the hospital. We take a risk. If we have already recovered with the medicine, why go to the hospital? If the medicine of the pharmacist did not work, I would go to another one. The pharmacists are all peyt *or the wives or husbands of* peyt *so they know the names of medicines.*

These *peyt* who have pharmacies clearly cater to the preference of their customers to self-medicate and to experiment with treatments until they hit on a cure. But on the other hand, the fact that they are*peyt* seems to these informants to carry an implicit guarantee that the medicines will be effective because the *peyt* knows how to store them properly and knows how to identify them.

The unspoken hope of these customers seems to be that at the pharmacy their choice of medicines will be wider than at the spice seller and the medicines will be screened and approved by the knowledgeable pharmacist. In this way the customer's impulse to self-medicate and the choice of a particular remedy for a complaint is validated by the pharmacist, especially if the pharmacist is associated with a *peyt.* In this case the extra expense and trouble of a visit to a health facility is also avoided.

The customer preference that is revealed by this use of the pharmacy as a provider of health service, is that choice ultimately rests with the consumer. The customer is free to buy, or not, or go to another provider if one pharmacy's medicine does not work. This emphasis on individual choice resonates with the value these customers place on self-medication in treatment of illness.

The risks associated with this procedure are also understood by some of the more sophisticated villagers. The following informant is a *kru khmer* and private *peyt* who was trained in the border camps in Thailand.

[Man, 33, rich, land zone (kru khmer)] *646*
People buy medicines themselves but they have low education so they use the medicines incorrectly. They don't take the quantity of medicine needed for treatment, so they don't recover. Or they take only once, it makes them feel better, then they stop but they are not cured. In a hospital the peyt *can follow up the patient and the medicine.*

When we consider the response of customers to health care facilities that provide treatment by way of a prescription to be filled at such a pharmacy, we will return to the role of these pharmacies, especially those owned by *peyt* as a profit making enterprise.

B. *PEYT*, PRIVATE AND PUBLIC

The term *peyt* is used by our informants indiscriminately to refer to a practitioner in medicine, regardless of qualification or training or experience. The key capability of a *peyt*, from our informants' point of view, appears to be to give an injection. The gross character of this concept allows graduated physicians, nurses, midwives, paramedics, medical attendants and injection-giving charlatans all to be known by the same professional term.

Our first task is to divide this large category into sub-groups that are more manageable. We follow a distinction our informants make between *peyt* who come to the house of the customer to provide treatment, and *peyt* who practice in their own homes. *Peyt* who make house calls seem to serve poorer clients. *Peyt* who practice in their homes or who have established a private clinic tend to serve richer clientele. Another distinction our informants make is between *peyt* who work strictly in private practice and *peyt* who work in government health facilities and who may or may not also have a private practice. It seems that the *peyt* working strictly in private practice typically make house calls, while *peyt* in government service who practice privately may make house calls, but more likely have clinics at their homes.

1. Private *peyt* who make house calls

There are two striking features of the *peyt* who makes house calls. One is that he is a neighbor who is willing to attend patients at any time of day or night. The other is that he is willing to extend credit to his patients. In these respects, this *peyt* is following a pattern we will discern in the indigenous paradigm, and appears to be satisfying a fundamental customer preference in health care provision.

One advantage our informants emphasize in having a *peyt* come to the house is that it avoids having to make an expensive and possibly unsafe journey to a distant health facility. And it also avoids having to deal with *peyt* at the health facility who are strangers.

[Woman, 86; Woman, 42; Man, 52, medium, land zone] *336*
This child had diarrhea and vomiting. If we went to the district hospital we would have to spend 20,000 or 30,000 on a motor taxi, and we couldn't go at night because the drivers were afraid of robbers. So we went to the private peyt *here. He can come even in the middle of the night. He gave tablets and could inject if we needed to. I don't know where the public hospital is because I have never gone. I don't know the* peyt *there. If we don't know them I wouldn't know how to ask for them.*

Even in fairly remote areas of the province, there are enough of these private *peyt* available that a customer can choose his or her preferred provider and get very quick service. The treatment costs can also be paid in installments. These conveniences apparently discourage many clients from seeking out public sector health facilities. This quote, like many others echoing the same theme, suggests that a concerted advertising campaign should be undertaken to spread an awareness of where health centers are and what services they are now offering and at what price.

[Woman, 20, poor, water zone] *66*
For serious sickness we go to the district hospital for an injection, or we ask the peyt *to come to our house. There are four* peyt *around here. I like S best because he injects well. All* peyt *charge money. If we go to the district hospital it is a full morning walk from here. When we need the* peyt *to come to our house, he comes quickly. If we cannot find one, we look for another one. If we don't have enough money we can owe them a debt for a month. An injection costs 10,000 or 20,000. We give them half, then the other half a month later.*

I don't go to the health center because it is very far away and I don't know where it is. We just go to the peyt *who lives near here who can come to give an injection at home.*

An added convenience of having the *peyt* come to one's home, over going to the health center, is that the patient remains in comfortable, familiar surroundings. This is even

more important for village families with livestock or small children, who cannot easily leave their homes for any length of time.

[Woman, 59, medium, north along road zone] *511*
If I were seriously ill I would call a peyt *to come to my house. I do not want to go to the health center or hospital. It would be difficult for me there. At home it is easy to boil water, and cook rice or porridge. We can eat anytime we get hungry. The price is about the same for the injections.*

An additional attraction of treatment by a *peyt* from the community who can come to the house of the patient is that he can come often to check on the patient's progress. The informant quoted below adds the important factor that the *peyt* will only expect payment once the patient has recovered. The patient and his family are apparently willing to trust the *peyt* to provide just the treatment required for recovery. At the same time the *peyt* apparently trusts that the patient, once recovered, will raise the funds needed to pay the medical costs.

[Man, 43, Woman, 39, medium, land zone] *435*
My family invited a private peyt *to cure at home. He came to my house twice a day if we did not use a serum injection and three times a day if we used an intravenous solution. If he wanted to see if we were well or not he would come by and ask how we were, then he would go back home. Later when the illness is over he will come for payment. I do not know how much it will be. Two bottles of serum cost 38,000 and there are two bottles left. I will borrow money from a relative and sell my chickens and rice for the payment. At the harvest I will repay my relative.*

Many informants from every part of the province echo the view that the private *peyt* extend credit and this clearly enables a farming family to afford the treatment.

[Man, 48; Woman, 42, medium, land zone] *294*
My husband had malaria so I called a private peyt. *He gave serum for three or four days and it cost 200,000 to 300,000. I sold rice and a pig to get the money. The* peyt *let me take time to sell the rice and pig and then pay him.*

[Woman, 54; Woman 32; Man, 35, poor, urban zone] *971*
For a private peyt *we may be cured first and pay later. We may ask for treatment and pay on credit.*

[Man, 59, rich, water zone] *18*
A poor person can go into debt to the peyt *for a month, or until the harvest season. The* peyt *cannot sue them, because they are poor*.

In many respects the private *peyt* seems to have adopted the characteristics of healers from the indigenous paradigm, as we will see. These *peyt* are trusted neighbors, with whom a long-term relationship is expected to develop. These *peyt* will come to help when a neighbor is in distress. The *peyt* is an expert who has access to the tools and products of modern medicine but he deploys them through relations of trust and care giving, on credit when necessary. At the same time, there are apparently enough *peyt* available that customers can choose the provider they wish, so the element of price competition appears to keep the costs fairly standard.

The village *peyt* places emphasis on offering responsive service by making house calls to his patients. In this respect he seems to resemble the way the *yiey mop* midwife functions as a health care provider within the indigenous paradigm. In his command

of the arcane arts of needles and injections, the *peyt* seems to me to occupy a place in villager thinking akin to that of the *kru khmer* magician-healer. Moreover, the *peyt*'s readiness to provide injections on demand, especially serum, which our informants seem to think is a panacea, caters to the preference for self-medication. The desire for serum is probably due to the experience of a rapid tonic effect that is provided by hydration, which traditional herbal teas provide as well, but more slowly.

The village *peyt* is also similar to midwife and herbalist healer in that he readily refers difficult cases for more specialized care in health facilities. Many informants suggest that the village *peyt* serves as a facilitator, helping them obtain the care they need at a local facility. This is a role they can play because they have built up a relationship of trust among their neighbors and because villagers think the*peyt*'s standing provides an entrée to the facility that the villager might not have on his own.

[Man, 43, Woman, 39, medium, land zone] *424*
We don't know about the medicines and what they cost so we give the peyt *what he asks. We can ask him to discount a little. If he asks 13,000 we can ask to pay only 10,000. There are several private* peyt *and they all use the same medicine, but I always invite one private* peyt *to come to my house if we are ill. Sometimes we can recover by his treatment, but sometimes not. But he knows if it is serious and then will send us to the hospital at once.*

[Woman, 42, poor, land zone] *287*
When we get sick we face a difficulty in looking for a peyt *and have no money to buy medicine. We go to the private village* peyt *who can bring us to the commune health center. Although the commune health center has no medicine, the commune* peyt *can write a permission letter to go to district or provincial hospital.*

Private *peyt* also apparently facilitate referrals to the provincial hospital. Our informants suggest that when an illness is too serious to be handled in the village, the case should be sent directly to the province level, bypassing the district level. That suggests that the local *peyt* are considered to have skills and medicines on a par with district level providers.

[Man, 59, rich, water zone] *7*
People stay in the village until the peyt *tells them that the disease is serious, then they have to hurry to get to the hospital. Sometimes the* peyt *goes with the ill person, but usually the ill person goes by himself. Sometimes they avoid the* peyt *at the district hospital and go directly to the provincial hospital themselves.*

[Man, 50, Cham, medium, water zone] *205*
The peyt *of the private clinic come to the patient's house if the disease is serious. If the* peyt *cannot cure the disease, they take him to the provincial hospital for a laboratory examination. I think they charge 10,000 per day.*

To end this section we will offer an illustration of how a poor person makes her decisions on seeking health care from providers available to her.

This informant's first recourse, expectably, is the medicine seller. For her next step, an injection by her local private *peyt* is a reasonable choice, given the cost of transportation to a health facility.

[Woman, 50, very poor, water zone] *114*
When my children get sick I buy medicine in the market or from the drug seller near here. It costs 1000 to 1500. Going to the hospital costs 3000 round trip in transportation. The peyt *in this village studied in the camps. Now he sells medicine and gives injections. One injection*

costs 1500. But other injections cost 2000 or 3000. We call the peyt *in the village to give an injection at home. Each needle costs 1500. He gives two in the morning and one in the evening for three days. I never go to the health center.*

For serious ailment this poor person goes to the district hospital. One of the challenges she faces is that if she wants an injection in addition to the tablets she gets for free, she must obtain them from a pharmacy. She apparently relies on the district hospital staff to make the purchase for her at the pharmacy as it involves the name of a foreign pharmaceutical or the use of a written prescription, which she, as an illiterate person, cannot decipher. The second challenge for her is that she must pay for this purchase in cash immediately. This is a sharp contrast with the arrangement of installment payment that is familiar to her from the village.

[Woman, 50, very poor, water zone] *117*
We told the hospital we are very poor so they gave us medicines to eat. But if we wanted injections we had to go to the pharmacy to buy the medicine, then bring it to the peyt *for injecting. Sometimes the* peyt *will go to the pharmacy for us. We only get an injection with money.*

We can owe the village peyt *for a month or more for the treatment. But if we go to the hospital we have to pay in cash at the time.*

2. Public *peyt* working privately

Many of our informants are well aware that *peyt* who work in the public sector health service also practice in a private capacity and either make house calls or maintain a private practice out of their homes.

[Man, 59, rich, water zone] *3*
We can go to the hospital in this district, but in the village we have a medical doctor who can inject and treat at home. These peyt *work in the commune and district hospitals, but besides their government work they work privately to do injections house by house.*

One peyt *is a midwife who also gives injections at home. Her salary is not enough so she must do private business. It is normal.*

This informant, a former *mekhum*, notes that a patient may first make acquaintance with a *peyt* at a public sector health facility, when the *peyt* is working in his government capacity. But on subsequent occasions, the customer may seek this provider out in a private capacity. In this case the *peyt* may come to the patient's house or the patient may go to the *peyt*'s house.

[Man, 59, rich, water zone] *15*
The patient goes to the district hospital and may get treatment for a day or two. Then he asks the peyt *to come to his house to give the injections. The* peyt *can also give a prescription to buy medicines at the drug seller or pharmacy in town. The medicine is not too expensive if you know where to buy it.*

If a patient has confidence in the peyt*, and got a cure from him before, he returns to him rather than going to the hospital or to town. Also because the* peyt *does not charge too much for the injection. There are many people who know how to inject.*

This informant, with many others, recognizes that competition among the private *peyt* keeps the price for injection service in check. However I sense that this literate person, with easy access to the town, unlike many villagers, can also take advantage of price competition among pharmacies.

Peyt in the public sector who also engage in private practice do make house calls, but often open a private clinic at their home. The treatment offered appears to include staying at the *peyt*'s house if the illness is serious.

[Woman, 33, medium, land zone] *764*
We go to the private peyt *for injections. He works at the district hospital but we go to his house for treatment. Many people go there to his house for treatment. He charges money for the treatment but once injected they become better. If they go to stay at the* peyt*'s house and it is a serious illness it may cost 15,000 [a day?].*

Many informants express a preference to see a *peyt* in his private capacity rather than in the public sector facility where he works. The explanation these informants give is that the *peyt* has access to good medicines, which they provide in their private capacity, but may not provide in their public sector capacity. The cost of these medicines is high, but, as our informants often put it, the price is a reflection of the responsibility or quality of care and the quality of the medicine that the private *peyt* offers. The opinion of our informants seems to be that in dealings with the private *peyt* who are also connected to public sector facilities, the customer gets what he pays for. Our informants are well aware that imported drugs are costly but are of high quality and they seem to trust some private providers to treat them responsibly and give value for money. The element of trust between a client and provider seems to be a key factor in the client's sense of quality treatment.

[Man, 60; Woman, 60, poor, north along road zone] *560*
The peyt *who works at the hospital has the good medicines at his house. In the hospital there are not good medicines. When he injects good medicines for us he charges money, so he must inject good medicines.*

[Man, 43, Woman, 39, medium, land zone] *432*
We could go to the public district hospital but we go to the private clinic. The private clinic is responsible for us, they charge much money because of their responsibility. If the peyt *were not responsible for us they would not cure us.*

[Woman, 50, medium, water zone] *177 I go to the* peyt*'s house. He works at the commune health center. His wife is also a midwife. It is a comfortable place and most people go to his house and not the health center. The health center has only tablets, but at home he has injections. The injections cost 2000 to 3000, including the ampoule.*

One informant maintained that the private *peyt* used superior medicines to effect a rapid cure and would not accept payment if they did not achieve a cure quickly. In contrast, according to this informant, the *peyt* working in the public sector facility have a reputation for duping the customer by using inferior medicine thus postponing a cure and prolonging treatment in order to increase their profit.

[Woman, 49; Man, 19, medium, north along road zone] *713*
They say that the hospital cak bondoh chumngeu *(inject step by step but not curing), in order to take a long time and get more money. At the private* peyt *they are cured soon. At the private* peyt *they set a limit of 15 days or half a month for the cure. If there is no cure within that time, they will not take any money. They dare to bet like this.*

The next two cases illustrate an important difference in the attitude of pubic sector *peyt* who are working in a private capacity. The first expresses satisfaction with

the way the *peyt* from the provincial hospital seems to follow the model of the strictly private sector *peyt* by making house calls and extending credit.

[Man, 64; Woman, 44; Woman 80; Man, 50, poor, urban zone] *1068*
The peyt *works at the provincial hospital but if we feel sick we can call them to come to our house. We can owe them until we have the money to repay them.*

But the second informant tells of her experience in seeking the help of a *peyt* from the hospital who also worked in a private capacity. When this *peyt* arrived at the woman's house and found that she had no money to pay in full for his services, he refused to treat her. This is illustrates quite a different attitude in a private *peyt* than we have been considering up to now. This example foreshadows the attitude often associated with the *peyt* in public sector facilities, which we will discuss in the next section.

[Man, 64; Woman, 44; Woman 80; Man, 50, poor, urban zone] *1080*
The peyt *from the provincial hospital rode his motorcycle to our house to give treatment. But he asked for money before treating. Since we had no money he would not treat. He got back on his motorcycle and drove back home.*

Our informants make distinctions about affordability and access to care that are instructive. The poor informant cited below, for example, suggests that the rich can afford to go to health facilities, while the poor use herbal remedies. But if the poor are willing to spend some money on health care they are free to choose whichever local *peyt* they find suitable, because the cost difference among them is not significant.

[Woman, 63, Woman, 21, Man, 32, poor, land zone] *470*
Commune peyt *and private* peyt *are the same, they all charge money for the treatment, so we go wherever we want. The rich go to the hospital. The poor drink khmer medicine.*

The perception of our wealthy informants is a little different. The informant quoted below has insider knowledge about the provincial hospital because she used to work there in a responsible position. In her view, private sector providers are preferable to public providers. She repeats the general opinion that if a customer can afford it, he or she will call a *peyt* to make a house call. When the rich seek a health care facility they choose a private clinic, while the less well off go to the public hospital.

[Woman, 60, (former staff of KC hospital); Man, 61, rich, urban zone] *788*
The private peyt *always will come to us because they receive a profit when our child or husband is cured. Anyway, the rich prefer to go to the private clinic rather than the hospital.*

In order to explore the opinions about the quality of care available at the hospitals and clinics and to understand basis for customer preferences about these providers, we will turn to an examination of health care facilities.

C. HEALTH CARE FACILITIES

Our informants drew a sharp distinction between private clinics and government health facilities. We follow our informants in organizing our presentation according to these two categories.

1. Private health care facilities

a. Adaptation to local needs

In our interviews among communities in the land zone of Kampong Chhnang we learned of one facility at the district level that was singled out for its reputation in treating malaria. Our informants in this zone frequently travel to nearby forests to cut wood and often complain of fevers on their return. The private facility has apparently recognized the peculiar needs of the locality and has adapted to them. This hospital apparently also extends credit to its customers, following the pattern we noted for private *peyt* in villages.

[Woman, 86; Woman, 42; Man, 52, medium, land zone] *318*
My husband goes to the forest to cut bamboo. But when he returns he has fever. He bought medicines from the village peyt *and got some relief. The treatment cost altogether 100,000. The* peyt *came to give serum. But one load of bamboo only earns 20,000. We spent more than we earned.*

[Man, 43, Woman, 39, medium, land zone] *424*
To go to the private hospital cost 200,000 for 5 days, plus 10,000 for transportation. We are neighbors, so if someone is ill we take him to the hospital by moto taxi, or suspended on a pole between two persons. We go there because all sick people with malaria will recover in that hospital. If they are taken to another hospital they will die.

All the villagers go to the forest two days away by cart to cut wood and we get malaria. We use a hammock with mosquito net, but it is very cold. We buy medicines there from the drug seller as well to prevent malaria. The disease we get is chainh tuk chainh dei *(defeated by or stricken with a disease from change of water and earth; i.e. malaria).*

[Man, 33; Woman, 31, medium, land zone] *625*
If we have a fever we go to the private hospital. They always pay attention to the patient but we have to give them money. When we come back from the hospital, a few days later we have to sell something in order to get money to pay the doctor.

b. Caring attitude

Other private facilities we heard about were located in the urban zone. These providers earn high praise from informants for their caring attitude toward patients. This is an attraction that echoes the way our informants often speak about the manner of the attentive traditional midwife in the village. Our informants also point out that these private facilities have invested in advanced equipment, which seems to inspire confidence in their capability to diagnose and prescribe effectively.

[Woman, 42, (wife of government official) rich, urban zone] *804*
A man and wife, both peyt, *have opened a private clinic here. She worked in a hospital in Phnom Penh. She speaks tenderly to the patients, all patients like her very much. He runs the business very well. He has an echo instrument that makes people want to know the disease inside their bodies. Their son is a* peyt *too and has opened a clinic. Many people go to his clinic because he can choose medicine that can cure the disease quickly.*

[Woman, 41; Woman, 30; Woman, 35, medium, urban zone] *824*
Peyt S is running a private clinic, we can go see him at his house. He does not frighten the patients. He says, "Take it easy, you will recover in two or three days." He always encourages us and never frightens us by saying, "Your illness is serious." He said if I did not feel better, I should come and see him again. He only charged for the medicines, 4,000 or 5000. One day I took my son to see him. He did not give me any medicine but advised me to use wet towels to lower the fever. He does not only expect money.

The last note that the doctor let a patient leave his office without medicine and without having to pay anything suggests that this *peyt* considers the practice of medicine to be

a professional service to a constituency of clients. The *peyt* probably rightly assumes that this attitude, which, as we will see, resembles the attitude of the *kru khmer* and *yiey mop* of the indigenous paradigm, will attract patients back to his practice. In this way he will be able to build a long term and durable relationship with the community, serving its health care needs.

Our informants recognize the important distinction among health care providers between those who emphasize providing a service to a community and those who emphasize the pursuit of money. This is an important distinction among health care providers in the global paradigm and underscores the relevance of the care-giving attitude that is typical of providers we will discuss presently who work within the indigenous paradigm.

c. Convenience and comfort

The relatively more wealthy informants, mostly in the urban zone, expressed a distinct preference for the private clinic over the government facility. The following quote is from a former staff person at the provincial hospital. She speaks of the importance of the greater personal freedom for the patient at the private clinic over the government hospital. Her remark suggests that there are rules and regulations in the government facility that are out of the control of the doctors who work there. When these government doctors open their own clinic they can apparently arrange the atmosphere of the therapeutic situation according to what they think is most appealing to the patients and most effective for the doctor.

The particular aspect of the private clinic that this informant mentions is the freedom to go home during the day. This assumes that the patient lives in Kampong Chhnang. But the sentiment reflects the same preference we have heard so often that people would rather be in their home when they are ill than at a health facility.

[Woman, 60, (former staff of KC hospital); Man, 61, rich, urban zone] *786 [Wife]*
Most of villagers go to private clinics. If they have money they will go to private clinics. In this rich family, the husband is in the military, so we go see the doctor when the husband gets sick. The doctor works at the provincial hospital but has his own big private clinic. People like to go to the private clinic because it is easier for them to go in and out. If they don't want to be hospitalized they can go home and come back at night. In the hospital they cannot do this.

A number of informants indicated their awareness of private facilities in Phnom Penh, which they preferred over the nearby provincial hospital. One urban informant cited below expressed a sentiment we often heard, that a patient needs to have some kind of personal entrée or introduction to gain access to a health facility. This view echoes the remarks of our rural informants. We saw that the private*peyt* often serve the function of personally introducing the patient to a commune facility. We also saw that the government *peyt* at the commune level also perform this function in a less personal way by writing a letter, or permit, for the villager to seek care at higher levels in the public health system.

[Woman, 41; Woman, 30; Woman, 35, medium, urban zone] *812*
When I felt sick I went to the Samdech hospital in Phnom Penh, behind the maternity hospital. I didn't go to the provincial hospital because I didn't know anyone there. But at the Samdech hospital my relative has a medical history card so she could come to the hospital properly and bring me there.

Another very rich family explained how their relatives could facilitate treatment abroad, in Viet Nam. This family of government officials bypassed the Cambodian public and private medical care system altogether when they faced a serious illness.

[Woman, 42, (wife of government official), rich, urban zone] *836*
When we went to Phnom Penh, one time we had to pay about 30,000 for transportation and $100 a day and night at the Chinese hospital. My husband has liver problems. We also went to Vietnam and spent $400 or $500 for two or three days. We had a relative living in Svay Rieng who took us there by taxi, which cost $20 round trip.

d. Alternatives and costs

Many of our urban informants have also realized that the Kantha Bopha hospital in Phnom Penh offers services that rival both what is available at private clinics and the provincial hospital in Kampong Chhnang. In the first quote below, a higher cost was incurred at the local private clinic, with what was perceived to be lower quality care, than at Kantha Bopha. Kantha Bopha evidently offers free service, and the only cost to the patient is transportation and maintenance away from home.

[Man, 35; Man, 48, medium, urban zone] *1000*
We learned of Kantha Bopha from what neighbors said. I first took my child to a private clinic in Kampong Chhnang but the treatment was not effective so we went straight to Phnom Penh. If we had gone to the provincial hospital we would have had to pay a high price for the treatment.

We wasted a lot of money at that clinic where we spent 500,000 for a week. But at Kantha Bopha it cost 200,000 for transportation and food. When the peyt *at Kantha Bopha saw the serum that had been given by the clinic in Kampong Chhnang, which had been donated by an organization, they pulled it out and replaced it with their serum. They said that the serum was not correct for dengue.*

A poor family, also from the urban zone in Kampong Chhnang, explained that their choice would have been between the government hospital and Kantha Bopha. This family stressed the difference between a welcoming reception they would expect at Kantha Bopha and the demand for money that they could expect at the government hospital. It is difficult to determine from this informant's account to what extent a decision to go to Kantha Bopha would have been driven by a difference in cost or by the difference in attitude prevailing in the two institutions.

[Man, 64; Woman, 44; Woman 80; Man, 50, poor, urban zone] *1077*
People prefer to go to Kantha Bopha hospital in Phnom Penh, they do not like to go to the provincial hospital. They welcome us warmly at Kantha Bopha hospital and we pay only for food. At Kampong Chhnang hospital, if we have no money they ignore us.

The combination of factors of money and attitude are brought up again in the next quote. This informant was clearly impressed that an attitude of care and service predominated over a concern for monetary gain at the Phnom Penh facility. This was evidently a contrast with what she had experienced at the Kampong Chhnang provincial hospital.

[Woman, 35, medium, south along road zone] *1188*
At the Pediatric hospital I wanted to give money of thanks, 10,000, to the peyt *who cured my child. But he said he could not take the money because my house was far away in Kampong Chhnang and I needed the money for transportation. I did not believe that he would not take the money I wanted to offer him in gratitude for his care, after all the money I had spent at Kampong Chhnang Hospital. But before I left there I had my mother buy two bunches of*

bananas and a kilo of apples, which I gave to him and he took the fruit from me. Next time if my child gets sick I will go directly to the Pediatric hospital. I will not go to Kampong Chhnang hospital again.

This informant wanted to find a way to acknowledge the caring and considerate way she and her child were treated at the private facility. She expressed herself in the traditional vocabulary of an offering of gratitude and respect to a trusted healer, with whom she expects a durable relation will grow.

As a transition to the next section we note a remark made by a family in Kampong Chhnang. Before they went to the public hospital to seek treatment, they undertook a spiritual preparation to appease spirits and enlist their support in the effort. These sentiments are quite understandable in terms of the outlook we will describe as the indigenous paradigm, although here employed in the city at the main public sector facility in the province.

[Man, 49; Woman, 48; Woman, 17, medium, urban zone] *1050*
When we go to the provincial hospital we have to buy a bunch of bananas to give to the spirit near the hospital and a candle and incense for the bodhi tree at the south of the hospital.

2. Public sector health care facilities

Relatively few words of praise were heard from informants concerning the government facilities as providers of health care. This contrasts, as we have seen, with the willingness expressed to seek the service of government *peyt* acting in their private capacity rather than in their government capacity. This suggests that there are systemic problems in the facilities and their management that accounts for the generally low esteem in which the government facilities are held by our informants. A closer look at the institutional culture of the government facilities is likely to identify the problems. But that was outside the scope of this study.

The complaints about the government facilities, which our informants voice, are complicated but they seem to consist of several interwoven concerns or uncertainties about these providers. We will organize the material we collected from our informants under the following five general categories, although there is much overlap among them:

a. An uncertainty about the staffing in the facility.
b. An uncertainty about the medicines in the facility.
c. Reactions to the costs at the facility.
d. Misgivings about the service in the facility.
e. An uncertainty about the changes underway at the facilities.

We will separate the complaints according to the commune, district and province level of the facilities discussed.

a. Uncertainty about the staffing in the facility

One of the strongest complaints we heard voiced was that the government *peyt* were often not on duty at the government facility in the commune or district, so the patients in need were obliged to resort to a private *peyt*, or to public facility like the provincial hospital where they could be sure someone would be on duty. The perception of informants is that the *peyt* is difficult to find at the commune health center because he is either at home or out on house calls in a private capacity or he is tending to his farm.

[Man, 43, Woman, 39, medium, land zone] *422*
There is a commune peyt *who would come to our house to inject if we called him. If we went to the commune health center we would never find him there. He is always at home. If we need him we seek him at his house. But sometimes we cannot meet him because he has 2 or 3 houses. So when villagers are ill they go to the district hospital.*

[Woman, 42, poor, land zone] *286*
I can meet the private peyt *if I go to his house. I am afraid of not meeting the commune* peyt *at the health center and his house is very far away. And they have no medicine for diarrhea at the health center. They only give drop medicine for children, otherwise they farm their land.*

Another informant notes that the health center has been reorganized in its scheduling and fees, but he observes that he could only find the *peyt* work in a private capacity at home.

[Man, 54; Woman, 26, north along road zone] *539*
When I felt dizzy and numb srep srep, prang prang, *as if a scorpion bit me, I went to the health center. They work on Monday and give medicines. We pay 500 for this prescription and they give the medicine for free. When the prescription is over we have to pay 500 again. They don't work the other days of the week. If we need medicine on another day we go to the* peyt *'s house. That may cost 1000 or 2000.*

The following account draws the familiar contrast between the private *peyt* who are responsive to their clients and the government *peyt* at the commune level who does not pay much attention to his duties.

[Man, 48; Woman, 42, medium, land zone] *295*
The private peyt *come immediately after they are called. The commune doctor comes into the health center for a minute and then goes out. He pays no attention to the health of the villagers.*

Another informant points out that not only is it difficult to find the commune *peyt* at the health center, but in addition the commune *peyt* might not have the medicines needed at an affordable price. As a result, this informant expresses the preference to call a private *peyt* who is considered much more responsive and reliable.

[Man, 43, Woman, 39, medium, land zone] *447*
If the peyt *stands by the commune health center we could find him. If we carry a patient between two persons, and arrive at the health center we don't see the* peyt *so we carry him back. There are 10 villages on the way, we don't know which village the* peyt *will be in, because he doesn't stand by in one place.*

If we go to the commune health center we have to buy the medicine ourselves and it is 3 km away. It has no ability to cure patients. If we go there we may meet the peyt *by chance but sometimes we may not meet him. At the commune health center we have to buy the medicines that they get from the government. So instead, we call the private* peyt *who lives near here and who buys his medicine in Udong. He would come even at midnight. If we went to the commune health center at night we would have to walk with an oil lamp to get the* peyt.

The alternative for some villagers is to go to a private clinic at the commune level, since they do not expect the government *peyt* will be standing by at the health center, but will more likely be working in his fields. This woman makes the important point that her decision about providers is between reliable private providers who may be

more expensive, and government providers who might be less expensive but are inaccessible.

[Woman, 27, medium, south along road zone] *486*
If we need treatment in a hurry we must give some money to the peyt *for an injection. If we go to the commune health center the* peyt *is not there. They are busy earning their living farming. But if we go to the private clinic we can meet them every time. The private* peyt *charges 30,000 for a serum and the government* peyt *charges 20,000. The private* peyt *come from the border camps.*

At the district hospital level some informants expressed great dissatisfaction with the level of care available. Here are the words of a rich retired commune chief who rails against the lack of time-discipline among government staff.

[Man, 59, rich, water zone] *31*
The trouble with peyt *is their working hours. Some time the* peyt *is not in the district hospital when the patient comes. When there is no patient staying at the district hospital, the* peyt *do not stay there. They do not respect working hours. So when we need the* peyt, *we go to his house.*

When villagers come from very far to the district hospital and find no peyt *on duty, they get angry. But as well, there is no medicine in the district hospital either. The* peyt *uses strong words with them so that they will follow the discipline of the hospital, but they do as they want to in their homes. So the* peyt *scolds them and that makes them mad. Actually the* peyt *is trying to advise them.*

If the government made the district hospital a real hospital with equipment, we would have to change the habit of the peyt, *to make them go to work on time.*

These district *peyt* are probably not standing by at the hospital because they are engaged in private practice out of their homes, as our informant suggests.

We have a comment from a Cham informant and a Vietnamese informant who both echo the sentiments we have heard from Khmer informants. The common complaint is that the government *peyt* take a very long time to attend to patients. Accordingly, patients often decide to self-medicate or to seek the service of a private *peyt*.

[Man, 50, Cham, medium, water zone] *203*
People don't like going to the hospital. They say, "Don't go to that hospital, it is a waste of time. You could spend that time doing another job, you should buy medicine at the market, spend less money and the medicine is good." If the work at the hospital is not done quickly, people will go elsewhere. But they do not charge at the hospital.

[Man, 59; two women, Vietnamese, medium, water zone] *243*
We are afraid of the government peyt. *If we go to their place we have to wait until we stop breathing for them to arrive. It is better to go a private* peyt *who will take care of us immediately. We can pay back the money to the private* peyt *by our labor or with money after the fishing season. With the government* peyt, *if you have no money they will give no treatment. And we have to wait for a long time. We get sicker waiting until we are willing to spend 10 or 20 or 100 thousand. If we go to the commune* peyt *we would die waiting for him. So we are willing to go to the private* peyt.

b. Uncertainty about medicines in the facility

The second major area of complaint about government health facilities is that they do not have medicines or equipment on hand. This is a perception that informants voice about public sector providers at the commune, district and provincial level.

An informant from the land zone voices a common perception that the commune *peyt* is actually just a village drug seller who also provides immunizations for children.

[Woman, 42, poor, land zone] *275*
There is a public peyt *from the commune who comes to give drop medicine to the children. He doesn't cure diseases of adults. They have no medicines at the commune health center. I buy paracetamol medicine at the private* peyt*'s house for 500.*

A woman from the water zone, whose son was accidentally wounded with a knife, voices another widespread complaint that the commune health center does not have basic emergency equipment like needles and sutures. In this case a private *peyt* was able to give an injection, although he was not able to close the wound. He did save the patient a futile trip to the health center and he could refer the patient to the provincial hospital.

[Woman, 50, medium, water zone] *76*
My child cut his leg and we went to Kampong Chhnang hospital. We couldn't take care of it here in the commune because they said they had no needle for sewing the wound. The peyt *came to give an injection, but had no needle. The* peyt *said the health center also had no equipment, so we did not go there.*

Informants from the urban zone also mention the function of the commune level *peyt* as essentially a referral mechanism within a medical bureaucracy, in the likely case that the commune level facility does not have the needed medicines.

[Woman, 40; Man, 60, medium, urban zone] *873*
If the peyt *says the commune hospital has no medicine they should go to the provincial hospital, he can provide a letter. The patient can go with or without the letter, but with the letter the* peyt *will think that the patient follows the hospital line.*

Other informants from the urban zone indicate that the commune health center may have effective medicines, but they are kept by the *peyt* for his private practice. According to the perception of these informants, lower quality medicines are offered to patients who approach the commune facility *peyt* who are serving in their public sector capacity.

[Man, 64; Woman, 44; Woman 80; Man, 50, poor, urban zone] *1092*
There are no good medicines at the commune health center. They injected us with bad medicines, which are not effective. Now we no longer trust the commune health center. They often hide the supplied medicines for their own interest. And they give us three pills for 500.

Such views as this suggest a deep suspicion about how the *peyt* are able to manage the division of their attention between their public sector practice with the government and their private sector practice for their own profit. This suspicion of divided motivation apparently does not arise in the case of commune level private *peyt* since they have no connection to government. As we saw, there is a strong customer preference for the convenience and responsiveness of these private *peyt* who make house calls. The

forthrightness of their position in private enterprise and the competition with other private*peyt* evidently provides the incentive for them to respond to their customers with speed and attention in a way that *peyt* in government cannot achieve.

The government *peyt* who practice privately may be able to compete with the strictly private *peyt*. But the government *peyt* conducting his private business arouses the suspicion, reflected in this quote, that he may divert public goods to his private profit, which undermines confidence in a visit to the government facility. A risk that emerges from these considerations is that government *peyt* might use their positions in the public sector facility to make initial contact with patients and then steer them towards their private clinics for future treatment. In which case, these *peyt* would have no incentive to make the public sector facility particularly appealing to customers.

Complaints about lack of medicine and equipment are also voiced about the district level government facilities. This rich and quite knowledgeable informant is suffering from TB and has much experience with health care providers available. He points out a number of reasons that villagers avoid going to a district facility and go instead directly to the province hospital for treatment.

[Man, 59, rich, water zone] *3*
When villagers are sick they have to go to the provincial hospital because the district hospital has no equipment. They have no O_2 for respiration, no blood testing, or parasite testing. They can take our temperature, that is all. But it takes so long to get to the hospital that the disease gets more serious.

If the district hospital were well supplied people would go there and not have to go to the provincial hospital.

The arguments and complaints our informants make about lack of medicine at the provincial hospital seem to have two main points. On one hand, the hospital claims it has no medicines, so they must refer the patient to a pharmacy to get a prescription filled. The pharmacy is a separate entity in the market, although it may well be connected to the *peyt* ordering the medicines. But the customer seems to feel that this division of responsibility for his treatment between a government entity and a private entity increases the uncertainty of obtaining affordable service. On the other hand, if the hospital has no medicines, the patient concludes that it is not competent to cure his illness, so he goes to a private clinic, perhaps owned by a government *peyt*. The private sector clinic has medicines on site and this evidently makes the customer more confident that the facility will take responsibility for providing effective treatment.

The first view that treatment may become unaffordable since it involves costs at two different places can be illustrated by the remarks of an urban family. They indicate that both the doctor at the hospital and the pharmacy require full payment at the time of sale or service.

[Woman, 40; Man, 60, medium, urban zone] *873*
If we don't have money we cannot go to the provincial hospital. I don't mean that the peyt *is the only one who asks for money. They will give prescriptions for medicines because they rarely provide medicines themselves. Then they will help us take the medicines we obtain from outside. They charge 2000 to inject.*

The aspect of affordability emphasized by our informants was the suspicion that the *peyt* and the pharmacist could collude with one another to dictate costs to the customer.

[Man, 59, rich, water zone] *21*
She went to the peyt *in Kampong Chhnang who works at the provincial hospital. He said the hospital did not have the medicine for her, so he directed her to go to buy the medicine at his pharmacy in town. His daughter works in the pharmacy.*

[Man, 35; Man, 48, medium, urban zone] *1026*
The peyt *at the provincial hospital have their own pharmacies and send us to buy medicines at their pharmacy. If we come back with medicine we bought at another pharmacy they say it is the wrong medicine. Only when we buy medicines at their pharmacy will they accept to cure us. It is like that. They have to give us a prescription and we need to buy the medicines outside and bring them back to the same* peyt *to cure us. It is really true.*

The second aspect of uncertainty about the facility and its supply of medicines can be illustrated by remarks from informants who recently visited the opening of a new commune health center. In this locality, the former pattern in which the old commune facility had no medicines has been replaced by a new system in which the commune health facility staff has medicines to provide for a flat fee. But this informant notes that the government *peyt* sell medicines in a private capacity, after working hours, at home. This is a familiar pattern at the commune level, as we noted above.

[Woman, 70; Woman, 33; Man, 45, rich, land zone] *352*
When we get sick and had fevers, we always went to the provincial hospital. The commune peyt *had no medicines. We go to the provincial* peyt *who writes down the name of medicines to buy at the pharmacy. The new commune health center has three people standing by, a women midwife and two male* peyt. *It is newly built and all the rooms are very cool and smooth. We spend only 500 for any medicines. The commune* peyt *makes a living selling medicines at his house during the night.*

Another informant makes the point that the government facility usually only gives prescriptions to buy medicines outside. However, if the customer is willing to pay a premium price, the government facility will obtain the medicines needed for treatment. In this case it would seem that the government *peyt* are acting in a private capacity, but within the framework of the public sector facility.

[Man, 43, Woman, 39, medium, land zone] *433*
The government hospital or health center does not offer medicines. The peyt *writes a prescription for the medicines we have to buy ourselves. They don't cure us, that is why we do not go there. But they will cure us if we have money to give them like 500,000 or 600,000, depending on the disease.*

The extra step in treatment at a government provider that requires the customer to go out to buy his or her medicines at a pharmacy after diagnosis and then return for treatment apparently convinces some customers that it is preferable to go to a private clinic. The virtue of a private clinic is that the extra step is eliminated, diagnosis and medicines and treatment are all available in one place.

[Woman, 27, medium, south along road zone] *483*
The public hospital has no medicines. They give a prescription for us to buy medicines outside. Then I went to a private hospital.

[Woman, 60; Man, 31, poor, north along road zone] *729 [Son]*
In the hospital they do not give as good care as the private peyt. *If we have money to give them, they will give good care, if no money, then not. In the private clinic they give very good treatment so we do not go to the provincial hospital. In the hospital we have to buy medicine, which they order us to get from the pharmacy, 200,000, 300,000, but we do not have the*

money. If we do not have the money, they leave us to die in the hospital, that is why we do not go there. It is better to get treatment in the private clinic and the peyt *there is also working for the hospital.*

c. Responses to costs in the facility

The third area of complaint our informants voice regarding the public sector health care providers has to do with an uncertainty about the costs that will be involved. Another way our informants express this uncertainty is that they doubt the legitimacy of many of the expenses. This combination of uncertainty and suspicion seems to indicate a deep mistrust of the government health providers by consumers.

At the commune level, this mistrust is expressed in the belief that the government *peyt* will adjust treatment to prolong the illness in order to maximize his income.

[Man, 35; Man, 48, medium, urban zone] *1021*
The peyt *at the commune hospital will come to the house to give injections, but he does not use effective medicines. That kind of injection is called* cak pras*, it takes a long time to inject in order to gain more profit. [*pras*means to assist some one out of danger, but it also means to keep an animal alive for slaughtering later].*

This peyt *gives two bottles of serum for 25,000 but sometimes he gives serum without adding medicines. Only someone who knows this trick will watch what he is doing and will get the medicines. His activity cheats us so much.*

Our informants are generally aware that the service at the commune health center is supposed to be free or is provided at token cost. But informants seem to mistrust these assurances and worry about the unknown costs that they will probably be asked to pay.

[Man, 60; Woman, 60, poor, north along road zone] *554*
The health center does not charge money but I never go there. We dare not go there. How can we go if we have no money? I am afraid they will charge money and we are poor. They will charge if the medicines are good.

We have to bribe the peyt *to get treatment. We have to say, "If I recover I will give you the money you want." When he has our money in his pocket he stays near us to give us care and if we are still ill he will write a medical letter [referral] for us.*

The oldest informants can compare the government health care system at village and commune level now with what they remember from the 1950's and 1960's. This informant mistrusts the excuses the commune *peyt* gives for the prices he charges because she can compare the prices charged by the private *peyt*. This comparison obviously drives business toward private *peyt*, as we have noticed several times above. But it is not really clear why the commune *peyt* is insensitive to the price competition for his services.

[Woman, 86; Woman, 42; Man, 52, medium, land zone] *350 [Old Woman]*
In the French colonial regime and Samdech Ouv regime the peyt *came to look for the ill people at their homes. Now we have to call them to come and cure our disease. In the past they did not demand money from sick people. Today they say that the remedies are expensive and that the commune must spend money on transport from the district hospital. But the private* peyt *get medicines from the district too and they sell us medicines at a reasonable price. We have to spend money on medicines and needles.*

When we turn to the provincial hospital, we find the same kind of mistrust that was expressed about the commune facilities. This is the way an individual who has insider knowledge about how the hospital works explains the treatment scenario. Many other informants suspect that treatment in a government facility is contrived to increase income to the provider and this suspicion clearly drives many customers to the private sector.

[Woman, 60, (former staff of KC hospital); Man, 61, rich, urban zone] *788*
It is faster to get cured at private clinics. It is difficult to say why people go to the government hospital. For example if a child has a fever and the mother brings the child to the hospital, she must say she will give money to the nurse to help her child if after two or three days of treatment the child has not recovered. The nurse knows the medicine for the fever but she doesn't tell. It is a trick in business.

Another rich and educated person describes the attitude of the hospital toward poor patients. His suspicion seems to be that the hospital will provide service to paying customers but it will not give its goods and services away to needy people who do not have the means to pay.

[Man, 34, rich, (teacher) south along road zone] *1207*
When a neighbor has a serious disease I accompanied them to the hospital. The physicians seemed to ignore us when they knew we had little money. They did not take care of us, so we took him back home. He later died at home. In case we are well off, we can offer the peyt *some money so that they can help cure us. If we have no money they don't pay attention to us.*

Many of our informants repeat the same observation that the provincial hospital does not want to admit poor patients. This informant mistrusts the *peyt*'s calculation of the cost of the treatment, which the customer has no way of rechecking. In the hospital there is apparently no way to get a second opinion or to do comparison shopping, as there is in the private sector.

[Man, 54; Woman, 26,medium, north along road zone] *542*
At the Kampong Chhnang hospital they don't care whether we have money or not. If we don't have money they won't treat us. Only the doctor who treats us charges any money. You cannot go to the hospital without money. They charge you after diagnosing like 100,000 or 200,000, it is up to them. If you go there without money, you will die.

Another informant indicates that once a diagnosis is made and an estimate of the number of hospital days needed for treatment is made, the hospital requires a lump sum advance payment against the estimated expenses. This sounds like a policy in the facility that would protect it against loss. But such a calculation would be likely to confirm the suspicion that the customer will be kept at a disadvantage in the public sector facility in regard to understanding how the costs for treatment are determined.

[Woman, 60, (former staff of KC hospital); Man, 61, rich, urban zone] *787*
One child drank petroleum and had difficulty breathing. The hospital suggested the child should stay 3 days and required a deposit of 30,000. But the child recovered in one day so the hospital only charged 10,000 and returned 20,000.

This lump sum payment policy has apparently been changed recently with the introduction of a scheme of user fees. The hospital now has a system of charging at the end of treatment and allows payments by installments. The informants we spoke to in this research were unaware of these changes. A close look at the actual hospital practices was outside the scope of our study.

Other informants indicate that once initial payments for the prescribed pharmaceuticals and for the hospital stay are paid, and the patient is admitted to the hospital, there are other fees to pay as well. The misgivings associated with these additional payments seem not to be due primarily to the amount of the fee, but to the fear that if the payment is not made the quality of care one receives may decrease. The customer is placed in disadvantaged position in a public sector facility because the assessments for care are decentralized and that leads uncertainty for the customer about what the actual costs will be.

[Man, 46, medium, land zone] *399*
We gave money to the peyt *for x ray when I had pneumonia. By law they don't get money but I am grateful for that they help to save my life. We know we are afraid by ourselves and we asked them to help us. If we didn't give them some money we would be afraid they wouldn't take care of us. So we must pay a little bribe.*

[Woman, 54; Woman 32; Man, 35, poor, urban zone] *962*
At the Kampong Chhnang hospital we have to pay every shift. If they give an injection we have to pay that peyt *immediately. We may leave the hospital when it is not their shift and they would not know, so we have to pay them at once.*

[Man, 35; Man, 48, medium, urban zone] *1002*
At the provincial hospital we have to pay the nurses at every shift about 3000. No one commands us to pay, but if we do not pay them they turn a blind eye toward us, they ignore us, but if we pay they focus on us.

Informants also report additional assessments, for electricity for example. This is apparently added to the standard hospital fee and the costs for any injections needed. In addition to these costs at the facility the customers from outside the town have to pay for their maintenance. This is an account of a family that came from the East Side of the river in the water zone to seek care in Kampong Chhnang hospital, after treatment in a commune health center.

[Woman, 50, medium, water zone] *77*
We went to the health center when a child had three boils. The peyt *gave two injections and tablets and asked for 10,000. Then we went to the Kampong Chhnang hospital. They operated on the boils, and now the child has a permanently bent arm. It cost 100,000. That is 10,000 per day, plus they asked 1000 a day for electricity from each patient. After the operation I asked them to give an injection for strength, it cost 2000. In addition it cost 120,000 to 130,000 for food and transport for the ten days. I had to borrow a boat to get there.*

We have seen that government *peyt* who have their own private clinic are able to grant credit to their customers for the medicines, health care and stay in the private facility. The next quote indicates that there is also some possibility for unofficial credit to be extended for medicines at the public hospital. But the hospital clearly maintains an advantage over the customer, because it can prevent the patient from leaving until the bill is settled.

[Woman, 35, medium, south along road zone] *1172-3*
The peyt *wrote a prescription for my uncle at the Kampong Chhnang hospital. I walked about 10 meters away and the* peyt *said that I should not go outside, but should buy the medicine in another room of the hospital. I told the* peyt *that sold the medicine that I had no money and I asked her if I could owe her or not. She agreed but asked me to put my fingerprint on a paper. She was afraid I would not pay her back. The* peyt *will not let the patient go home from the hospital unless we pay the* peyt *back. Kampong Chhnang hospital does this.*

A rich woman with military connections made a similar observation about hospital financial policy. The hospital evidently has the power to refuse to discharge a patient until all payments have been made. The atmosphere of distrust in the hospital facility towards the customer clearly annoyed this informant. She seemed to expect that her social status should have protected her from doubt about her ability to pay. The lump sum payment and the power of the government hospital to detain a patient would seem to create an intimidating atmosphere for most customers.

[Woman, 41, (wife of army officer), rich, urban zone] *851*
If we step into the hospital we may have to sell paddy to get treatment. It is terrible, if we are injected already but we have no money to pay them, we are not allowed to come out, until we find the money to pay.

Another example an informant gave about facing difficulty leaving the hospital had to do with her decision to seek care at a private facility. The fear the customer initially felt towards the *peyt* and the anger she finally felt about her experience in the provincial hospital seem to result from misgivings the mother had about the relation of cost to quality of treatment provided for her child at the government facility.

[Woman, 35, medium, south along road zone] *1182*
My child was in the Kampong Chhnang hospital for three days but did not recover and still had a high temperature. I was very worried about his illness so I was not afraid of the peyt *any longer. I asked what disease he had and why he still had a fever. I said I wanted to leave, but the* peyt *said my child was nearly recovered and that I must not leave. I got angry and said I wanted to leave and if they did not allow me to leave I would escape and go to the children's hospital, Kantha Bopha. After this he agreed and wrote me a medical letter.*

d. Misgivings about service in the facility

The fourth area of uncertainty and doubt in regard to the government health care facilities has to do with perceptions about the care available or the attitude of the care givers.

At the level of the commune health center a number of informants had complaints about what they perceived might have been mistakes in treatment. But they were generally unwilling to formulate their impression as an accusation, as if they feared confronting the *peyt*'s power as a government official.

[Woman, 45, medium, north along road zone] *523*
My sister's child just died. After they injected him, he died. He was a month old, the peyt *wanted to inject to be good and I couldn't blame them. Before the injection he wasn't sick but they gave tetanus vaccine and he got a reaction. He got a fever and convulsions. It was at the commune health center, but I don't want to blame.*

Our informants also expressed a fear of offending the commune *peyt* by returning for additional treatment if a first treatment seemed not to suffice. This informant indicates that she was not explicitly invited to return, so she felt if she did return her action might be interpreted by the *peyt* as an intrusion. The underlying fear here, as above, is of offending a government *peyt* by raising a question about his treatment.

[Woman, 40; Man, 60, medium, urban zone] *875*
After taking the medicines from the peyt *at the health center, my son was not better from the fever. I did not go back and tell them because I was afraid. I was afraid they would blame me for disturbing them. It was my thought, they gave me some medicine, I don't want to make*

difficulty. If they had told me to come back in case of any difficulty I would, but they did not say that. So how could I go to disturb them?

At the district level the same kind of complaint is voiced about the government providers' lack of a welcoming attitude. In addition to the lack of supplies and a concern about the cumulative costs for every service, which we have already discussed, these remarks add a perception of unfriendliness or an uncaring atmosphere at the government facility when a customer has no sense of personal rapport with the care givers.

[Man, 35; Woman, 40, poor, north along road zone] *600*
I would not go to the hospital near the primary school because if we have no money they will not take care of us. They are unfriendly. They do not want to take care of us. Many people prefer to go to the private clinic, but we must spend more money.

[Man, 60; Woman, 60, poor, north along road zone] *571*
The hospital near the primary school does not take care of us. They tell us to look for another hospital because we will not recover there. Their medicines are not effective. When my aunt went there unconscious the peyt*said that he had no effective medicine and that we had to buy effective medicine for him to inject. They looked at our face and ignored us. They said they had no medicine and the* peyt *had gone out. We took my aunt to another* peyt*'s house for the injection, she works at the hospital too. If we don't know the* peyt *or someone who works there it is difficult to get treatment. If we do not have money and do not know anyone there they will ignore us.*

I stayed at that hospital near the primary school for four or five days. They are bad. I just see the peyt *who work at that hospital and I hate them so much. They are ineffective in curing people. We don't recover and we have to pay them money. The* peyt *ask for money for medicine. I gave him 40,000 to 50,000. If we had no money we would die. Without money they will not inject us.*

The remarks above refer to a facility in the north of the province. The following quote refers to a district facility in the south of the province.

[Woman, 63, Woman, 21, Man, 32, poor, land zone] *473*
There is a public hospital in the district but they don't care for ill people. The private hospital in the district is very different. They take great care and we can pay the money later on. They are from the border camps.

The private hospital mentioned here is the facility that specializes in treating malaria, as we learned in our earlier discussion of private facilities.

The attitude of the health care providers at the district level seems to induce the same kind of fear in patients that we observed at the commune level. It is if there were a power asymmetry in play in the interaction with a government *peyt* in which the customer is made to feel intimidated or at a disadvantage in relation to the provider.

[Woman, 20, poor, water zone] *43*
I don't go to district hospital although I know there is a woman there who helps with deliveries. I am afraid I would speak wrong and that makes me feel shy and afraid. If I asked her anything I am afraid she would blame or scold me. I received a tetanus injection there. They said I must be injected three times. I have had it twice, but the third injection day has not arrived yet.

At the provincial level we find a wide range of complaints about the quality of care available at the facility. One informant, for example, drew attention to the lack of cleanliness of the hospital room. She apparently had to clean it herself.

[Woman, 50; Man, 42; Woman, 36; Man, 17, Cham, poor, south along the road zone] *1288 The* peyt *only know money. We spent much money to buy ice, goods and getting a remorque from home to the hospital. We slept on the floor on a mat and pillow I borrowed from relatives in Kampong Chhnang. The place where I slept was so dirty. I washed and cleaned and under the bed in the room it was disgusting. My husband needed a clean place. A lot of people such as seriously injured and dead persons were permitted to stay in that place. Patients who were not seriously ill could get worse and worse if they stayed in those dirty rooms.*

Other informants focused on the feelings of intimidation induced by the staff at the provincial facility. They especially seem to worry that they would be scolded or spoken to harshly or angrily by the*peyt*. This fear of an angry response from a power figure is a very familiar theme in Cambodian psychology, as we will see in our discussion of traditional healers.

One rich informant, with connections to government, described her experience of the reception she got when she brought her son to the hospital with a fever. A wealthy informant like this has alternatives and can simply avoid the provincial hospital in the future. But that someone of her standing can be made to feel intimidated when visiting a public sector provider suggests that common villagers are even more vulnerable.

[Woman, 42, (wife of government official) rich, urban zone] *793*
I am afraid of the provincial hospital, my child died in the hospital. When I went at night the woman peyt *scolded me for bringing the child so late. But during the day he looked fine. The* peyt *ordered me to buy dengue medicine but I didn't have any money. I borrowed money from the male* peyt *and he went to buy the medicine, but the child died when the medicine was just inserted in the syringe. I never took any other of my children to that hospital, I took them to Kantha Bopha in Phnom Penh. They don't charge. I only paid 10,000 for the taxi round trip plus meals.*

A poor young woman in her first pregnancy was taken to the provincial hospital by her husband. She perceived the manner of the examining physician to be rude and angry, which convinced her not to return to the hospital again.

[Woman, 20, poor, water zone] *37*
When I was 2 or 3 months pregnant my husband took me to the hospital in Kampong Chhnang in order to have my abdomen measured. But the peyt *scolded me and said that when I came he did not allow me to eat anything before the appointment. I was busy and did not go back there again.*

Part of the issue of staff attitude in a government facility may have to do with the fact that the interests of many *peyt* are divided between their government duties, and their enterprise in their own clinic. This divided attention might account for why many informants report rude and angry treatment in a government setting and kind, attentive, but expensive, treatment by a government *peyt* in a private setting.

[Woman, 50; Man, 42; Woman, 36; Man, 17, Cham, poor, south along the road zone] *1274*
I faced difficulties in treating my husband at Kampong Chhnang hospital. I was told I had to spend much money on buying medicines but I had no money. My husband complained of severe pain in his chest, and I asked the peyt *at the hospital to treat the pain, but the* peyt *did not pay attention and got angry at me. The* peyt *told me to take my husband to the* peyt*'s house but I faced difficulty doing that so I took him back home.*

[Woman, 63, Woman, 21, Man, 32, poor, land zone] *475*
The public hospital is careless. The peyt *do not come when there is a problem, so finally I decided to go to a private clinic, owned by the chief of the public hospital. I made up my own mind to go to his clinic. I did not care how much I had to spend so my grandfather would recover. His treatment cost 700,000. I did not have to pay transportation because I have a horse cart.*

A few informants offered positive reports about the provincial hospital. For instance, a well-to-do teacher noted that wives of government officials in the province were beginning to utilize the resources of the government facility when they were ready to deliver.

[Man, 34, rich, (teacher) south along road zone] *1219*
A very small proportion of women deliver at the hospital, maybe 2 out of 100. In general, civil servants take their wives to hospital to give birth.

And a commune militia man reports attentive, inexpensive treatment when he goes to the hospital to have a wound dressed.

[Woman, 30; Man, 32, medium, urban zone] *773 [Husband]*
The chief of the hospital knows me and knows I am in the commune police. I go to the hospital every three days to take care of my wound. They charged 500. There is always a doctor and nurse on duty there at night.

But other informants criticized this tendency for government officials to be given favorable treatment at the government facilities. They seem to suggest that the government resources are being made available to the local elite, while the common villagers and farmers are discouraged from seeking access to those resources.

[Man, 35; Man, 48, medium, urban zone] *1003*
At the provincial hospital if any one is a civil servant or high ranking officer the peyt *focus on them. But for workers, farmers and the poor they ignore us. They blame us rudely. They look down on ordinary people.*

e. Uncertainty about the changes underway at the facilities

The last area of uncertainty we will consider to conclude this overview of the sentiments our informants expressed about providers in the government facilities has to do with recent changes introduced in health care in the province.

At the commune level, new health centers have been constructed and new staffing and fee arrangements have evidently been put in place. Some relatively wealthy and well-informed villagers described the changes in these words.

[Woman, 70; Woman, 33; Man, 45, rich, land zone] *362*
Before the commune health center opened, the peyt *cured and injected people at their homes. But now they treat village people at their office. They alternate during the day and night so stand by all day and night. They have a board listing the treatments at the commune health center. If the* peyt *do not have the ability to treat a seriously ill person they will provide a remorque to take the person to the provincial hospital. Angkar (the general term for donor organization) built the health center without raising any money from villagers.*

Elections have also apparently been held to create committees in the commune that would have some responsibility for assisting in the improvement of health care delivery in their locality. The following informant explained that the election was to

choose new *peyt* who, presumably, would be the future staff of the health center. But this may be a misunderstanding of the intended functions of the "feedback committee."

[Woman, 41, (wife of army officer), rich, urban zone] *852 The feedback committee members were elected, two men and two women. They are all* peyt. *We were told that the election was to select* peyt *we liked who could help us with problems like getting to the hospital even at night. They are not really* peyt *yet. They are just 20 years old, and have not gone to study yet.*

Recruiting new *peyt* to the healing profession by elections, if that is what the purpose of this committee actually is, probably marks an improvement over the policy under the Vietnamese supported Communist regime of Peoples Republic of Kampuchea 20 years ago to appoint health workers (and teachers and local officials) from among loyal cadre. But the key issue that underlies current uncertainty about the new *peyt* is the quality of their training.

[Woman, 70; Woman, 33; Man, 45, rich, land zone] *389*
Commune peyt *have not been trained because high level have not come to teach them to have deeper knowledge. They do not demand money from us. If they cannot cure a patient they will send the patient to the provincial hospital. But today the commune* peyt *cannot earn money because Angkar has announced the fees for treatment. Now no one forges the fees, 1000 is really 1000. Formerly they demanded more than 10,000.*

Some villagers have already had negative experiences with the new commune facilities and have decided to stay away from the health center.

[Man, 64; Woman, 44; Woman 80; Man, 50, poor, urban zone] *1099*
The commune peyt *were newly recruited they are young, 22-23, they have never attended any course. They are uneducated so we do not go to the health center. They are careless and they have no knowledge of medical treatment. After an injection we often have an abscess. They share one ampoule with several people and they never give us a full syringe of medicine.*

But probably a more typical reaction to the changes is "wait and see." Cambodians in Kampong Chhnang are like villagers anywhere in the world. They are initially suspicious but ultimately extremely pragmatic and will tend to judge an innovation on its merits.

[Man, 50, Cham, medium, water zone] *204 People don't trust the commune* peyt.
That doesn't mean the peyt *is incompetent or that they charge too much money. But people prefer to go to the provincial hospital or to Phnom Penh. People do not want to make a test with a* peyt *who is unknown. The*peyt *in the province hospital and in Phnom Penh are well known and qualified, so we are confident in them.*

[Woman, 21; Woman, 29, (business family), rich, south along the road zone] *1132*
People are not accustomed to going to the health center because it has just opened. They don't know much about it. If it is a good hospital they will go, we just do not know yet if it is a good hospital or not.

II. INDIGENOUS PARADIGM

The litany of complaints about the public sector health system suggests that our informants in Kampong Chhnang have a standard against which they can evaluate the government facilities. The criteria for quality care derive from expectations and experiences that we can discuss now. There are providers, who are situated in what we have called the indigenous paradigm, who appear to establish the benchmark for quality care, from the customers' point of view. The quality care provided by these

traditional healers, which we can draw from many examples given by our informants, helps explain the basis for comparison our informants must have in mind when they make their complaints against the government providers.

The practice of traditional healers also helps explain the success of the private *peyt* who make house calls. These *peyt* have accommodated their service to the preferences and expectations of their customers. The *peyt* in the public sector generally seem to ignore the preferences of their customers and the concept of quality care that is fundamental in the indigenous paradigm. These *peyt* in the public sector are Cambodians. If they are unaware of the expectations fostered by the traditional healers that suggests that there is a remarkable gap in understanding between these providers and their customers. But if the public *peyt* are aware of the traditional expectations for health providers and choose not to apply those expectations to their own service that suggests an equally remarkable indifference on the part of these providers. One possibility is that these *peyt* in the public sector may feel that they are insulated from the appeals and practices associated with providers in the indigenous paradigm because of their elevated status as powerful government officials in the modern urban sector, who are in contact with a global medical outlook.

A. HERBAL HEALING

1. Self-help

One of the prominent leitmotifs of our interview material is reliance on self-help and self-medication and on keeping control over the healing of family members within the household. The most familiar expression of this impulse is treatment by *kos khyal*. This involves scoring the skin with a coin edge using *preng khyal* (wind oil) embrocation until long red welts are formed. Other variations include cupping or moxibustion to raise circular suction welts on the skin, or using adhesive tape impregnated with hot pepper as a counter-irritant. *Kos khyal* is the most typical first-aid family members or friends will offer one another when "wind" has entered the body causing discomfort and malaise that often resembles what we call a "cold."

[Woman, 66, poor, water zone] *37*
If I have a headache or fever, I stay at home and have my husband kos khyal *me, then I buy medicine at the pharmacy.*

But *kos khyal* is also the basic remedy resorted to when more complex treatments do not seem to provide the instant change and relief desired. In the following instance a relatively wealthy farmer was apparently poisoned by using an agricultural chemical without understanding the dangers and without using proper safeguards.

[Woman, 22, pregnant, rich, water zone] *144*
When my father sprayed the beans against worms he got a numb arm and leg and head ache and couldn't walk far. First he went to the pharmacy to get French (i.e. imported) medicine, but it was not effective. He went to get khmer traditional medicine because he was afraid of injections. But the infusions did not work either. When he had pain he got kos khyal.

Rich and poor Cambodian families alike also attribute curative properties to herbal remedies, *tnam boran* (ancient or traditional medicine). Many households have a small patch of garden devoted to medicinal plants or grow a few pots of medicinal plants or spices on their veranda. Some remedies we heard about can be viewed as self-medication, but others involve the assistance of an expert. Here are a few

examples of the way people talk about the use of herbal remedies that are part of village or family lore to deal with common discomforts by self-help.

[Woman, 50, very poor, water zone] *112*
I got a reis *on my leg, I scratched it and then a water bubble and a bump came up. I applied the hot resin from firewood and it recovered. Now hair grows on it but it is pale.*

[Man, 54; Woman, 26, medium, north along road zone] *543 [Father]*
Someone told me to take angkream angkraam *seeds to boil with water to make a medicine for blood pressure (*srep srep, prang prang*). I drink that medicine and the pills from the* peyt *at the same time.*

[Woman, 49; Man, 19, medium, north along road zone] *708 [Mother]*
When I am swollen I did not go to the hospital because I believed in khmer medicine because it can cure me. If it didn't cure me I would not believe in it.

[Woman, 41, (wife of army officer), rich, urban zone] *861*
My mother told me that there is nothing as effective as traditional medicine. If we have a stomach pain, we only take one pot of traditional medicine it would become comfortable rapidly. It also makes us have beautiful skin as well.

The following example of self-help also illustrates the familiar theme that traditional remedies are frequently combined with modern medicine. Traditional herbal remedies are held to work slowly, but are believed to assure a complete recovery. Western medicine, especially injections, on the other hand, are attractive partly because, like *kos khyal*, they work very quickly and produce a sense of instant change. However, as the old woman seems to understand, a complete course of the appropriate treatment of modern medicine must be taken to assure a recovery and to avoid a relapse.

[Woman, 86; Woman, 42; Man, 52, medium, land zone] *324 [Son-in-law]*
I was shaking and dizzy when the peyt *injected me with serum and I drank khmer traditional medicine. I hoed my farm and wanted to die. But I didn't die and finally felt relief. I went to the forest to cut herbs and trees for medicines that the old people recommended. The* chruy *tree,* dang kep kdam *tree,* phreang, jhreauv *and* thkov *tree, and* krala bos *tree. We cut them into small pieces and boil them to make a red tea.*

[Mother]
The peyt's *medicine is quicker than traditional medicine. It takes a long time to drink the traditional remedies, but we must combine medicine with traditional remedies. By using traditional remedies we can recover completely from diseases. When we take modern medicine and run out of it, we get a relapse.*

2. Itinerant medicine sellers

Since many families do not have the knowledge and skill to go into the forest themselves to collect the herbs they need, they rely on traditional medicine sellers. In the villages of Kampong Chhnang, old women, *yiey* (grandmother) often carry baskets or bundles of herbs from house to house on regular rounds. These old women are considered expert in assembling the ingredients needed for various teas and infusions. They especially seem to focus on homes where there is a woman in her last trimester of pregnancy or in the first three months after delivery. This is a six month period when the consumption of certain herbal remedies is considered particularly important in order to safeguard the health of the mother.

[Man, 48; Woman, 42, medium, land zone] *303 [Wife]*
I buy Khmer traditional medicine from a grandmother who sells from house to house. One bag costs 1000. She comes here every 10 days. Most of her medicine is for post partum women, or rheumatism or vein disease.

[Woman, 66, poor, water zone] *48*
Maternal medicine includes chhke sreng, stok stol, mekantus, *and others. The medicine sellers know them all.*

[Woman, 50, medium, water zone] *83*
This morning I bought herbal medicine from a medicine seller for 4000. She just left a few minutes ago. I am sick with back pain. The medicine reduces the pain, but if we stop taking the medicine it will be painful again.

[Woman, 20, poor, water zone] *46*
*After delivery the woman must warm by the charcoal fire (*tumlak changkran*). They do that so that they will get better faster and be able to work and be strong. The rich people get injections after the warming. Poor people take traditional medicine. When the traditional medicine seller comes to the house, we buy maternal traditional medicine. They bring a package for us to boil and drink for 2 months. It costs 500. One* tauv *costs 1000. If someone has an old man in the family who can go to the forest they can get the maternal traditional medicine themselves. Those people usually share the medicine with their neighbors.*

The itinerant herb sellers seem to facilitate the preference for self-medication by gathering the raw materials that a family can then process by boiling and can drink in dosages they find fitting. The connection of herbal remedies to the customs surrounding childbirth will be considered in a moment. The last informant also draws attention to a widely heard sentiment, that the herbal or traditional treatments were the recourse of the poor, but that the rich used medicine. The convenience for the poor is that herbal remedies are affordable and part of a lore that is shared as community knowledge. Our informant also makes the important point that herbal remedies are to be shared. The *yiey* who peddles the herbs around to village homes is a small step from the sharing, exchanges and reciprocity among neighbors that knits a community together.

[Man, 43, Woman, 39, medium, land zone] *438 [Wife]*
The Khmer medicine costs 1 kampheach *of paddy (1kg to 2kg) if we have no money. The herbal medicine seller doesn't think only of money. If we only have 100 she will still give us a basin of medicine.*

3. *Kru Khmer*

For more serious ailments Cambodians often seek help from neighborhood experts in traditional cures. One such expert is the *kru khmer*. In fact this is a generic term for healers of many kinds, each with his or her own specialty. As we will see in the quotes from interviews given below, many of these different kinds of *kru* are identified by the term for their special skill or technique.

The treatments of *kru khmer* very often include a spiritual or supernatural dimension and we will consider that aspect of his or her healing in a subsequent section. But for now we note a few examples of the work of the *kru khmer* who are known mainly for their herbalist expertise.

a. Herbalist

In this example the herbalist's traditional remedy for a common childhood disease is known to a rich family, although now they evidently use the health center services, instead of going to the *kru khmer*.

[Woman, 70; Woman, 33; Man, 45, rich, land zone] *375 [Old woman]*
The kru khmer *knows the traditional remedy for measles. The branches of palm and* trey krem *are first boiled and then the baby is soaked and bathed in the water so the measles will disappear. This was used before we had the commune health center.*

Another very familiar example of the kind of remedy the herbalist is called upon to provide is an herbal tonic to counteract the exhaustion due to the exertions of farming work. This quote also notes the extremely affordable payment in kind for the tonic.

[Woman, 63, Woman, 21, Man, 32, poor, land zone] *468 [Daughter]*
When I was exhausted from carrying wood I drank khmer herb remedy. My mother obtained it from a kru khmer. *Many people go to him because his herbs are effective. The payment is an offering of bananas and white cloth. He also makes amulet belts for 4000 to 5000.*

The amulet belt this informant mentions is a powerful supernatural protection the *kru khmer* can provide for pregnant women, which we will consider below.

The herbalist's remedies are not always inexpensive, but these treatments have the important advantage of being paid for in manageable installments, unlike the payments often required at medical facilities, as we have seen.

[Woman, 49; Man, 19, medium, north along road zone] *717 [Mother]*
The healer takes money little by little. One pot of medicinal tea costs 17,000. In one month I will drink 10 pots. [i.e. 170,000]. The peyt *at the hospital may charge 120,000 for half a month, but he wants all the money at once and I cannot pay that.*

On the other hand, the herbalist or *kru khmer* often does not claim or expect any payment at all if his treatment is not considered effective. The experience of this informant illustrates that the customer is free to choose providers and to decide which provider's treatment worked.

[Woman, 50, medium, water zone] *80*
My daughter got a boil we took her to a kru khmer *to spit medicine and make the boil burst quickly. He chews betel leaf and areca nut and lime and says a magical prayer. We brought incense and he spit [over the patient] once in the morning and once in the evening but we did not give any money because it didn't work so we went to the district* peyt. *The* peyt *asked 10,000 but I gave 9,000.*

The herbalist is not only an important provider for poor, illiterate villagers. The following example shows that educated people living in semi-urban surroundings also value the herbalist for his healing expertise, especially in view of the perceived low quality of medical service that may be locally available.

[Man, 34, rich, (teacher) south along road zone] *1210*
Last year I had dysentery, the kru khmer *cured me because at that time it was late at night. We did not know where to call a* peyt. *Anyway the* peyt *never goes out at night even if we are seriously sick. How hard we knock at his door he would not respond to us. There is a* kru khmer *who comes at any time we call him. He doesn't require money. We just offer him offerings as gratitude to his master. When we recover fully we bring bananas to him. I offered him 3500. It is up to us. He doesn't define any amount of money.*

The teacher's remarks highlight some of the most important aspects of the practice of the herbalist. The herbal remedies are relatively inexpensive. In fact the payment seems to be treated more like a gift between neighbors than a purchase of goods or services. The payment is made long after the treatment is completed, when, and if, the patient has recovered. But the patient may well have combined many different treatments from different sources. So this payment to the *kru khmer* is a gesture of gratitude that actually conveys a public acknowledgement of the patient's view of the significance of the contribution of the herbalist to the patient's recovery.

b. Customer preference and decision making

The *kru khmer* is a member of the community who, like his or her neighbors, is mainly a farmer and not a full time professional healer. The herbalist appears to share his or her expertise with neighbors in return for a symbolic payment that enhances the healer's reputation and esteem in the community. The exchanges between elderly, wise neighbors and those in need are a traditional mode by which Cambodians create and maintain community solidarity.

Besides being affordable, the *kru khmer* is also accessible. The healer is a neighbor who is devoted to caring for those who seek his or her help. The readiness of the *kru khmer* to tend to the teacher in the middle of the night is an expression of neighborly concern that members of a community extend to one another. A culture of mutual concern and a web of reciprocal exchanges identifies a community and enables a *kru khmer* to serve in the role of healer and make his living as a farmer at the same time. This is brought out in the words of the next informant.

[Woman, 45, medium, south along road zone] *1256*
I believe in the kru khmer. *He doesn't claim any money. If we get better and truly recovered we can pay him 4000 to 10,000. He helps the villagers in the village. When he has trouble transplanting rice or threshing rice, if he asks the villagers they come to help him.*

The key point here is that the herbalist embodies traditional wisdom and carries that knowledge into social relations, which are strengthened just as the individual is strengthened by the herbal tonic. The*yiey* medicine seller or the *kru khmer* herbalist are experts in a field of common knowledge. These experts share their knowledge on the pattern of village reciprocity, where someone with particular skills lends assistance to a neighbor as needed.

Money changes hands in these transactions in the indigenous paradigm for health care, but they are exchanges within traditional village culture. The ritual aspect of the payments assures that they are considered distinct from secular commercial transactions typical of market dealings, which are characteristic of the modern urban culture. The readiness of some *peyt* to make house calls, to treat patients at any time of day or night and to accept installment payment is clearly based on the expectations villagers have about the *kru khmer* as a caring health provider.

B. SPIRITUAL HEALING

Cambodians generally seem to perceive a totality of social, psychological and physical factors that affect health, illness and cure. Western medical specialists tend to try to separate these factors and deal with them in isolation from one another. The Cambodian holistic approach to health seeking is especially evident in the prominence of the spiritual dimension in their customs and practices in seeking health care.

1. Self-help

The self-help element of Cambodian supernaturalism is apparent in everyone's access to the spirit world by means of incense and prayer. When a person feels ill, one of the first steps he or she will take is to make an offering to the spirits, especially the ancestors, to obtain relief.

[Woman, 71; Woman, 45; Man, 20, medium, urban zone] *894 [Son]*
Sometimes my mother feels worse, so on tngay sil *(weekly Buddhist holy day) she burns incense and makes* slek thmor *or* bay sii *(offerings) and then she prays for good health. She possibly gets better.*

[Woman, 42, poor, land zone] *279*
I burned incense sticks to pray to my dead grandparents because I was worried about what we had done wrong. If our praying doesn't make our disease better we will look for a p*ey*t.

Even when medical treatment is sought, many informants expressed the view that the householder must first consult and obtain permission from the spirits at home, to assure the success of the treatment.

[Woman, 56, medium, land zone] *1334*
If we go to a hospital without celebrating a ceremony for the house spirit, we might die, because the house spirit will think we oppose them in our belief and will make us die.

[Woman, 86; Woman, 42; Man, 52, medium, land zone] *347 [Old Woman]*
I burned incense sticks to pray to the ancestors to help the p*ey*t *make my children recover from the disease. The* p*ey*t *charges 2000 every time for an injection. He said he will inject the child until recovery.*

2. *Kru Khmer*

Most *kru khmer* are credited with an ability to deal with the supernatural causes of disease. The remedies these *kru* recommend, generally in the form of offerings of atonement, appear to clear the way for any further treatments by other providers, if necessary. This psychological preparation for a medical intervention is an important function of the *kru khmer*, since villagers often feel they should consult with a *kru khmer* before going to a *peyt.*

From the villagers' point of view the *kru khmer* fit into a traditional spectrum of providers available to a seeker of health services. This is a reflection of the villagers' holistic view that encompasses social, psychological, spiritual and medical dimensions of health seeking. Within the indigenous paradigm there does not seem to be any obstacle preventing the search for treatment from any provider.

In this research on consumer preferences we did not seek out providers to interview. We do not know how the *peyt* (members of the medical profession) and the *kru khmer*, (traditional healers) view one another. Further research would be needed to determine if *peyt* generally view *kru khmer* as complementary providers who play an important role in dealing with the psycho-social aspects of healing, or as rival and bogus providers who should be suppressed. Likewise, research among traditional healers would clarify how they see their interventions in the context of health system reform and modernization in Cambodia.

We have the strong impression that from the point of view of consumers of health care services both traditional healers and medical practitioners are significant and complementary providers. Most informants maintain a distinction between supernatural and natural causes of illness, but they do not separate them. On the contrary they combine them.

One woman articulated the limitations of the *kru khmer* in terms of a difference between internal and external afflictions.

[Woman, 56, medium, land zone] *1325*
The kru khmer *can help outside body diseases that are caused by evil spirits or by the anger of the ancestors. Inside body diseases he does not have the capacity to treat. I go to a* kru khmer *first to learn if we have anything wrong with the spirits, such as something wrong with the ancestor of our father or other relative in the house or to learn if we are affected by someone's magic spells. If there is any such problem the* kru *will tell us. If our disease is beyond their capacity they will tell us to go to the hospital. When my child was sick I went to the* kru khmer *and* lok sang *(monk) to have them spray holy water. I worried about my child's disease so I went to every provider.*

The kru khmer *doesn't know about intestinal disease he only counts his fingers to know whether we have anything wrong with spirits of what direction, such as ground spirit,* meba *(ancestor spirit) or house spirit. If we have anything wrong with them, we do a ceremony for them, then we go to the* p*ey*t.

Another family did take their child to a *kru* to seek his help with the child's internal afflictions. The *kru* used a traditional remedy of burning drops of resin on the child's stomach to effect a cure. The parents also took the child to a *peyt* for injections and also conducted the following remarkable healing based on a common belief in the luck associated with elephants. This case, like the views expressed in the previous quote, illustrates the strong tendency among our informants to combine all manner of self-help treatments and the interventions of *kru* and *peyt* to find a remedy for their ailments.

[Man, 64; Woman, 44; Woman 80; Man, 50, poor, urban zone] *1072*
The p*ey*t *cost 40,000 which we owed him until I could earn money to repay the debt. Then my child's illness got more serious and they told me to give up hope for my child. But he recovered due to the elephant's stomach. We offered 1000 to the elephant owner to allow us to walk under the elephant's stomach three times, hitting the stomach three times then we went away. Then intestinal worms and flat worms came out of my child in his excrement and he recovered. You can see these small spots burned by the* kru auch*, but he recovered by the elephant.*

The external afflictions that the *kru khmer* can deal with seem to be of two sorts. The first originates in magic or sorcery (probably via another *kru*), which we can analyze as an awareness of anger or hostility from a living person. The second originates in a spirit offense, which is interpreted as resulting in the anger of some spirit or ancestor. In dealing with cases of a spirit offence the *kru khmer*healer-sorcerer shares the field with *kru pengcol, col rup,* and *banh cuen arak* spirit mediums who are specialists in possession and trance healing. The topic of magic and sorcery, witchcraft and possession in Cambodian village belief could take us far beyond the present issue of illness and health seeking behavior to larger issues of the achievement and loss of luck, success, and power. For the purposes of this paper we can confine ourselves to a few illustrations of the health-related activities of the spirit healer.

a. Magic and sorcery

One extremely poor woman seemed chronically ill. She apparently could get some relief in the knowledge that she had an ally who would use his magic powers on her behalf to counteract the evil magic directed against her that made her sick.

[Woman, 50, very poor, water zone] *123*
I was shaking and had no energy. I went to a kru khmer *who said that someone had put magic on me. He sprayed me with water and prayed in Pali over me for seven days, every morning and evening. I gave him 5 candles and 5 incense sticks. I gave him 3000 but he only took 1000 because he knew I was poor.*

Another example can illustrate the most common form that sorcery takes. That is the introduction of a foreign particle into an enemy's body, usually the abdomen. The foreign particle is usually steel nails or a needle or sharp fish bones or small stones or other objects. The healer can extract these intrusions from the afflicted person by suction through a straw or have them expelled by other magical means.

[Woman, 50, medium, water zone] *196*
Kru khmer *can treat someone who is under a spell. An influential person in this vicinity was sick but the* pɐyt *could not help him recover, so he went to a* kru cham *who told him he was under a spell with rice in his abdomen. After the treatment the rice fell out of his bottom. Then once the spell was broken, he went to the hospital to get an injection for strength.*

Khmer people often attribute sorcery of this kind to Cham (Muslim) healers and magicians, as if *kru khmer* were less likely to dabble with malign forces. *Kru cham* are especially renown for their expertise in love potions and sex magic. So we can guess that the Khmer victim in this case went to a Cham healer because he suspected that his ailment might be connected to his relations with the opposite sex. The illustration also makes a point we will hear repeatedly, that an injection is considered to serve the same purpose as many herbal cures, namely to provide a tonic for strength and well being.

b. Spirit offences

Cambodians are very sensitive to the dangers of offending a more powerful being. *Kru khmer* and other spiritual healers and mediums have the extremely important healing role of dealing with the anxiety associated with having committed a status offence, which is expressed as having aroused the anger of nature spirits or ancestor spirits.

Nature spirits, *neak ta*, are identified with locations. In a village or domesticated space, the *neak ta* are known and can be propitiated at a shrine. But they can still afflict susceptible individuals, as in the following case.

[Woman, 60; Man, 31, poor, north along road zone] *[Old Woman]*
I experienced santhum *(loss of consciousness) for two days.* Neak ta *came into my body. If I was conscious how could I at my age dance on the road like that? I am shy. But people around me said* neak ta kach. *The* neak ta *asked for music so I spent 35,000, by going into debt. Now I can see one instead of double as before, but I still tremble and have nightmares. I see all night as if something were on my eyelids. I vomit when I eat and my limbs are tired. The* pɐyt *said I should have an injection for 2000 to 8000 and serum at 20,000, but I have no more money, not one* riel.

In the forests and mountains, or wild space, the *neak ta* are not so well known, and it is easy to give offence by an unguarded remark or a misstep.

[Woman, 42, medium, land zone] *609*
When they go to the mountain to cut wood they get fever called chainh tek chainh dey *(defeated by water and earth, i.e. malaria)* or chainh neak ta *(spirit illness) The latter is more serious. If one gets* chainh neak ta *he has to hire an orchestra to play classical music and give a pig's head as an offering to the spirit and it costs 100,000. The offering is put towards the forest, in order to send the spirit back. The spirit possessing the medium tells what disease was caused by the spirit. In a case like this we have to go to both the medium and the doctor.*

The all night séance that includes a gong orchestra is often staged in the precincts of the Wat. The music and food attracts the entire community to take part in the healing ceremony on behalf of one of their members. The situation reported above comes from the land zone of Kampong Chhnang where villagers often go into the forest. We can imagine that many individuals might join in this ceremony either because they also suffered the affliction, or they know that it is a common complaint that could very well affect them at another time. As with most rituals, the elements of renewing social solidarity and attending to anxieties that many in the community share are implicit aspects of the event beneath the manifest aspect, in this case healing a sick person.

A more common psycho-social or spiritual source for physical ailments is an offence or fault or mistake in one's relations to ancestors. In a society like this that is strongly age ranked, giving an offence to a living elder, or failing to give adequate respect, especially to a parent, can be a source of danger. There are many ritual ways in Cambodian culture to atone for that potential disrespect in order to minimize the elder's anger.

Disrespect to an ancestor, or dead elder, cause a more dangerous form of anger that is associated with serious illness. This anger has to be appeased in order for the illness to be treated effectively. Appeasing that anger is the task of the spiritual healer.

[Man, 48; Woman, 42, medium, land zone] *299*
I was afraid my husband had a pestilence disease so I went to the kru khmer *first to get his advice. That cost 500 and five incense, five candles and three betel leaves. He told my husband that he had a mistake with the spirits of his grandparents of his father. So we offered a pair of* slek toah *and a pair of* bay sii (*offerings*). *This cost about 1000. We made these offerings so that it would be easy to get better soon, and then we went to get an injection. We get medical treatment from the* peyt *but we comply with the* kru khmer *to give us a good feeling. If we only took medicine from the* peyt, *it may not meet the disease.*

The theme of averting the ancestor spirit's anger and enlisting the ancestor's agreement with the modern treatment for a disease is expressed in many of our informants' accounts. This perception suggests that the spirit healer could be a useful ally to a culturally sensitive and open minded *peyt* who considers the importance of the psycho-social dimension of a patient's condition, along with the biological dimension of healing the disease.

[Woman, 27, medium, south along road zone] *494*
When my children got ill and took medicines they vomited and did not recover. When they got a serious fever I called in a medium to become possessed. She explained that the spirit in our house made them not recover. We did something wrong with my mother's spirit. The medium told us to scatter rice on Wednesday. She accepted an offering of one hat *(1 m) of white cloth, and then we made an offering of wine, soup and incense to my mother's spirit. Then we could*

call a p*ey*t *to inject the child. We explained to the ancestor not to be angry with us, the injection was only to reduce heat.*

In many accounts the offended spirits are not identified as particular personalities in the family, but seem to be more generalized angry or evil spirits, *arak*. But the same theme of atonement and offering is considered a necessary preliminary to seeking a medical intervention, as was the case with ancestor spirits. In the two illustrations given below, an injection of medicine could not be accomplished until the spirits had been appeased and had given their permission for the new treatment to be administered.

[Man, 60; Woman, 60, poor, north along road zone] *564*
When my child had fever the kru khmer *said I had a fault with the* arak *(bad spirits). I gave incense and candles to pray for all* kru, arak *and ancestors for any of our faults and that we would make no such mistakes again. If we didn't apologize the needle of the injection would not enter my child's body.*

[Woman, 59, medium, north along road zone] *513*
*We cannot give up our belief. We must find out the reason for the illness, who makes us ill, and after we make an offering to the spirits, we can go to the hospital. For example, in 1979 the spirits disagreed with us. The*peyt *tried to inject me three times for my fever, but the needle bent each time. After that, I lit incense to ask pardon from the spirits for our misconduct. Then the* peyt *could inject me easily because I was released.*

c. Spiritual aspect of the preference for injections

I think the extraordinary efficacy that our Cambodian informants attribute to injections is related to traditional beliefs about the work of *kru khmer* and other spiritual healers. On one hand the penetration of the body by a sharp foreign object is associated with sorcery and the anger of living enemies. The spirit healer must counteract this anger to permit a cure. On the other hand, the successful injection of a needle by a *pey*t requires that the anger of the spirits must first be appeased and any offences forgiven in order for the treatment to be possible.

When the *pey*t successfully inserts the needle and then, after a moment, withdraws it, he accomplishes the sorcerer's task of removing an inserted foreign object to achieve a cure. On the other hand, with modern disposable sharp needles, the *pey*t is able to inject with minimum discomfort to the patient, and that success verifies that the spirits must be well-disposed towards the healer's treatment.

I think the injection by the *pey*t conjours up a world of traditional spiritualist associations related to psycho-social dimensions of health and this helps explain why many of our informants seemed so eager to seek medicine by injection rather than by tablet.

d. Protection against spirit attacks

The last aspect of the *kru khmer*'s expertise as a healer that we will consider is his importance in preventing and curing spirit attack associated with pregnancy. Many Cambodian villagers believe that a pregnant mother and new born infant are vulnerable to the attentions of *mday daem,* a spirit who is considered to be the mother of the child in a previous life. The previous mother is thought to be still emotionally attached to the child. If the original mother finds fault with the current mother, either during pregnancy or once the baby is born, the spirit mother will try to take the baby

back, and this will result in *kralar pleung*, an illness in the mother (eclampsia ?) or in *aarih*, a usually fatal disease of infants.

The protection that the *kru khmer* can provide against this threat is a string wound around the waist of the woman. Thin sheets of metal on which magic formulas have been written (*kietha*) are wrapped around the string at intervals, to provide a magical protective barrier surrounding the wearer.

[Woman, 50, medium, water zone] *180*
My children died because of aarih, *affected by the spirits of previous mother from earlier life. When we are pregnant we wear an amulet belt to prevent the baby's spirit from being taken by previous mother. The* kru khmer *ties the belt. All pregnant women do this and get sprinkled with water in order to have a safe pregnancy. The* kru *writes magic letters and diagrams on metal and wraps them around the yarn. And offers prayers. I wore the belt until my baby was born, then I tied it around the baby's neck to protect him from the previous mother. Some women already have an amulet belt before getting pregnant. But they get an additional one from the* kru khmer *when they get pregnant and wear both.*

Another informant suggests that the *kru khmer* tries to make contact with an angry *mday daem* in order to pacify her with an offering so that she will release her grasp on the child and allow him to be healed. This informant also indicates another aspect of dealings with the *kru khmer*. The *kru* is a powerful magician, and he too is likely to become angry and vengeful if offended. So the offerings of gratitude to a *kru khmer* also have a strong element of paying respect and acknowledging the esteem in which the healer is held.

[Woman, 33, poor; Woman, 20, medium, land zone] *739*
The child was ill for two or three days with fever, always hot on his stomach and head. He was often sprayed with magic water by the kru khmer. *We dare not bring him to health center because he was often startled. That area is not comfortable, it is difficult to get there by walking and the child gets startled (*khangark*) there. I am afraid of meeting something invisible like a ghost that can see us but we cannot see it, walking along the road to the health center and that would make the illness even more serious than before we went to the health center. So I am afraid of the health center.*

We went to the kru khmer *first because he could invoke the spirit of the* mday daem *and help prepare an offering for her. But if the* kru khmer *could not make him recover we would go to seek a* peyt *later. We pay the* kru*with what we have, 500 or 1000 and candles, incense sticks, betel and areca nut. If our child recovered after the* kru khmer *had sprayed magic water and we did not give him an offering, I am afraid he would break the neck of my child with magic. My mother and the neighbors help one another when there is a need like this to prepare an offering for the* mday daem. *We called* a kru pengcol *(medium) who came to* antong *(invoke the spirit) so we could implore her to help cure the child.*

In the following case the *kru khmer* was sought as a last resort after injections had been administered to no effect. The *kru khmer*'s psychological-spiritual treatment here seems designed to prepare the mother to accept the eventuality of the loss of her child.

[Woman, 50, medium, water zone] *182*
My child was 18 months old, and got a high fever and cough. He was weak and pale and thin. I took him for an injection to the Vietnamese peyt, *but the treatment did no good. The injection cost 8000. I took him to a* kru khmer *later who said the child had* aarih *disease. He sprinkled cool water on the child. I offered clothes and perfume to the previous mother, as the* kru *instructed. But the child arrived at his time to die. I gave incense and candles to the* kru khmer.

The mother and newborn are also felt to be vulnerable to more generalized evil spirits and demonic beings like the vengeful spirits of women who died in childbirth. The *kru khmer* can protect the mother with an amulet string belt and by reinforcing the customary taboos that are designed to assure safety during this dangerous time.

[Woman, 27, medium, south along road zone] *498*
To prevent kralar pleung, *the disease that can happen after giving birth, we wear an amulet belt. But at delivery we take it off and after having the baby we wear it again. When we are pregnant there are evil spirits that menace us. We may not walk under a clothesline nor take a skirt off over the head.*

Aside from preparing an amulet belt for the mother, the *kru khmer* can also set up other magical boundaries around the house and compound to protect the mother and child and household from malevolent influences. By setting up these boundaries in the space visible to the public, the entire community is drawn into an awareness that a family is enacting the traditional steps of a significant life-cycle event. The family has taken the customary ritual precautions against any hostile forces or feelings that may exist in the surroundings which, in effect, explains why they are withdrawing from community life for a brief period. The reintegration of the mother and child into the community comes at the end of the "roasting," which we will consider below.

[Woman, 56, medium, land zone] *1336*
The kru khmer *sets up a* pat sima *(magic boundary) against evil spirits and ghosts. If the boundary is weak, children will cry at night or the mother will see something that makes her scared. She stays in bed over the fire and visitors are not allowed in the house. The traditional midwife can also make a* sima *to wear on the hand and ankle to keep evil spirits from entering the body, the* kru *puts up boundaries against evil spirits entering the house. The* kru *carries water and sprays in the house with spells then he places four cross signs on the house where the mother and baby live. Everyone believes in* sima*, elders of the village know how to set* sima.

The *sima* is also the boundary around a Watt, signified by the ritual boundary stones that separate sacred inside space from secular outside space. When the *kru khmer*, as an elder in the community, constructs a *pat sima* boundary, it is as if to say that the best traditional wisdom available has been mobilized to bless and protect these vulnerable members of the community. By means of this protection endorsed by the elders of the community, evil spirits can be repelled and illness averted.

e. Customer preferences and decision making

The *kru* is called upon to deal with anxiety that affects the health of his patients. The work of the *kru khmer* as a spiritual healer can be seen as treatment aimed at repairing psychological and social relationships, and especially relationships with powerful beings who are angry because they may have been offended. These offended spirits are often identified as members of the patient's kinship network, which suggests that the *kru* is dealing in particular with feelings of anger between generations. These anxieties probably grow out of patterns of child rearing and parent-child relationships established in Cambodian families, which would bear further study.

From the point of view of the patient, the *kru khmer* also seems to be attending to fears and anxieties related to negligence of status obligations. A super-ordinated being feels slighted or offended by the misconduct of a subordinate being and, in anger, punishes the offender with illness. The offender must make a gesture of atonement and obtain forgiveness in order for the illness to be treated successfully.

The Cambodian villagers we talked to look at health and illness holistically and consider the possibility that an illness has not only a physical dimension but also psychological, sociological and spiritual dimensions as well. This explains why a combination of treatments from diverse expert providers is nearly always sought. Our Cambodian informants express a great preference to attend to all possible causes of illness along these different dimensions, rather than to confine themselves to one modality. The implication for our study is that the quality of a treatment, when seen from the point of view of the customer for health services, depends on the ability of the customer to combine appropriate elements from various dimensions of causation of illness to suit this holistic view of healing. A low quality treatment would be one in which the options for health care were reduced to a single dimension, neglecting all the other aspects of healing that the customers believe are components of a successful treatment.

C. PHYSICAL HEALING

The *kru khmer* experts in social, psychological and spiritual aspects of healing are mostly men (although spirit mediums are generally women). Another important expert provider of health care in Cambodian communities is the *yiey mop*. These midwives are exclusively women and they are considered to be experts in the traditions and physical interventions needed to assure a save delivery and recovery from childbirth.

The *yiey mop* is an expert in the herbs needed for a pregnant woman or new mother. She is also expert in massage for pregnant women that can ease the physical discomfort especially of the latter stages of pregnancy. The midwife supervises the delivery of the child, the cutting of the umbilical cord, the disposal of the afterbirth and clean-up of the body fluids in the place where the delivery took place, and the cleaning of mother and newborn. She also supervises the ritual of roasting the new mother to hasten her recovery.

a. Choice of yiey mop

The first point to make is that there are usually many experienced midwives in a Cambodian community. An expectant mother can choose the midwife she prefers. In the following interview the informant stressed the skill of the midwife in massage and the midwife's pleasant bedside manner. Although this midwife is an expert who does massage at her own home, she will, as is usual, come to the pregnant woman's house when the time for delivery arrives.

[Woman, 20, poor, water zone] *38*
If I feel sick, I ask the neighbors who have many children for their advice. I would not ask a peyt. *My neighbors said that having an upset stomach,* siet pueh, *during pregnancy was usual. But I already asked them twice or three times, so I am reluctant to ask them again. Now I just worry alone. The* peyt *is too far. If I were seriously ill I would ask my husband to take me to the hospital to have my abdomen measured. If I felt pain in my waist, I would go to the midwife's house and ask the midwife to massage me. After the massage my waist and abdomen do not hurt. There are many midwives, but I choose this one because her words are sweet and she does the massage softly, even though she is farther than other midwives from my house. She charges money, but it depends on how much we can give her. I gave her 500 and two cans of rice. (2 or 2 ½ cans cost 300; one kilo costs 750). I went for this massage five times. This midwife also does massage for other ailments. She cures dislocation and* kap sa sai *(strains of ligaments) for men who do hard work. If you take a little herbal medicine after the massage, you recover.*

We trust this midwife. If we are 10 months pregnant, she told us that we must come for a massage of pregnancy [induced delivery?]. When it is time for me to give birth, I will call her to come to my house, this is much cheaper than going to a hospital. But if I had difficulty in giving birth at home, the midwife would take us to the district hospital. Some women stay there. But if the district hospital cannot help, it would send her to the provincial hospital.

Midwives who are not trained in medicine are apparently aware of their limitations and expect to work closely with health care facilities available. One of the familiar themes in our data for both *krukhmer* and *yiey mop* is that if they face a problem they cannot handle, they quickly refer the patient to another provider who may be better equipped. To put the point another way, the customers for health care recognize the limitations of traditional providers and value the ability to choose an affordable, local, traditional practitioner if there are no complications, and to resort to other providers when that seems necessary.

[Woman, 27, medium, south along road zone] *489*
When I was pregnant two months, I began to hemorrhage from my vulva I asked the midwife and she told me to see a doctor. Two days later I went to the district hospital. They told me I had a womb ache. When I returned from the hospital I was still in pain so I called the midwife to massage my abdomen. The midwife told me to drink khmer traditional medicine. It cost 3000 for a pot. I drank two pots full of boiled herbs and I recovered from the hemorrhage. Before the delivery I drank traditional medicine made from tathok *plant to make the delivery easy and the baby beautiful.*

The quote also indicates the important association of the midwife with the tradition of herbal remedies we discussed above. The midwife may or may not be an herbalist herself, but she is steeped in the lore of herbal cures and uses this treatment on a long-term basis with her clients.

[Woman, 70; Woman, 33; Man, 45, rich, land zone] *369*
We drink khmer traditional medicine for three months after delivery. There are many ingredients for warming the ligaments. Roots of pong sam, *leaves of* pheu phleng. *Before the delivery they make peels of wild guava tree fruit that fall,* kramor pun *and roots of* takhup, *hen eggs, and* krapul bay. *These are drunk three months before delivery.*

These illustrations indicate that the midwife provides a combination of physical treatments of massage and appropriate herbs for the needs of members of the community from all socio-economic levels. She often serves a family as an important and attentive care-giver for three months before delivery and for three months after delivery, and occupies the role of trusted and reliable support during a potentially dangerous time.

b. Payment to* yiey mop *after "warming"

As we saw was the case with the *kru khmer*, the payment to a *yiey mop* looks more like an offering or ritual of gratitude than a purchase of goods or services. As one poor informant suggests, the midwife herself may help a very poor neighbor in need. The role of the midwife as long-term caregiver for the childbearing women of the community appears to extend, in some cases, to a concern for the general welfare of the poorest members of her community.

[Woman, 63, Woman, 21, Man, 32, poor, land zone] *466*
I will call the midwife to help deliver the baby. Although we have nothing she does her best to help. Sometimes she provides rice to poor villagers. We will offer her one tauv *of* ponley *rice with 5000 if we have it. She can touch our abdomen and tell what time we will deliver the baby. I am very concerned about how to avoid having many children.*

The intimate connection or rapport that exists between the pregnant woman and the midwife is expressed by the next informant, who comes from a rich family. She describes the ritual offering prepared for the midwife at the end of the *ang phleung* (roasting). She suggests that the *yiey mop* puts herself at spiritual risk when she agrees to perform her midwifery. The midwife apparently becomes vulnerable herself, and is spiritually involved with the family of the pregnant woman while she is performing her midwife role. This condition is only resolved at the moment when the post-partum warming period ends and a careful ritual offering of gratitude and payment of respect is made for the midwife, signaling the successful conclusion to the delivery, some days after the actual event.

[Woman, 70; Woman, 33; Man, 45, rich, land zone] *373*
The warming consists of fire below the bed. According to ancient customs all the ashes under the bed must be removed so we can prepare a new fire for the mother to warm herself again. They do not allow us to remain in the same place, they move the bed to another place and make a fire under the bed. This is out of fear of the stove demon. Some women have problems and begin to bite the wood that we burn under the bed. But this trouble will disappear if we offer food and prayer to the spirits. When the mother gets off the bed where she warms herself, there is an offering of cooked rice and soups and we eat the offerings after the prayer.

We provide a tauv *of paddy and a hen to mark the ritual of getting off the bed where the woman warms herself by the fire. This is the custom from ancient time. We have to arrange the offering properly with incense, candles, betel leaves and areca. If we make a mistake the* yiey mop *will have convulsions. The* yiey mop *also helped with naming the child. While praying the* yiey mop *threw a ball of cotton wool against the wall. If the cotton stuck the name would be good.*

The danger to the *yiey mop* is probably understandable in terms of all the spiritual threats that are thought to attend the pregnancy and childbirth, which are dealt with by the *kru khmer* or other elders who erect magical boundaries against malign influences. But the concern of the new mother for the health of the midwife clearly reflects a mutually caring relationship between the client and her health care provider that grows over the many months that the midwife monitors the pregnancy and delivery and post-partum recovery.

c.** Peyt-midwife **and quality of care

These characteristics of tender care and attention over a long period, and a deep sense of trust and affection for the midwife are clearly the elements that affect an understanding of what "quality" in health care signifies for a midwife's clients. The customer for health service providers is able to choose the midwife most agreeable to her, and to repay her with a ritual that acknowledges the gratitude and respect that the client feels for the expert. But the offering is also in the form of a religious gesture that highlights the sacred link between client and practitioner within the concept of reciprocal exchanges of food that establish a community. The payment is also affordable and on a sliding scale, according to the means of the client.

The ancient art of midwifery is apparently often passed from mother to daughter. But a new element has been introduced in the form of training for midwives to make them *peyt* who can give injections. There seems to be a corresponding disparagement of the traditional midwife by the modern terminology "TBA," (Traditional Birth Attendant) for these *yiey mop*.

[Woman, 86; Woman, 42; Man, 52, medium, land zone] *341 [Daughter]*
Both the mother and daughter are midwives. The mother has been a midwife since previous regimes, since I was a baby in my mother's body. I would call the mother although the daughter is also very skilled and can also give injections. We pay a half basket of fried paddy rice and a hen and 10,000. The injections are additional but I have never been injected. I drank traditional khmer medicine.

Some of our informants in Kampong Chhnang were aware of the reforms underway to improve provider services by training midwives in medical skills. The new *p*ey*t*-midwives are often based in the commune health centers that are being established and upgraded in the province. The following two quotes are from relatively wealthy interviewees who seem better informed about changes underway in the public sector health facilities than many of our poorer respondents.

[Woman, 70; Woman, 33; Man, 45, rich, land zone] *364*
All pregnant women with their first child can give birth in the commune health center. If a baby cannot reach out of the mother's body, the mother will be taken to the provincial hospital. The women who have had several children go to a traditional midwife first and if there is any problem the midwife will take her to the commune health center. If they do not face any problems, 90% of village women go to the traditional midwife.

[Man, 59, rich, water zone] *22*
The traditional midwives got training at the district hospital when it opened. They got salary and training in town. Now their hygiene is better and they have modern techniques. They used to use an old scissors now they use a blade to cut the umbilical cord.

The major difference that informants stress between traditional *yiey mop* and *p*ey*t* midwives is that the latter can give injections. The injections are believed by many to substitute for the *ang phleung*warming and to substitute for the traditional regime of post-partum herbal infusions. But in many cases it seems that the *yiey mop* works with the *p*ey*t* midwife and that the customer is able to combine options from traditional and modern resources. This reflects a strong preference for freedom of choice in seeking providers, which is quite typical, as we have seen.

[Woman, 45, medium, north along road zone] *530 The* peyt *midwife is more important than the traditional midwife because the* peyt *can give an injection if the mother is tired. The midwife only helps with the delivery. The* peyt *came to the house for several days and injected every day. Maybe it will cost 10,000 or 20,000 riel, my sister has not paid yet, so I don't know how much it will cost. The traditional midwife costs 5000 and the traditional offering. After delivery my sister also drank traditional medicine. It costs 2500 a* tauv *or 10,000 for a sack of 4* tauv. *Drinking it is good for health and prevents sickness.*

In this quote above it is interesting to note that the *p*ey*t* midwife follows the pattern of the traditional midwife in coming to the house, in this case to give injections. This is a pattern we saw was also characteristic of private *p*ey*t* whom we discussed in the first part of the paper. The *p*ey*t* midwife also apparently extends credit to her clients for both medicine and her service, enabling her clients to take the time needed raise funds for payment. This is also a characteristic of many private *p*ey*t*, as we saw.

d. Customer preferences and decision making

The following quotes reflect the awareness of some poor and medium economic level informants of the options available to them and the considerations they have in mind as they decide about health care providers during pregnancy.

[Woman, 33, medium, land zone] *767*
When I am pregnant maybe I will go to the health center because the midwife there can give injections. But it is the custom to drink khmer medicine because we are farmers and work hard. They say khmer drugs are better for health than medicine.

[Woman, 63, Woman, 21, Man, 32, poor, land zone] *464 [Daughter]*
This is my first pregnancy I believe in destiny because I do not have any money. I want to go to the hospital to have the baby so the peyt *can help immediately if something goes wrong. It is more reliable than in my house. But I heard it costs 100,000. They inject some medicine in the hospital for 4 to 10 days so we don't need to warm ourselves by the fire. Often we warm for 2 weeks, but some only 3 days.*

[Woman, 20, poor, water zone] *52*
If we have no money we can owe the peyt *midwife for a half month or a month. If I need medicine she has the chemist mix it for me. She will allow me to pay in time, when I have money.*

One articulate informant from town probably had a generally valid insight when she remarked that the choice of delivery and warming and post-partum tonics followed generational, socio-economic and urban-rural lines.

[Woman, 40; Man, 60, medium, urban zone] *881*
We can deliver at home, take injections, take boiled khmer herbal medicine or ang phloeng *according to our preference. Young people like to deliver in the hospital. My daughter delivered in the hospital and never* ang phloeng. *But for me I must* ang phloeung *and drink khmer medicine because I work very hard.*

Women in the rural areas of our case study site appear generally to value the tradition of a ritual payment to the *yiey mop* for her services in the form of food, a little money and a symbolic offering of gratitude. The payment to the *yiey mop* can be seen as recompense for time, skilled intervention and knowledgeable care giving. But the importance of the ritual offering for the midwife suggests that the family of the mother and newborn also wish to acknowledge the special bond of trust and respect that has been formed between mother, child and midwife and which may endure throughout a woman's childbearing years.

The midwife is a highly skilled and experienced specialist in the community , but she also works alongside other essential specialists. In her attention to the physical and emotional health of her client before, during and after delivery, the midwife complements the *kru khmer* who attends to the psychological and spiritual well being of the mother and family during this anxious period of vulnerability. Meanwhile, both *yiey mop* and *kru khmer* appear ready to refer a client to other specialists, like medical practitioners, when that seems necessary.

The *yiey mop* and *kru khmer* are known and familiar long-term neighbors in the community. They offer their expertise to others in the spirit of reciprocity. The traditional payments of a basket of paddy rice to the *yiey mop* or bananas to the *kru khmer* are gestures of mutuality between farming families. They are also gestures of respect for the expert's skill and gratitude for the provider's attention.

The sliding scale of payment of cash allows the differences in means to be compensated for in a spirit of trust and honesty in order that all members of the community will have access to essential services. Moreover, the postponement of payment until recovery relieves the client of the added anxiety about affordability

when the main concern at hand is a condition that is beyond self-help and requires the assistance of an expert.

The trained *peyt* midwives bring new skills and tools to the ancient art of care for the pregnant woman. But they seem to have adapted to the traditional needs and preferences of their clientele. This is apparent in their willingness to make house calls and extend credit to their poorest customers, following a pattern for interaction among mutually trusting members of the community that is also characteristic of many private peyt. These modern services of the *peyt* midwife are, however, associated with specialized training and techniques and involve costly manufactured medicines and require the client to make a rather large outlay of money for the service. As we saw, these are some of the characteristics of the global paradigm with which we began this paper.

III. CONCLUSIONS AND RECOMMENDATIONS

A. CONCLUSIONS

This study began by drawing a distinction between the global paradigm and the indigenous paradigm as a way to present a discussion of the various kinds of providers known to and utilized by those seeking health care in the case study province. We examined the reasons customers gave for using, or avoiding, these providers and we noted the approval they expressed for some providers and the complaints they made about other providers. From these expressions, richly documented in the informants' own words, we can discern the contours of a concept of "quality" care that is operating in the judgments and preferences of our informants. These underlying values drive the decision-making that is manifested in health seeking behavior.

In this conclusion to the study we review and summarize our findings about providers from each of the two paradigms. We also identify a third, intermediate category of providers who are especially highly valued by informants. This intermediate category is very instructive as it reveals an integration of virtues from both traditional and modern healing. Accordingly this category of local providers may offer insights and lessons that could be valuable to policy makers involved in deliberations over the establishment of effective, appealing and affordable health care services in Cambodia.

1. Approach of the study.

The distinction we employ between a global paradigm and an indigenous paradigm is a first approximation to perceiving the social reality of interest here, health seeking behavior. The distinction is a heuristic device to present sharp contrasts between the figure of the *peyt* and the figure of the *kru,* impelling subsequent steps to make refinements needed to obtain a nuanced view of the behavior and values revealed in our interview data.

The global paradigm, for purposes of this exposition, centers on a biological view of health, illness and healing. The premise here is that it is useful to separate naturalistic from supernatural elements, physical from mental elements, biological from sociological elements in considering health, illness and healing. The global paradigm utilizes an impersonal, systematic, scientific approach that favors interventions that are

narrowly focused on physical, chemical and biological agents that have a known and predictable effect.

The indigenous paradigm, in this case, takes a holistic, multidimensional view of health, illness and healing. The fundamental premise of the paradigm is that social, psychological, spiritual and physical factors work in combination to yield health and illness. Healing is accordingly understood in terms of interventions that attend to all these factors in combination.

The global paradigm is represented by providers who come from a literate culture, in which university training and expertise and technical skill is offered to individuals recruited, selected, trained, tested, qualified and graduated by complex social and ideological mechanisms designed to produce the most suitable candidates.

The indigenous paradigm is represented in our case study by providers who come from an oral culture or a manuscript tradition of transmitting age-old wisdom, traditional lore, common and customary practices and local knowledge. This knowledge is conveyed to those with a penchant for it who undergo an apprenticeship to a master teacher within a lineage of initiation to the lore and practice.

The global paradigm is culturally situated in urban areas where expensive imported manufactured pharmaceuticals are available and where the expected form of exchange is cash in commercial transactions for goods and services.

The indigenous paradigm is culturally situated in the rural areas where virtually free herbal remedies abound and where exchanges, in kind, between farmers is an accepted mode of reciprocity.

2. Global Paradigm.

On the basis of our interview data we can summarize the satisfactions and complaints registered by informants in regard to providers working within the global paradigm.

a. Public Sector Providers.

The government providers appear in many ways to be the antithesis of providers in the indigenous paradigm. The complaints our informants voice about public sector providers, taken as a whole, present a model for health care to which our informants are generally averse. The complaints suggest, by contrast, a standard of quality that we find represented in the recurrent practices associated with providers situated in the indigenous paradigm. These complaints about the government health service facilities can be summarized as perceptions of the customers or health seekers and can be expressed as follows:

Perception 1. The government providers are not easily accessible.

Our informants seem to feel that government providers consider their duties as a government job rather than a calling. Our informants recognize that since government officials are poorly paid, they often do not come to work and find alternative paths to an income.

Perception 2. The government facilities do not have medicines and thus cannot cure patients.

Our informants seem to feel that the unavailability of medicines on site is a sign of inadequacy and low quality of the facility. But the desired medicines are available outside the government facility in the private sector where the health seeker is obliged

to go. Our informants generally express misgivings about this intersection of the public sector and the private sector, which they have to confront. Many informants simply avoid the public sector altogether and deal solely with the private sector providers where their freedom of choice is preserved.

The experiences of our informants with some public sector providers suggests the risk that government providers may purposefully steer health care seekers to certain private sector facilities (their own pharmacies or clinics) in order to maximize their income. In this case the providers would have no incentive to make the government facilities welcoming or attractive to customers. And the health care seeker may feel that his range of options had been manipulated to his disadvantage.

Perception 3. The government facilities require an immediate lump sum payment, which is difficult for a farmer to make.
The impersonal and transient nature of the encounter between health care seeker and government provider apparently does not permit an assessment of the customer's creditworthiness. But the large payments demanded are difficult for a farmer to make quickly because his wealth is not in a liquid form. Private providers, by contrast (often government facility staff) have recognized this problem of their rural clients and have evidently solved it by offering their services on credit.

The suspicion that the government facility has the power to detain a patient until full payment has been made suggests that customers perceive the government facility as an extension of the power of the State. The asymmetry of power suggested here, which subordinates the customer to the provider, runs counter to the strong customer preference for preserving autonomy. This element of government power in play in the relations of health seeker and provider contributes to customer fear of the government providers, which can be interpreted as an expression of the poor quality of care at the government facility, from the customer's point of view.

Perception 4. The staff of the government facility all seem to need a payment on a regular basis to assure that they attend to the customer.
The apparent decentralization of financial management in government facilities gives customers a sense that the facility is in the business of selling goods and services by way of fleeting commercial transactions between strangers interested primarily in maximizing their individual advantage. This is the opposite of the strong customer preference for a personal rapport and long-term relationship of trust and caring between health care provider and customer and affects the estimation of poor quality of the government facility.

Perception 5. The government facilities present an intimidating atmosphere where officials are arrogant and rude to relatively powerless petitioners.
The strong aversion of our informants for situations in which their autonomy is threatened and in which they may experience anger or rebuke or scolding from a powerful being affects the estimation of poor quality of government health facilities. Cambodian facility staff must know of the perception among their patients that an oppressive atmosphere exists at the government facility where low status persons might feel that they are looked down upon, neglected or treated carelessly. In this case, inaction to remedy the perception and failure to make the facility appealing from the point of view of a central Cambodian concern about status difference and potential status offence can be interpreted as positive action to keep the facility uninviting. If the Cambodian government facility staff are genuinely unaware of the widespread misgivings about the public sector facilities among customers then that would suggest a remarkable cultural gap between providers and customers.

One obvious reason for ignoring well-known customer preferences might be to drive customers to the private sector. But there may be other causes as well that have to do with the institutional culture of the facilities. The inner dynamics of the government facilities and the strategic decision making about what ethos should prevail in these facilities, and the patterns of motivation of government medical officials all remain obscure to us. These issues were outside the scope of our study.

b. Private Providers

The clinic facilities in the private sector present a contrast to the government facilities on a point-by point basis.

Perception 1. The private facilities are accessible as they are always open and always have staff standing by. Many informants indicate that the reason the public facilities are not staffed is that the provider is at home or at a private clinic attending to patients.

Perception 2. The private facilities are equipped with staff, equipment and medicines on site. This avoids the extra step to the outside pharmacy and the additional stress of purchasing an unfamiliar and expensive product under pressure of time and urgency of need.

Perception 3. The private facilities are relatively expensive but they are affordable because they extend credit or delay payment until recovery. The farmer is given the time needed to sell produce or livestock to raise the cash required.

Perception 4. The private facilities are characterized by a home-like atmosphere of caring and attention. In fact, the private facility is often in the home of the government *peyt* who is also acting in the private sector. The private clinic is on a smaller scale and the staff recruitment procedure may operate on different principles than in the government facility. The result is that the private provider is relatively more highly esteemed than providers in the public sector.

Perception 5. The private clinics compete in the market to attract customers and so they have an incentive to make themselves attractive to health seekers. The clinics often seem to adapt to the peculiar health care needs of the locale where they are located, and offer services attuned to the common complaints of their customers.

In a comparison between private and public sector facilities these perceptions indicate the areas of greater perceived quality of care in the private sector over the public sector providers.

3. Indigenous Paradigm.

On the basis of interview data we have identified several key providers who work within the indigenous paradigm. The views and preferences expressed by our informants about each of these providers contribute to our understanding of the underlying values held by our informants, which can be analyzed as various aspects of their concept of "quality" care.

a. The herbalist

The herb seller is a significant provider and reflects the importance of self-help and self-medication in Cambodian health seeking behavior. The value in self-medication with herbal remedies is that it preserves the sense of choice and autonomy for the

consumer, within a common community lore about natural resources that are free or available at very low cost.

b. The *kru khmer*

The *kru khmer* native healer is a significant provider reflecting the importance of feelings of anxiety, fear and dread that are associated with physical illness and affect Cambodian health seeking behavior. The *kru khmer* serves as trusted ally to the health seeker when expert help is thought needed to fend off and appease the anger or vengefulness of supernatural beings. The *kru*'s interventions may accomplish a cure, or may serve as the preparations that are considered necessary to enable other interventions by other providers to be effective.

The quality of freedom of choice of the health seeker to choose a *kru khmer* from many practitioners available, to believe or disbelieve his diagnosis, undertake or not his recommended treatment, and to acknowledge or not the efficacy of his interventions remain intact throughout the relationship. This preservation of the health seeker's autonomy is symbolized in the payment for services rendered. The payment is a ritual of gratitude that can be tendered or withheld, according to the judgment of the health seeker.

c. The *yiey mop*

The *yiey mop* midwife is a significant provider reflecting the importance of emotional needs for long-term, intimate, warm support during the stressful time of pregnancy, delivery and post-partum recovery. The emotional, physical and herbal interventions of the midwife are aimed at restoring the health and strength of the new mother, often over a six-month period. Families expect that the *yiey mop* may attend each of a woman's pregnancies and then attend the pregnancies of a woman's daughters. The value esteemed here is the life-long relation of trust, compassion and expert care that is generated between the midwife and the families she serves.

The payment to a midwife consists of a ritual of gratitude and respect that emphasizes the sacred bond between mother, child and midwife. The sliding scale for payment assures that no pregnant woman would be denied the midwife's help because of lack of funds. There are many *yiey mop* from among whom a health seeker may choose, and it is virtually unthinkable for a midwife working within the indigenous paradigm to refuse service to a woman in need.

d. Traditional quality care

The aspect of quality care that is highlighted by these traditional healers is that they take the performance of their roles as a sacred duty or a vocation or calling, in the spirit of service to a community. The *kru khmer* and *yiey mop* represent health care providers that attend not only to the physical, psychological and emotional needs of the health seeker, but also to prevailing socio-cultural expectations. This becomes apparent in the character of the payment to these providers. The payments are made in kind and are postponed until recovery. This creates a condition of mutuality and trust between health seeker and provider, which preserves the autonomy and dignity of the health seeker and the esteem of the health provider.

The payment consists of a public acknowledgement of faith in the provider, as a highly valued and expert member of the community. An expectation of neighborliness and reciprocity that consolidates a community is built into the function of the midwife whose task it is to introduce new members into the community. But it is also central to

the role of the magician and sorcerer who protects members of his community against evil influences from outside.

One aspect of quality care that these providers from the indigenous paradigm exemplify is an integrated holistic view of health that is advanced by experts with a professional attitude. A second aspect of quality exemplified is dedication to a life of service and care-giving, whose reward is primarily the esteem of the community and only secondarily material gain.

4. The Intermediate Category

These are providers we identify on one hand adapt to many of the values and preferences exemplified in the indigenous paradigm, but on the other hand use the techniques and products of the global paradigm. The success of these providers may suggest lessons for how health care reform might best accommodate to the concept of quality expressed by the customers.

a. Drug sellers

Local pharmacists or chemists are often an important private provider who makes pharmaceutical products available but dispense the medicines according to the strong customer preference for self-medication and experimentation. The perception of quality care that preserves customer choice and autonomy should be distinguished from the effectiveness of this approach to the use of powerful modern drugs. But this technical consideration of "effectiveness" is outside the scope of our study.

b. Private local *peyt* who make house calls

These providers seem generally to be the most favored provider of health care in our case study. The explanation for this strong preference has to do with the following main perceptions of the quality of care and service that these providers offer.

Perception 1. These peyt dispense injections on demand. They fulfill the strong preference for autonomy, self-medication, especially with substances that give rapid tonic or "feel-good" effects. They administer modern drugs, which are otherwise difficult for an illiterate villager to choose or obtain. By the act of giving successful injections the *peyt* echoes the highly esteemed work of the *kru khmer*magician who can withdraw sharp objects from the body and shaman who can obtain the blessings of ancestor spirits for a cure.

Perception 2. These peyt are very accessible, and are willing to come to the home of the ill person at any time of day or night. They provide attentive, responsive care in a situation where the customer remains in control, in his or her own home surroundings. In this respect, the *peyt* resembles the highly esteemed *yiey mop* in maintaining long-term, respectful relations with the customer.

Perception 3. These peyt accept payment in installments, which makes the treatment very affordable. This provider may defer payment until after the patient's recovery, following the model of *kru khmer*and *yiey mop* in deferring to the judgment of the customer about provider effectiveness.

Perception 4. These peyt present themselves as trusted local neighbors and members of the community who compete with other similar providers to make services available within the customers' frame of reference for quality. The *peyt* attempt to build a practice, a network of long-term relations of trust, and appear to follow a business

model of offering a professional service rather than a business model of selling goods, which appears in many government facilities.

B. RECOMMENDATIONS

1. The recognition and empowerment of providers in the indigenous paradigm would improve their ability to function effectively as referral and screening agents for serious ailments, complementing the modern providers.

2. An increase in understanding of the value of a holistic approach to health, healing and quality of life, which is already acknowledged in the most advanced modern approaches to medicine, should become part of the repertoire of all medical providers in Cambodia.

3. A clarification of the excessively broad concept "*peyt*" should be made through a system of credentialing by testing and retraining and re-qualification, so that customers know exactly what degree of competence they can expect from a provider. Sanctions for malpractice and guarantees of accountability should be a part of any reform effort of this kind.

4. A study of the institutional culture of government facilities could determine why they are not sensitive to competition from private sector providers.

5. A credit scheme that would provide loans for needy patients facing catastrophic illness and huge costs should be considered to avoid driving the poorest patients into landlessness. The success of this initiative would depend on adopting the best and most appropriate practices from the micro-credit sector of Cambodian development NGOs.

6. The formation of a health consumers' protection organization should be considered, operated by an independent NGO, which could advocate for higher quality service and receive and mediate complaints about service and charges in both public and private sectors.

7. The formation of a professional association of *peyt* should be considered, including both those working in the private and public sectors. The association could foster interchange between providers and could provide the germ for peer assessment and discipline. Such a professional association at the province level could advocate on behalf of provincial health care providers to MOH and International Organizations and donors. A professional association at the national level could serve as a mechanism to assure the accountability of Ministry of Health officials. These associations would be the likely targets for capacity strengthening efforts.

8. Capacity building in the skills and attitudes of the culturally sensitive public service professional might be considered. Technical in-service training offered to practicing medical personnel might be complemented by training that cultivates an understanding of a medical career as a sacred profession of responsible care giving.

9. If a market approach to medical service is adopted in Cambodia, those who supply medical service should become aware of the need to be responsive to customer preferences and demand. Capacity building for health service policy makers in techniques for assessing customer preferences and customer satisfaction might be

considered so that appropriate research can be commissioned and interpreted and so that informed policy decisions can be assured.

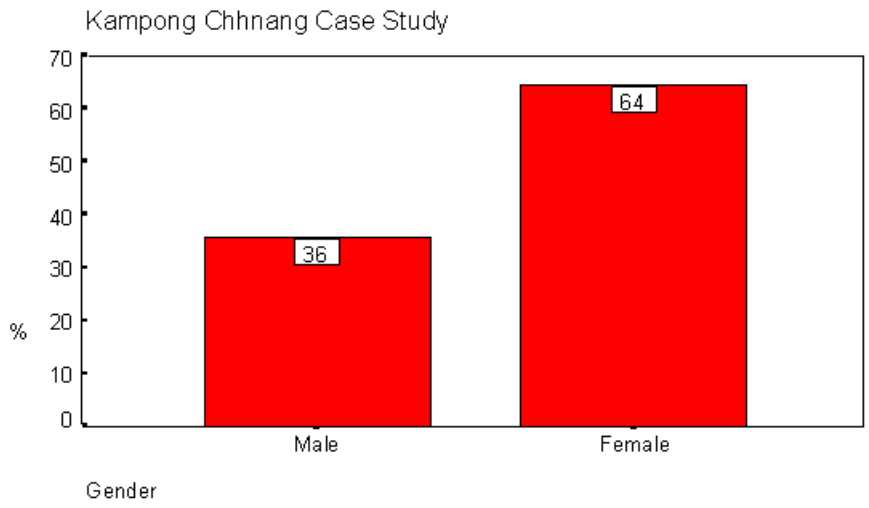
ANNEX

SAMPLE FOR KAMPONG CHHNANG CASE STUDY
Number of Households

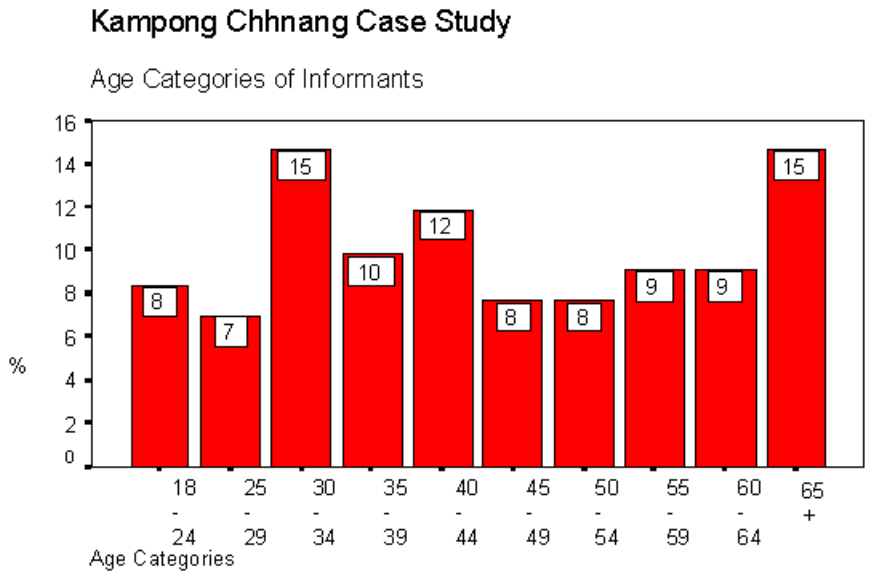
(N=149 Individuals)

ZONE	RICH	MEDIUM	POOR	Sub total
Along NR 5				
North of KC	**0**	**9**	**7**	**16**
Kp Chhnang	**15**	**11**	**7**	**33**
South of KC	**3**	**6**	**4**	**13**
Water (Chulkiri, Boribo, Kampong Leng)	**7**	**8**	**10**	**25**
Land (Tuk Phos, Samaki Meanchey)	**7**	**14**	**14**	**35**
Total	**32**	**48**	**42**	**122**

GENDER DISTRIBUTION IN SAMPLE



AGE DISTRIBUTION IN SAMPLE



The WHO Kampong Chhnang Customer Preference Study
Interview Orientation for CAS Researchers

1. **Focus Groups and In Depth Interviews**.

The WHO terms of reference specified Focus Groups as a methodology, but I think this qualitative research will have better results with an interviewing methodology.

Focus Groups have their advantages. They are cheap, speedy, flexible and do obtain face-to-face social data. But they have their disadvantages too. They cannot be easily directed by the interviewer, they are extremely difficult to analyze, it is difficult to assemble a homogeneous group, especially in a rural village setting, but most important, the social setting of the group encourages a conformity to the dominant speakers' views. Cambodians are very reluctant to contradict one another in public, especially when any difference in status is manifest in the group. So, what often results is very bland, vague consensus, which is informative but superficial.

The MSF[1] has recently done some qualitative studies using Focus Groups and Interviewing, which are instructive. The "demand" side for health service was dealt with by Focus Groups. We learn that customers complain that the service providers are "not polite" or "they have to wait a long time" or that there are "not enough drugs" or that the "drugs are incorrect" or that the personnel are "corrupt." But we are given no idea what "polite" means to a Cambodian villager, or what a "long time" is or how villagers know what "enough" and "correct" drugs are, or what they have in mind by the word "corrupt."

The only way to unpack such vague generalities is to talk to people at length and get examples from them of what they mean by the notions they use. The Focus Groups may be a good first step, but real depth will only come from sensitive interviewing.

When MSF looked at the "supply side," the providers, they turned away from Focus Groups for the very understandable reason that it would be too awkward to include in

the same Focus Group members of staff of different ranks. It was obvious to the MSF researcher that the status difference would affect the ease with which Focus Group members could contribute to the discussion. So they used interviews instead.

What the MSF researcher and others who are not trained in cultural studies overlook is that status differences are also all-important in a village setting, and will affect the results of a Focus Group there, just as much as in a health system where ranks are more visible. Moreover, it is next to impossible in a village setting to shield the Focus Group from a village audience of lookers-on. This adds to the social pressure in the direction of bland superficial results.

2. **Generalizations in Qualitative Studies**.
Our methods in this study are qualitative. We can try to identify themes, patterns, tensions and dilemmas in the Cambodian interview material, which are part of the cultural context in which the health system operates. But we cannot address questions like: how prevalent is that?, or how often did that happen?, or what is the distribution of that? Those are questions for a different study, using quantitative methods.

Quantitative studies are most successful when they build on a qualitative base. A survey can only ask the right questions if underlying categories of attitude, values, and worldview are understood. For example, in order to explore how extensive the complaint about "impolite service provider" is, with a view to recommending a solution, we have to understand the category of "polite" and "impolite," from the point of view of informants who use those terms.

Or, for example, in order to construct a survey instrument that aims to assess the prevalence of customer perception of corruption of service providers, we have first to grasp what a Cambodian villager means by "corruption." What, exactly is the dynamic of the transaction that is objectionable? What aspect of the interaction is called into focus here, with this strong word? Qualitative research aims to uncover the feeling of anxiety or vulnerability or anger that is generated or brought up in the experience of the social interaction, which gives rise to the use of the label "corrupt" or "impolite"

The question may be asked how widely shared are those values, or those anxieties? How representative are the views of a few informants about what is "polite" or "corrupt?" Another way to ask the question is how important are those categories or those values in the culture under study? Or, more particularly, in applied qualitative research like this, do our qualitative, in-depth findings promise to suggest any interventions that would be congruent with the underlying cultural concepts and that might steer behavior in the desired direction? Without the relevant qualitative cultural information we are confined to the rather shallow level of recommendations like "Be more polite" or "Be less corrupt."

Another way to approach this question of generalization of qualitative data is to ask how few Khmer speakers do you have to talk to in order to learn the Khmer language? The answer is, obviously, one. Every normal native speaker speaks his native language fluently enough, that he can be an adequate informant for a skilled interviewer to elicit the vocabulary and grammar of the language. Of course, the better the informant and the more skilled the student, the quicker the pace. An experienced language teacher of Khmer may give the apt and motivated language learner fast access to the language. Moreover, there are differences between informants, once you start to look carefully. There are dialect differences in Khmer, depending on region of origin. There are class differences in Khmer, and different vocabulary sets appropriate

for various rank and profession statuses. Not everyone knows all these niceties, and accordingly one actually has to perfect his knowledge of the language by talking to several people.

The case is similar with fundamental conceptual categories, valuations, and worldview attitudes in a culture. A few well chosen informants can reveal to the skilled interviewer the values, which are incorporated in language, that are widely shared in the community. One skill of the researcher is to discern the segments of the community that can be expected to have systematically different values. Socio-economic level, gender and age are typical markers of important segments of society that may have different values and attitudes.

Another skill of the researcher is to be able to elicit the feelings and attitudes surrounding the concepts of interest. If the research is alerted to the importance of "polite" behavior or "corrupt" conduct, in the context of health care seeking customer and service provider, sensitive interviewing is needed to elicit the meanings of these notions to informants from different parts of society.

The most important skill of the interviewer consists mainly in making the informant feel safe and respected in sharing his/her thoughts about the matter at hand, while guiding the interview to stay on the subject and cover the questions and issues that have been included in the interview design schedule.

3. **Customer Preference Research Outline**.
There are four basic questions we will be asking in this fieldwork.

A. For a family of a given socio-economic level (High, Medium, Low) living in one or other zone of Kampong Chhnang (zone 1,2 or 3), and perhaps with a pregnant woman in the family, who are the family members, what are their age, gender, kinship relations.

B. What do the family members remember about catastrophic illnesses or other complaints over the last year, say, that required some medical care. And what antenatal care was sought by the pregnant woman, or if with a newborn, what immunizations were sought. We want to know:
1. Who were the care providers?
2. What illnesses were remembered?
3. Which provider was sought for which person's illness or need?
4. In what order were providers visited, in case of multiple providers?
5. How much did the care cost for each illness, for each provider? Total, including travel, time etc.

C. Why did this family member choose this provider for this illness? What are the feelings of satisfaction/complaint, expectation, and affordability, regarding providers?
1. According to each family member
2. For each illness or complaint
3. For each provider

D. How did the family decide on a choice of provider?
1. How does the family rank providers in terms of their expectations of quality of service?
2. How does the family rank their standards of satisfaction/complaints?
3. How does cost figure in the scale of preferences and concerns?

4. How are these factors negotiated in the family to reach a decision on seeking care?
5. What is the concept of quality of care that underlies decision-making?

4. Details of Research Design, in relation to TOR from WHO

A. Objective 1.

"What is the health seeking behavior of households in terms of provider choice and expenditures incurred in the purchase of priority service such as curative care for minor and major illnesses, antenatal care, birth spacing, immunizations etc."

Chart 1.
The facts about family members,
illnesses and providers known and used in what order.

Providers (examples)

Family Member for example:	**A** (e.g. Kru Khmer)	**B** (e.g. TBA)	**C** (e.g. Pharmacy)	**D** (e.g. Health Center)	**E** (e.g. Private clinic)
1 (grandmother)	**[illness/cost order of visit if multiple]**				
2 (husband)					
3 (wife)					
4 (daughter)					
5 (son in law)					
6 (adolescent)					

We want to elicit from the family the providers known to them, the concepts of illness appropriate for care by each provider in the view of the family, the cost of care from each provider for the illness that the family has experienced.

The intersection of family member and a care provider consulted is an **illness/cost cell** that represents information about the illness experienced by a family member. In case of multiple care providers for one illness, we will note the order in which providers were consulted. The cost of treatment in each illness/cost cell will be noted.

B. **Objective 2.**

"What are the opinions of customers regarding satisfaction, expectation and reaction to services received at public and private providers."

Chart 2.
The feelings of family members about the attractive and disagreeable characteristics of each provider, specific sources of satisfaction and complaint, preferences and aversions associated with each provider. What are the expectations and experiences, both positive and negative, that families have regarding providers?

Provider	Satisfactions	Complaints
A	**[1.opinions of each family member]** **2.** **3.**	
B		
C		
D		
E		

We will have identified the Providers known to the family in Chart 1. Now we want to elicit the feelings of the family members about, for example the manner and attitude of specific providers, the effectiveness of their treatment, the reputation of the provider, the cost of the treatment, the convenience of the provider's location, availability of provider at all hours, the fears about the provider, the bad experiences with the provider.

The intersection of family member sentiments and a provider represents an **opinion about provider cell**. We will try to distinguish the opinions of different family members regarding different providers, especially if they differ. But there may only be a family consensus that can be elicited in regard to some providers.

C. **Objective 3**

"What are the household perceptions of quality, in relation to utilization of priority services?"

Chart 3.
Ranking of preferences by each family member regarding the strength of their preferences and complaints, satisfactions and dissatisfactions.

Ranking of satisfactions/complaints in deciding on a provider

Family member	**Most highly satisfactory characteristics of Providers.**	**Satisfactory characteristics of Providers**	***Unsatisfactory characteristics of Providers. Complaints***	***Least satisfactory characteristics of Providers. Serious complaints.***
	High Quality	**Good Quality**	***Poor Quality***	***Worst Quality***
1	**[characteristics]**			
2				
3				
4				
5				

Our aim is to obtain a sense of how a family makes a decision about their health care provider. We know from Chart 1 which providers are used and in what order for what complaints. We know from Chart 2 what the preferences and aversions are in relation to specific providers known and used by the family. Now we want to know what each

family member thinks is the most important appealing feature of providers in general and what is the least agreeable feature of providers. The intersection of family member and opinion about characteristics of health care providers is a **quality feature cell.** It may be that quality feature cells for different family members are different. They may disagree on what features are more or less important in assessing the quality of provider service. This disagreement would require negotiation in order to yield the decision making that we observe in Chart 1.

D. **Objective 4.**

The project funding agency also wishes us to ask what suggestions informants may have on improvements needed in the public health care providers' services.

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[1] Dr. Lucilla Magherini and Bruno Meessen, *Financing and Management of Public Health Facilities in Rural Cambodia: Module 1, Initial Assessment*. (Médecins Sans Frontieres CH/H/B, Updated Version, August 1998)
Dr. Lucilla Magherini, Financing and Management of Public Health Facilities in Rural Cambodia: Module 2, A Qualitative Study on Knowledge, Attitude and Practice of the Public Health System, Demand Side and Supply Side, (MSF H/CH/B, March-July 1998)