REPORT ON THE BASELINE DEMAND SURVEY

for the

HEALTH SERVICES FOR THE URBAN POOR PROJECT

Conducted amongst the urban communities of Sangkat Boeung Kak, Sangkat Tonle Bassac and Khan 7 Makara in the City of Phnom Penh, capital of the Kingdom of Cambodia

Conducted by Crossroads Consultancies

Working to Options Consultancies, Financed by DFID, and under the aegis of The Urban Health Project Task Force

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# Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
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<tr>
<td>BDS</td>
<td>Baseline Demand Survey</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
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<tr>
<td>CENAT</td>
<td>National TB Centre</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<tr>
<td>DOTS</td>
<td>Directly Observed Treatment Scheme</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme of Immunisation</td>
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<tr>
<td>HC</td>
<td>Health Centre</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HSR III</td>
<td>Health sector Reform III Project</td>
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<tr>
<td>HSUP</td>
<td>Health Services for Urban Poor project</td>
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<tr>
<td>MHD</td>
<td>Municipal Health Department</td>
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<tr>
<td>MPA</td>
<td>Minimum Package of Activities</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
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<tr>
<td>NMCHC</td>
<td>National Mother and Child Health Centre</td>
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<tr>
<td>NORAD</td>
<td>Norwegian Agency for Development Co-operation</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PLA</td>
<td>Participatory Learning and Action</td>
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<td>SUPF</td>
<td>Solidarity Among Urban Poor Federation</td>
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<tr>
<td>UHP</td>
<td>Urban Health Project</td>
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<tr>
<td>UNCHS</td>
<td>United Nations Centre for Human Settlements</td>
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<td>UNDP</td>
<td>United Nations Development Fund</td>
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<td>USG</td>
<td>Urban Sector Group</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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</table>
EXECUTIVE SUMMARY

1. INTRODUCTION

1.1 Background

There are estimated to be some 35,000 families living in squatter areas of Phnom Penh and they form part of a much larger group of around a quarter of a million urban poor who live in roof top slums, on the street or scattered through the city. The squatter areas are excluded by definition from many of the services and the social and productive systems of the capital. The families in the settlements are extremely poor and vulnerable to risks, particularly of loss of health and income. Their settlements are degraded environments that constitute further health risks. Other pressures, including the cost of living in the settlements and the cost of medical treatment, contribute to the inability of these people to break the cycle of poverty and leave the settlements.

According to the Cambodian Health Sector Reform Group:

"Despite a huge quantity of provision, the health care market is repeatedly failing to meet the health care needs of the population. This is because often the services provided are of a poor quality and/or represent bad value for money for the consumer. This situation is particularly acute for urban poor people, who are more likely to need health care and who have less resources and information to be able to access good quality services."

The Urban Health Project (UHP) is part of the Health sector Reform III Project (HSR III) which is being executed by the Ministry of Health (MoH) and the World Health Organisation (WHO). The purpose of HSR III, which is being funded by the United Nations Development Programme (UNDP), the Department for International Development (DFID), the Norwegian Agency for Development Co-operation (NORAD) and WHO, is to contribute to the reduction of poverty in Cambodia through the development of quality basic health services.

The UHP is being funded by DFID, and operates in Phnom Penh. The Managing Consultant is Options Consultancy Services Ltd., in association with the Health Policy Unit of the London School of Hygiene and Tropical Medicine.

The Phnom Penh Urban Health Project aims:

- To improve the utilisation of good quality and affordable basic health services in Phnom Penh, particularly in poor communities, by implementing two pilot projects that will establish new delivery systems involving the public and private sectors. One of these is the Health Services for Urban Poor (HSUP) component.

1 Health Sector Reform 111 Project, "Urban Health Project, sub-contracted under Health Sector Reform 111 Project" paper dated 10 August 1998
To gain a better understanding of the health care needs and health seeking behaviour of the population of Phnom Penh and particularly the urban poor.

To use information obtained from evaluating these projects to formulate strategies to improve the workings of the health care market in Phnom Penh.

1.2 Health Services for the Urban Poor: Rationale

The purpose of the HSUP component of the LTHP is to increase the utilisation of quality Health Care services (both primary and secondary) by the urban poor through improved quality and removal of barriers to access, including financial barriers. The experience of working to provide these services in an urban context will also inform the development of policy for improving the health status of the urban poor.

2. THE BASELINE DEMAND SURVEY

2.1 Research objectives and questions

A baseline demand survey (BDS) was conducted to investigate the nature of health care demand in Phnom Penh.

The objectives of the BDS were as follows:

° To enable Government and donors to gauge firsthand community health needs and perspectives on the acceptability, affordability and accessibility of health services;

° To inform the project's key secondary stakeholders about the issues facing poor people as they seek health care in Phnom Penh;

° To help to inform the design of the two pilot projects and refine their performance indicators;

° To provide a baseline against which to measure change during the lifetime of the project.

This report focuses on the findings from the health services for the urban poor (HSUP) component of the BDS.

The BDS aimed to understand the experiences, perceptions and suggestions for improvement of the people living in the squatter communities and the reality of their lives. The areas of interest were perceptions of health and illness, health-seeking behaviour, issues around paying for health care and how people accessed and responded to information on health care, health behaviour and health products. A detailed list of questions is given in Annex 1.

The BDS was conducted by a team fielded by Crossroads Consultancies in Phnom Penh with technical assistance from an outside consultant fielded by Options. The team was trained by the
Crossroads team leader and deputy team leader and the Options consultant in FGD and PLA, SSI and individual interviews, recording, observation and analysis.

2.2 Approach and Methodology

2.2.1 The design of the BDS

The BDS was carried out in two phases. The first phase used qualitative participatory methods, that is, Participatory Learning and Action (PLA) and semi-structured interviews (SSI). The findings from this phase were used to begin project design and to design the second phase of the BDS, a quantitative household survey that included evaluation indicators.

The BDS methodology is described in detail in a separate document on lessons learned from the methodology.

Three squatter areas were selected for the BDS, that is Sangkat Boeung Kak, Sangkat Tonle Bassac and the Borei Geyla area. The latter was selected to understand how the poor accessed health care in the richer area selected for the APS. The BDS team walked around the project areas and divided them into eight zones on the basis of environmental and economic conditions. The sample for group discussions and interviews was purposively selected from the 600 or so families to the south and west of Sangkat Boeung Kak, 4000 families on and near the river bank in Sangkat Tonle Bassac and 300 families in the Borei Geyla area of Khan 7 Makara. In total, 674 people participated in the first phase of the BDS and 366 in the second.

Phase 1

Focus Group Discussions (FGD) were held with 55 peer groups selected on the basis of age, sex, income level, ethnicity and location. This strategy revealed differences between groups and enabled people to freely discuss common problems. Twelve PLA tools using diagrams and roleplay were used to address the study questions from different angles.

Researchers worked in teams of facilitator, note-taker and observer. Discussions were recorded on tape-cassette, video and camera with permission and notes were taken. Each interviewee is given $1 at the end of the interview process to cover opportunity costs. Reports on the discussions were compiled by the team and 'interviewed' by the Team Leaders to cross-check and clarify the information before finalising.

The PLA activities contributed to the building of trust and rapport, the initiation of a consultative process, increased ownership and open discussion. Participants enjoyed the activities more than questionnaires and felt that they built confidence. They kept the diagrams, enabling follow-up for further planning. Participation in the design of health interventions begins the process of recognising and claiming consumer rights and strengthens civil society.

Semi-structured interviews (SSI) were held with 155 individuals using a purposive sample of people who had recently experienced an acute illness, chronic illness, an emergency situation, childbirth or a disability. This reflected the content of the MHD’s Minimum Package of Activities (MPA). The Krom leader identified these individuals.
Phase 1 aimed to understand the reality of life in the squatter communities in a broad way. A dissemination workshop was held to present the findings of phase 1, begin project design and identify indicators against which to measure impact. The phase 2 questionnaire was then designed.

**Phase 2**
A quantitative questionnaire survey was administered to 366 individuals found at home whilst visiting every eighth household. Phase 2 aimed to complement the findings from phase 1 and provide a baseline against which to measuring the impact of the project. The data was put on computer and analysed using SPU software.

Informal conversations, key informant interviews and observations continued throughout the survey period.

2.2.2 Strengths and Limitations of the study

Carrying out the BDS was emotionally demanding because of the grim situations faced by many respondents. Individuals were not always willing to talk openly about illness, particularly TB and STI, which are stigmatised. The team spent 3 months in the project communities developing credibility and trust. Talking with different people (sex, age, economic level, location, ethnicity, type of health problem); having researchers with different characteristics (sex, age, background) and using different methods (PLA diagrams and role-play, SS interviews and individual questionnaires) allowed the team to compare results and understand different perspectives. Participants were asked what they had learned at the end of each discussion. The report will be fed back to the groups who participated to ensure that the findings reflect what they said. The teams sat down together after each session and discussed and compared what they learnt from the session as facilitator, note-taker and observer. Translation from Khmer to English was time consuming and there was not sufficient time to develop for all the researchers to develop skills in probing and note-taking. The analysis and synthesis of the two phases was difficult because the chief investigator was not able to work closely with the team in country.

3. MAIN FINDINGS

The findings described below are generated by a synthesis-of data from FGD, SSI and HS. There is a wealth of data from these sources that is not included in this report because of time and space constraints. The data is available for use by groups who wish to analyse specific areas in more detail or to disaggregate the findings further or in other ways.

1.1 Characteristics of the study communities

The squatter areas are illegal and unofficial regulations prevent public utilities reaching this area. It is government policy for squatters to be voluntarily re-settled but this is unlikely to happen in the short-term. This situation exposes the community to high living costs, exploitation of many kinds and greatly inflated charges for basic needs such as water and housing. For
example, piped water costs about R7000 per m³ while in other areas of Phnom Penh it costs only R350. Electricity costs are also high. There is no sewerage system. Households in the squatter communities were classified into poor, very poor and ultra poor according to their ability to pay for health care and the balance between their income and expenditure. The ultra poor could not afford to pay anything for health care, the very poor could pay up to R2000 a day for seven days and the poor up to R5000 a day for seven days.

The ultra poor live on or next to the lake or river and suffer from flooding in the rainy season. The lake and river water is polluted. Their homes are makeshift and contain little or no possessions. They are surrounded by mud, sewage and rubbish, which attracts flies and mosquitoes.

The very poor live higher up the bank and have more substantial wooden houses but they are also at risk of flooding and live in a polluted environment.

See Annex for detailed description of the study areas.

3.1 HEALTH AND ILLNESS

3.1.1. The meanings of health and illness

People in the study communities think of health as a state of not being sick and having enough energy to cope with their demanding lives. Being well is having the body in balance, not too hot or cold, not having bad blood or wind in the body, having a good complexion, not working too hard and eating and sleeping well. Mental health is being clever with a calm mind and not being under stress. Good health includes having spiritual lives in balance, the physical and spiritual are inter-linked.

Illness is something that upsets the state of being healthy. Signs of serious illness are: not being able to work, not being able to walk properly or far; feeling tired; having fever, pain, headache; not being able to sleep or sit for a long time; loss of appetite; coughing blood, pain in chest, short of breath or constant cough and loss of consciousness.

3.1.2 The health problems

The most common health problems affecting women in order of frequency were reported to be vaginal discharge, haemorrhage and menstrual problems, and cancer of the breast or ovaries. 17% of the women in the HS suffered from a sexual or reproductive health problem compared with 4% of men.

25% of the who delivered in the previous 18 months in the HS had a complication, specifically haemorrhage, blurred vision, discharge, pain in the uterus and chills.

Generally, it was not always clear whether people were they were referring to STI or other diseases. 'Syphilis' was used as a generic term and uterine ulcers might refer to STI. These are hidden diseases and they could only speculate on their incidence.

A\BDS Summary Gill Gordon.doc
The most common diseases reported in men were fever, dizziness, itching, stomach ache, haemorrhoids, heart attacks and hypertension and rheumatism and back pain and AIDS.

People were aware that AIDS can only be diagnosed by a blood test, but they reported seeing people suffering from AIDS and dying one after the other in their communities. They recognised the common signs and symptoms of the infection and its association with TB. The chief of the study area reported 19 deaths from AIDS in the past year. People reported that many sex workers have HIV infection and wives are contracting it through their husbands.

Fever incidence (25%) was similar for women and men in the HS. More men suffered from accidents and women from domestic violence.

Children under 15 years comprised of 44% of the most recently sick people in the HS sample. The most frequent diseases reported were fever, diarrhoea, cough. Worms, stomach pains, dengue, measles, skin diseases, typhoid, chicken pox and malnutrition were also reported.

Older persons suffered more from high blood pressure and coughing of blood and the middle aged from fever, diarrhoea, stomach problems and coughing;

Acute diseases

Acute diseases were defined as those that could be treated successfully in five days to one month. The most commonly occurring acute diseases were fever, typhoid, diarrhoea, cold and cough, stomach ache and dengue. Skin problems, headache and dizziness were also common.

56% of households in the HS had at least one member suffering from diarrhoea over the past six months.

Only 2 of the 75 adult deaths reported by the Group Chiefs in the study areas were caused by acute infections.

Chronic diseases

Chronic diseases were those that had gone on for longer than one to three months and persisted, either for years or until death. People in the FGD gave the following list of chronic conditions in order of frequency: painful joints and bones, TB and lung diseases, stomach pains, liver diseases, haemorrhoids, cancers, skin, ear and eye problems, vaginal discharge and AIDS.

30% of those with chronic conditions had TB or coughing with blood and 26% in the HS. People were reluctant to admit to coughing with blood because of the fear and stigma attached to TB because it is spread by personal contact and associated with AIDS.

Other chronic problems included ulcers, diabetes, malaria, syphilis, swollen belly, spleen, giddiness, heart problems, depression, paleness, gallstones, inflammation of the uterus, heart disease, hypertension and insomnia.
25% of the 75 deaths in the study areas reported by the Group Chiefs over the past year were caused by AIDS and 6% by TB which may be associated with AIDS. 9% were caused by liver diseases. Two died from heart or blood pressure problems.

**Emergencies**

An emergency was defined as any type of health problem that needed treatment immediately. In FGD, the most common emergencies reported in order of frequency were traffic accidents, cholera, dengue fever, high blood pressure, bleeding, uncontrollable fever, coughing or vomiting with blood, poisoning, abortion, loss of consciousness, appendicitis and abscess with septicemia. In the HS, 41% of respondents reported an emergency in their household in the last six months. Accidents accounted for 30% of the emergencies, diarrhoea, high fever and dengue for around 14%, injuries from violence 9% and high blood pressure 5.3%. In the SSI, 60% of the emergency cases were traffic and falling accidents. Surprisingly, obstetric emergencies were not specifically mentioned.

25% of the 75 adult deaths in the study areas reported by the Group Chiefs were caused by accidents and 13% by violence. We were told also of three women who died from haemorrhage.

**Disability**

The problems of disabled Cambodians are particularly severe. The team interviewed ten disabled people, nine of whom had no work except begging. The disabilities were caused in equal numbers by war and accidents, with one polio victim and one paralysis from an injection.

**Fatal Illnesses**

People thought that the following diseases could cause death: AIDS and TB, high blood pressure, appendicitis (if not operated on), breast cancer, allergies, uterine cancer and ulcers, abortions, dengue, bleeding, diphtheria, fever and typhoid (if untreated) and cholera.

**2.3 The causes of poor health**

People recognise the major causes of their health problems as poverty, a grossly unsanitary and unsafe environment, many poor people crowded together with untreated infections, malnutrition and low immunity, dangerous work, stress and a lack of preventive and curative health services.

"We have a permanent headache because we are always worried about daily food and business. We get dizziness and lack of energy because we don't eat enough. Hard work causes dizziness, chest pains and cramp." (Older women, BK)

People recognise that diarrhoea, cholera, typhoid, worms and stomach ache are caused by the piles of rubbish and excrement near their homes, flies, unboiled river water used for drinking or washing vegetables or food and unclean food.
They know that mosquitoes cause dengue, fevers and malaria; bathing in the polluted lake or river water causes skin, ear and eye problems and weak, malnourished children are easily susceptible to disease.

People are aware that they should remove or burn rubbish, use toilets, boil drinking water, spray their homes and destroy mosquito breeding grounds, treat their water and sleep under mosquito nets. They try to feed their children well, vaccinate them and prevent them from playing in dirty or mosquito infested areas.

People are only able to act on this knowledge to a limited extent because of poverty, the nature of the environment, the excessive charges made for water and rubbish collection, and the lack of ownership of the land and a leader who can generate community spirit. It is difficult to build effective toilets in the area and to prevent children from playing in unhygienic and mosquito infested areas.

People put their energies into personal actions such as keeping their homes clean, using mosquito nets and treating of water pots.

Seasonality has a major influence on disease patterns. Mosquitoes, flooding and the heat and humidity in the rainy season cause bad colds, fevers and dengue in children. The rising river sweeps away the rubbish from under houses on the bank, making them cleaner, but people suffer stress from worries about flooding. People only contracted malaria outside Phnom Penh but they reported relapses at this time.

In the dry season, more polluted lake water, less water for hygiene and dried sweat cause skin and eye diseases, diarrhoea and lung diseases. Measles occurs between November and May, when “the winds come from the north and the disease spreads.”

The rainy season is a time of maximum seasonal stress because work in construction and transport is reduced and sickness increases. The deteriorating environment causes stress and people spend a lot of money moving and rebuilding their homes and paying charges to the police.

People are knowledgeable on the causes of AIDS and report that they follow advice to stay away from brothels and use condoms.

People believe that talking with a TB patient, smoking, working very hard, air pollution and lack of hygiene cause TB.

“One woman died of TB in our community. She was very thin, she worked very hard, ate left-over food, fought with her husband, had a lot of pressure at home, so she worried a lot and could not sleep and something then affected her lungs.” Young women, BK

People believe that a common cold can develop into a cough and worsen to TB is not treated correctly in time. People have heard that TB is very infectious and greatly fear it in association with AIDS.
'We were advised not to talk directly or eat with TB patients, because TB is a dangerous disease that can lead to death and can spread widely. TB patients should keep their sputum in a bedpan containing some ashes.'

People know that alcohol, smoking and glue sniffing cause serious health problems. Those who use alcohol and tobacco would like to reduce their intake or give up entirely but find this very difficult. They blame advertisements for their addiction. Glue sniffing is common in young men and street children.

2.4 The consequences of poor health

The most devastating and frequent consequence of poor health is the loss of a job and the inability to work or to work hard. This loss of income happens at the same time as high expenditure on health care costs. Many of the urban poor arrived in their present situation because of ill health and high treatment costs. Health spending is a major reason for indebtedness and loans at high interest rates can lead to destitution. In order to pay for treatment, people may sell economic assets such as motor-bikes and further limit their ability to earn a living. As expenditure exceeds income, the well-being of the household worsens with less food, less care for children and more work for those who are not ill. Depending on the strategy used to obtain money, other negative impacts may follow. (See Section 4.) The other consequences of illness include weakness and tiredness, inability to go out, unpleasant symptoms and stress.

III. HEALTH SEEKING BEHAVIOUR

3.1 Human and Material Resources Available for Health Care

There are a number of options for treating health problems in and outside the study area: these are traditional self-medication; drugs purchased from a grocery or pharmacy, treatment by a health provider in the public or private sector, traditional treatment and spiritual remedies.

In traditional self-medication people carry out 'coining' (scraping the skin with a coin to rub in Tiger Balm or, in the case of the very poor, kerosene) and 'cupping' (raising the blood to the surface of the skin by creating a vacuum within a glass cup by igniting spirits). These are cheap and most people can perform them for others. People find relief from less serious illnesses through these practices.

In self-medication with purchased drugs, people recognise two types of drug sellers, those without training who often operate from groceries and those with medical training who operate from pharmacies. In the former, customers will often request a brand name drug or if they do not know it, describe their symptoms. The drug sellers will then provide an assortment of medicines according to their knowledge and the ability of the customer to pay. People will buy the number of days treatment that they can afford and this often results in them taking an incomplete course of antibiotics or other medicines. Trained pharmacists will usually examine the patient before prescribing drugs, injections or IV drips.
In BK there is one pharmacy with a soldier trained in health care, and six untrained people selling drugs from stores. In Sangkat Tonle Bassac (STB), there are seven pharmacies with trained staff, including a doctor, and 17 stores with untrained people selling drugs. Half of these stores are run by Vietnamese people. Very few of the drug sellers will provide credit.

*Private clinics and home visitors* provide health care for payment in the study areas. In STB, there are seven clinics with 8 beds between them run by trained health personnel. Two are exclusively Vietnamese. In BK there are four small clinics headed by trained staff. These clinics mainly operate from homes. The health provider will perform examinations and give drugs, injections and IV drips. They refer difficult illnesses to the hospitals. Their charges are relatively small, but they mainly will not treat on credit and will charge extra for home visits. They are rarely attended by the really poor. They mark the boundary between self-medication and prescribed medication over which the patients' family have little control.

A *home visitor* is usually a local off duty health professional, a local pharmacist, drug seller, midwife, nurse or medical student. For R2-5000 they will walk to the patient's house bringing medicines, injections or intravenous drips for which they charge extra.

There are two *Kru Khmer* in each study area and traditional herbs can be purchased in the market also. Normally people seek the advice of the Kru and treat themselves at home with herbal medicines. Krus may visit the patient's home for illnesses with spiritual causes. Certain diseases such as STI are usually treated by the Kru because their treatments are thought to be more effective.

*Public sector health services* include the Health Centres and free hospitals Kantak Bopha for children and Samdech Ouv for adults outside the study areas.

There is a vast array of *private sector* doctors, clinics, polyclinics and fee-for service hospitals and maternities outside the study area.

Many people pray as well as seeking treatment. They pray to get treatment quickly and that the treatment will work fast.

People, particularly in BK, complained that there were not enough public and NGO health workers in their area.

"So far we have never seen any NGO or public health person here giving medicine, besides vaccination for children. You all just come here to talk about health for poor people”. (YM, BK2)

**3.2 People's evaluation of the local services**

The table which follows is a summary of the comments made in FGD and SSI on available health resources.
<table>
<thead>
<tr>
<th>Health provider</th>
<th>Good points</th>
<th>Bad points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samdech Ouv, the Centre for Hope Hospital</td>
<td>Most staff are friendly</td>
<td>Long wait now, used to be quick service</td>
</tr>
<tr>
<td></td>
<td>Good medicine</td>
<td>Small number of doctors speak roughly to patients</td>
</tr>
<tr>
<td></td>
<td>Low cost or free medicine</td>
<td>Treated rich person but not poor woman who had waited a long time</td>
</tr>
<tr>
<td></td>
<td>Modern equipment</td>
<td>No medicine</td>
</tr>
<tr>
<td></td>
<td>Close to BK</td>
<td></td>
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<tr>
<td></td>
<td>Pay attention</td>
<td></td>
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<tr>
<td></td>
<td>Proper diagnosis</td>
<td></td>
</tr>
<tr>
<td>Kantak Bopha</td>
<td>Serious patients treated first</td>
<td>Long wait and sometimes cannot get treatment at the end of the day.</td>
</tr>
<tr>
<td></td>
<td>Treat children</td>
<td>Far from BK</td>
</tr>
<tr>
<td></td>
<td>Doctor</td>
<td>Dirty in front of hospital</td>
</tr>
<tr>
<td></td>
<td>Friendly</td>
<td>Some staff behave badly</td>
</tr>
<tr>
<td></td>
<td>Free treatment, give money</td>
<td>Don't tell diagnosis</td>
</tr>
<tr>
<td></td>
<td>(20008) to stay</td>
<td></td>
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<tr>
<td></td>
<td>Hygienic</td>
<td></td>
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<tr>
<td></td>
<td>Comfortable</td>
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<td></td>
<td>Good quality and sufficient medicine</td>
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<td></td>
<td>Pay attention</td>
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<tr>
<td></td>
<td>Examine children</td>
<td></td>
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<tr>
<td></td>
<td>Proper diagnosis</td>
<td></td>
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<tr>
<td></td>
<td>Recover quickly</td>
<td></td>
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<td></td>
<td>Sleep at hospital free</td>
<td></td>
</tr>
<tr>
<td>National Paediatric Hospital</td>
<td>Nearby</td>
<td>Expensive</td>
</tr>
<tr>
<td></td>
<td>Friendly</td>
<td>Not clean in hospital</td>
</tr>
<tr>
<td></td>
<td>Pay attention</td>
<td>Some staff unfriendly</td>
</tr>
<tr>
<td></td>
<td>Ask type of sickness</td>
<td></td>
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<tr>
<td></td>
<td>Good medicine</td>
<td></td>
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<tr>
<td></td>
<td>Check if patient recovered after treatment</td>
<td></td>
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<tr>
<td>The Russian Hospital</td>
<td>Less waiting time, fast treatment</td>
<td>No medicine, have to buy from elsewhere.</td>
</tr>
<tr>
<td></td>
<td>Doctors behave well because fewer patients so not so tired.</td>
<td>Long way from home</td>
</tr>
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<td></td>
<td>Would go there for operation</td>
<td>Cost 83000</td>
</tr>
<tr>
<td>Calmette Hospital</td>
<td>Staff are polite</td>
<td>Refuse to treat anyone without money even if emergency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have to buy own medicine from pharmacy</td>
</tr>
<tr>
<td>Chamcar Mon Dispensary, Japanese or Red Cross Hospital</td>
<td>Cheaper than the others for delivery</td>
<td>Lock woman in ward until the family pays 8150,000 for first baby.</td>
</tr>
<tr>
<td></td>
<td>Charges posted up at reception</td>
<td>No credit</td>
</tr>
<tr>
<td>Preah Ang Duong Hospital</td>
<td>Staff are polite</td>
<td>Have to pay for travel, consultation and medicine,</td>
</tr>
<tr>
<td>The Municipal Hospital</td>
<td>Free medicine</td>
<td>Long wait</td>
</tr>
<tr>
<td></td>
<td>Low cost</td>
<td>May make appointment for next visit</td>
</tr>
<tr>
<td></td>
<td>Triage</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Advantages</td>
<td>Disadvantages</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Preah Kossmak Hospital</td>
<td>Free treatment, good quality medicine and large stock</td>
<td>Not so friendly or hygienic, get annoyed if not punctual</td>
</tr>
<tr>
<td>NGO India Clinic and World Organisation clinic</td>
<td>Give a lot of free medicine to the poor, only travelling costs</td>
<td>Medicines not very effective, only provide sexual and reproductive health services, India only open on weekends, not popular, have to wait in a long queue.</td>
</tr>
<tr>
<td>Private hospital or clinic</td>
<td>Get treatment 24 hours a day, quick service, no waiting, get treatment on credit, good medicine</td>
<td>Expensive for all services, 10 times that of public services, sometimes give expired medicine, mainly interested in profit, sells unnecessary injections, drips.</td>
</tr>
<tr>
<td>Kru Khmer</td>
<td>Asks type of illness, cheap, friendly, good traditional medicine, pays attention, can treat STI, can pray with family</td>
<td>No credit, deceives the patient about power of medicine, sometimes expensive, do not recover, only uses magic.</td>
</tr>
<tr>
<td>Traditional drugs</td>
<td>Expensive, bitter, ineffective</td>
<td></td>
</tr>
<tr>
<td>Drug seller</td>
<td>Cheap and can buy on credit, near home, fast treatment</td>
<td>Grocers, not trained so no examination or diagnosis, ask client what drug they want, ineffective treatment, only use because of poverty, drugs cost 3 times that of drug seller.</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Spend less time getting treatment, cheaper than some hospitals, trained staff can diagnose and give correct treatment, effective treatment</td>
<td>No credit.</td>
</tr>
<tr>
<td>Coining</td>
<td>Traditional practice that most people know how to do, effective if the illness is not serious, free or very low cost</td>
<td>It is not effective for any serious illness.</td>
</tr>
<tr>
<td>Home visit</td>
<td>Visit the house</td>
<td>Will not visit at night, same cost as hospital but not so effective, try to pressure people to buy injections and drips.</td>
</tr>
</tbody>
</table>
3.3 The use of the available health resources

3.3.1 Overview

Individual response to particular health problems is very variable, depending on available money, time, perception of illness and services.

The table below shows the health seeking behaviour of the 155 people whose treatment was detailed in the SSI and the 358 who responded to the HS.

Stages of treatment reported by respondents in SSI and HS

<table>
<thead>
<tr>
<th>Treatment</th>
<th>First treatment %</th>
<th>Second treatment %</th>
<th>Third treatment %</th>
<th>Fourth treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SSI 155</td>
<td>HS 358</td>
<td>SSI 86)</td>
<td>HS 189</td>
</tr>
<tr>
<td>Coining</td>
<td>41</td>
<td>19</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Pharmac</td>
<td>26</td>
<td>50</td>
<td>59</td>
<td>40</td>
</tr>
<tr>
<td>Home visit</td>
<td>4</td>
<td>2</td>
<td>4.5</td>
<td>2</td>
</tr>
<tr>
<td>Traditional</td>
<td>6</td>
<td>NA</td>
<td>NA</td>
<td>31</td>
</tr>
<tr>
<td>Health service</td>
<td>18</td>
<td>24</td>
<td>29</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private clinic</td>
<td>1</td>
<td>5</td>
<td>5.5</td>
<td>15</td>
</tr>
<tr>
<td>Kru Khmer</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>No treatment</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>recovered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-fully</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-partly</td>
<td>27%</td>
<td>51%</td>
<td>45%</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Coining was used by less than half the respondents in both surveys, although it was tried again by respondents in the HS if other treatments failed.

Between 25 and 50% visited the pharmacy first when they were sick. This proportion increased if the first treatment failed and fell by the third treatment.

Trained health providers were used by around one fifth of the patients as the first treatment, over a quarter on the second and one fifth on the third. The most popular hospitals were Samdech Ouv (the Centre for Hope) Hospital for adults and Kantak Bopha Hospital for children. The local Health Centres were used by only two people in the HS.

A tiny minority visited private practitioners and krus initially but this to 15% of the patients on the second and third round of treatment. Home visits were rarely used.
The data show that people make great efforts to find effective treatment for illness, changing providers and treatment if the first action does not work or they are dissatisfied with their treatment.

Many families had run out of money and become indebted by the third round of treatment. They could no longer afford to continue their search for effective health care.

**3.3.2 Health seeking behaviour for acute illness**

The type of health problem is an important factor in health seeking behaviour. If people believe the illness to be 'not serious', they will do nothing or try coining, the grocery pharmacy and the pharmacy first. If the person does not recover, they will diagnose the problem as serious and go to a health provider. This is a rational use of resources if the disease is not serious because the initial treatment is cheap in cost and time and in many cases the person does recover. 27% of patients in the HS completely recovered and 1% partially after the first course of treatment.

However, people do not prefer to use groceries and pharmacies first, they are obliged to do so because of poverty. There is a high level of dissatisfaction with groceries and pharmacies (70% and 24% respectively in the HH survey) because they do not examine, diagnose, inform the patient of the diagnosis and give correct treatment. Their lack of qualifications means that they often give the wrong medicines and the illness becomes more serious because it is not prevented early.

If an illness is perceived to be serious, people will seek treatment from a health facility first. In order of frequency, people in the SSI perceive the following to be the most important signs of serious illness: the patient is not able to work, not able to walk properly or far, feels tired, has fever, pain, headache, is not able to sleep or sit for a long time, has no appetite, coughs blood, pain in chest, short of breath, constant cough or is unconscious.

People may go to the hospital first to get a correct diagnosis so that they can buy the correct drugs at the pharmacy. They may go to a health worker first for correct treatment and advice on diet and care so that the illness does not become chronic.

Illnesses in children requiring immediate attention at the hospital include dengue fever (recognised by the rash) measles and cough.

Age influences health-seeking behaviour. In the HS, 34% of children under five were taken immediately to a health facility compared to 19% of over 35 year olds. The main diseases were fever, cough, diarrhoea, dengue and typhoid. In the SSI, over 50% of sick children were taken directly to a health facility as the first treatment, usually Kantak Bopha. 86% of the children treated by a pharmacist recovered and the majority who did not were taken to Kantak Bopha. The diseases in children treated by pharmacy drugs and taken to a health facility were very similar, that is fever, coughs and diarrhoea. All dengue cases, accidents, malaria and measles were taken to the hospital.
In the HS, 72% of the 10% of households who had a child under ten having diarrhoea reported using Oralyte or substitutes correctly. Oralyte was only mentioned by a few focus groups and rarely reported in health messages.

83% of respondents were able to mention at least one sign of serious respiratory infection, including fast breathing, frequent coughing and fever. However, only 18% of the respondents in the HS would take a child with serious Acute Respiratory Infection to a qualified health provider. The majority would begin by coining and buying drugs from the pharmacy.

In the SSI, 50% of people with an acute illness sought treatment at a hospital or private clinic and 50% visited the pharmacy. Half of the latter had typhoid and were examined and given drugs and drips by the pharmacist. Only 30% recovered and none were satisfied. People complained that the treatment was expensive and ineffective and the staff unfriendly. A high percentage ran out of money and stopped treatment although they were still sick.

Number of days of treatment

84% of the respondents in the HS spent fewer than seven days on their first treatment for an illness, with the majority of these spending less than 4 days. A similar pattern occurred in the second and third courses of treatment, although by this time over a quarter had around 10 days treatment and 14% over two weeks.

3.3.3 Health seeking behaviour for chronic illnesses

People sought treatment in the free or cheaper hospitals for chronic diseases, particularly the Samdech Ouv Hospital, which was reported to treat chronic diseases at no cost with good medicine, good hygiene and emergency procedures in place. If the hospitals fail to cure the condition, patients discharge themselves when the available funds finish. People then turn to buying western and traditional medicines, seeing the Kru Khmer and praying.

In the SSI, 50% of respondents with chronic illnesses reported going to a health facility first and 30% after self-treatment had failed. Only 27% of the patients were satisfied with their treatment. The remainder complained in order of frequency that treatment was too expensive and they could not afford to complete it; they did not recover fully; the staff were unfriendly, the place unhygienic and they had to buy their own medicines. 23% had turned to herbal medicine. This failure of the health service to treat these chronic cases effectively is particularly worrying when we consider that 30% of the patients have chronic cough with bleeding.

People preferred to treat some illnesses with traditional practises or herbal medicine because in their experience it was cheaper and more effective. An example of this is haemorrhoids where the sufferer sits on a hot stone covered with a papaya leaf or a burned coconut is used.

Health seeking behaviour for TB is described in detail below because of its public health importance.
Chronic diseases cause a huge drain on household resources in terms of the cost of health care and loss of work and income.

**Health seeking treatment for TB**

The National TB Centre (CENAT) operates an 8 monthly Directly Observed Treatment Scheme (DOTS) programme. TB workers on motorbikes deliver drugs and supervise the treatment several times a week. Core TB treatment is supposed to be free but this was not the experience of the respondents. They had heard that TB treatment is supposed to be free in Cambodia. They reported that initial charges for documentation, x-rays and sputum tests at the CENAT TB Hospital prevent them getting to the free treatment and those who did reported that they were asked to buy their own drugs on prescription. If admitted, they also have to pay for their food.

50% of the respondents in the SSI with signs of TB had attended the TB hospital at least once and had X-rays and a diagnosis. Not one of them had continued with treatment because they could not afford the ongoing prescription charges. Costs at first treatment varied between $5 and $15 dollars (how much is $870,000?). Costs for other treatments ranged from $84,000-27,000 for herbal medicine; $8,500-10,000 at the pharmacy; $84,000 at the Kru Khmer and $8,400,000 for a home visit. Over half of the respondents had not recovered at all or fully as a result of treatment.

In the HS, 21% of people with signs of TB had not received any treatment in the week of the survey, 56% had bought drugs from the pharmacy, 11% attended the Health Centre, 2% home visits and 11% other providers (WHO ARE THESE, ANY DOTS OR CENAT?). 43% of respondents paid less than 2000 in the previous week, 46% paid between 2000 and 10,000 and 11% paid more than 10,000.

In one interview, a neighbour who had TB died:

"From having TB and many diseases at the same time. He was unable to go to hospital because he had no money for his treatment. We think if he had money he would have got better and lived for a long time."

### 3.3.4 Emergencies

An emergency is defined as a health problem requiring immediate treatment. Transport in emergencies is a problem. 86% of emergencies in the HHS were carried to hospital in a cyclo or motorbike taxi. The cyclo is slow and people have died on the road. Two women died of postpartum haemorrhage in the week to the study, one because she could not afford transport and the other because she could not access it. People wanted a telecommunication system so that they could access an ambulance in an emergency and save lives. They were willing to pay for this because they "would still be alive". Once people have reached the hospital they face the problem of demands for money before treatment and finding a donor if blood is needed. If they are unconscious, they may wake up with a bill that impoverishes them for years to come. Soldiers were taken to the military 1/79 Hospital whilst others go to Calmette, Lok Sang which is cheaper than Calmette and Kantak Bopha in the case of children.
Emergency treatment is known to require special procedures and cost more than other diseases. 30% of the cases spent from R10,000 to R50,000 and 20% between R51,000 and R100,000.

78% of the respondents in the HHS were satisfied with their emergency care. 25% had recovered only partially and 6% not at all.

71% of the emergencies have left the patients with chronic conditions or disabilities. The majority of people were not satisfied with their treatment because it was very costly (except for Kantak Bopha and 1/79), they did not recover, the staff were rude and refused to treat people without money and they are still buying drugs, having run out of money for treatment.

Emergencies incur heavy costs at the time and later if more treatment or rehabilitation is needed. They often put the person out of work and result in destitution for the household.

3.3.5 Disability

None of the disabled people were satisfied with their treatment. Those who had fought in wars felt abandoned, there is no support for disabled people and no one could afford to continue with treatment.

3.3.6 Sexual and reproductive health

Birth spacing
The large majority of sexually active respondents in the FGD, SSI and HS (90%) did not wish to have a child in the coming year. In one FGD in BK, older women reported that they had over five children because they had not been able to avoid pregnancy, they would prefer two or three.

Women in FGD in STB had considerable knowledge of modern contraceptive methods and preferred them to traditional methods. Women in FGD in BK knew nothing about birth spacing. People knew about monthly and daily pills, condoms, injections and IUCDs. (ADD %) A few people had heard of vasectomy, tubal ligation and Norplant. Traditional methods include drinking papaya sap and wine before sex or using medicine from the Kru Khmer. Sources of information included the radio and television and group discussions with the Friendly Organisation (Met Somlaing). This NGO provides counselling on STI/AIDS and birth spacing, provides free pills, injections and IUD, has the phone number of an ambulance and pays for treatment and transport. Women had learnt about withdrawal and periodic abstinence from neighbours and friends.

Some people thought that many people used modern contraception but keep it a secret, even from their husbands. Others believe that "there is no-one in our village spacing by medicine because they fear this will cause trouble to the user". In the household survey 74% of those who did not wish to have a baby in the next 9 months were using a modern contraceptive, 12% a traditional method and 13% nothing at all. In the SSI, only 25% of the women who had given birth in the previous 18 months were using a modern method and 33% doing nothing to avoid pregnancy. Reasons for not using modern contraceptives were a lack of money and knowledge of methods and where to obtain them and experience or fear of
negative effects on the body. These included being unable to work hard, tiredness, body heat, bleeding, tumours, changes in weight and ulcers, at times they believed, made worse by malnutrition. Women found it difficult to manage withdrawal and periodic abstinence because of drunken husbands.

People who used modern methods obtained them mainly from the health centre (40%) private providers 34%) and pharmacy (20%) . The daily pill costs R1500 per cycle and the monthly pill R800 from the private clinic. Some mentioned an ineffective birth spacing medicine sold by pharmacists.

One quarter of respondents in the SSI had had an abortion and people in FGD thought that abortion was a common but secret way of controlling fertility. Abortion costs $10-20 for a one-month foetus and $30-40 for a two to three-month foetus in local private clinics. Several women reported chronic gynaecological problems following abortion and viewed abortion as potentially life-threatening. Women in one FGD were very interested to learn about the Cambodia Women's Clinic, which provides safe abortion for $15 up to three months gestation. Kru Khmer provide herbs to cause abortion.

**Reproductive Tract Infections and Sexually Transmitted Infections, including HIV/AIDS**

Many people do not feel free to talk about STI.

Many people preferred to seek early diagnosis and treatment for STI from a particular Kru Khmer called Ly Bounarith. They believe his treatment to be effective, cheap and nonjudgemental. People also purchase traditional treatment from the market at 815,000 - 30,000 for a full course. One Kru Khmer is reported to be able to treat AIDS (Preah Ang in Takeo province) However, people with AIDS have been strongly advised by Home Care not to visit the Kru Khmer for treatment because AIDS patients have died from their medicines.

District health staff care for people with AIDS, providing them with $10 and free medicines. The Met Somlaing provides counselling on STI and AIDS and the Indradevi Hospital treats clients with STI and AIDS.

Men in FGD who use sex workers were aware that many have HIV infection and used condoms. 47% of the respondents in the SSI reported that they had followed AIDS messages and avoided brothels or used condoms. Some women talked to their husbands and children about the messages. In several FGD, people agreed when asked that a 100% condom use with sex workers campaign in Phnom Penh would reduce deaths from AIDS.

**3.3.7 Pregnancy and Childbirth**

In the HS, 47% of women who delivered in the last 18 months delivered in the hospital, 39% at home and 12% at the health centre, 2% used a private clinic or other provider. 53% of all deliveries were attended by a trained midwife and 21% by a trained TBA. 19% of women were helped by an untrained TBA and 7% by a partner, neighbour or relative.
37% of respondents spent less than R50,000 on their delivery and 31% of respondents spent more than R110,000.

75% of mothers did not have any problems during delivery. Problems reported during delivery included haemorrhage, pain in the uterus, breathing difficulties and chills.

In the SSI, women reported the following problems before or during delivery: pre-partum haemorrhage, blurred vision and numbness, fainted from stomach pain before delivery, difficult delivery, diarrhoea and vomiting (allergy?), haemorrhage, vaginal discharge, dizzy, tired and poor appetite.

In the SSI, only two out of eleven women delivered at home, the rest delivered in the Red Cross, Municipal or 1/79 Hospital, Tbal Thnol and India Clinic. Dissatisfaction with the delivery was high. Those delivering at home planned to deliver in the hospital next time because the TBA did not have enough equipment or skills. Half of those delivering in Hospital complained that the staff behaved badly, refused to assist at all or to suture without payment, did not provide food or did not allow the client to wear pants. The NCMHC was praised for being clean, safe and providing serum when tired, and the Red Cross and Kbal Thnol for treating the poor with the same care as the rich.

The NCMCH charged R71,500; the Red Cross from R10,000-20,000; TBAs charged R5000-10,000; the midwife at Kbal Thnol was free. India Clinic asked for $50 in advance and R20,000 at the time. The Municipal Hospital charged one client R10,000 without suturing and another R100,000.

3.3.8 Child health

Treatment of sick children is described in health seeking behaviour for acute illnesses (3.2.2)

Mothers interviewed in the SSI reported a range of actions aimed at keeping their children healthy. In order of frequency, these were: using a mosquito net; washing the child; ensuring plenty of sleep; vaccinations; providing regular, clean, nourishing food in sufficient quantity; boiling drinking water or giving clean water; not allowing the child to play on the ground, in dark corners or near sewage; clean the house; give vitamin tonic; prevent or treat fever at once and put lotion on the skin. Many of these actions were aimed at preventing dengue fever and diarrhoea. Oralyte was mentioned by one person.

Vaccination
85% of parents with children under the age of 18 months intended to have their children vaccinated within the previous year and all these children had received at least one vaccination. Nearly half of the children received vaccinations from outreach units, a quarter from the public children's hospitals and a fifth from health centres. Polio drops were mentioned by respondents in the SSI and nearly half sought vaccinations to keep their children healthy. One disabled person put the cause of his problem down to not being vaccinated against polio whilst two became paralysed after a vaccination by injection.
In FGD, people reported accessing 6 vaccinations from the Municipality outreach workers or the hospital. These included TB, measles, tetanus, dengue and polio. A key informant reported that the MI-ID no longer has the resources to provide vaccinations in outreach and people complained about this.

3.3.9 Additional problems for Vietnamese people

The Vietnamese respondents thought that living on the boats is less healthy than living on the land. People suffer from itching because they live on the water and bath in polluted water. No one wants to live on a boat because it is difficult to go to market or travel. They have no land and so are obliged to live on the boats. They have no security of tenure even though they have lived there for 10 years. They pay 5000-10,000 riels for mooring their boat for six months in the floating seasons and less in the dry season. Those who live on the riverside pay $10 for a cottage and $20 for a shelter on the land.

Vietnamese people rarely go to Khmer health services because they cannot afford it and will not be treated without money. They do not use public hospitals because they feel embarrassed when the health staff ask them for identify cards, addresses and nationality because they do not have Cambodian identity cards. Also, they speak Khmer badly and would not be able to give clear information on their diseases. Some people felt that they might be treated equally as normal people if they had money, but generally, they preferred to use pharmacies or private clinics, particularly those run by Vietnamese in front of the Russian Embassy. They sometimes invite private health providers to come to their home to give them tablets or injections.

3.4 Type of treatment

The majority of people (around 60%) take drugs by mouth as their first course of treatment. In the SSI, on first treatment, 11.5% of all cases were given IV drips. Of these 50% were accident cases and 27% had diarrhoea or typhoid. The reminder had haemorrhage, anaemia, cancer and dizziness. On second treatment, 14 people had serum, for accident, diarrhoea or typhoid, fainting, anaemia, heart failure, TB, bronchitis and cancer. This does not suggest an overuse of unnecessary intravenous drips. The use of drips was evenly divided between public and private health facilities, pharmacies and home visits.

In the HS, 6% of patients received drips on the first line of treatment and 16% injections. On the second line of treatment this rose to 8% and 18% respectively. Drips and injections were most frequently given by Calmette, private practitioners and a health centre (?). One would expect more drips and injections for emergencies. The profit motive may account for the higher number by private practitioners.

3.4 Factors influencing health seeking behaviour

3.4.1 Overview

It is apparent that people make a rational cost-benefit analysis of their various options based on the health problem, their knowledge and the cost, quality and travel and waiting time of
available options. Costs include money needed to travel and access diagnosis and treatment; time taken to travel to and from the health provider and wait for examinations and diagnosis and treatment. Benefits come from high quality care resulting in speedy and complete recovery.

People in FGD prioritised quality of care issues over cost issues

In the SSI, 63% of respondents mentioned quality of care issues in their likes and only 22% cost issues; 15% mentioned speedy recovery. In dislikes, the percentage mentioning cost and quality of care issues was the same (37%).

High quality services reduce costs of further treatment and lost work for patients and carers. If patients are examined, given the correct diagnosis and drugs, with information and advice, they will be able to treat themselves at home with pharmacy drugs and thus reduce costs.

However, people were not always able to use their preferred services because of an absolute lack of resources and options for accessing them.

The type of illness is an important factor in health seeking behaviour.

3.4.2 Cost factors

*Cost of total treatment process*

Cost is a major factor in making a decision. Some people cannot afford to spend any money on health care and leave their illnesses untreated, perhaps leading to death. One FGD defined spending a small amount as costing 81000 at one visit, including the examination, drugs and counselling. If people believe that the illness is not serious, they will do coining or buy cheap drugs from the local pharmacy first to save time and money. If this does not work, people choose the free hospitals Kantha Bopha and Samdech Ouv, so that they can save their money to buy medicine. Some use the free NGO clinics for specific problems. People were concerned about hidden costs including charges for each step of the process.

"I really don't like the Municipal Hospital because the staff charged me for every step of the examination. I paid R1000 for 'permission', R500 for weighing, R3000 for a urine test and R1,500 for the drugs".

The Chamcar Mon Dispensary wins some approval for listing charges above the reception desk, although the practice of locking maternity patients in their ward until the charges have been paid is seen as doubtful practice.

In FGD, people claim that they no longer know which hospitals are public as they charge the same as private hospitals and will not treat patients without money.

Calmette Hospital is known to have a free ward run by Medicins Sans Frontiers, but it can only accept about 20 patients a day, and the interrogation by medical staff to determine whether patients are entitled to use it is seen as humiliating.
Some people know about exemptions, but find the process of accessing them daunting and humiliating. They are treated with contempt because of their dress and speech; subjected to humiliating public interrogation to assess whether they are exempt; have to wait a long time for a senior officer to sign the paperwork; are expected to obtain district leaders signatures; are put in separate wards or unpleasant places and then face demands for unofficial payments from health workers anyway. A woman who was granted an exemption was refused suturing without a payment to the doctor. She now has long term health problems.

In the Chamcar Mon Health Centre, 3.3% (86) and 6.3%(154) of the total clients were poor people exempted from paying and a small number had discounts of 10-50%. Around 10% of maternity cases had an exemption or discount.

It is understood that health workers on low salaries need extra payments to survive. For this reason, people would prefer to be treated by NGO staff on good salaries or pay into a credit or insurance scheme, which contributes to health worker salaries.

There was a distrust of private practitioners because people felt that they were only interested in profit and exploited people.

"Private practitioners are friendly if we have money. If we have a disease needing 4 injections, they will give 15 injections. Pharmacies foster illness so that they make more money"

**Distance**

Physical distance relates to the cost, time and difficulty involved in taking a patient to hospital. This is an important factor, especially for the ultra poor. In one FGD, people measured distance by cost, $R1000$ was thought to be a short distance and over $R4000$, far. However, some people could not afford even $1000R$ to travel to the hospital. "I have a liver disease. So far, I have not recovered because I only have enough money to go to the pharmacy. I cannot go to hospital, although it costs only $R1000$ per day. It is not much money but it is not small for me as a member of a poor family". People get into debt for the $R3000$ needed to go to the hospital. "For us, $R3000$ might as well be $300$, because we do not have it". In emergencies, the type of transport is important because a patient might die on the way in a cyclo.

Social distance is also an issue. A poor person with old clothes will not travel one kilometre to a health facility where they have to share a waiting room with rich, well-dressed people and be shamed by staff who reject them because they have no money.

**Waiting time**

Waiting is an opportunity cost for the patient and the accompanying family member, who are both losing income. In one FGD, people judged waiting for an examination less than one hour to be a short waiting time and over four hours a long waiting time. People add waiting and travel time when they make a decision on the cost of health care.

In some cases people have to wait a long time for examinations, tests, consultation and treatment. Samdech Ouv and Kantak Bopha have a number system that involves queuing for a
from 04.00 hours and patients might not be treated on that day. They then have to start again the next
day. This deters them from using the hospital promptly and raises the question of emergency cases.
Triage is practised in some hospitals and people complained about queue jumping. In others, emergency
cases have to wait in line and people fear that death will come before treatment. People suggested a
triage system with a separate waiting area for the emergency cases.

3.4.3. Benefits

Benefits depend on quality of care, which is made up of a number of factors, including health worker
behaviour, examination, diagnosis, correct treatment, informing the client about the diagnosis,
treatment, care and prevention and the environment.

Health worker behaviour
Good health worker behaviour was mentioned most frequently in factors that people liked about the
services they used. It included being friendly, polite, welcoming, do not look down on poor patients,
treat them the same as rich ones; interested in the patient and encourage him or her to relax. Bad
behaviour included insulting the patient and showing a lack of respect, looking down on patients because
of their clothes or way of talking; blaming people for not bringing the patient earlier, keeping the person
waiting a long time and refusing to treat them or putting them in a bad place because of lack of money.

Examination
People thought that health staff should examine the patient fully and do any necessary tests. They
should take a full history of the illness and treatment to date.

Diagnosis
Following the examination, the health staff should make a correct diagnosis and explain it fully to the
patient. Wrong diagnosis can mean more than one curative episode, threatening lives and finances.
Correct diagnosis allows the patient to buy drugs and treat the illness at home.

Correct treatment
The health staff should provide the correct treatment for the particular illness. This includes giving
good quality drugs (Thai and French) that are not expired; selecting the correct drug for the illness
rather than giving a mixture of many drugs; not giving unnecessary drugs to make a profit and giving
effective drugs that cured the illness quickly. The health service should have enough drugs to give the
patient so that they do not have to go to the pharmacist, who might give the wrong drugs.

In a few FGDs, people said that they believed injections to work faster and more effectively than oral
drugs. Intravenous drips were only mentioned as a like by 7 people in the SSI and in FGDs, even when
asked, people thought that drips were only needed for serious illness or used by rich people to give
them energy. Several people reported that private practitioners and hospitals like to sell serum
regardless of need.
"When we are sick and ask a health worker to treat us at home, they rarely ask us 'do you want medicine?' They always tell us 'you have to inject and get serum so that you get better quicker'.

"Doctors say that hypertension needs serum and hypotension also needs serum. The doctors in the clinic in front of the Russian Embassy have a passion to sell their serums"

Provision of information
People were eager for information on the diagnosis of their illness, the correct treatment and how to take the drugs, how to care for the patient in terms of diet and care and how to solve or prevent the same problem recurring. They regarded this information as power because it would enable them to treat themselves at home cheaply and effectively and prevent illness in future. The less they spent on hospital costs, the more money they could spend on medicine. In some cases, health staff were reluctant to inform patients and relatives of their diagnosis and get angry if questioned. Some respondents felt that they did this to increase their power over the patient.

Hygiene
A minority of people mentioned the importance of hygiene in health facilities in FGD and SSI.

Speedy recovery
Patients should recover quickly, that is in 3 to 5 days after the first treatment.

3.5 Suggestions for a high quality health service

3.5.1 Characteristics of a good health service

People had a very clear idea of the characteristics of a good health service:

- The whole process, including examination, drugs and counselling costs RION or less. Many people would prefer it to be free, but feared that this might not be sustainable.
- Staff should be friendly and well-qualified. They should be well-trained to they are careful and give good advice to patients. They should be well-paid so that they are happy and can concentrate on their work.
- The services should have enough modern equipment.
- Services are accessible 24 hours a day, in the community.
- The staff find out the cause of the disease by asking the patient questions and providing examinations and tests.
- The staff tell the patient the diagnosis and how to prevent, care for and treat the disease.
- The staff provide the correct treatment for the disease, using effective drugs.
- Patients wait for one hour or less for examination and definitely less than 4 hours.
- Transport to the hospital costs R500 or less and anyway not more than R1000.
- Provide all services together in the same place, for example maternal and child health and care for adults.
- Separate the people with serious diseases from those with not such serious diseases in different rooms and treat the serious ones first.
"The most important thing is that the health providers are ethical and work to help the patient, not to make a profit out of them."

3.5.2 Strategies for providing good health care

Public and NGO services
Many people suggested encouraging NGOs to provide services in the squatter communities because "they love the poor", they have better-qualified, caring and friendly staff on good salaries, good equipment and provide free services. On the other hand, people recognised that public services would be more sustainable in the long-term and suggested that they should be improved in terms of quality of care, staff behaviour and charges. They thought that the NGO and municipality should co-operate and refer between facilities.

Health workers and health facilities in the community
People had a number of ideas on ways to provide a good health service including:

° a health worker from the municipality to visit regularly. They would examine and treat poor people and provide information on prevention, these actions would prevent further sickness and spread of infection. The main problem would be that people fall sick in the night or on the days that the workers are not there.

° A health worker to live in the community so that they can provide treatment at night. There are many health workers in the community now but without NGO support, they have to charge a lot of money for services to support their families. The project should collaborate with health workers who have worked in their zone for a long time. "They know the people in our zone very well, who is rich and who are the poorest, who should get free treatment and care."

° Provide more information on the NGO facilities in the area so that they could access high quality, cheaper care and provide a 30% subsidy.

° Provide a health facility near or in the community so that they could easily access treatment even at night. The health staff should provide examinations and treatment for less serious disease so that people did not have to go to the hospitals.

° Train five members of the community to work at the health centre. They should explain health risks and prevention to people, work as security officers and contact other NGO and hospitals when necessary. The health centre would support people to connect to the public hospitals such as Kantha Bopha and Calmette.

° A mobile clinic to visit all poor areas once a week to provide treatment and referrals.

° A floating clinic moored to the river or lake which could treat minor ailments and refer to the hospitals, undisturbed by major flooding.
The Community Health Representative
People in STB suggested that a qualified nurse or doctor from this community should act as a community health representative to explain about health risks, hygiene and how to prevent diseases; notify the Municipality about health problems, treat the less serious diseases and refer others.

Transportation
People wanted a telephone or radio and the number of the hospital at the chief of village or group so that they could access the ambulance in an emergency. "I think that many people have died because they could not reach health care quickly in an emergency. An old woman last year died because she was bleeding a lot and she died on the cyclo because it was so slow. If we had a car she might be alive today. We can pay the cost later if we are still alive."

The environment
The project should help people to clean up the environment. The insect killing campaign should come to the community every month to eradicate mosquitoes. It is supposed to visit every community but it has never come to BK3. The authority should repair the water pipe and pump water from the lake. The rubbish needs to be cleared up to prevent many types of diseases.

2. PAYING FOR HEALTH CARE

4.1 Economic groupings and paying for health care

In the FGD, people were asked to classify people into three categories according to their ability to pay for health care, to describe typical work in each category and to 'guesstimate' the proportion of people falling into each one. The proportions varied in each FGD. This may reflect economic differences between zones or the difficulty of making such a judgement.

Category one people who can pay nothing for health services. This category includes unemployed persons, people who do not own their house or land and disabled people. It was reported to represent about 30% in TB and 85% in BK.

Category two people can afford some money for health treatment but not more than 82000 a day for seven days. This group includes construction workers, motorbike taxi and cyclo drivers, grocery seller, NGO workers, cake sellers, seamstresses and vegetable vendors. It is reported to represent about 10% in BK and 50% in TB.

Category three people can afford to pay R5000 to R10,000 a day for health treatment. This category includes government staff, companies' staff, businessmen, noodle sellers, taxi-drivers, fishermen, engineers, promotion girls, meat sellers, second hand clothes sellers and private loan providers. It comprises about 5% in BK and 20% in BK.

Category four people can pay more than R10,000 a day for seven days. This category includes gold, car, bike, radio or TV sellers, pharmacists, high rank officials, doctors and directors of big companies, hotels or factories. This category of people do not live in the study areas.
When asked about their own ability to pay, the majority of people in the FGD could not afford more than R2000 a day for seven days. If they needed to pay more than this, they would be obliged to adopt a strategy to source additional funds, with negative impact on the household.

In the household survey and SSI, two indicators were used to assess economic status and ability to pay for health care.

a) The outcome of subtracting weekly expenditure from weekly income. If the balance was positive, the household was classified as poor. If income equalled expenditure, the household was classified as very poor and if expenditure was more than income, as ultra poor.

b) The weekly income per capita in the household.

In the SSI, 70% of households were poor, 9% very poor and 21% ultra poor. In the household survey, 42% were poor, 22% very poor and 36% ultra poor. The reasons for the difference in proportions is not clear. The household survey sample is younger and may be not so well established as the older group.

In the household survey, 16% of households earned less than R5000 per head per week, 38% earned between 5,100 and 10,000 per head per week, 20% earned between 11-15,000 and 14% earned over 20,000.

In terms of total income per household per week, 5% earned less than 10,000R; 19% from 11,000-30,000; 43% from 31,000-60,000 and 24% from 61,000-90,000.

Expenditure includes high rates for water, electricity, rubbish, rent. Food and health care are major costs.

4.2 Costs and expenditure on health care

**Coining or cupping** are free or cost less than R500. **Oral medicine from the pharmacy** costs between R500 to R3500 for a day, depending on the drugs given. The home visit is very expensive. Most of the respondents who had used home visit said that they paid R20,000 too R210,000 for a treatment period, lasting from one day to a week. The high cost is due to the charge for a home visit and the use of injections and IV drips. **Private treatment** is also expensive, costing as much as R1,170,000. In the emergency cases, many patients had been transferred to the public hospitals where they spent from R35,000 to $156 for their treatment. Delivery of babies at hospitals is also expensive, costing from R50,000 to R150,000 for deliveries at the public hospital. In the HS about 30% of respondents paid more than R110,000 for delivery. A few people in STB spent 81500 a month for contraceptive pills or $10 to $20 for an abortion. Free treatment is provided by NGOs for specific groups and was rarely accessed. People use the hospitals that provide free treatment, that is Samdech Ouv and Kantak Bopha most frequently. Funerals cost between $26 and $210.

Expenditure on health care is extremely variable, depending on the health problem. For example, in the HS, the first treatment cost ranged from zero to R780,000. On average the
people spend 14% of their income on health care. In the first treatment, 27% of the respondents paid less than R200; and a further 21% less than R5000. A quarter spent more than R20,000. The average cost of second line treatment is R15,000 higher than first line because people are obliged to pay more to trained health providers.

The recurrent costs of chronic illnesses represent a severe drain on the household and many people stop taking any treatment for this reason. The high costs for emergency treatment often put households into debt and a downward spiral of poverty.

"We used to call doctors to visit us at home but nowadays we don't. Even if we visit their houses they won't treat us because they know we have no money."

"One day I saw a patient who was nearly dying. A hospital staff member asked his daughter if she had money. When she said 'No', the staff member said "I'm surprised that you would bring him here without money."

In the FGD, people were dissatisfied with paying at public hospitals for poor quality of care. Staff were unfriendly and did not examine them or give them effective treatment. Nowadays, medicine is more costly then food.

4.3 Strategies used by the poor to access health care when a family member is seriously ill

Most of the people in the two target areas cannot afford to pay more than R10,000 per day for health treatment. When they need more money to pay for a seriously illness they most consider different strategies. In FGD, people discussed the following strategies for coping with high health costs. They are written roughly in order of popularity.

Private loans
Most people would first choose to borrow money from private loan providers or neighbours with interest because they can borrow money at any time. People known to the borrower might charge between 8-15% interest per month with private lenders charging 20% to 30 % per month. There is no loss of face in getting a loan and if it is paid back people do not lose their property.

However, borrowing money with high interest rates would affect the well being of the household very badly in the future if they cannot find the money to pay the interest or the borrowed money. Respondents in TB two said,

"headache is the most common illness here because the people cannot sleep well as they are always thinking about the money to re-pay the loan".

The interest would accumulate and the loan therefore increases. The lender would force people, often violently, to leave their house or land, kidnap a daughter to sell to the brothel. Some people had been forced to leave the province because they could not repay a loan and had sold all their land and animals.
**Sell assets**

Only few of people said that they would sell their assets before going for a loan because they would not have the headache of trying to find the money to pay back to loan providers. However, they cannot sell their asset at the 'book value' prices. "We must sell our asset at the cheapest price". They regret selling their property because they will not be able to buy it again or borrow it when they need it.

People in the provinces sold small animals as second choice but large animals only as fourth choice.

Selling economic assets can reduce earning power and access to information.

"I sold my new motorbike to pay for my family's health care and food and bought an old one. Now it's difficult to earn money by 'motordop' because I keep getting problems with it."

"I sold my radio to pay for my son's health care."

Some people would pawn their goods rather than sell them, but they often lost them in the end.

**Borrow money from relatives**

Some people preferred to borrow money from their relatives first when they needed only a small amount of money. However, they would feel shy of their in-laws and could only borrow a little money because "our relatives are also poor". Most of them considered that borrowing money from the relatives can lead to conflict because the relatives want the money back quickly.

**Borrow money from friends**

Many people do not like to borrow money from friends because they will then look down on them and scold them if they cannot pay the money back.

**Reduce expenditure**

People reduce their meals from three a day to two. However, they are not able to sleep well and feel hungry, weak and pale. This makes it difficult for them to work hard to earn more money and puts them at risk of illness, which again will stop them earning.

**Work harder**

Some people decide to have family members, particularly the husband, work overtime. But this can lead to health breakdowns and stress so that a person needs to take care of the patient. This may result in the husband and the carer not earning any money at all. Some people look for work as a hired hand, but they feel depressed because the employers look down on poor people and speak badly to them.

**Children**

Some people take their children out of school to save the R200-500 a day costs for each child. The children then work as labourers, food or water sellers. This could be a fourth choice for
them but the problem is that some families do not have children of work age. "They are very small". Stopping their children attending school and sending them to work for money is considered worse than selling the house because they are damaging the future of their children. They are illiterate, malnourished, tired and do not have time for sleep.

"We are well aware of the consequences of taking our children out of school, but food and health have to take priority. If we could find better ways, we would not do this. We do it because we have no choice."

If they owed a money lender, they would have to take the children out of school and to work. Some people keep their children in school, but they work after school.

*Obtain medicine on credit*
Few respondents said that they could buy medicine or get treatment on credit, particularly because they come from poor areas. If you cannot pay back the credit, you cannot buy from that person again.

*Borrow money on their house or land*
The people could also borrow money on their house, but if they had no money to pay their loan back, the people would take the house and then where would they live? But this is not common, particularly in the very poor areas where housing appears temporary.

People lost their farmland because they could not repay loans. They then had no land to farm or build their house on and had to rent it. This will make the future very difficult. Some people in the FGD in TB had sold all their farm land, animals and house. With nothing left to pawn or sell, they were forced to run away from the province.

*Send children to live with relatives*
Some respondents sent their children away to live with relatives to save the expense of feeding them. They feel sorry for them because they have never been separated before. They worry about their health, mistreatment and overwork.

*Sell house for money*
Some respondents said that they might sell their house for money if they needed it badly for the treatment of illness. A few of them said they were staying in rented houses. "We have no house to sell!". This should be the last choice because they would then have to ask for land to build a small shack, live in the wat or on the streets or under the trees. Some groups thought that selling the house is the very worst option. They would lose face and need to pay monthly rent on another house. Sometimes they are forced onto the street or under the trees because they cannot find the money to pay for the rent. Their very lives then become vulnerable. Mr. Soung Sothy, Health Co-ordinator from the Indradevi Association said that they there are many AIDS patients who have no shelter. They are at a high risk of additional infections. However, one focus group said that selling the house is better than having a loan with high interest because they do not worry about loans.

*Sell family members*
They could sell one of the female family members to a brothel. Some people said that they are afraid of diseases, AIDS or mistreatment if they sell themselves to the brothel. They will feel shy of their neighbours, dishonourable and have a bad future. They could sell their baby. One woman said she sold her baby for R60,000, but had to give R20,000 to the broker. She also said she had never recovered from the sadness.

_Beg_
Sometimes people sell everything they own, land, house and property and are forced to beg. They fell very shy to do this and often send their children to beg some money from the Svay Rieng.

_Steal_
If they become a robber, the police may catch them, beat them and put them in prison.

In the SSI, nearly one third of respondents did not access extra money for health care, they coped with their existing income. People obtained extra money in the following ways: 25% obtained money from partners, children or parents, 20% took out a loan with interest and the same number borrowed from neighbours and friends without interest; 15% worked overtime or took on extra jobs and 7.5% took their children out of school or asked them to work or beg. 12% were able to use their savings. For 15% of the respondents, these strategies had no impact on household well-being. For the rest, negative impacts included anxiety about repaying loans (15%), a lower standard of living and daily worries about paying for basic needs as expenditure exceeds income (15%); reduced food intakes (10%); children forced out of school (6%) and dependency on children or relatives (8%). 15% of the respondents were unable to work hard or to work at all because of their illness, with devastating effects on household well-being.

4.4 Suggestions for reducing financial barriers to health care

4.3.1 Overview

Many people initially could not think of any strategies for making payment easier other than loans and credit schemes. When community insurance was suggested, they were eager to discuss this type of scheme further because it would enable them to spread out payments for health care rather than being hit by a devastating bill.

4.3.2 Free services or free services for the poor

In the SSI interviews, most people wished for a free health service, probably provided by an NGO. When asked to think of strategies for coping if free health services were not possible, people agreed that it was unlikely that health services could be provided free in the long-term.

In one FGD, people thought that the chief of the groups and villages should identify which people are poor and very poor because at the moment many rich people receive more assistance from the NGO and government than poor people. The NGO should have a health office representative in the community and give cards to the poor people. They could then refer them
to the right sector for specific problems. The card should be used for selected hospitals. To
prevent people selling the card to make money, it should have the photos of the family members
with their names and an official stamp. (See section on costs of health care on exemptions)

4.3.3 Credit

A credit system was a popular idea, particularly for serious diseases.

"Even though I am an AIDS patient, if I could borrow R50,000 from a credit system, I could
pay back R12,500R per month."

If they were to pay into a credit scheme, the majority thought that they would be able to pay
R2000-3000 a month if they had work and R500-1000 if they had very small jobs. Some people
thought that daily payment of R100 would be easier as they are employed on a daily basis.

OM in TB5 thought that:

"a Credit Community would "mean that we help ourselves in advance of a problem - no
organisation or government will pay 100% of the cost of health care."

One group suggested 'Credit Community' (CC) in which people pay 500R per week and can
borrow up to 10,000R per month with 10% interest. The CC would ensure that money was
borrowed for the right purpose. The CC would not be able to provide loans for serious sickness,
for example, requiring 100,000R because a sick person would not be able to pay back this
money. In this case, the NGO would have to help with a low cost loan.

People also wanted a credit programme to help people to establish successful businesses in order
to improve their health. The credit should attract about 5% interest.

4.3.4 Health insurance

People thought that health insurance was a good idea because no health provider was likely to
provide totally free treatment. They might be able to help with 40% of the costs. People are not
able to pay a lot of money at one time, but if they could pay a little money each month then
everyone could get treatment.

The main anxiety with this system was that the procedures would not allow people to access the
services quickly or that people would try to use the money for other business. This could be
overcome by asking a trusted chief, NGO, rich person or Community Association to handle the
funds. They thought that people with a job could pay R2000-3000 a month into the scheme. And
those with no job or low income could not pay anything or a maximum 500-1000 riels per
month.

Some people suggested creating a committee or having a community representative in the
community to co-ordinate the NGO and a selected hospital in Phnom Penh so that when
someone was ill, the committee or representative would send them to the hospital. The members of the insurance scheme would have a card to use for transport and the NGO would reimburse the driver. The money would be kept in a bank to generate interest and audited every six months. The representative should be close to the community and available 24 hours a day in case someone was sick at night. They could rent some land for $10 a month to build a small clinic with two rooms.

People thought that:

"the health insurance scheme would "mean we are with friends, we pay attention to our health and the health staff will treat us with happiness"."

Young men in STB suggested learning from the Vietnamese who have a Health Association in the community, in which people help each other to ensure that people were sent to a low cost Hospital using the health insurance.

One person suggested reducing the cost of water and electricity.

5. HEALTH EDUCATION AND PROMOTION

In the semi-structured interviews and FGD, all respondents could mention at least one health message that they had received over the past year, with the exception of one poor young woman who had recently arrived from a rural area, did not have a radio and television and remained in the house to care for young children. Many respondents mentioned two or three different messages.

5.1 Sources of information

66% of the respondents in semi-structured interviews had received the health messages from the television, 35% from radio, 15% from neighbours or relatives and 12% from NGO and government health workers. A small number had seen messages on posters and in newspapers.

In the household survey, about a third of respondents had discussed ideas about health in the past three months, with staff from NGOs (Bamboo Shoot Community, Friendly Organisation and Indradevi) and neighbours, relatives and village leaders.

5.2 Content of health information

The most frequently mentioned health information related to AIDS prevention, dengue fever prevention and care and avoidance of diarrhoea by hygienic measures. The need for vaccination, extra water in diarrhoea treatment, wrapping a person with fever in a wet cloth and using only prescribed medicines were mentioned far less frequently.
One person remembered an AIDS message on TV, telling people to "not hate people with AIDS, but lift the sick person's spirit, please them, encourage them to eat a lot, to sleep well and not to think too much."

Several people mentioned advice on not giving aspirin to children.

In the SSI, only one person mentioned Oralyte for diarrhoea treatment and contraceptives were rarely mentioned.

The vast majority of respondents were able to explain the health messages correctly. The only doubtful message was one concerning how to avoid a cough turning to TB by avoiding smoking and clearing rubbish. The message to avoid people with TB was a cause for concern because of discrimination towards those with TB and people with AIDS, which is now associated strongly with TB.

The picture provided by SSI was similar to that seen in the FGD. Participants had largely correct and detailed knowledge on topics such as the prevention of AIDS, dengue fever and typhoid, which they had acquired from TV and radio. Beehive Radio gave information on various sexual health problems and advised people to go to the Hospital for treatment. Two women had taken their husbands for treatment themselves following an episode with sex workers without a condom. Another participant practised putting a condom on a banana.

5.3 Behaviour change

In the SSI, it was not always easy to tell the difference between knowledge and practice. However, the great majority of people reported that they had managed to put at least some of the messages into practice. In several cases, women reported that they had informed their husbands or children to avoid AIDS by staying away from sex workers or asked husbands to use condoms.

47% of respondents in the SSI mentioned AIDS prevention messages, 41% dengue, 22% diarrhoea and typhoid, 7% vaccinations and 4% each alcohol, smoking and TB.

In two FGD, the majority of participants said that they were only able to follow perhaps half of the health advice because of their poverty and unhygienic environment.

One woman reported that:

"My family had to built a shack on a very crowded site. We didn't have enough space to build a toilet, leave rubbish or drain sewage. So we have polluted the environment in our community."

In FGD, people reported that it was very difficult to give up alcohol and tobacco although they were well-aware of the diseases caused by these drugs. One man reported that he had found it very difficult to give up alcohol:
"I am addicted to alcohol and I can't give it up. When I drink alcohol, I feel stronger and that encourages me to work."

In another group, young men aimed to reduce smoking to one box per day and drinking to one litre a day.

In the household survey, 44% of respondents reported that they had changed their behaviour as a result of health education. The remainder said that they were too busy with their daily work or the information was not relevant because of their age.

Fewer than 10% of respondents had participated in community activities to improve health, for example, cleaning the environment, constructing toilets, putting Albet into water pots or discussing birth spacing. Those who did participate thought that their communities had become more hygienic, with sufficient toilets, fewer mosquitoes and less dengue fever.

5.4 Advertisements

Over 90% of respondents in semi-structured interviews could recall at least one advertisement promoting a product with an effect on health. The sources followed a similar pattern to the health information, with 62% of the respondents seeing advertisements on TV and 33% on radio. Advertisements on vans, in shops and on posters were mentioned by 18, 14 and 12% respectively. 70% of the respondents recalled products with a positive impact on health, in order of frequency, medicines, toothpaste, soap, condoms and mosquito coils, whilst 30% recalled alcohol and cigarettes. Almost 50% of the sample purchased an advertised health product, whilst a third of respondents did not buy any goods, because they could not afford them or felt they were bad for their health. In one FGD people explained that they bought the advertised medicines to treat children at night for mild symptoms such as fever, cough, cold and dizziness. If the illness was serious, they would go straight to the hospital.

People preferred advertisements that provided information on how to stay healthy and strongly disliked advertisements for products, specifically drugs, that had a negative impact on health.

All the respondents reported that they learnt about health facilities outside the neighbourhood through the recommendation of a neighbour, relative or friend. The main factors of interest were low cost and effective treatment. People saw local health facilities "with their own eyes" and decided to use them. People did not trust advertisements for health services of any kind because they felt that the promoter was only interested in profit.

5.5 Suggestions on the most effective way to reach people with health information

5.5.1 Television

TV was a popular medium for providing health information, although people might switch channels for a favorite Thai or Chinese story. TV is a better medium of instruction for illiterate people than radio because people can understand the action even if they miss some of the words.
In spite of only 20% of people owning TV, over 60% of respondents had learned new health information from TV or seen an advertisement for a health product on TV. People either watched a neighbour's TV or talked with someone who had.

The most popular time for watching TV is from 6.00 - 11 pm, with a peak of 6.30-7.30pm. The most popular channels are Apsara TV, Bayon TV and TVK.

Use popular comedians or TV stars to give health information.

Show a handsome doctor giving advice to a beautiful but poor patient on a full range of health problems in ordinary language.

5.5.2. Radio

30% of people own a radio. The favourite times for listening depended on the owner's occupation, with pre-work (6-7.OOam) lunchtimes (11.OOam) and evenings (from 6pm) the most popular. Those working from home, doing stationary work or unemployed tended to have the radio on all day.

People thought that an early evening programme featuring a doctor advising a patient on health care in ordinary language would be very popular.

People become devoted to certain radio stations, with 107FM, 103FM, 90FM, I IFM, Beehive Radio and national Radio Station the most popular. Some older women were very keen on Beehive radio because it never advertised things that were bad for health and gave frequent health messages.

5.5.3 Posters

People reported that they had studied carefully and absorbed information that they had read from posters in health facilities, stuck on trees and walls and in people's houses. Some people did not favour posters because people who could not read and write would not be able to understand them.

5.5.4 Word of mouth

Information on the advantages and disadvantages of different health providers and changes in pricing policies spreads quickly through word of mouth. Many interviewees thought that the "May krom" or group leaders could spread health information effectively through group meetings or informally as opportunities arose. Qualified advisers could also give information at group meetings. People had more trust in information given personally by credible sources than in mass media. People thought it was important to be able to discuss things face to face in order to understand them well.
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ANNEX 1 Research Questions
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ACKNOWLEDGEMENTS

This report represents the outcome of a huge amount of dedicated and difficult work by the Crossroads research team. The areas were often flooded and the researchers had to wade through rubbish and mud to reach the groups and households. At first the team had doubts whether community members would be willing and able to make diagrams and perform role-plays but they enthusiastically and gently gave it a try. The warm welcome they received in the communities whenever they visited is a reflection of their friendliness and the trust that was built up. Carrying out the BIDS was emotionally demanding because of the distressing situations described by many respondents and the overwhelming poverty. The courage and resourcefulness of the people living in the squatter communities is humbling. It gives cause for optimism that a real partnership between the project and the community will ensure that the additional resources so desperately needed are well used.

John Holloway and Dr UyVengky ensured that all the logistics were in place and provided skilled and supportive leadership. They worked hard to make the translations of Khmer into English as full and accurate as possible. They put a huge amount of work into organising and analysing the information from PLA activities and individual interviews, analysed the notes and questionnaires Chom Sok managed to organise, often at short notice whatever type of group or interviewee was needed.

The Crossroads team has enabled the project and wider development community to hear the voices of the poor men and women in Tonle Bassac, Boeung Kak and Borei Geyla as they talk about the reality of their struggle to survive and live as whole human beings in desperate circumstances. For this, a debt of gratitude is owed to the Crossroads team, John, Vengky, Sok, Sithana, Lany, Leakan, Sokco, Chanborn, Hoeung, Chandeth, Borei, Sinath and Som Onn. I also want to thank all members of the team for their great hospitality and warm friendship shown to a stranger arriving for the first time in Cambodia. We had fun as well as hard work.

Thanks also to all the community members who gave their time, described their experiences and gave their creative and sensible ideas on how the project might go about improving health services and health. They took on trust that this process was not just talk, that it would result in relevant action.

I really appreciated the friendship and hospitality of Sharon and David Wilkinson and their guidance and skilled facilitation of the dissemination workshop.

Finally thanks to Katie Chapman for her always pertinent inputs, flexibility, totally reliable management of this consultancy and editing of this report.

Gill Gordon  
February 2000
PREFACE

The findings described in this document represent a synthesis of analysed data from the two phases of the Baseline Demand Survey (BIDS), which together encompassed Focus Group Discussions (FGD) using Participatory Learning and Action tools (PLA), semi-structured interviews (SSI) and a questionnaire-based household survey (HHS). There is a wealth of data from these sources, particularly direct quotations from community members, details of treatment from the SSI and cross tabulations from the questionnaire survey that is not included in this report because of time and space constraints. The analysis of the data will continue as the project progresses, related to specific activities or needs. The data is also available for use by groups who wish to analyse specific areas in more detail or to further disaggregate the findings.

This document was written in the UK by the consultant responsible for the BIDS, Gill Gordon. It would have been easier and more participatory for the Crossroads team and consultant to have worked together on the Synthesis so that it represented their collective perception of reality. This ideal situation was not possible because of financial and time constraints. The information presented in this document is based on the reports prepared by Crossroads on phase one (qualitative research) and phase two (quantitative household surveys), some additional analysis of the original data in FGD notes and SSI and HHS tables. It represents the consultant's interpretation and organisation of this evidence and needs to be seen as a working document for ongoing discussion with the community, the Crossroads team and other stakeholders.
**ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>APS</td>
<td>Approved Providers Scheme</td>
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<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
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<td>BDS</td>
<td>Baseline Demand Survey</td>
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<td>BK</td>
<td>Boeung Kak</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
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<td>CENAT</td>
<td>National TB Centre</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<td>DOTS</td>
<td>Directly Observed Treatment (Short-Course) Strategy</td>
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<td>EPI</td>
<td>Expanded Programme of Immunisation</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>HC</td>
<td>Health Centre</td>
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<td>HHS</td>
<td>Household Survey</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HSR III</td>
<td>Health Sector Reform III Project</td>
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<td>HSUP</td>
<td>Health Services for Urban Poor project</td>
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<td>MHD</td>
<td>Municipal Health Department</td>
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<td>MPA</td>
<td>Minimum Package of Activities</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NMCHC</td>
<td>National Mother and Child Health Centre</td>
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<tr>
<td>NORAD</td>
<td>Norwegian Agency for Development Co-operation</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PLA</td>
<td>Participatory Learning and Action</td>
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<td>SSI</td>
<td>Semi-structured interview</td>
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<td>STB</td>
<td>Sangkat Tonle Bassac</td>
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<td>SUPF</td>
<td>Solidarity Among Urban Poor Federation</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>UHP</td>
<td>Urban Health Project</td>
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<td>UNCHS</td>
<td>United Nations Centre for Human Settlements</td>
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<td>UNDP</td>
<td>United Nations Development Fund</td>
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<td>USG</td>
<td>Urban Sector Group</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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*Assumption throughout report that Riel 3,800 = US$1*
EXECUTIVE SUMMARY

The Urban Health Project (Section 1)

1. The Ministry of Health and World Health Organisation are implementing an Urban Health Project (UHP) in two squatter areas of Phnom Penh, Sangkat Boeung Kak and Sangkat Tonle Bassac as part of the Health Sector Reform III Project. The UHP is funded by DFID and managed by Options Consultancy Services. This report describes the findings of the Baseline Demand Survey (BDS) for one component of the UHP, the Health Services for the Urban Poor (HSUP).

2. The purpose of the HSUP component is to increase the utilisation of primary and secondary quality health care services by the urban poor through improved quality and removal of social and economic barriers to access. The experience of working to provide these services in an urban context will also inform the development of policy for improving the health status of the urban poor.

The Baseline Demand Survey (Section 2)

3. Crossroads Consultancies, Phnom Penh conducted the BDS with technical assistance in survey design, training, analysis and report writing from a consultant contracted by Options Consultancy Services. The BDS was conducted between June and November 1999.

4. The BDS aimed to understand the experiences, perceptions and suggestions for improvement of the people living in the squatter communities and the reality of their lives. The areas of interest were perceptions of health and illness, health-seeking behaviour, issues around paying for health care and how people accessed and responded to information on health care, health behaviour and health products.

5. The BDS was conducted in two phases. The first was a qualitative phase using Focus Group Discussions and Participatory and Learning and Action tools with 55 peer groups and 155 semi-structured interviews with individuals selected because they had recent experience of an acute or chronic illness, an emergency, childbirth or disability. A total of 674 people were involved. The findings from this phase were used to begin the design of the project and to de-sign the second phase of the BDS, a random sample questionnaire-based household survey aimed at complementing the first phase and measuring indicators to assess impact. The household survey was administered to 366 individuals.

6. The BDS was undertaken in Sangkat Boeung Kak, Sangkat Tonle Bassac and Borei Geyla area of Khan 7 Makara.

7. Findings from phase one of the BDS were disseminated at a workshop with key secondary stakeholders in September 1999. The findings were used to set the parameters for the project design of the Health Services for Urban Poor component in overcoming barriers to access to health services for the urban poor. Findings from
phase two are being used as baseline data against which project progress will be assessed.

8. Further analysis of data from the BDS will be undertaken as the Project progresses related to specific components and needs.

Health and Illness (Section 3)

9. People consulted in the study communities think of health as a state of not being sick and of having enough energy to cope with their demanding lives.

10. The most common health problems affected women were reported to be vaginal discharge, haemorrhage and menstrual problems, and cancer of the breast or ovaries. The most common diseases reported in men were fever, dizziness, itching, stomach ache, haemorrhoids, heart attacks and hypertension, rheumatism and back pain, and AIDS.

11. Children under 15 years comprised 44% of the most recently sick people in the household survey sample. The most frequent diseases reported were fever, diarrhoea, cough with others such as worms, dengue fever, measles and malnutrition also reported.

12. Accidents accounted for almost one-third of emergency cases reported in the household survey, and traffic and falling accidents accounted for almost two-thirds of emergencies reported in semi-structured interviews.

13. People recognised the major causes of their health problems as poverty, a grossly unsanitary and unsafe environment, many poor people crowded together with untreated infections, malnutrition and low immunity, dangerous work, stress and a lack of preventive and curative health services. Seasonality has a major influence on disease patterns.

14. The most devastating and frequent consequences of poor health is the loss of a job and the inability to work or to work hard. This loss of income happens at the same time as high expenditure on health care costs.

Health Seeking Behaviour (Section 4)

15. Options for health care in and outside the study area include: traditional selfmedication (coining and cupping); drugs purchased from a grocery or pharmacy, treatment by a health provider in the public or private sector, traditional treatment and spiritual remedies. People have an understanding of the strengths and limitations of these options and seek care accordingly. Prayers may be said at all stages to obtain good care, to strengthen the effect of the treatments and to effect a cure.

16. Individual response to particular health problems is very variable, depending on available money, time, age of the sick person, type of health problem, perception of
severity of the illness and of services.

17. The data show that people make great efforts to find effective treatment for illness, changing providers and treatment if the first action does not work or they are dissatisfied with their treatment. However, many families had run out of money and become indebted by the third round of treatment. They could no longer afford to continue their search for effective health care.

18. For most health problems, people would prefer to obtain care from a qualified health provider. For some problems, for example STI, some prefer the treatment of kru khmers.

19. People prefer to use the two free hospitals rather than the nearer PHC centres. For the MHD, this is an inefficient use of health resources and the reasons need to be better understood and remedied.

20. People are eager for knowledge about health care so that they can take responsibility for treating themselves when this is appropriate and visit the correct service when necessary. This would reduce demand on the health services and is seen as empowering.

21. People reported many cases of chronic coughing with blood that was not being effectively treated. Prevalence rates for untreated TB are likely to be high in poor, overcrowded urban areas. The great majority of people with TB are not receiving effective treatment because of cost, time and distance barriers to the TB Centre. DOTS was not mentioned in any of the interviews. The avoidance of people with signs of TB resulting from health messages is likely to make it more difficult to identify and treat cases through DOTS.

22. Emergencies are frequent and have devastating health and financial consequences. In the previous six months, 41% of the HHS respondents had required access to emergency cares. The most common cause of emergencies were reported to be accidents, violence, cholera, dengue, diarrhoea and high fever and high blood pressure. Accidents and violence are reported to cause 25% of all deaths. Transport, money and blood for transfusion are major barriers to getting good emergency care and many people are left disabled and unable to work because of accidents. People suggested a 24 hour telephone or radio that could be used to call an ambulance or vehicle. The presence of a health worker in the community able to treat worrying symptoms, especially in children, was seen as important.

23. 53% of women interviewed in the HHS were assisted in labour by a trained midwife. 25% had a complication. The majority of women preferred to be assisted by a trained provider with sufficient drugs and equipment to deal with complications. Some women with obstetric emergencies are not able to access or afford a vehicle and died. Deliveries are costly and extra payments are demanded for interventions such as suturing. Some people were ready to pay for an emergency transport system for obstetric emergencies.
24. There is a high level of sexual and reproductive health needs in men and women, including STI and HIV, birth spacing, abortion, cancers and obstetric emergencies.

25. There is a high demand for modern contraception in both the study areas and according to the "household survey 75% of those who wish to postpone pregnancy are using a modern contraceptive (note: this is not the same as contraceptive prevalence - IN rate). The main reasons for not using contraception are negative experiences or worries about the effect of contraceptives on the body, cost and lack of information about methods and providers. Periodic abstinence and withdrawal are difficult because of drunk and uncooperative husbands.

26. The incidence of HIV and AIDS is high and a leading cause of morbidity and death. Vaginal discharge is reported to be the most common health problem in women, but this may not be caused by an infection or even abnormal. Many people prefer to visit a Kru Khmer for STI treatment, finding it more effective.

Quality of Care (Section 4.5.3)

27. Many people have a clear understanding of the components of a high quality health service. These include friendly staff, thorough examination, correct diagnosis and treatment, explanations of the diagnosis, treatment and care needed and how to prevent it next time.

28. Many people value quality of care above low cost in services because high quality services enable patients to recover quickly and this in turn reduces the costs of repeated treatments, chronic illness and loss of work. However, some people have an absolute lack of resources and are not able to choose high quality care. Also patients with chronic illness such as TB may not appreciate that the treatment will make them feel worse before they feel better and that they need to take it over a long period of time. Many of the health problems in the study communities are not easily treatable. Examples are liver disease, gynaecological problems and disabilities.

29. Correct treatment means the use of only the specific drugs needed to cure the illness, medicine from Thailand or France that is not expired and no unnecessary drugs, injections or drips. Although injections were thought by some to act faster than oral medicines, IV drips were only thought necessary for serious illness and people complained that private providers promoted the use of injections and drips for profit.

Paying for Health Care (Section 5)

30. It is apparent that people made a rational cost-benefit analysis of their various options based on the health problem, their knowledge and the cost, quality and travel and waiting time of available options. Cost is a major factor in making a decision about health-seeking behaviour.

31. Costs of health care include travel costs and the money paid officially and unofficially for different-stages in the care process; opportunity costs for the patient and
accompanying carer in travel and waiting time and possibly the cost of a loan. People compute all these costs when make decisions about health care.

32. The community perceives four categories of people in terms of ability to pay for health care. These are those who cannot pay anything (30%), those who can pay up to R2000 a day for 7 days health treatment (50%), those who can pay up to R5000 (20%) and those who can pay up to R10,000 for seven days health treatment. In BK, those who cannot pay anything were estimated to be 85%.

33. People are paying more for health care than they can afford. The strategies used to access money include: taking a loan at high interest rates, borrowing from relatives and friends, selling assets, eating less and working harder, taking children out of school and having them work, sending children away to relatives, selling or raising money on a house or land and selling girls to the brothel or babies. All these strategies have severe consequences for the household and push people further into poverty and ill health. People with severe chronic illness have become destitute and sleep on the streets.

34. Whenever possible people choose the cheapest source of care compatible with the severity of the illness and quality of care provided. They choose the free hospitals which are set up by NGOs.

35. People assess the prospects for complete or partial recovery from different sources of treatment in order to prevent chronic disease and reduce recurrent costs and loss of work.

36. People may invest in a hospital visit to obtain a diagnosis and information on how to prevent and manage an illness at home more cheaply in future.

37. People are paying high costs for ineffective health care from untrained drug sellers, private practitioners, the public sector and the traditional system. A large percentage finish treatment before they have recovered because they run out of money. They are left with a chronic illness or disability, which reduces their ability to work and in the case of TB, spreads disease.

38. Having insufficient money to pay for health care results in people receiving poor quality of care or no care at all. People delay treatment or go to the cheapest, nearest source of care first unless they believe the illness to be serious. This is generally an untrained drug seller. People buy the quantity and quality of drugs that they can afford at the drug stores. They do not take a full course of antibiotics or continue their TB drugs, which must result in high levels of multi-drug resistance. People are refused help in labour or suturing because they cannot pay. This poor quality of care results in chronic illness and disability, reducing work capacity and increasing health care costs.

39. The impact of high health costs is magnified when the whole amount has to be paid immediately. This puts people into debt or forces them to sell major assets. Emergencies and deliveries fall into this category.
40. Chronic diseases represent a huge drain on household resources because of loss of work and recurrent costs.

41. On average people spend around 14% of their income on health care. Some spend three or four times their income.

42. Very few people accessed exemptions and those that did found the process of accessing them daunting and humiliating. They were often made to wait a long time, get official signatures, go to a separate ward and changed unofficially anyway. People were actively discouraged from obtaining an exemption.

43. People would prefer free high quality health care close to their homes because this would drastically reduce their expenditure on travel costs and reduce the opportunity costs due to travel time. They would be satisfied with exemptions or discounts if strategies could be found to identify those who really need them in a dignified manner and the health providers honoured the exemption. Strategies suggested were that the group leaders and local nurses should identify the very poor and they should be given cards with photographs of all the family to prevent misuse by others. A 40% discount was thought to be reasonable.

44. People understand that realistically they will have to contribute to sustainable health care, particularly to pay health worker salaries so that they are able to concentrate on their work. They are very interested in any scheme that would help them to spread health care costs over a period of time, particularly a community health insurance or credit scheme. They are aware of the potential problems with such schemes and have many ideas as to how they could be overcome.

45. The cost of health prevention is very high because people are charged very high rates for water, shelter, rubbish disposal and electricity. Also, the unhealthy environment means that good child minding is very time-consuming.

46. The cost of the morbidity in the squatter settlements to the public health service is high. The care of people involved in accidents and violence and with chronic conditions such as TB, AIDS and liver disease is very high. The cost of treating complicated or severe cases of infectious diseases such as measles, dengue and typhoid is also high. (The private sector is making a profit from the high level of morbidity)

47. The uncertainty of costs at the health facilities makes people reluctant to use them. People may be unofficially charged for registration, examination, treatment and extras. They would like to have charges clearly displayed at the entrance and no unexpected charges in the course of treatment.

48. Information on health service costs is spread through word of mouth by trusted sources in the community.

*Health Education, Communication and Promotion (Section 6)*
49. Many people in the project sites are highly motivated to learn more about the prevention and treatment of health problems in order to preserve health and life for its own sake, for strength to earn a living and save health care costs.

50. People want information that enables them to make good decisions on the care of sick people. This includes signs and symptoms of serious illness requiring treatment from a health provider, which drugs to buy for 'non-serious' symptoms and other first aid measures, which health facilities in their area they should use for different problems and how to prevent the illness spreading.

51. Families are concerned to take good care of their children and provide them with the correct treatment when they are sick. Yet, 17% of respondents in the household survey could not name one sign of serious ARI and only around 20% took a child with ARI to a trained health provider.

52. Few people mentioned the use of Oralyte for diarrhoea in the qualitative research but 16% of those with diarrhoea in the household survey had used it and this rose to 71% in children under the age of ten years.

53. The incidence of diseases varies seasonally largely as a result of climatic changes and their effect on the environment.

54. People with symptoms of TB are being stigmatised following advice to cover the mouth when talking to someone with TB and the observation that it is often associated with AIDS. This makes people reluctant to acknowledge that they have a chronic cough and possible TB.

55. People learn about how to prevent illness from the television, radio, posters and health workers in that order. In spite of low rates of TV and radio ownership, poor people in the project sites access, appreciate, recall and use health information from these sources.

56. The household survey data showed that 60% of people watch television and 33% listen to the radio but these are likely to be the poor rather than the ultra poor. The majority of people learn new ideas about health through these media and they believe that TV is the best because people can see actions as well as listen to words. People had some creative ideas about how to put across messages in an interesting way on the media and these should be developed in further work with user groups.

57. The most frequently mentioned health information related to AIDS prevention, dengue fever prevention and care, avoidance of diarrhoea by hygienic measures.

58. People wanted a health worker to live in the community or visit it regularly so that she could share information with them and discuss problems and solutions face to face.

59. People see, appreciate and respond to advertisements for health products on the TV,
radio, posters and vans and dislike adverts for smoking and drinking.

60. People reported that they are not able to follow all the health advice given because health problems are caused by factors outside their control such as poverty and an unsanitary environment. People are able to practise some health promoting behaviour in their own home and in their personal lives. Examples are the use of mosquito nets, treating of water pots and use of condoms. Community members can learn from each other's successes.

Partnerships (Section 7)

60. Respondents in the study areas perceived potential constraints to participation to include: a history of political violence breeding mistrust; a high population turnover; the opportunity costs for people attending meetings or doing voluntary work without payment; the intractable nature of the causes of ill-health; lack of resources; lack of a sense of ownership, permanence and active leadership in the communities, heightened by neglect and exploitation by officials and land-owners.

61. People also identified positive indicators of potential participation as: several self-help groups and associations already in existence; great interest in forming credit or insurance associations and employing community members for health care activities; offers to rent land and to erect a building for the project service providers; 9% of respondents in the household survey had participated in communal activities for improving the environment and health over the past year.

62. The multiple causes of ill-health in the project sites (poverty, unsanitary environment, lack of clean water and shelter, overcrowding, unsafe workplaces, and promotion of alcohol and tobacco) demand a multi-sectoral approach for addressing them.

63. A number of well-regarded NGOS and CBOs already exist in the project sites, particularly addressing sexual and reproductive health in Tonle Basac. However, Boeung Kak is less well-served and the community feels isolated.

Programme and Policy Implications (Section 8)

64. Programme and policy implications in each of the study areas are outlined in order to inform the design of the Health Services for Urban Poor pilot project.
1. INTRODUCTION

1.1 Background to the Urban Health Project

There are estimated to be some 35,000 families living in squatter areas of Phnom Penh and they form part of a much larger group of around a quarter of a million urban poor who live in roof top slums, on the street or scattered through the city. The squatter areas are excluded by definition from many of the services and the social and productive systems of the capital. The families in the settlements are extremely poor and vulnerable to risks, particularly of loss of health and income. Their settlements are degraded environments that constitute further health risks. Other pressures, including the cost of living in the settlements and the cost of medical treatment, contribute to the inability of these people to break the cycle of poverty and leave the settlements.

According to the Cambodian Health Sector Reform Group:

"despite a huge quantity of provision, the health care market is repeatedly failing to meet the health care needs of the population. This is because often the services provided are of a poor quality and/or represent bad value for money for the consumer. This situation is particularly acute for urban poor people, who are more likely to need health care and who have less resources and information to be able to access good quality services."

The Urban Health Project (UHP) is part of the Health sector Reform III Project (HSR III) which is being executed by the Ministry of Health (MoH) and the World Health Organisation (WHO). The purpose of HSR III, which is being funded by the United Nations Development Programme (UNDP), the Department for International Development (DFID), the Norwegian Agency for Development Co-operation (NORAD) and WHO, is to contribute to the reduction of poverty in Cambodia through the development of quality basic health services.

The UHP is being funded by DFID, and operates in Phnom Penh. The Managing Consultant is Options Consultancy Services Ltd., in association with the Health Policy Unit of the London School of Hygiene and Tropical Medicine.

The Phnom Penh Urban Health Project aims:

- To improve the utilisation of good quality and affordable basic health services in Phnom Penh, particularly in poor communities, by implementing two pilot projects that will establish new delivery systems involving the public and private sectors. One of these is the Health Services for Urban Poor (HSUP) component. The second component is Working with Private Providers.

1 Health Sector Reform III Project, "Urban Health Project, sub-contracted under Health Sector Reform I I I Project" paper dated 10 August 1998
• To gain a better understanding of the health care needs and health seeking behaviour of the population of Phnom Penh and particularly the urban poor.

• To use information obtained from evaluating these projects to formulate strategies to improve the workings of the health care market in Phnom Penh.

1.2 Health Services for the Urban Poor: Rationale

The purpose of the HSUP component of the UHP is to increase the utilisation of quality Health Care services (both primary and secondary) by the urban poor through improved quality and removal of barriers to access, including financial barriers. The experience of working to provide these services in an urban context will also inform the development of policy for improving the health status of the urban poor.
2. THE BASELINE DEMAND SURVEY

2.1 Research Objectives and Questions

A baseline demand survey (BIDS) was conducted to investigate the nature of health care demand in Phnom Penh.

The objectives of the BDS were as follows:

- To enable Government and donors to gauge firsthand community health needs and perspectives on the acceptability, affordability and accessibility of health services;
- To inform the project's key secondary stakeholders about the issues facing poor people as they seek health care in Phnom Penh;
- To help to inform the design of the two pilot projects and refine their performance indicators;
- To provide a baseline against which to measure change during the lifetime of the project.

This report focuses on the findings from the health services for the urban poor (HSUP) component of the BIDS.

Scope of the Baseline Demand Survey

The BDS aimed to understand the experiences, perceptions and suggestions for improvement of the people living in the squatter communities and the reality of their lives. The areas of interest were perceptions of health and illness, health seeking behaviour, issues around paying for health care and how people accessed and responded to information on health care, health behaviour and health products. A detailed list of questions is given in Annex 1.

2.2 Approach and Methodology

2.2.1 The Design of the BDS

The BDS was carried out in two phases. The first phase used qualitative participatory methods, that is, Participatory Learning and Action (PLA) and semi-structured interviews (SSI). Findings from phase one of the BIDS were disseminated at a workshop with key secondary stakeholders in September 1999. The findings were used to set the parameters for the project design of the Health Services for Urban Poor component in overcoming barriers to access to health services for the urban poor. The findings from this phase were also used to design the second phase of the BIDS, a quantitative household survey-that included evaluation indicators. Findings from phase two are
being used as baseline data against which project progress will be assessed.

The BDS methodology is described in detail in a separate document on lessons learned from the methodology.

Three squatter areas were selected for the BDS, that is Sangkat Boeung Kak, Sangkat Tonle Bassac and the Borei Geyla area. The first two areas are project sites for the HSUP interventions. The latter was selected to understand how the poor accessed health care in the richer area selected for the "Approved Provider Scheme". The BDS team walked around the project areas and divided them into eight zones on the basis of environmental and economic conditions. The sample for group discussions and interviews was purposively selected from the 600 or so families to the south and west of Sangkat Boeung Kak, 4000 families on and near the river bank in Sangkat Tonle Bassac and 300 families in the Borei Geyla area of Khan 7 Makara. In total, 674 people participated in the first phase of the BDS and 366 in the second.

The BDS was conducted by a team fielded by Crossroads Consultancies in Phnom Penh with technical assistance from an outside consultant fielded by Options. The team was trained by the Crossroads team leader and deputy team leader and the Options consultant in FGD and PLA, SSI and individual interviews, recording, observation and analysis.

Phase 1
Focus Group Discussions (FGD) were held with 55 peer groups selected on the basis of age, sex, income level, ethnicity and location. This strategy revealed differences between groups and enabled people to freely discuss common problems. Twelve PLA tools using diagrams and role-play were used to address the study questions from different angles.

Researchers worked in teams of facilitator, note-taker and observer. Discussions were recorded on tape-cassette, video and camera with permission and notes were taken. Each interviewee was given $1 at the end of the interview process to cover opportunity costs. Reports on the discussions were compiled by the team and 'interviewed' by the Team Leaders to cross-check and clarify the information before finalising.

The PLA activities contributed to the building of trust and rapport, the initiation of a consultative process, increased ownership and open discussion. Participants enjoyed the activities more than questionnaires and felt that they built confidence. They kept the diagrams, enabling follow-up for further planning. Participation in the design of health interventions begins the process of recognising and claiming consumer rights and strengthens civil society.

Semi-structured interviews (SSI) were held with 155 individuals using a purposive sample of people who had recently experienced an acute illness, chronic illness, an emergency situation, childbirth or a disability. This reflected the content of the MHD's Minimum Package of Activities (MPA). The Krom leader identified these individuals.
Phase 2
A quantitative questionnaire-based household survey (HHS) was administered to 366 individuals found at home whilst visiting every eighth household. Phase 2 aimed to complement the findings from phase 1 and provide a baseline against which to measuring the impact of the project. The data was put on computer and analysed using SSPU software.

Informal conversations, key informant interviews and observations continued throughout the survey period.

2.2.2 Strengths and Limitations of the Study

Strengths
The team spent 3 months in the project communities developing credibility and trust, resulting in people being more likely to be open in presenting the reality of their lives. Triangulation of sources, team members and methods allowed the team to cross-check and compare results. That is, talking with different people (sex, age, economic level, location, ethnicity, type of health problem); having researchers with different characteristics (sex, age, background) and using different methods (PLA diagrams and role-play, SS interviews and individual questionnaires) allowed the team to compare results and understand different perspectives. Participants were asked what they had learned at the end of each discussion. The report was fed back to the groups who participated to ensure that the findings reflected what they said. The teams sat down together after each session and discussed and compared what they learnt from the session as facilitator, note-taker and observer.

Limitations
Individuals were not always willing to talk openly about illness, particularly TB and STI, which are stigmatised. Translation from Khmer to English was time-consuming and there was not sufficient time for all the researchers to develop skills in probing and note taking. The analysis and synthesis of the two phases was difficult because the chief investigator was not able to work closely with the team in country.

2.3 Characteristics Of The Study Communities

The squatter areas are illegal and unofficial regulations prevent public utilities reaching this area. It is government policy for squatters to be voluntarily re-settled but this is unlikely to happen in the short-term. This situation exposes the community to high living costs, exploitation of many kinds and greatly inflated charges for basic needs such as water and housing. For example, piped water costs about R7000 per cubic metre, while in other areas of Phnom Penh it costs only R350. Electricity costs are also high. There is no sewerage system.

Households in the squatter communities were classified into poor, very poor and ultra poor according to their ability to pay for health care and the balance between their income and expenditure (see Section 4.1). The ultra poor could not afford to pay anything for health care, the very poor could pay up to R2000 a day for seven days and
the poor up to R5000 a day for seven days.

The ultra poor live on or next to the lake or river and suffer from flooding in the rainy season. The lake and river water is polluted. Their homes are makeshift and contain little or no possessions. They are surrounded by mud, sewage and rubbish, which attracts flies and mosquitoes.

The very poor live higher up the bank and have more substantial wooden houses but they are also at risk of flooding and live in a polluted environment.

See Annex 2 for detailed description of the study areas.
3. HEALTH AND ILLNESS

3.1 The Meanings of Health and Illness

People in the study communities think of health as a state of not being sick and having enough energy to cope with their demanding lives. Being well is having the body in balance, not too hot or cold, not having bad blood or wind in the body, having a good complexion, not working too hard and eating and sleeping well. Mental health is being clever with a calm mind and not being under stress. Good health includes having spiritual lives in balance, the physical and spiritual are inter-linked.

Illness is something that upsets the state of being healthy. Signs of serious illness are: not being able to work, not being able to walk properly or far; feeling tired; having fever, pain, headache; not being able to sleep or sit for a long time; loss of appetite; coughing blood, pain in chest, short of breath or constant cough and loss of consciousness.

3.2 The Health Problems

The most common health problems affecting women were reported, in order of frequency, to be vaginal discharge, haemorrhage and menstrual problems, and cancer of the breast or ovaries. 17% of the women in the HHS reported to suffer from a sexual or reproductive health problem compared with 4% of men.

25% of the women who delivered in the previous 18 months in the HHS had a complication, specifically haemorrhage, blurred vision, discharge, pain in the uterus and chills.

Generally, it was not always clear whether people were referring to STI or other diseases. 'Syphilis' was used as a generic term and uterine ulcers might refer to STI. These are hidden diseases and they could only speculate on their incidence.

The most common diseases reported in men were fever, dizziness, itching, stomach ache, haemorrhoids, heart attacks and hypertension, rheumatism and back pain, and AIDS.

People were aware that AIDS can only be diagnosed by a blood test, but they reported seeing people suffering from AIDS and dying one after the other in their communities. They recognised the common signs and symptoms of the infection and its association with TB. The chief of the study area reported 19 deaths from AIDS in the past year. People reported that many sex workers have HIV infection and wives are contracting it through their husbands.

Fever incidence (25%) was similar for women and men in the HHS. More men suffered from accidents and women from domestic violence.

Children under 15 years comprised of 44% of the most recently sick people in the HHS sample. The most frequent diseases reported were fever, diarrhoea, cough. Worms,
stomach pains, dengue, measles, skin diseases, typhoid, chicken pox and malnutrition were also reported.

**Older persons** suffered more from high blood pressure and coughing of blood and the **middle aged** from fever, diarrhoea, stomach problems and coughing;

**Acute diseases**
Acute diseases were defined as those that could be treated successfully in five days to one month. The most commonly occurring acute diseases were fever, typhoid, diarrhoea, cold and cough, stomach ache and dengue. Skin problems, headache and dizziness were also common.

56% of households in the HHS had at least one member suffering from diarrhoea over the past six months.

Only 2 of the 75 adult deaths reported by the Group Chiefs in the study areas were caused by acute infections.

**Chronic diseases**
Chronic diseases were those that had gone on for longer than one to three months and persisted, either for years or until death. People in the FGD gave the following list of chronic conditions in order of frequency: painful joints and bones, TB and lung diseases, stomach pains, liver diseases, haemorrhoids, cancers, skin, ear and eye problems, vaginal discharge and AIDS.

30% of those with chronic conditions in the FGD had TB or coughing with blood, and 26% in the HHS. People were reluctant to admit to coughing with blood because of the fear and stigma attached to TB because it is spread by personal contact and associated with AIDS.

Other chronic problems included ulcers, diabetes, malaria, syphilis, swollen belly, spleen, giddiness, heart problems, depression, paleness, gallstones, inflammation of the uterus, heart disease, hypertension and insomnia.

25% of the 75 deaths in the study areas reported by the Group Chiefs over the past year were caused by AIDS and 6% by TB which may be associated with AIDS. 9% were caused by liver diseases. Two died from heart or blood pressure problems.

**Emergencies**
An emergency was defined as any type of health problem that needed treatment immediately. In FGD, the most common emergencies reported in order of frequency were traffic accidents, cholera, dengue fever, high blood pressure, bleeding, uncontrollable fever, coughing or vomiting with blood, poisoning, abortion, loss of consciousness, appendicitis and abscess with septicemia. In the HHS, 41% of respondents reported an emergency in their household in the last six months. Accidents accounted for 30% of the emergencies, diarrhoea, high fever and dengue for around 14%, injuries from violence 9% and high blood pressure 5.3%. In the SSI, 60% of the emergency cases were traffic and falling accidents. Surprisingly, obstetric emergencies
were not specifically mentioned.

25% of the 75 adult deaths in the study areas reported by the Group Chiefs were caused by accidents and 13% by violence. We were told also of three women who died from haemorrhage.

Disability
The problems of disabled Cambodians are particularly severe. The team interviewed ten disabled people, nine of whom had no work except begging. The disabilities were caused in equal numbers by war and accidents, with one polio victim and one paralysis from an injection.

Fatal Illnesses
People thought that the following diseases could cause death: AIDS and TB, high blood pressure, appendicitis (if not operated on), breast cancer, allergies, uterine cancer and ulcers, abortions, dengue, bleeding, diphtheria, fever and typhoid (if untreated) and cholera.

3.3 The Causes of Poor Health

People recognise the major causes of their health problems as poverty, a grossly unsanitary and unsafe environment, many poor people crowded together with untreated infections, malnutrition and low immunity, dangerous work, stress and a lack of preventive and curative health services.

"We have a permanent headache because we are always worried about daily food and business. We get dizziness and lack of energy because we don't eat enough. Hard work causes dizziness, chest pains and cramp.” (Older women, BK)

People recognise that diarrhoea, cholera, typhoid, worms and stomach ache are caused by the piles of rubbish and excrement near their homes, flies, unboiled river water used for drinking or washing vegetables or food and unclean food.

Environmental Factors Influencing Poor Health

Respondents knew that mosquitoes cause dengue, fevers and malaria; bathing in the polluted lake or river water causes skin, ear and eye problems and weak, malnourished children are easily susceptible to disease.

People were aware that they should remove or burn rubbish, use toilets, boil drinking water, spray their homes and destroy mosquito breeding grounds, treat their water and sleep under mosquito nets. They try to feed their children well, vaccinate them and prevent them from playing in dirty or mosquito infested areas.

However, people were only able to act on this knowledge to a limited extent because of poverty, the nature of the environment, the excessive charges made for water and rubbish collection, and the lack of ownership of the land and a leader who can generate community spirit. It is difficult to build effective toilets in the area and to prevent children from playing in unhygienic and mosquito infested areas.
**Seasonality** has a major influence on disease patterns. Mosquitoes, flooding and the heat and humidity in the rainy season cause colds, fevers and dengue in children. The rising river sweeps away the rubbish from under houses on the bank, making them cleaner, but people suffer stress from worries about flooding. People only contracted malaria outside Phnom Penh but they reported relapses at this time.

In the dry season, more polluted lake water, less water for hygiene and dried sweat cause skin and eye diseases, diarrhoea and lung diseases. Measles occurs between November and May, when "the winds come from the north and the disease spreads." The rainy season is a time of maximum seasonal stress because work in construction and transport is reduced and sickness increases. The deteriorating environment causes stress and people spend a lot of money moving and rebuilding their homes and paying charges to the police.

People are knowledgeable on the causes of AIDS and report that they follow advice to stay away from brothels and use condoms.

People believe that talking with a TB patient, smoking, working very hard, air pollution and lack of hygiene cause TB.

"One woman died of TB in our community. She was very thin, she worked very hard, ate left-over food, fought with her husband, had a lot of pressure at home, so she worried a lot and could not sleep and something then affected her lungs." Young women, BK

People believe that a common cold can develop into a cough and worsen to TB is not treated correctly in time. People have heard that TB is very infectious and greatly fear it in association with AIDS.

"We were advised not to talk directly or eat with TB patients, because TB is a dangerous disease that can lead to death and can spread widely. TB patients should keep their sputum in a bedpan containing some ashes."

People know that alcohol, smoking and glue sniffing cause serious health problems. Those who use alcohol and tobacco would like to reduce their intake or give up entirely but find this very difficult. They blame advertisements for their addiction. Glue sniffing is common in young men and street children.

### 3.4 The Consequences of Poor Health

The most devastating and frequent consequence of poor health is the loss of a job and the inability to work or to work hard. This loss of income happens at the same time as high expenditure on health care costs. Many of the urban poor arrived in their present
situation because of ill health and high treatment costs.

**Indebtedness**

Health spending is a major reason for indebtedness and loans at high interest rates can lead to destitution. In order to pay for treatment, people may sell economic assets such as motor-bikes and further limit their ability to earn a living. As expenditure exceeds income, the well-being of the household worsens with less food, less care for children and more work for those who are not ill. Depending on the strategy used to obtain money, other negative impacts may follow (see Section 4).

The other consequences of illness include weakness and tiredness, inability to go out, unpleasant symptoms and stress.
4. HEALTH SEEKING BEHAVIOUR

4.1 Human and Material Resources Available for Health Care

There are a number of options for treating health problems in and outside the study area: these are traditional self-medication; drugs purchased from a grocery or pharmacy, treatment by a health provider in the public or private sector, traditional treatment and spiritual remedies.

In traditional self-medication people carry out 'coining' (scraping the skin with a coin to rub in Tiger Balm or, in the case of the very poor, kerosene) and 'cupping' (raising the blood to the surface of the skin by creating a vacuum within a glass cup by igniting spirits). These are cheap and most people can perform them for others. People find relief from less serious illnesses through these practices.

In self-medication with purchased drugs, people recognise two types of drug sellers, those without training who often operate from groceries and those with medical training who operate from pharmacies. In the former, customers will often request a brand name drug or if they do not know it, describe their symptoms. The drug sellers will then provide an assortment of medicines according to their knowledge and the ability of the customer to pay. People will buy the number of days treatment that they can afford and this often results in them taking an incomplete course of antibiotics or other medicines. Trained pharmacists will usually examine the patient before prescribing drugs, injections or IV drips.

In BK there is one pharmacy with a soldier trained in health care, and six untrained people selling drugs from stores. In Sangkat Tonle Bassac (STB), there are seven pharmacies with trained staff, including a doctor, and 17 stores with untrained people selling drugs. Half of these stores are run by Vietnamese people. Very few of the drug sellers will provide credit.

Private clinics and home visitors provide health care for payment in the study areas. In STB, there are seven clinics with 8 beds between them run by trained health personnel. Two are exclusively Vietnamese. In BK there are four small clinics headed by trained staff. These clinics mainly operate from homes. The health provider will perform examinations and give drugs, injections and IV drips. They refer difficult illnesses to the hospitals. Their charges are relatively small, but they will rarely treat on credit and will charge extra for home visits. They are rarely attended by the really poor. They mark the boundary between self-medication and prescribed medication over which the patients' family have little control.

A 'home visitor' is usually a local off-duty health professional, a local pharmacist, drug seller, midwife, nurse or medical student. For R2-5000 they will walk to the patient's house bringing medicines, injections or intravenous drips for which they charge extra.

There are two Kru Khmer in each study area and traditional herbs can be purchased in the market also. Normally people seek the advice of the Kru and treat themselves at
home with herbal medicines. Krus may visit the patient's home for illnesses with spiritual causes. Certain diseases such as STI are usually treated by the Kru because their treatments are thought to be more effective.

*Public sector health* services include the Health Centres and free hospitals Kantha Bopha for children and Samdech Ouv for adults outside the study areas.

There is a vast array of *private sector* doctors, clinics, polyclinics and fee-for service hospitals and maternities outside the study area.

Many people *pray* as well as seeking treatment. They pray to get treatment quickly and that the treatment will work fast.

People, particularly in BK, complained that there were not enough public and NGO health workers in their area.

"So far we have never seen any NGO or public health person here giving medicine, besides vaccination for children. You all just come here to talk about health for poor people". (Young men, BK 2)

### 4.2 People's Evaluation of the Local Services

The table that follows is a summary of the comments made in FGD and SSI on available health resources.

<table>
<thead>
<tr>
<th>Health provider</th>
<th>Good points</th>
<th>Bad points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samdech Ouv, the Centre for Hope Hospital</td>
<td>Most staff are friendly, Good medicine, Low cost or free medicine, Modern equipment, Close to BK, Pay attention, Proper diagnosis</td>
<td>Long wait now, used to be quick service, Small number of doctors speak roughly to patients, Treated rich person but not poor woman who had waited a long time, No medicine</td>
</tr>
<tr>
<td>Kantak Bopha</td>
<td>Serious patients treated first, Treat children, Doctor, Friendly, Free treatment, give money (2000R) to stay, Hygienic, Comfortable, Good quality and sufficient medicine, Pay attention, Examine children, Proper diagnosis, Recover quickly, Sleep at hospital free</td>
<td>Long wait and sometimes cannot get treatment at the end of the day, Far from BK, Dirty in front of hospital, Some staff behave badly, Don't tell diagnosis</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>Provisions</td>
<td>Cons</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>National Paediatric Hospital</td>
<td>Nearby, Friendly, Pay attention, Ask type of sickness, Good medicine, Check if patient recovered after treatment.</td>
<td>Expensive, Not clean in hospital, Some staff unfriendly.</td>
</tr>
<tr>
<td>The Russian Hospital</td>
<td>Less waiting time, fast treatment, Doctors behave well because fewer patients so not so tired, Would go there for operation</td>
<td>No medicine, have to buy from elsewhere, Long way from home, Cost R3000.</td>
</tr>
<tr>
<td>Calmette Hospital</td>
<td>Staff are polite</td>
<td></td>
</tr>
<tr>
<td>Chamcar Mon Health Centre, Japanese or Red Cross Hospital</td>
<td>Cheaper than the others for delivery, Charges posted up at reception, Effective treatment</td>
<td></td>
</tr>
<tr>
<td>Preah Ang Duong Hospital (eye, ear, nose &amp; throat hospital)</td>
<td>Staff are polite</td>
<td></td>
</tr>
<tr>
<td>The Municipal Hospital (Somphoub Krong)</td>
<td>Free medicine, Low cost, Triage, Reliable quality</td>
<td></td>
</tr>
<tr>
<td>Preah Kossmak Hospital</td>
<td>Free treatment, Good quality medicine and large stock</td>
<td></td>
</tr>
<tr>
<td>NGO India Clinic and World Organisation clinic</td>
<td>Give a lot of free medicine to the poor, Only travelling costs</td>
<td></td>
</tr>
<tr>
<td>Private hospital or clinic</td>
<td>Get treatment 24 hours a day, Quick service, no waiting, Get treatment on credit, Good medicine</td>
<td>Expensive for all services, 10 times that of public services, Sometimes give expired.</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| Kru Khmer    | Asks type of illness  
Cheap  
Friendly  
Good traditional medicine  
Pays attention  
Can treat STI  
Can pray with family  
Mainly interested in profit, sells unnecessary injections, drips.  
No credit  
Deceives the patient about power of medicine  
Sometimes expensive  
Do not recover  
Only uses magic |
| Traditional drugs | Cheap and can buy on credit  
Near home  
Fast treatment  
Spend less time getting treatment  
Cheaper than some hospitals  
Expensive  
Bitter  
Ineffective |
| Drug seller  | Trained staff can diagnose and give correct treatment  
Effective treatment  
Traditional practice that most people know how to do.  
Effective if the illness is not serious.  
Free or very low cost  
Visit the house  
Grocers, not trained so no examination or diagnosis.  
Ask client what drug they want.  
Ineffective treatment  
Only use because of poverty  
Drugs cost 3 times that of drug seller  
No credit  
It is not effective for any serious illness. |
| Pharmacy     |                                                                                                                                                    |
| Coining      |                                                                                                                                                                                                               |
| Home visit   | Will not visit at night  
Same cost as hospital but not so effective  
Try to pressure people to buy injections and drips |
4.3 The Use of the Available Health Resources

4.3.1 Overview

Individual response to particular health problems is very variable, depending on available money, time, perception of illness and services.

The table below shows the health seeking behaviour of the 155 people whose treatment was detailed in the SSI and the 358 who responded to the HHS.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>First treatment %</th>
<th>Second treatment %</th>
<th>Third treatment %</th>
<th>Fourth treatment %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SSI (155)</td>
<td>HHS (358)</td>
<td>SSI (86)</td>
<td>HHS (189)</td>
</tr>
<tr>
<td>Coining</td>
<td>41</td>
<td>19</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>26</td>
<td>47</td>
<td>59</td>
<td>40</td>
</tr>
<tr>
<td>Home visit</td>
<td>4</td>
<td>2</td>
<td>4.5</td>
<td>2</td>
</tr>
<tr>
<td>Traditional</td>
<td>6</td>
<td>NA</td>
<td>NA</td>
<td>31</td>
</tr>
<tr>
<td>Health service</td>
<td>18</td>
<td>24</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16 (6 changed hospital)</td>
</tr>
<tr>
<td>Private clinic</td>
<td>1</td>
<td>5</td>
<td>5.5</td>
<td>15</td>
</tr>
<tr>
<td>Kru Khmer</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>No treatment</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Coining was used by less than half the respondents in both surveys, although it was tried again by respondents in the HHS if other treatments failed.

Between 26% (SSI) and 47% (HHS) visited the pharmacy first when they were sick. This proportion increased (on average between SSI and HHS responses) if the first treatment failed and fell by the third treatment.

Trained health providers were used by around one fifth of the patients as the first treatment, over a quarter on the second and one fifth on the third. The most popular hospitals were Samdech Ouv (the Centre for Hope) Hospital for adults and Kantha Bopha Hospital for children. The local Health Centres were used by only two people in the HHS.

A tiny minority visited private practitioners and krus initially but this rose to 15% of the patients on the second and third round of treatment. Home visits were rarely used.

The data show that people make great efforts to find effective treatment for illness, changing providers and treatment if the first action does not work or they are dissatisfied with their treatment. Many families had run out of money and become indebted by the third round of treatment. They could no longer afford to continue their search for effective health care.

4.3.2 Health Seeking Behaviour for Acute illness

The type of health problem is an important factor in health seeking behaviour. If people believe the illness to be 'not serious', they will do nothing or try coining, the grocery pharmacy and the pharmacy first. If the person does not recover, they will diagnose the problem as serious and go to a health provider. This is a rational use of resources if the disease is not serious because the initial treatment is cheap in cost and time and in many cases the person does recover. 27% of patients in the HHS completely recovered
and 51% partially after the first course of treatment.

However, people do not prefer to use groceries and pharmacies first, they are obliged to do so because of poverty. There is a high level of dissatisfaction with groceries and pharmacies (70% and 24% respectively in the HH survey) because they do not examine, diagnose, inform the patient of the diagnosis and give correct treatment. Their lack of qualifications means that they often give the wrong medicines and the illness becomes more serious because it is not prevented early.

If an illness is perceived to be serious, people will seek treatment from a health facility first. In order of frequency, people in the SSI perceive the following to be the most important signs of serious illness: the patient is not able to work, not able to walk properly or far, feels tired, has fever, pain, headache, is not able to sleep or sit for a long time, has no appetite, coughs blood, pain in chest, short of breath, constant cough or is unconscious.

People may go to the hospital first to get a correct diagnosis so that they can buy the correct drugs at the pharmacy. They may go to a health worker first for correct treatment and advice on diet and care so that the illness does not become chronic.

Illnesses in children requiring immediate attention at the hospital include dengue fever (recognised by the rash) measles and cough.

Age influences health-seeking behaviour. In the HHS, 34% of children under five were taken immediately to a health facility compared to 19% of over 35 year olds. The main diseases were fever, cough, diarrhoea, dengue and typhoid. In the SSI, over 50% of sick children were taken directly to a health facility as the first treatment, usually Kantak Bopha. 86% of the children treated by a pharmacist recovered and the majority who did not were taken to Kantak Bopha. The diseases in children treated by pharmacy drugs and taken to a health facility were very similar, that is fever, coughs and diarrhoea. All dengue cases, accidents, malaria and measles were taken to the hospital.

In the HHS, 72% of the 10% of households who had a child under ten having diarrhoea reported using Oralyte or substitutes correctly. Oralyte was only mentioned by a few focus groups in the first phase of the BIDS and rarely reported in health messages.

83% of respondents were able to mention at least one sign of serious respiratory infection, including fast breathing, frequent coughing and fever. However, only 18% of the respondents in the HHS would take a child with serious Acute Respiratory Infection to a qualified health provider. The majority would begin by coining and buying drugs from the pharmacy.

In the SSI, 50% of people with an acute illness sought treatment at a hospital or private clinic and 50% visited the pharmacy. Half of the latter had typhoid and were examined and given drugs and drips by the pharmacist. Only 30% recovered and none were satisfied. People complained that the treatment was expensive and ineffective and the staff unfriendly. A high percentage ran out of money and stopped treatment although they were still sick.
Number of days of treatment

84% of the respondents in the HHS spent fewer than seven days on their first treatment for an illness, with the majority of these spending less than 4 days. A similar pattern occurred in the second and third courses of treatment, although by this time over a quarter had around 10 days treatment and 14% over two weeks.

4.3.3 Health Seeking Behaviour for Chronic Illnesses

People sought treatment in the free or cheaper hospitals for chronic diseases, particularly the Samdech Ouv Hospital, which was reported to treat chronic diseases at no cost with good medicine, good hygiene and emergency procedures in place. If the hospitals fail to cure the condition, patients discharge themselves when the available funds finish. People then turn to buying western and traditional medicines, seeing the Kru Khmer and praying.

In the SSI, 50% of respondents with chronic illnesses reported going to a health facility first and 30% after self-treatment had failed. Only 27% of the patients were satisfied with their treatment. The remainder complained in order of frequency that treatment was too expensive and they could not afford to complete it; they did not recover fully; the staff were unfriendly, the place unhygienic and they had to buy their own medicines. 23% had turned to herbal medicine. This failure of the health service to treat these chronic cases effectively is particularly worrying when we consider that 30% of the patients have chronic cough with bleeding.

People preferred to treat some illnesses with traditional practices or herbal medicine because in their experience it was cheaper and more effective. An example of this is haemorrhoids where the sufferer sits on a hot stone covered with a papaya leaf or a burned coconut is used.

Chronic diseases cause a huge drain on household resources in terms of the cost of health care and loss of work and income.

Health seeking behaviour for TB is described in detail below because of its public health importance.

Health seeking treatment for TB

The National TB Centre (CENAT) operates an 8 monthly Directly Observed Treatment (Short-Course) Strategy (DOTS) programme. TB workers on motorbikes deliver drugs and supervise the treatment several times a week. Core TB treatment is supposed to be free but this was not the experience of the respondents. Respondents had heard that TB treatment is supposed to be free in Cambodia. They reported that initial charges for documentation, x-rays and sputum tests at the CENAT TB Hospital prevent them getting to the free treatment and those who did reported that they were asked to buy their own drugs on prescription. If admitted, they also have to pay for their food.

50% of the respondents in the SSI with signs of TB had attended the TB hospital at least once and had X-rays and a diagnosis. Not one of them had continued with treatment.
because they could not afford the ongoing prescription charges. Costs at first treatment varied between $5 and $17.5 dollars. Costs for other treatments ranged from R4,000-27,000 for herbal medicine; 8500-10,000 at the pharmacy; R4000 at the Kru Khmer and R400,000 for a home visit. Over half of the respondents had not recovered at all or fully as a result of treatment.

In the HHS, 21% of people with signs of TB had not received any treatment in the week of the survey, 56% had bought drugs from the pharmacy, 11% attended the Health Centre, 2% home visits and 11% other providers (from Khana's home care programme for people who are terminally ill, and Servants to Asia's Poor who provide DOTS in urban poor areas). 43% of respondents paid less than 2000R in the previous week, 46% paid between 2000 and 10,000R and 11% paid more than 10,000R.

In one interview, a neighbour who had TB died:

"From having TB and many diseases at the same time. He was unable to go to hospital because he had no money for his treatment. We think if he had money he would have got better and lived for a long time."

4.3.4 Health Seeking Behaviour for Emergencies

An emergency is defined as a health problem requiring immediate treatment. Transport in the event of emergencies is a problem. 86% of emergencies in the HHS were carried to hospital in a cyclo or motorbike taxi. The cyclo is slow and people have died on the road. Two women died of postpartum haemorrhage in the week prior to the study, one because she could not afford transport and the other because she could not access it. People wanted a telecommunication system so that they could access an ambulance in an emergency and save lives. They were willing to pay for this because they "would still be alive". Once people have reached the hospital they face the problem of demands for money before treatment and finding a donor if blood is needed. If they are unconscious, they may wake up with a bill that impoverishes them for years to come. Soldiers were taken to the military 1/79 Hospital whilst others go to Calmette, Lok Sang which is cheaper than Calmette and Kantak Bopha in the case of children.

Emergency treatment is known to require special procedures and cost more than other diseases. 30% of the cases spent from 810,000 to 850,000 and 20% between 851,000 and 8100,000.

78% of the respondents in the HHS were satisfied with their emergency care. 25% had recovered only partially and 6% not at all.

However, 71% of the 14 SSI respondents with former emergency cases were left with chronic conditions or disabilities. The majority of these people were not satisfied with their treatment because it was very costly (except for Kantak Bopha and 1/79 Hospital), they did not recover, the staff were rude and refused to treat people without money and they are still buying drugs, having run out of money for treatment.

Emergencies incur heavy costs at the time and later if more treatment or rehabilitation
is needed. They often put the person out of work and result in destitution for the household.

4.3.5 Health Seeking Behaviour for Disability

None of the disabled people were satisfied with their treatment. Those who had fought in wars felt abandoned, there is no support for disabled people and no one could afford to continue with treatment.

4.3.6 Health Seeking Behaviour for Sexual and reproductive health

**Birth spacing**

The majority of sexually active respondents in the FGD, SSI and HHS (90%) did not wish to have a child in the coming year. In one FGD in BK, older women reported that they had over five children because they had not been able to avoid pregnancy, they would prefer two or three.

Women in FGD in STB had considerable knowledge of modern contraceptive methods and preferred them to traditional methods. People knew about monthly and daily pills, condoms, injections and IUCDs. A few people had heard of vasectomy, tubal ligation and Norplant. Traditional methods include drinking papaya sap and wine before sex or using medicine from the Kru Khmer. Sources of information included the radio and television and group discussions with the Friendly Organisation (Met Somlaing). This NGO provides counselling on STI/AIDS and birth spacing, provides free pills, injections and IUD, has the phone number of an ambulance and pays for treatment and transport. Women had learnt about withdrawal and periodic abstinence from neighbours and friends. Whereas, women in FGD in BK knew very little about birth spacing:

"Our village is considered as an isolated area. We never get any information concerning the prevention of sexual diseases or birth spacing either. We don't know much about the usefulness of condoms" (FGD in BK Zone 1 - only a few hundred metres from the main roads of Phnom Penh).

Some people thought that many people used modern contraception but kept it a secret, even from their husbands. Others believed that "there is no-one in our village spacing by medicine because they fear this will cause trouble to the user". In the household survey 74% of those who did not wish to have a baby in the next 9 months were using a modern contraceptive, 12% a traditional method and 13% nothing at all. (It should be noted that this figure is not equivalent to contraceptive prevalence rate). In the SSI, only 25% of the women who had given birth in the previous 18 months were using a modern method and 33% doing nothing to avoid pregnancy. Reasons for not using modern contraceptives were a lack of money and knowledge of methods and where to obtain them and experience or fear of negative effects on the body. These included being unable to work hard, tiredness, body heat, bleeding, tumours, changes in weight and ulcers, at times they believed, made worse by malnutrition. Women found it difficult to manage withdrawal and periodic abstinence because of drunken husbands.

People who used modern methods obtained them mainly from the health centre (40%),

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private providers (34%) and pharmacy (20%). The daily pill costs 81500 per cycle and the monthly pill 8800 from the private clinic. Some mentioned an ineffective birth spacing medicine sold by pharmacists.

One quarter of respondents in the SSI had had an abortion and people in FGD thought that abortion was a common but secret way of controlling fertility: Abortion costs $1020 for one-month gestation and $30-40 for two to three-month gestation in local private clinics. Several women reported chronic gynaecological problems following abortion and viewed abortion as potentially life-threatening. Women in one FGD were very interested to learn about the Cambodia Women's Clinic, which provides safe abortion for $15 up to three months gestation. Kru Khmer provide herbs to cause abortion.

Reproductive Tract Infections and Sexually Transmitted Infections, including HIV/AIDS

Many people do not feel free to talk about STI. Many people preferred to seek early diagnosis and treatment for STI from a particular Kru Khmer called Ly Bounarith. They believe his treatment to be effective, cheap and non-judgemental. People also purchase traditional treatment from the market at 815,000 - 30,000 for a full course. One Kru Khmer is reported to be able to treat AIDS (Preah Ang in Takeo province). However, people with AIDS have been strongly advised by Home Care not to visit the Kru Khmer for treatment because AIDS patients have died from their medicines.

Khana (International HIV/AIDS Alliance) has established an effective home care programme with community health teams that work with health centre staff, and providing people with AIDS with $10 and free medicines. The Met Somlaing provides counselling on STI and AIDS and the Indradevi Hospital treats clients with STI and AIDS.

Men in FGD who use sex workers were aware that many have HIV infection and used condoms. 47% of the respondents in the SSI reported that they had followed AIDS messages and avoided brothels or used condoms. Some women talked to their husbands and children about the messages. In several FGD, people agreed when asked that a 100% condom use with sex workers campaign in Phnom Penh would reduce deaths from AIDS.

4.3.7 Health Seeking Behaviour for Pregnancy and Childbirth

In the HHS, 47% of women who delivered in the past 18 months delivered in the hospital, 39% at home and 12% at the health centre. 2% used a private clinic or other provider. 53% of all deliveries were attended by a trained midwife and 7% of women were helped by a partner, neighbour or relative, with others being attended by TBAs (it is difficult for people to distinguish between those who are trained and those who are untrained).

37% of respondents spent less than 850,000 on their delivery and 31% of respondents spent more than 8110,000.

75% of mothers did not have any problems during delivery. Problems reported during delivery included haemorrhage, pain in the uterus, breathing difficulties and chills.
In the SSI, women reported the following problems before or during delivery: pre-partum haemorrhage, blurred vision and numbness, fainted from stomach pain before delivery, difficult delivery, diarrhoea and vomiting (allergy?), haemorrhage, vaginal discharge, dizzy, tired and poor appetite.

In the SSI, only two out of eleven women delivered at home, the rest delivered in the Red Cross, Municipal or 1/79 Hospital, the MHD-run Kbal Thnol Health Centre and India Clinic. Dissatisfaction with the delivery was high. Those delivering at home planned to deliver in the hospital next time because the TBA did not have enough equipment or skills. Half of those delivering in Hospital complained that the staff behaved badly, refused to assist at all or to suture without payment, did not provide food or did not allow the client to wear pants. The NCMHC was praised for being clean, safe and providing serum when tired, and the Red Cross and Kbal Thnol for treating the poor with the same care as the rich.

4.3.8 Health Seeking Behaviour for Child health

Treatment of sick children is described in health seeking behaviour for acute illnesses (3.2.2)

Mothers interviewed in the SSI reported a range of actions aimed at keeping their children healthy. In order of frequency, these were: using a mosquito net; washing the child; ensuring plenty of sleep; vaccinations; providing regular, clean, nourishing food in sufficient quantity; boiling drinking water or giving clean water; not allowing the child to play on the ground, in dark corners or near sewage; clean the house; give vitamin tonic; prevent or treat fever at once and put lotion on the skin. Many of these actions were aimed at preventing dengue fever and diarrhoea. Oralyte was mentioned by one person.

Vaccination

85% of parents with children under the age of 18 months intended to have their children vaccinated within the previous year and all these children had received at least one vaccination. Nearly half of the children received vaccinations from outreach units, a quarter from the public children’s hospitals and a fifth from health centres. Polio drops were mentioned by respondents in the SSI and nearly half sought vaccinations to keep their children healthy. One disabled person put the cause of his problem down to not being vaccinated against polio whilst two became paralysed after a vaccination by injection.

In FGD, people reported accessing 6 vaccinations from the Municipality outreach workers or the hospital. These included TB, measles, tetanus, dengue and polio. A key informant reported that the MHD no longer has the resources to provide vaccinations in outreach and people complained about this.

4.3.9 Additional Problems for Vietnamese People

The Vietnamese respondents thought that living on the boats is less healthy than living on the land. People suffer from itching because they live on the water and bathe in polluted water. No-one wants to live on a boat because it is difficult to go to market or travel. They have no land and so are obliged to live on the boats. They have no security
of tenure even though they have lived there for 10 years. They pay 5000-10,000 riels for mooring their boat for six months in the floating seasons and less in the dry season. Those who live on the riverside pay $10 for a cottage and $20 for a shelter on the land.

Vietnamese people rarely go to Khmer health services because they cannot afford it and will not be treated without money. They do not use public hospitals because they feel embarrassed when the health staff ask them for identify cards, addresses and nationality because they do not have Cambodian identity cards. Also, they speak Khmer badly and would not be able to give clear information on their symptoms/diseases. Some people felt that they might be treated equally as ethnic Cambodians if they had money, but generally, they preferred to use pharmacies or private clinics, particularly those run by Vietnamese in front of the Russian Embassy. They sometimes invite private health providers to come to their home to give them tablets or injections.

4.4 Type of treatment

The majority of people (around 60%) take drugs by mouth as their first course of treatment. In the SSI, on first treatment, 11.5% of all cases were given IV drips. Of these 50% were accident cases and 27% had diarrhoea or typhoid. The reminder had haemorrhage, anaemia, cancer and dizziness. On second treatment, 14 people had serum, for accident, diarrhoea or typhoid, fainting, anaemia, heart failure, TB, bronchitis and cancer. This does not suggest an overuse of unnecessary intravenous drips. The use of drips was evenly divided between public and private health facilities, pharmacies and home visits.

In the HHS, 6% of patients received drips on the first line of treatment and 16% injections. On the second line of treatment this rose to 8% and 18% respectively. Drips and injections were most frequently given by Calmette and private practitioners. One would expect more drips and injections for emergencies (at Calmette). The profit motive may account for the higher number by private practitioners.

4.5 Factors Influencing Health Seeking Behaviour

4.5.1 Overview

It is apparent that people make a rational cost-benefit analysis of their various options based on the health problem, their knowledge and the cost, quality and travel and waiting time of available options. Costs include money needed to travel and access diagnosis and treatment; time taken to travel to and from the health provider and wait for examinations and diagnosis and treatment. Benefits come from high quality care resulting in speedy and complete recovery.

People in FGD prioritised quality of care issues over cost issues. In the SSI, 63% of respondents mentioned quality of care issues in their likes and only 22% cost issues; 15% mentioned speedy recovery. In dislikes, the percentage mentioning cost and quality of care issues was the same (37%).
High quality services reduce costs of further treatment and lost work for patients and carers. If patients are examined, given the correct diagnosis and drugs, with information and advice, they will be able to treat themselves at home with pharmacy drugs and thus reduce costs.

However, people were not always able to use their preferred services because of an absolute lack of resources and options for accessing them.

As section 3.3 demonstrated, the type of illness is an important factor in health seeking behaviour.

4.5.2 Cost factors

Cost of total treatment process
Cost is a major factor in making a decision. Some people cannot afford to spend any money on health care and leave their illnesses untreated, perhaps leading to death. One FGD defined spending a small amount as costing R1000 at one visit, including the examination, drugs and counselling. If people believe that the illness is not serious, they will do coining or buy cheap drugs from the local pharmacy first to save time and money. If this does not work, people choose the free hospitals Kantak Bopha and Samdech Ouv, so that they can save their money to buy medicine. Some use the free NGO clinics for specific problems. People were concerned about hidden costs including charges for each step of the process.

"I really don't like the Municipal Hospital because the staff charged me for every step of the examination. I paid R1000 for 'permission', R500 for weighing, R3000 for a urine test and R1,500 for the drugs".

The Red Cross Chamcar Mon Health Centre won some approval for listing charges above the reception desk, although the practice of locking maternity patients in their ward until the charges have been paid was seen as doubtful practice.

In FGD, people claimed that they no longer knew which hospitals were public as they charged the same as private hospitals and would not treat patients without money.

Calmette Hospital was known to have a free ward run by Medicins Sans Frontiers, but it could only accept about 20 patients a day, and the interrogation by medical staff to determine whether patients are entitled to use it was seen as humiliating.

Accessing Exemptions

Some people know about exemptions, but find the process of accessing them daunting and humiliating. They are treated with contempt because of their dress and speech; subjected to humiliating public interrogation to assess whether they are exempt; have to wait a long time for a senior officer to sign the paperwork; are expected to obtain district leaders signatures; are put in separate wards or unpleasant places and then face demands for unofficial payments from health
In the Chamcar Mon Health Centre, 3.3% (86) and 6.3%(154) of the total clients were poor people exempted from paying and a small number had discounts of 10-50%. Around 10% of maternity cases had an exemption or discount.

It was understood that health workers on low salaries need extra payments to survive. For this reason, people would prefer to be treated by NGO staff on good salaries or pay into a credit or insurance scheme, which contributes to health worker salaries.

There was a distrust of private practitioners because people felt that they were only interested in profit and exploited people.

"Private practitioners are friendly if we have money. If we have a disease needing 4 injections, they will give 15 injections. Pharmacies foster illness so that they make more money"

**Distance**

Physical distance relates to the cost, time and difficulty involved in taking a patient to hospital. This is an important factor, especially for the ultra poor. In one FGD, people measured distance by cost. R1000 was thought to be a short distance and over R4000, far. However, some people could not afford even 1000R to travel to the hospital:

"I have a liver disease. So far, I have not recovered because I only have enough money to go to the pharmacy. I cannot go to hospital, although it costs only R1000 per day. It is not much money but it is not small for me as a member of a poor family".

People get into debt for the R3000 needed to go to the hospital.

"For us, R3000 might as well be $300, because we do not have it".

In emergencies, the type of transport is important because a patient might die on the way in a cyclo.

Social distance is also an issue. A poor person with old clothes will not travel one kilometre to a health facility where they have to share a waiting room with rich, well dressed people and be shamed by staff who reject them because they have no money.

**Waiting time**

Waiting is an opportunity cost for the patient and the accompanying family member, who are both losing income. In one FGD, people judged waiting for an examination less than one hour to be a short waiting time and over four hours a long waiting time. People add waiting and travel time when they make a decision on the cost of health care.

In some cases people have to wait along time for examinations, tests, consultation and treatment. Samdech Ouv and Kantak Bopha have a number system that involves queuing for a from 04.00 hours and patients might not be treated on that day. They then have to start again the next day. This deters them from using the hospital promptly
and raises the question of emergency cases. Triage is practised in some hospitals and people complained about queue-jumping. In others, emergency cases have to wait in line and people fear that death will come before treatment. People suggested a triage system with a separate waiting area for the emergency cases.

4.5.3 Benefits - Quality of Care

On the benefit side of the cost-benefit equation, people assess quality of care in terms of a number of factors, including health worker behaviour, examination, diagnosis, correct treatment, informing the client about the diagnosis, treatment, care and prevention and the environment.

Health worker behaviour
Good health worker behaviour was mentioned most frequently in factors that people liked about the services they used. It included being friendly, polite, welcoming, do not look down on poor patients, treat them the same as rich ones; interested in the patient and encourage him or her to relax. Bad behaviour included insulting the patient and showing a lack of respect, looking down on patients because of their clothes or way of talking; blaming people for not bringing the patient earlier, keeping the person waiting a long time and refusing to treat them or putting them in a bad place because of lack of money.

Examination
People thought that health staff should examine the patient fully and do any necessary tests. They should take a full history of the illness and treatment to date.

Diagnosis
Following the examination, respondents felt that the health staff should make a correct diagnosis and explain it fully to the patient. Wrong diagnosis can mean more than one curative episode, threatening lives and finances. Correct diagnosis allows the patient to buy drugs and treat the illness at home.

Correct treatment
Respondents thought that the health staff should provide the correct treatment for the particular illness. This includes giving good quality drugs (Thai and French) that are not expired; selecting the correct drug for the illness rather than giving a mixture of many drugs; not giving unnecessary drugs to make a profit and giving effective drugs that cured the illness quickly. The health service should have enough drugs to give the patient so that they do not have to go to the pharmacist, who might give the wrong drugs.

In a few FGDs, people said that they believed injections to work faster and more effectively than oral drugs. Intravenous drips were only mentioned as a like by 7 people in the SSI and in FGDs, even when asked, people thought that drips were only needed for serious illness or used by rich people to give them energy. Several people reported that private practitioners and hospitals like to sell serum regardless of need.

"When we are sick and ask a health worker to treat us at home, they rarely
ask us 'do you want medicine?' They always tell us 'you have to inject and get serum so that you get better quicker'.

"Doctors say that hypertension needs serum and hypotension also needs serum. The doctors in the clinic in front of the Russian Embassy have a passion to sell their serums".

Provision of information
People were eager for information on the diagnosis of their illness, the correct treatment and how to take the drugs, how to care for the patient in terms of diet and care and how to solve or prevent the same problem recurring. They regarded this information as power because it would enable them to treat themselves at home cheaply and effectively and prevent illness in future. The less they spent on hospital costs, the more money they could spend on medicine. In some cases, health staff were reluctant to inform patients and relatives of their diagnosis and got angry if questioned. Some respondents felt that they did this to increase their power over the patient.

Hygiene
A minority of people in the FGD and SSI mentioned the importance of hygiene in health facilities.

Speedy recovery
Respondents expected that patients should recover quickly, that is in 3 to 5 days after the first treatment.

4.6 Suggestions for a High Quality Health Service

4.6.1 Characteristics of a Good Health Service

People had a very clear idea of the characteristics of a good health service:

- The whole process, including examination, drugs and counselling costs R1000 or less. Many people would prefer it to be free, but feared that this might not be sustainable.
- Staff should be friendly and well-qualified. They should be well-trained to ensure they are careful and give good advice to patients. They should be well-paid so that they are happy and can concentrate on their work.
- The services should have enough modern equipment.
- Services are accessible 24 hours a day, in the community.
- The staff find out the cause of the disease by asking the patient questions and providing examinations and tests.
- The staff tell the patient the diagnosis and how to prevent, care for and treat the disease.
- The staff provide the correct treatment for the disease, using effective drugs.
- Patients wait for one hour or less for examination and definitely less than 4 hours.
- Transport to the hospital costs R500 or less and anyway not more than R1000.
- Provide all services together in the same place, for example maternal and child health and care for adults.
Separate the people with serious diseases from those with not such serious diseases in different rooms and treat the serious ones first.

"The most important thing is that the health providers are ethical and work to help the patient, not to make a profit out of them".

4.6.2 Strategies for Providing Good Health Care

Public and NGO services
Many people suggested encouraging NGOs to provide services in the squatter communities because "they love the poor", they have better-qualified, caring and friendly staff on good salaries, good equipment and provide free services. On the other hand, people recognised that public services would be more sustainable in the long-term and suggested that they should be improved in terms of quality of care, staff behaviour and charges. They thought that the NGO and municipality should co-operate and refer between facilities.

Health workers and health facilities in the community
People had a number of ideas on ways to provide a good health service including:

- a health worker from the municipality to visit regularly. They would examine and treat poor people and provide information on prevention, these actions would prevent further sickness and spread of infection. The main problem would be that people fall sick in the night or on the days that the workers are not there.

- A health worker to live in the community so that they can provide treatment at night. There are many health workers in the community now but without NGO support, they have to charge a lot of money for services to support their families. The project should collaborate with health workers who have worked in their zone for a long time. "They know the people in our zone very well, who is rich and who are the poorest, who should get free treatment and care."

- Provide more information on the NGO facilities in the area so that they could access high quality, cheaper care and provide a 30% subsidy.

- Provide a health facility near or in the community so that they could easily access treatment even at night. The health staff should provide examinations and treatment for less serious disease so that people did not have to go to the hospitals.

- Train members of the community to work at the health centre. They should explain health risks and prevention to people, work as security officers and contact other NGO and hospitals when necessary. The health centre would support people to connect to the public hospitals such as Kanta Bopha and Calmette.

- A mobile clinic to visit all poor areas once a week to provide treatment and referrals.

- A floating clinic moored to the river or lake which could treat minor ailments and refer to the hospitals, undisturbed by major flooding.
The Community Health Representative
People in STB suggested that a qualified nurse or doctor from this community should act as a community health representative to explain about health risks, hygiene and how to prevent diseases; notify the Municipality about health problems, treat the less serious diseases and refer others.

Transportation
People wanted a telephone or radio and the number of the hospital at the chief of village or group so that they could access the ambulance in an emergency. "I think that many people have died because they could not reach health care quickly in an emergency. An old woman last year died because she was bleeding a lot and she died on the cyclo because it was so slow. If we had a car she might be alive today. We can pay the cost later if we are still alive."

The environment
The project should help people to clean up the environment. The insect killing campaign should come to the community every month to eradicate mosquitoes. It is supposed to visit every community but it has never come to BK3. The authority should repair the water pipe and pump water from the lake. The rubbish needs to be cleared up to prevent many types of diseases.
5. **PAYING FOR HEALTH CARE**

5.1 **Economic Groupings and Paying for Health Care**

*In the FGD,* people were asked to classify people into four categories according to their ability to pay for health care, to describe typical work in each category and to 'guesstimate' the proportion of people falling into each one. The proportions varied in each FGD. This may reflect economic differences between zones or the difficulty of making such a judgement.

![Economic Status Perceived by Focus Group Discussion Participants](image)

When asked about their own ability to pay, the majority of people in the FGD could not afford more than 82000 a day for seven days. If they needed to pay more than this, they would be obliged to adopt a strategy to source additional funds, with negative impact on the household.

In the *household survey and SSI,* two indicators were used to assess economic status and ability to pay for health care.

**Indicators Used to Assess Economic Status in Household Survey and Semi-Structured Interviews**

- The outcome of subtracting weekly expenditure from weekly income. If the balance was positive, the household was classified as poor. If income equalled expenditure, the household was classified as very poor and if expenditure was more than income, as ultra poor.
- The weekly income per capita in the household
In the SSI, 70% of households were poor, 9% very poor and 21% ultra poor. In the household survey, 42% were poor, 22% very poor and 36% ultra poor. The reasons for the difference in proportions is not clear. The household survey sample is younger and may be not so well established as the older group.

In the household survey, 16% of households earned income of less than R5,000 per head per week, 38% earned between 5,100 and 10,000 per head per week, 20% earned between 11-15,000 and 14% earned over 20,000.

In terms of total income per household per week, 5% earned less than R10,000; 19% from R11,000-30,000; 43% from R31,000-60,000 and 24% from R61,000-90,000 and the remainder over R91,000 (data from HHS).

Expenditure includes high rates for water, electricity, rubbish collection, rent. Food and health care are major costs.

5.2 Costs and Expenditure on Health Care

Coining or cupping are free or cost less than 8500 (US$0.13).

Oral medicine from the pharmacy costs between 8500 to R3500 (US$0.13 to US$ 1) for a day, depending on the drugs given.

The home visit is very expensive. Most of the respondents who had used home visit said that they paid R20,000 to R210,000 (US$5.3 to US$55.3) for a treatment period, lasting from one day to a week. The high cost is due to the charge for a home visit and the use of injections and IV drips.

Private treatment is also expensive, costing as much as R 1,170,000 (US$308).

In the emergency cases, many patients had been transferred to the public hospitals where they spent from R35,000 (US$9.2) to $156 for their treatment.

Delivery of babies at hospitals is also expensive and varies with location of delivery. In the HHS about 30% of respondents paid more than R110,000 (US$29) for delivery.
Birth spacing. A few people in STB spent R1500 (US$0.4) a month for contraceptive pills or $10 to $20 for an abortion.

Funerals cost between $26 and $210.

Free treatment is provided by NGOs for specific groups and was rarely accessed. People use the hospitals that provide free treatment, that is Samdech Ouv and Kanta Bopha most frequently.

Expenditure on health care is extremely variable, depending on the health problem and stage of treatment, as the following box illustrates.

**Increasing Health Expenditure with Stage of Treatment**

In the household survey, the first treatment cost ranged from zero to 8780,000 (US$205). On average the people spent 14% of their income on health care.

In the first treatment, 27% of respondents paid less than 8200 (US$0.05); and a further 21% less than R5000 (US$1.3). A quarter spent more than R20,000 (US$5.3).

The average cost of second line treatment is R15,000 (US$4) higher than

The recurrent costs of chronic illnesses represent a severe drain on the household and many people stop taking any treatment for this reason. The high costs for emergency treatment often put households into debt and a downward spiral of poverty.

"We used to call doctors to visit us at home but nowadays we don't. Even if we visit their houses they won't treat us because they know we have no money."

"One day I saw a patient who was nearly dying. A hospital staff member asked his daughter if she had money. When she said 'No', the staff member said 'I'm surprised that you would bring him here without money'"

In the FGD, people were dissatisfied with paying at public hospitals for poor quality of care. Staff were unfriendly and did not examine them or give them effective treatment. Nowadays, medicine is more costly than food.

5.3 **Strategies Used by the Poor to Access Health Care when a Family Member is Seriously Ill**
Most of the people in the two target areas cannot afford to pay more than 810,000 per day for 7 days for health treatment. When they need more money to pay for a serious illness they most consider different strategies.

In FGD, people discussed the following strategies for coping with high health costs. They are written in approximate order of preference:

**Private loans**
Most people would first choose to borrow money from private loan providers or neighbours with interest because they can borrow money at any time. People known to the borrower might charge between 8-15% interest per month with private lenders charging 20% to 30% per month. There is no loss of face in getting a loan and if it is paid back people do not lose their property.

However, borrowing money with high interest rates would affect the well being of the household very badly in the future if they cannot find the money to pay the interest or the borrowed money. Respondents in STB two said,

"headache is the most common illness here because the people cannot sleep well as they are always thinking about the money to re-pay the loan".

The interest would accumulate and the loan therefore increases. The lender would force people, often violently, to leave their house or land, kidnap a daughter to sell to the brothel. Some people had been forced to leave their home province because they could not repay a loan and had sold all their land and animals.

**Sell assets**
Only a few of the people said that they would sell their assets before going for a loan because they would not have the headache of trying to find the money to pay back to loan providers. However, they cannot sell their asset at the 'book value' prices. "We must sell our asset at the cheapest price". They regret selling their property because they will not be able to buy it again or borrow it when they need it.

People in the provinces sold small animals as second choice but large animals only as fourth choice.

Selling economic assets can reduce earning power and access to information.

"I sold my new motorbike to pay for my family's health care and food and bought an old one. Now it's difficult to earn money by 'motordop' because I keep getting problems with it."

"I sold my radio to pay for my son's health care."

Some people would pawn their goods rather than sell them, but they often lost them in the end.


Borrow money from relatives
Some people preferred to borrow money from their relatives first when they needed only a small amount of money. However, they would feel shy of their in-laws and could only borrow a little money because "our relatives are also poor". Most of them considered that borrowing money from the relatives can lead to conflict because the relatives want the money back quickly.

Borrow money from friends
Many people do not like to borrow money from friends because they will then look down on them and scold them if they cannot pay the money back.

Reduce expenditure
People reduce their meals from three a day to two. However, they are not able to sleep well and feel hungry, weak and pale. This makes it difficult for them to work hard to earn more money and puts them at risk of illness, which again will stop them earning.

Work harder
Some people decide to have family members, particularly the husband, work overtime. But this can lead to health breakdowns and stress so that a person needs to take care of the patient. This may result in the husband and the carer not earning any money at all. Some people look for work as a hired hand, but they feel depressed because the employers look down on poor people and speak badly to them.

Children
Some people take their children out of school to save the 8200-500 a day costs for each child. The children then work as labourers, food or water sellers. This could be a fourth choice for them but the problem is that some families do not have children of work age. "They are very small". Stopping their children attending school and sending them to work for money is considered worse than selling the house because they are damaging the future of their children. They are illiterate, malnourished, tired and do not have time for sleep.

"We are well aware of the consequences of taking our children out of school, but food and health have to take priority. If we could find better ways, we would not do this. We do it because we have no choice."

If they owed a money lender, they would have to take the children out of school and to work. Some people keep their children in school, but they work after school.

Obtain medicine on credit
Few respondents said that they could buy medicine or get treatment on credit, particularly because they come from poor areas. If you cannot pay back the credit, you cannot buy from that person again.

Borrow money against their house or land
The people could also borrow money against their house, but if they had no money to pay their loan back, the people would take the house and then where would they live? But this is not common, particularly in the very poor areas where housing appears

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People lost their farmland because they could not repay loans. They then had no land to farm or build their house on and had to rent it. This will make the future very difficult. Some people in the FGD in STB had sold all their farm land, animals and house. With nothing left to pawn or sell, they were forced to run away from the province.

Send children to live with relatives
Some respondents sent their children away to live with relatives to save the expense of feeding them. They feel sorry for them because they have never been separated before. They worry about their health, mistreatment and overwork.

Sell house for money
Some respondents said that they might sell their house for money if they needed it badly for the treatment of illness. A few of them said they were staying in rented houses. "We have no house to sell". This should be the last choice because they would then have to ask for land to build a small shack, live in the wat or on the streets or under the trees. Some groups thought that selling the house is the very worst option. They would lose face and need to pay monthly rent on another house. Sometimes they are forced onto the street or under the trees because they cannot find the money to pay for the rent. Their very lives then become vulnerable. Mr. Soung Sothy, Health Co-ordinator from the Indradevi Association said that there are many AIDS patients who have no shelter. They are at a high risk of additional infections. However, one focus group said that selling the house is better than having a loan with high interest.

Sell family members
They could sell one of the female family members to a brothel. Some people said that they are afraid of diseases, AIDS or mistreatment if they sell themselves to the brothel. They will feel shy of their neighbours, dishonourable and have a bad future. They could sell their baby. One woman said she sold her baby for 860,000, but had to give 820,000 to the broker. She also said she had never recovered from the sadness.

Beg
Sometimes people sell everything they own, land, house and property and are forced to beg. They feel very shy to do this and often send their children back home (commonly Svay Rieng Province) to beg for work or assistance from relatives.

Steal
If they become a robber, the police may catch them, beat them and put them in prison.

In the SSI, nearly one third of respondents did not access extra money for health care, but they coped with their existing income. The other two-thirds of respondents who had to obtain additional money to pay for health care did so in the following ways:

**Strategies to access extra money for health care**

(n=103)
For 15% of the respondents, these strategies had no impact on household well-being. For the rest, negative impacts included anxiety about repaying loans (15%), a lower standard of living and daily worries about paying for basic needs as expenditure exceeds income (15%); reduced food intakes (10%); children forced out of school (6%) and dependency on children or relatives (8%). 15% of the respondents were unable to work hard or to work at all because of their illness, with devastating effects on household wellbeing.

5.4 Suggestions for Reducing Financial Barriers to Health Care

5.4.1 Overview

Many people initially could not think of any strategies for making payment easier other than loans and credit schemes. When community insurance was suggested, they were eager to discuss this type of scheme further because it would enable them to spread out payments for health care rather than being hit by a devastating bill.

5.4.2 Free Services or Free Services for the Poor

In the SSI interviews, most people wished for a free health service, probably provided by an NGO. When asked to think of strategies for coping if free health services were not possible, people agreed that it was unlikely that health services could be provided free in the long-term.

In one FGD, people thought that the chief of the groups and villages should identify which people are poor and very poor because at the moment many rich people receive more assistance from the NGO and government than poor people. The NGO should have a health office representative in the community and give cards to the poor people. They could then refer them to the right sector for specific problems. The card should be used for selected hospitals. To prevent people selling the card to make money, it should have the photos of the family members with their names and an official stamp. (See Section 4.2).

5.4.3 Credit

A credit system was a popular idea, particularly for serious diseases.

"Even though I am an AIDS patient, if I could borrow R50,000 from a credit system, I could pay back R12,500 per month."

If they were to pay into a credit scheme, the majority thought that they would be able to pay R2000-3000 a month if they had work and R500-1000 if they had very small jobs. Some people thought that daily payment of R100 would be easier as they are employed on a daily basis.

One old man in STB5 thought that:

"a Credit Community would "mean that we help ourselves in advance of a
problem - no organisation or government will pay 100% of the cost of health care."

One group suggested 'Credit Community' (CC) in which people pay 5008 per week and can borrow up to 10,0008 per month with 10% interest. The CC would ensure that money was borrowed for the right purpose. The CC would not be able to provide loans for serious sickness, for example, requiring 100,0008 because a sick person would not be able to pay back this money. In this case, the NGO would have to help with a low cost loan.

People also wanted a credit programme to help people to establish successful businesses in order to improve their health. The credit should attract about 5% interest.

5.4.4 Health Insurance

People thought that health insurance was a good idea because no health provider was likely to provide totally free treatment. They might be able to help with 40% of the costs. People are not able to pay a lot of money at one time, but if they could pay a little money each month then everyone could get treatment.

The main anxiety with this system was that the procedures would not allow people to access the services quickly or that people would try to use the money for other business. This could be overcome by asking a trusted chief, NGO, rich person or Community Association to handle the funds. They thought that people with a job could pay R2000-3000 a month into the scheme. And those with no job or low income could not pay anything or a maximum 500-1000 riels per month.

Some people suggested creating a committee or having a community representative in the community to co-ordinate the NGO and a selected hospital in Phnom Penh so that when someone was ill, the committee or representative would send them to the hospital. The members of the insurance scheme would have a card to use for transport and the NGO would reimburse the driver. The money would be kept in a bank to generate interest and audited every six months. The representative should be close to the community and available 24 hours a day in case someone was sick at night. They could rent some land for $10 a month to build a small clinic with two rooms.

People thought that:

" the health insurance scheme would "mean we are with friends, we pay attention to our health and the health staff will treat us with happiness"."

Young men in STB suggested learning from the Vietnamese who have a Health Association in the community, in which people help each other to ensure that people were sent to a low cost Hospital using the health insurance.

One person suggested reducing the cost of water and electricity.
6. HEALTH EDUCATION, COMMUNICATION AND PROMOTION

In the semi-structured interviews and FGD, all the respondents except one could mention at least one health message that they had received over the past year. Many respondents mentioned two or three different messages.

6.1 Sources of Information

66% of the respondents in semi-structured interviews had received the health messages from the television, 35% from radio, 15% from neighbours or relatives and 12% from NGO and government health workers. A small number had seen messages on posters and in newspapers.

In the household survey, about a third of respondents had discussed ideas about health in the past three months, with staff from NGOs (Bamboo Shoot Community, Friendly Organisation and Indradevi) and neighbours, relatives and village leaders.

6.2 Content of Health Information

The most frequently mentioned health information related to AIDS prevention, dengue fever prevention and care and avoidance of diarrhoea by hygienic measures. The need for vaccination, extra water in diarrhoea treatment, wrapping a person with fever in a wet cloth and using only prescribed medicines were mentioned far less frequently.

One person remembered an AIDS message on TV, telling people to:

"not hate people with AIDS, but lift the sick person's spirit, please them, encourage them to eat a lot, to sleep well and not to think too much."

Several people mentioned advice on not giving aspirin to children.

In the SSI, only one person mentioned Oralyte for diarrhoea treatment and contraceptives were rarely mentioned.

The vast majority of respondents were able to explain the health messages correctly. The only doubtful message was one concerning how to avoid a cough turning to TB by avoiding smoking and clearing rubbish. The message to avoid people with TB was a cause for concern because of discrimination towards those with TB and people with AIDS, which is now associated strongly with TB.

The picture provided by SSI was similar to that seen in the FGD. Participants had largely correct and detailed knowledge on topics such as the prevention of AIDS, dengue fever and typhoid, which they had acquired from TV and radio. Beehive Radio gave information on various sexual health problems and advised people to go to the Hospital for treatment. Two women had taken their husbands for treatment themselves following an episode with sex workers without a condom. Another participant practised putting a condom on a banana.
6.2 Behaviour Change

In the SSI, it was not always easy to tell the difference between knowledge and practice. However, the great majority of people reported that they had managed to put at least some of the messages into practice. In several cases, women reported that they had informed their husbands or children to avoid AIDS by staying away from sex workers or asked husbands to use condoms.

47% of respondents in the SSI mentioned AIDS prevention messages, 41% dengue, 22% diarrhoea and typhoid, 7% vaccinations and 4% each alcohol, smoking and TB.

In two FGD, the majority of participants said that they were only able to follow perhaps half of the health advice because of their poverty and unhygienic environment.

One woman reported that:

"My family had to built a shack on a very crowded site. We didn't have enough space to build a toilet, leave rubbish or drain sewage. So we have polluted the environment in our community."

In FGD, people reported that it was very difficult to give up alcohol and tobacco although they were well-aware of the diseases caused by these drugs. One man reported that he had found it very difficult to give up alcohol:

"I am addicted to alcohol and I can't give it up. When I drink alcohol, I feel stronger and that encourages me to work."

In another group, young men aimed to reduce smoking to one box per day and drinking to one litre a day.

In the household survey, 44% of respondents reported that they had changed their behaviour as a result of health education. The remainder said that they were too busy with their daily work or the information was not relevant because of their age.

Fewer than 10% of respondents had participated in community activities to improve health, for example, cleaning the environment, constructing toilets, putting Albet into water pots or discussing birth spacing. Those who did participate thought that their communities had become more hygienic, with sufficient toilets, fewer mosquitoes and less dengue fever.

6.4 Advertisements

Over 90% of respondents in semi-structured interviews could recall at least one advertisement promoting a product with an effect on health. The sources followed a similar pattern to the health information, with 62% of the respondents seeing advertisements on TV and 33% on radio. Advertisements on vans, in shops and on posters were mentioned by 18, 14 and 12% respectively. 70% of the respondents
recalled products with a positive impact on health, in order of frequency, medicines, toothpaste, soap, condoms and mosquito coils, whilst 30% recalled alcohol and cigarettes. Almost 50% of the sample purchased an advertised health product, whilst a third of respondents did not buy any goods, because they could not afford them or felt they were bad for their health. In one FGD people explained that they bought the advertised medicines to treat children at night for mild symptoms such as fever, cough, cold and dizziness. If the illness was serious, they would go straight to the hospital.

People preferred advertisements that provided information on how to stay healthy and strongly disliked advertisements for products, specifically drugs, that had a negative impact on health.

All the respondents reported that they learnt about health facilities outside the neighbourhood through the recommendation of a neighbour, relative or friend. The main factors of interest were low cost and effective treatment. People saw local health facilities "with their own eyes" and decided to use them. People did not trust advertisements for health services of any kind because they felt that the promoter was only interested in profit.

### 6.5 Suggestions on the Most Effective Way to Reach People with Health Information

#### 6.5.1 Television

TV was a popular medium for providing health information, although people might switch channels for a favorite Thai or Chinese story. TV is a better medium of instruction for illiterate people than radio because people can understand the action even if they miss some of the words.

In spite of only 20% of people owning a television, over 60% of respondents had learned new health information from TV or seen an advertisement for a health product on TV. People either watched a neighbour's TV or talked with someone who had. The most popular time for watching TV is from 6.00 - 11 pm, with a peak of 6.30-7.30pm. The preferred channels are Apsara TV, Bayon TV and TVK. One suggestion for improving health communication was to use popular comedians or TV stars to give health information. Another suggestion was to show a handsome doctor giving advice to a beautiful but poor patient on a full range of health problems in ordinary language.

#### 6.5.2 Radio

30% of people own a radio. The favourite times for listening depended on the owner's occupation, with pre-work (6-7.OOam) lunchtimes (11.OOam) and evenings (from 6pm) the most popular. Those working from home, doing stationary work or unemployed tended to have the radio on all day.

People thought that an early evening programme featuring a doctor advising a patient on health care in ordinary language would be very popular.

People become devoted to certain radio stations, with 107FM, 103FM, 90FM, 11FM,
Beehive Radio and national Radio Station the most popular. Some older women were very keen on Beehive radio because it never advertised things that were bad for health and gave frequent health messages.

6.5.3 Posters

People reported that they had studied carefully and absorbed information that they had read from posters in health facilities, stuck on trees and walls and in people's houses. Some people did not favour posters because people who could not read and write would not be able to understand them.

6.5.4 Word of mouth

Information on the advantages and disadvantages of different health providers and changes in pricing policies spreads quickly through word of mouth. Many interviewees thought that the "May krom" or group leaders could spread health information effectively through group meetings or informally as opportunities arose. Qualified advisers could also give information at group meetings. People had more trust in information given personally by credible sources than in mass media. People thought it was important to be able to discuss things face to face in order to understand them well.
7. PARTNERSHIPS

Community participation is an important component of the Minimum Package of Activities (MPA) and is recognised as essential for addressing the health situation in the study areas.

Potential constraints to participation perceived by people in the study areas included:

- a history of political violence breeding mistrust;
- a high population turnover with people coming from different districts;
- the opportunity costs for people attending meetings or doing voluntary work without payment;
- the lack of a sense of ownership, permanence and active leadership in the communities, worsened by neglect and exploitation by officials and land owners;
- the intractable nature of the causes of ill-health.
- People tend to take care of their own house and family as well as they can but do not have the resources to improve things outside this.

Positive indicators of potential participation include:

- A number of self-help groups and associations.
- Appreciation of specific community leaders and service providers, with a recommendation that they should work as partners with the project.
- People expressed great interest in forming associations to provide credit or insurance and help each other with health problems, in employing community members as community representatives or health centre liaison people and in working as partners with the project, NGOs and MHD.
- Offers to rent land and put up a building for the project service providers.
- Suggestions to involve community comedians and actors in health education activities.
- An understanding of the needs of health staff and the reasons for their negative behaviour.
- The quality of communication in the BIDS in groups discussions showed honesty, a sharing of information, knowledge and ideas and enthusiasm for being asked about their own views, lives and choices.
- 9% of respondents in the HHS had participated in communal activities for improving the environment and health over the past year, including building toilets and rubbish clearance.

The multiple causes of ill-health in the project sites demand a multi-sectoral approach for addressing them. The causes include poverty, the unsanitary environment, lack of clean water and shelter, overcrowding, unsafe and exploitative workplaces and promotion of alcohol and tobacco.

There are a number of well-regarded NGOs and CBOs in the project sites, particularly addressing sexual and reproductive health in Tonle Bassac. Boueng Kak is less well-served and the community feels isolated.
8. PROGRAMME AND POLICY IMPLICATIONS

8.1 Services and Quality of Care

8.1.1 Demand creation

The appreciation of the components of high quality care, the preference for using trained service providers, the sensible assessment of available services and ideas on how they might be provided suggest that there is already considerable demand for high quality services in the project areas. The long queues at the two high quality, free hospitals (Kantak Bopha and Samdouk Ouv) provide further evidence of this.

People will need information about:

- The preventive and curative services provided by the project, who will benefit from them and any costs.
- Signs and symptoms of illnesses that need treatment by a trained provider. Appropriate treatment for non-serious illnesses.
- Information about other high quality providers in specific areas such as sexual and reproductive health.
- Information on referral facilities.
- Information on their rights to quality treatment and exemptions.

People trust information about the quality of health services from relatives, neighbours and friends rather than advertisements which may be aimed more at profit than patient benefit.

- Provide information to community leaders and user groups on the above issues and with them find strategies for disseminating the information in the community.

8.1.2 Emergencies

- The project and community need to design an emergency transport system that would operate with no delays and demands for cash at the time of the emergency.

- The project needs to collaborate with emergency referral facilities dealing with accidents, violence, obstetric and childhood emergencies, among others, (Calmette, the Health Centre and Kantak Bopha respectively) to ensure that people get high quality treatment without demands for money.

- First aid classes for community groups or designated people could save lives. This could include ORS, wet cloths for fever, heart attacks as well as accidents.

- A service provider or community worker is needed in each project site to provide basic treatment and first aid at night.

8.1.3 Sexual and reproductive health
High quality SRH services for women and men are needed. The project should collaborate with the NGOs providing SRH services, inform the community about them and refer clients.

Good counselling is essential, with service providers listening to client ideas about methods and lifestyles in helping them to choose a suitable method. The high incidence of STI/HIV, malnutrition, hard work and unco-operative men indicate the importance of barrier methods, perhaps female condoms, with emergency contraception.

The provider should encourage follow-up visits in case of problems and method switch.

More assessment of STI treatment by health services and kru khmers and sharing of ideas with the community is needed before promoting allopathic services.

4 Safer motherhood

All mothers should be encouraged to deliver with the help of a trained provider and given information on quality of care and costs of their nearest provider.

There is an urgent need for a community transport system to carry obstetric emergencies to hospital. A system of exemptions or discounts needs to be arranged during ante-natal care to cover all necessary interventions at delivery.

5 Tuberculosis

Case finding and case holding should be a priority for the project.

Arrangements should be made with CENAT to diagnose and provide TB treatment and follow-up free to people from the project sites.

There is an urgent need to establish DOTS in the communities, either through mobile workers from CENAT or with outreach workers in the community.

The services should be free, convenient and confidential, taking into account the stigma attached to having TB.

BCG vaccination as part of EPI should be a priority.

8.2 Costs

The financial barriers to accessing health care could be reduced by:

Reducing the total costs of health care by providing services in or close to the community, at convenient times with short waiting times, with free or low cost services.
Providing high quality effective treatment so that people recover on the first course of treatment thereby avoiding further costs and loss of income. In the case of chronic diseases, provide free treatment inside or near the community with short waiting times.

Display service charges clearly outside health facilities and provide sufficient incentive and supportive supervision to staff that they do not ask for unofficial payments.

Design a strategy for spreading the cost of health care over a period of time at low or zero interest rates.

Find ways to provide exemptions to the poor with minimum time cost and loss of face.

Meet with community groups regularly for feedback on how well the cost reducing measures are working and suggestions for improvement.

This cost to the health service could be reduced by:

- addressing the underlying causes of ill-health through health education and promotion;
- allocating more resources to primary health care (PHC) in the community so that secondary facilities are only used for illnesses that cannot be treated at primary level
- providing more cost-effective treatment.

8.3 Health Education, Communication and Promotion

Information and messages alone are often not sufficient to enable people to adopt healthy behaviours. Participatory approaches to health promotion are needed to analyse the underlying causes of health problems and find ways to create the social support, enabling environments, skills and behaviour to reduce them.

Health promotion includes activities to prevent accidents, to clean up the environment and reduce mosquitoes, improve water supplies, to help people control their use of alcohol, tobacco and glue and prevent STI and AIDS are needed. This has been successfully achieved in some communities with the assistance of Solidarity with the Urban Poor Federation, Bamboo Shoot and Indradevi and local leaders. Lessons learned by these NGOs should inform the UHP.

Health education and promotion activities need to reflect seasonal changes in disease incidence and causes to maximise impact.

Careful health education on TB prevention and treatment is needed to prevent stigmatisation. This should focus on the role of correct treatment in reducing
infectivity as well as preventing infection through sputum. Once a free, confidential TB service is in place, a major education programme is needed to encourage people to use it.

Participatory small group activities, such as those described in the adapted version of Stepping Stones being used by Khana, might help people to adopt safer sexual behaviour and utilise SRH services. These discussions would allow people to talk about their concerns about different contraceptive methods and acquire more detailed knowledge.

Beehive Radio broadcasts popular programmes on reproductive health, which could include more detailed information on contraception, STI and other SRH topics.

Health education needs to include the advantages of avoiding unwanted pregnancy by using effective contraception and emergency contraception and where to obtain a safe abortion.

Health education should include the signs of serious ARI needing immediate care from a trained health provider and the use extra fluids or Oralyte for diarrhoea.

Lobby to ban advertisements for alcohol and cigarettes.

The community might want to set up support groups for those who want to reduce or stop smoking, drinking and glue sniffing.

Strategies to reach the ultra poor with health education are needed, particularly in BK.

8.4 Partnerships

promote community participation the project needs to:

Build on the participation and enthusiasm generated by the BDS by continuing to work with community groups to design its components in detail, implement, monitor and evaluate the project.

Give community members sufficient financial incentive to make up for loss of income if they are involved in substantial community work.

Continue to use participatory approaches that enable community groups to build trust among themselves and gain increasing confidence and skill in planning and working with service providers and other agencies.

Train all staff and community workers involved in the project in interpersonal communication skills, attitudes and behaviour towards poor people and participatory approaches.

Provide opportunities for service providers to consult with community groups on an
ongoing basis. Begin with some activities designed to increase trust and rapport between them.

Support service providers to work in more participatory ways through encouraging supervision, incentives and acknowledgement of the additional emotional and time demands.

Collaborate with NGOs working in the project sites who use participatory approaches and contract them to train and provide support to project staff.

The Project needs to form partnerships with NGOs and others who are working to alleviate poverty, improve the environment, establish safe water supplies and housing, reduce workplace risks, make roads safer, ban alcohol and tobacco advertisements and help people to overcome their addiction.