“MANGO ILLNESS”: HEALTH DECISIONS AND THE USE OF BIOMEDICAL AND TRADITIONAL THERAPIES IN CAMBODIA

A DISSERTATION SUBMITTED TO THE GRADUATE DIVISION OF THE UNIVERSITY OF HAWAI I IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

IN

ANTHROPOLOGY

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By

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Dissertation Abstract:

This study explores the health care system in Cambodia as it relates to caring for people living with HIV/AIDS. The Cambodian system of illness and health transects religious and cultural beliefs, illness experiences, and the HIV/AIDS epidemic. This study therefore focuses on illnesses affecting the people in Sdaov village, the site for this study, and how Cambodians make decisions about health care and illness. Specifically, it examines the health-seeking behaviors of AIDS patients with an emphasis on the cultural construction of AIDS. This study makes general contributions to medical anthropology and cross-disciplinary research on Cambodia. Two theoretical perspectives frame this research: medical decision-making and medical pluralism. Methods used during the course of fieldwork included both unstructured and structured interviews, participant-observation, and focus discussions. Altogether, 338 people in 5 provinces were interviewed between 1999 and 2001. Cambodians identify sexually transmitted diseases under the illness category 'svay' ('mango' illness). The mango metaphor, suggesting illnesses related to STDs or skin diseases, seems to safeguard those who contract the illnesses from social contempt. It provides sanction for people who have been afflicted with sexually transmitted infections. Svay illnesses include chlamydia, gonorrhea, genital herpes, and (more recently) AIDS. Cambodians have a unique understanding of AIDS in part because they do not all share a similar explanatory model of svay illness. Although the HIV/AIDS epidemic has been included in the svay category for STDs, not all Cambodians believe that HIV/AIDS should be treated in the same manner as other 'mango' illnesses. This study also examines how foreign assistance, development, and aid impact medical pluralism and medical decision-making in Cambodia. It focuses on the kinds of social problems that prevent people from having control over their own lives and thus limiting their decision-making potential.
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<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Clinic</td>
</tr>
<tr>
<td>AUSAID</td>
<td>Australian Agency for International Development</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioral Surveillance System</td>
</tr>
<tr>
<td>CAAFW</td>
<td>Cambodian Association for Assistance to Families and Widows</td>
</tr>
<tr>
<td>CDHS</td>
<td>Cambodian Demographic Health Survey</td>
</tr>
<tr>
<td>CFDS</td>
<td>Cambodian Families Development Services</td>
</tr>
<tr>
<td>COERR</td>
<td>Catholic Office for Emergency Relief and Refugees</td>
</tr>
<tr>
<td>CPA</td>
<td>Complementary Packages of Activities</td>
</tr>
<tr>
<td>CPK</td>
<td>Communist Party of Kampuchea</td>
</tr>
<tr>
<td>CPP</td>
<td>Cambodian People’s Party</td>
</tr>
<tr>
<td>CRS</td>
<td>Catholic Relief Services</td>
</tr>
<tr>
<td>CWDA</td>
<td>Cambodian Women’s Development Association</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>DK</td>
<td>Democratic Kampuchea</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FAC</td>
<td>French Cooperation</td>
</tr>
<tr>
<td>FUNCINPEC</td>
<td>National United Front for an Independent, Neutral, Peaceful, and Cooperative Cambodia</td>
</tr>
<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>GTZ</td>
<td>German Technical Cooperation</td>
</tr>
<tr>
<td>HCs</td>
<td>Health Centers</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HMA</td>
<td>heteroduplex mobility assays</td>
</tr>
<tr>
<td>HSS</td>
<td>HIV Sentinel Serological Surveillance System</td>
</tr>
<tr>
<td>ICRC</td>
<td>International Committee of the Red Cross</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IOs</td>
<td>International Organizations</td>
</tr>
<tr>
<td>ITM</td>
<td>Institute of Tropical Medicine</td>
</tr>
<tr>
<td>JICA</td>
<td>Japanese International Cooperation Agency</td>
</tr>
<tr>
<td>KHANA</td>
<td>Khmer Khmer HIV/AIDS NGO Alliance</td>
</tr>
<tr>
<td>Loa PDR</td>
<td>Lao People Democratic Republic</td>
</tr>
<tr>
<td>MPA</td>
<td>Minimum Packages of Activities</td>
</tr>
<tr>
<td>MD</td>
<td>Medical Doctor</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MoMSALVY</td>
<td>Ministry of Social Affairs, Labor, Vocational Training and Youth Rehabilitation.</td>
</tr>
<tr>
<td>MSF</td>
<td>Medicins Sans Frontieres</td>
</tr>
<tr>
<td>NAA</td>
<td>National AIDS Authority</td>
</tr>
<tr>
<td>NAC</td>
<td>National AIDS Committee</td>
</tr>
<tr>
<td>NAP</td>
<td>National AIDS Program</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
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<tr>
<td>NAP</td>
<td>National AIDS Plan</td>
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<tr>
<td>NAS</td>
<td>National AIDS secretariat</td>
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<td>NCHADS</td>
<td>National Centers for HIV/AIDS, Dermatology and STDs</td>
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<td>NGOs</td>
<td>Non-governmental Organizations</td>
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<td>NHSR</td>
<td>National Health Statistics Report</td>
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<td>ODs</td>
<td>Operational Districts</td>
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<td>PAO</td>
<td>Provincial AIDS Office</td>
</tr>
<tr>
<td>PAS</td>
<td>Provincial AIDS Secretariats</td>
</tr>
<tr>
<td>PhD</td>
<td>Doctor of Philosophy</td>
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<tr>
<td>PMER</td>
<td>Policy, Monitoring, Evaluation and Research Unit</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Preventing Mother-to-Child Transmission</td>
</tr>
<tr>
<td>PRK</td>
<td>People’s Republic of Kampuchea</td>
</tr>
<tr>
<td>PRPK</td>
<td>People’s Revolutionary Party of Kampuchea</td>
</tr>
<tr>
<td>PSF</td>
<td>Pharmaciens Sans Frontieres</td>
</tr>
<tr>
<td>QSA</td>
<td>Quaker Services Australia</td>
</tr>
<tr>
<td>RHAC</td>
<td>Reproductive Health Association of Cambodia</td>
</tr>
<tr>
<td>RGC</td>
<td>Royal government of Cambodia</td>
</tr>
<tr>
<td>RHs</td>
<td>Referral Hospitals</td>
</tr>
<tr>
<td>SEADO</td>
<td>Social Environment Agriculture Development Organization</td>
</tr>
<tr>
<td>SERVANT</td>
<td>SERVANTS to Asia’s Urban Poor-Cambodia</td>
</tr>
<tr>
<td>SSC</td>
<td>Social Services Cambodia</td>
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<tr>
<td>STDs</td>
<td>Sexually Transmitted Diseases</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>SUPF</td>
<td>Squatter and Urban Poor Association</td>
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<tr>
<td>THs</td>
<td>Traditional Healers</td>
</tr>
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<td>UNAIDS</td>
<td>Joint United Nations Program on HIV/AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Program</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
</tr>
<tr>
<td>UNTAC</td>
<td>United Nations Transitions Authority Commission</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WOMEN</td>
<td>Women Organization for Economy and Nursing</td>
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<td>WVI</td>
<td>World Vision International</td>
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CHAPTER 1: THE PROBLEM

1.1 Introduction

This study explores the health care system in Cambodia as it relates to caring for people living with HIV/AIDS. This chapter examines HIV/AIDS as a global problem, then reviews literature on HIV/AIDS and STDs in Cambodia. The scope and implications of the research problem are summarized, followed by a chapter outline of the dissertation.

1.2 The HIV/AIDS Epidemic as a Global Problem

The HIV/AIDS epidemic is a global problem. Today, an estimated 34-46 million people are living with HIV/AIDS. Already, more than 20 million people have died from AIDS, 3 million in 2003 alone (WHO 2004:3). About 5 million people became infected with HIV worldwide in 2003 (Ahmad 2004(4): 2). Four million children have been infected since the virus first appeared (WHO 2004:3). The pandemic affects African nations at the most alarming rate, with about 8% of the population of sub-Saharan Africa are HIV positive as of 2002, followed by Caribbean countries at 1.9 -2.3%, South and Southeast Asia and North America at around 0.6% and Latin America at 0.5% (UNDP Fact Sheets 2004). The HIV
prevalence rate among other regions, including Western Europe, North Africa and the Middle East, East Asia and the Pacific, Australia, and New Zealand is much lower. HIV prevalence in East Asia, the Pacific, and Australia was only 0.1% by end of 2002.

Table 1.1: HIV Prevalence Rates by Region

<table>
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<tr>
<th>Region</th>
<th>% Adult Population</th>
<th># Adults and Children Infected</th>
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<tr>
<td>Sub-Sahara Africa</td>
<td>7.5-8.5</td>
<td>25-28.2 million</td>
</tr>
<tr>
<td>Caribbean</td>
<td>1.9-3.1</td>
<td>470,000-730,000</td>
</tr>
<tr>
<td>South &amp; Southeast Asia</td>
<td>0.4-0.8</td>
<td>4.6-8.2 million</td>
</tr>
<tr>
<td>North America</td>
<td>0.5-0.7</td>
<td>790,000-1.2 million</td>
</tr>
<tr>
<td>Latin America</td>
<td>0.5-0.7</td>
<td>1.3-1.9 million</td>
</tr>
<tr>
<td>Eastern Europe &amp; Central Asia</td>
<td>0.5-0.9</td>
<td>1.2-1.8 million</td>
</tr>
<tr>
<td>Western Europe</td>
<td>0.3</td>
<td>520,000</td>
</tr>
<tr>
<td>North Africa &amp; Middle East</td>
<td>0.2-0.4</td>
<td>470,000-730,000</td>
</tr>
<tr>
<td>East Asia &amp; Pacific</td>
<td>0.1</td>
<td>700,000</td>
</tr>
<tr>
<td>Australia &amp; New Zealand</td>
<td>0.1</td>
<td>12,000</td>
</tr>
</tbody>
</table>

Sources: UNAIDS and WHO 2003.

Forty million people lived with HIV globally in 2003, with 26.6 million in sub-Saharan Africa alone (UNAIDS and WHO 2003:2). Botswana, Zimbabwe, and Swaziland have the highest rates of HIV infection (see Table 1.2 below). In Zimbabwe alone, AIDS has claimed 1.1 million lives through 2000 (UNAIDS 2004: 1). In South Africa, 4.7 million people were reported HIV positive (UNAIDS 2002:2).
Table 1.2: Countries with ≥15% HIV Adult Prevalence Rate

<table>
<thead>
<tr>
<th>Country</th>
<th>% of Adult Population</th>
<th># Adults (15-49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>38.80</td>
<td>300,000</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>33.73</td>
<td>2,000,000</td>
</tr>
<tr>
<td>Swaziland</td>
<td>33.44</td>
<td>150,000</td>
</tr>
<tr>
<td>Lesotho</td>
<td>31.00</td>
<td>330,000</td>
</tr>
<tr>
<td>Namibia</td>
<td>22.50</td>
<td>200,000</td>
</tr>
<tr>
<td>Zambia</td>
<td>21.52</td>
<td>1,000,000</td>
</tr>
<tr>
<td>South Africa</td>
<td>20.10</td>
<td>4,700,000</td>
</tr>
<tr>
<td>Kenya</td>
<td>15.01</td>
<td>2,300,000</td>
</tr>
<tr>
<td>Malawi</td>
<td>15.00</td>
<td>780,000</td>
</tr>
</tbody>
</table>

Source: UNDP Statistical Fact Sheet on HIV, Barcelona, July 2002.

Although slightly less alarming than in Africa, other countries have shown a similar rise in infection rates. In Brazil, 600,000 adults died of AIDS by end of 2001 (UNAIDS, WHO & UNICEF 2002:2). In the Ukraine in 1995, fewer than 300 people were reported to be HIV positive, but by the end of 2001, 9,752 people registered as HIV positive (UNAIDS, WHO & UNICEF 2002:2). Russia reported 173,068 infected people in 2001. The number of HIV infected people in 2001 was 118.2 per 100,000 (UNAIDS, WHO & UNICEF 2002:2). Large outbreaks of HIV in IDUs have occurred since 1996.

Asian countries generally have lower infected populations, but some may be at the brink of an epidemic. In China, 820,000 people were infected with HIV by the end of 2001 (UNAIDS, WHO & UNICEF 2002:2). Seventy-six thousand
orphans were already living with HIV symptoms and 30,000 adults had died from AIDS during the same year (UNAIDS, WHO & UNICEF 2002:2). In Guangxi province, 9.9% of sex workers were found to have HIV in the second quarter of 2000 (Cambodia Daily, 5 October 2001). The figure rose to 10.7% by the fourth quarter of the same year (Cambodia Daily, 5 October 2001). Surveillance data on China's huge population are sketchy, it was estimated that the number of people living with HIV/AIDS at 1 million in mid 2002 (UNDP 2004:1). In India, 4.58 million people were infected with HIV/AIDS by end of 2002, of a total 7.2 million people living with HIV/AIDS in Asia and the Pacific (UNAIDS and WHO 2003 Report:1; UNDP 2004:1). Almost 1 million people in Asia and the Pacific acquired HIV in 2002, an increase of 10% since 2001 (UNDP 2004:1).

In Southeast Asia, about 1.6 million people were infected with HIV/AIDS by 2001 and the number continues to increase annually. Table 1.3 below compares rates of infection among selected Southeast Asian countries. Malaysia has the fifth highest rate of HIV/AIDS among twelve countries in the Asia-Pacific region (Cambodia Daily, 2 August 2001). It was estimated that 180,000-400,000 people were HIV positive in Myanmar at the end of
2001 (UNAIDS, WHO and UNICEF 2002:2). As of August 2002, Thailand had a 1.8% rate of infection in the adult population (amfAR 2004:1).

Although similar economic, political, and social problems exacerbate the HIV/AIDS problem throughout Southeast Asia, many cases go unreported, so it is difficult to get accurate figures on HIV prevalence. Thailand has 650,000 people who are living with HIV/AIDS by end of 2001 (USAID 2003:16). Compared to Cambodia, the prevalence is low in Thailand, where the national government has been instrumental in fighting the epidemic and is now sponsoring third-phase vaccine trials. Prevalence rates reported for Vietnam, the Philippines, Indonesia and Lao PDR are much lower than for Cambodia, but these figures (Table 1.3) may be unrealistically low because there is still a lack of systematic national seroprevalence survey to determine the real rates.

Table 1.3: The 2002 HIV Prevalence in Southeast Asia (% of Population)

<table>
<thead>
<tr>
<th>Country</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>2.60</td>
</tr>
<tr>
<td>Thailand</td>
<td>1.80</td>
</tr>
<tr>
<td>Vietnam</td>
<td>&lt;0.3</td>
</tr>
<tr>
<td>Philippines</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Indonesia</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>0.05</td>
</tr>
</tbody>
</table>

For many years, HIV/AIDS went undetected in Indonesia, but a report by three health centers indicated that HIV had increased from 6% to 26% in 2001 among sex workers and that there had also been an outbreak among drug users (Macfarlane Burnet Institute 2002: 40; Cambodia Daily, 5 October 2001). Similarly, there is no formal system for determining HIV prevalence rate in Lao PDR. The government estimated 0.05% of adults were infected based on testing blood samples of students entering high school for the first time. The average age for this group was 14 years old. Therefore the actual rate for the adult population ages 15 to 49 is not known. Guidelines for HIV/AIDS programs in Lao PDR are under revision, but whether or not they will be adopted as government policy remains to be seen. The government has been unwilling to admit that there is an HIV/AIDS problem even though the country has high-risk groups similar to those in Thailand and Cambodia (e.g., sex workers, migrant workers, and drug users).

Another of Cambodia's neighbors affected by the HIV/AIDS epidemic is Vietnam. The government reported that only 37,000 people tested positive for HIV (Cambodia Daily, 8 August 2001), but the number reached 130,000 among the
adult population by end of 2001 (UNAIDS, UNICEF and WHO 2002:2; amfAR 2004:1). According to the Ministry of Social Affairs, HIV prevalence among sex workers in 1998 was 39.2% in Hanoi, the capital of Vietnam. The percentage among sex workers was even higher than the 31.4% for heroin users (Cambodia Daily, 8 April 2001). There have been rumors that the government has forbidden further HIV prevalence studies following these initial findings and so far no conclusive report on HIV prevalence has been released. Considering the increasing prevalence rates among their neighboring countries, Lao PDR, Myanmar, and Vietnam are likely to face a serious HIV epidemic in the near future. All of these countries, including Cambodia, face a severe lack of resources for dealing with the HIV/AIDS epidemic.

Brown has noted that HIV infections have not reached the high levels observed in some other parts of the world (Brown 2002:69), including Asia. The epidemic in Asia is expanding rapidly, however. More recent evidence exists for a rapid increase in China, Indonesia and Vietnam (UNAIDS 2004:5). The HIV/AIDS epidemic remains largely concentrated among sex workers, injecting drug users, clients of sex workers and their partners, and men having sex with men in this part of the world.
1.3 HIV/AIDS in Cambodia

Some literature on Cambodia focuses on health and diseases (Yanagisawa et al. 2004; Horm et al. 2003; Delvaux et al. 2003; Wolff 2002; Hill 2003; Baudon 1999; Busza et al. 1999b). It is important for this research to discuss the availability of literature because of the historical uniqueness due to the atrocities and almost two decades of isolation. It was only after 1992 (the UN sponsored National Elections) that there were efforts from both international and Cambodian communities in research and publications. Books written in the 1980s in the United States and elsewhere reflected the situations of the 1960s, 1970s, and early 1980s with the primary focus on Cambodian politics, particularly Kiernan's (1982) work on peasants and politics, Shawcross' (1981) Sideshow, Chandler's (1996) Facing the Cambodian Past with the attempt to the question was why almost one-third of the Cambodians were killed during the Pol Pot regime. An example is Ngor's (1987) autobiography of experiences of the holocaust. These books are relevant to this research because they provide a basis in which to conduct fieldwork in Cambodia as well as an
explanation why Cambodia suffered dramatically from the HIV/AIDS epidemic.

At the time this fieldwork was conducted (1997-2000), there was already a fair amount of literature on HIV/AIDS in Cambodia. Most of the work on HIV/AIDS in Cambodia has been published since 1997. Major contributors to HIV/AIDS research include the Cambodian Ministry of Health, and non-governmental and international organizations such as CARE International (1993), the International HIV/AIDS Alliance (1997), Mith Samlanh/Friends (1999), and UNAIDS in Cambodia on HIV/AIDS Profiles (1999, 2000, 2001, 2002).

Eisenbruch (1997) provides a technical discussion on HIV/AIDS for the National AIDS Review. Eisenbruch's aim was to encourage dialog between health care professionals at a time when only the first few AIDS cases were being reported. Tarr's (1996) report on contextual factors affecting risk-related sexual behaviors among young people in Cambodian society has had the most significant impact on this study. Tarr's discussion of the roles and meanings of sex in Cambodian society offered a starting point for this research.
1.4 Research Problem

This study broadly explores current health and the health care system in Cambodia, particularly as relevant to the support and care of people living with HIV/AIDS. This study follows up on the restructuring of the health care system since the 1980s, when the People's Republic of Kampuchea (PRK) attempted to strengthen health care in Cambodia. The PRK was faced with restructuring all its social systems in the mid-1980s as a result of the execution of most professionals (including medical doctors) during the Pol Pot regime. The Cambodian government heavily depends on external funds and international technical assistance to run most of its social systems. Systematic reporting of illnesses and health-related problems did not take place until the 1990s. In 2000, Cambodia was shown to have one of the highest maternal mortality rates in Southeast Asia, but the under-five mortality rate was low, second only to Lao PDR (MoH 2000:2). Rates of malnutrition are also high in Cambodia. Eighteen percent of infants are born with a low birth weight (MoH 2000:3). Fifty-six percent of children under five years old have a height-for-age ratio more than two
standard deviations from the international standard. Moreover, more than half the children under five years of age have suffered from preventable communicable disease such as diarrhea, Acute Respiratory Infection (ARI), and dysentery (MoH 2000). According to the National Health Survey of 1998, about 14% of adults surveyed require health care for illness or injury in any given period of thirty days. Two thousand four health statistics for Cambodia show no improvement (WHO 2004).

The Cambodian system of illness and health transects religious and cultural beliefs, illness experiences, and the HIV/AIDS epidemic. This study therefore focuses on illnesses affecting the people in Sdaov village, the site of this study and how Cambodians make decisions about health care and illness. Specifically, it examines the health seeking behaviors of AIDS patients with an emphasis on the cultural construction of AIDS. Two theoretical perspectives frame this research: medical decision-making and medical pluralism. Medical pluralism characterizes many health care systems worldwide in that people often turn to more than one medical paradigm for maintaining health and dealing with illness. The medical decision-making perspective seeks to understand what people do when
faced with illness and tries to account for the actions they take (Garro 1999: 319). It considers individuals rational decision-makers who choose among a variety of medical options in order to maintain health.

Making health care choices among multiple options does not occur by trial and error, nor do people tend to fuse discrete medical systems. Furthermore, healing is not a singular event, but a therapeutic process (Etkin 1997:287). Decisions are made each step of the way as people seek health care, whether through self-medication (e.g., the use of pharmaceuticals or over-the-counter remedies without the consultation of a physician), consultation with a trained biomedical practitioner, or use of indigenous Cambodian medicine (primarily medicinal plants). With the HIV/AIDS epidemic burdening the health care system in Cambodia, specific questions that need to be addressed include: What is the role of government in responding to the epidemic? Is there a support system for those who live with HIV/AIDS? What roles do various medical providers play in responding to the HIV/AIDS epidemic? What resources (biomedical, self-medicinal, or indigenous) are available for Cambodians to combat the HIV/AIDS epidemic?
This study focuses on the cultural construction and social negotiation of STDs and HIV/AIDS. Cambodians identify sexually transmitted diseases under the illness category 'svay' (‘mango illness’). The mango metaphor, suggesting illnesses related to STDs or skin diseases, seems to safeguard from social contempt. It provides sanction for people who have been afflicted with sexually transmitted infections. Svay illnesses include chlamydia, gonorrhea, genital herpes, and (more recently) AIDS. Some of the questions for this part of the research include: What is 'mango illness'? Are there different types of 'mango illness'? How has AIDS been incorporated into this illness category?

Cambodians have a unique understanding of AIDS in part because they do not all share a similar explanatory model of svay illness. Although the HIV/AIDS epidemic has been included in the svay category for STDs, not all Cambodians believe that HIV/AIDS should be treated in the same manner as other 'mango' illnesses. Cambodians have yet to grasp the full implications of HIV/AIDS.¹ Some Cambodians simply view AIDS as an illness without a cure. Whereas most Cambodians can explain the mode of transmission, therapy,

¹As yet, there is no specific term in the Cambodian language for the disease. It is written in the Khmer language using the acronym 'AIDS.'
and how/where to obtain medicine for other STDs, few can explain the etiology, symptoms, or treatment of AIDS. Instead, they resort to quoting public announcements from the television or radio when describing the disease. Stages of 'mango' illness are characterized as 'normal mango,' 'erupted mango,' and 'crouching mango,' corresponding to the clinical manifestations of primary, secondary, and tertiary syphilis (Eisenbruch 1997). Some Cambodians interpret the late phase of 'crouching mango' as AIDS. Because Cambodians are now experiencing a crisis of full-blown AIDS, this ambiguity may create difficulty in advocacy, treatment, and care of HIV/AIDS patients. This research therefore focuses on how the disease category svay shapes perceptions of HIV/AIDS and influences preventive and therapeutic behaviors.

1.5 Objectives and Implications

This study makes general contributions to cross-disciplinary research on Cambodia and to the field of medical anthropology. The work transcends the common polarization of studies on indigenous medicine and medical pluralism (as critiqued by Nordstrom 1988 and Silva et al. 1994) and provides a basis for comparison with other
societies in which biomedical and local health care
options co-exist. The examination of cultural features of
health care further contributes to understanding how
individuals make medical choices. This dissertation more
specifically adds to growing ethnographic research on AIDS.
A major portion of this work describes the illness
categories of STDs and HIV/AIDS in Cambodia, providing a
deeper understanding of the cultural construction of a
specific illness category (svay) that ambiguously sanctions
the afflicted and protects them from social stigma.

It is critical for health practitioners to know what
resources are available to the average Cambodian dealing
with HIV/AIDS. The main objective of this study is to
share research findings with Cambodian health officials and
IO/NGO health workers and interest groups. This study has
other practical implications. Few societies today remain
culturally isolated, free from the influence of the
biomedical paradigm and Western pharmaceuticals. Thus,
research on the interaction between non-Western and Western
health beliefs and practices provides a basis for
developing health education strategies and national health
care systems. After three decades of human destruction and
the erosion of most social systems, Cambodia has only very
recently begun to restructure its health care system (McGrew 1990, Eisen 1982, Heng 1995). Few indigenous healers remain after three decades of war and civil unrest, and much local knowledge of medicinal plants has been lost. The new generation has been slow to recapture this tradition in the face of tremendous change. This research will therefore benefit local communities as well as the Cambodian government by describing a variety of medical options available to Cambodian AIDS patients.

1.6 Organization of the Dissertation

This chapter has addressed the HIV/AIDS epidemic as a global health problem and presented the scope and significance of this study. Chapter 2 discusses the conceptual framework for this research, focusing in detail on the models of medical pluralism and medical decision-making. Chapter 3 describes the larger Cambodian context, examining its geography, demographics, life ways, sociopolitical history, and the impact of sociopolitical discontinuities on health. Chapter 4 examines health and the health care system in Cambodia today. Chapter 5 focuses on health and illness patterns in Sdaov village, particularly the accessibility of health care services and
perceptions of STDs and HIV/AIDS. Chapter 6 describes the research methodology as well as problems encountered during fieldwork. Chapter 7 presents research findings with particular attention to local and biomedical/formal healing modalities. Chapter 8 then discusses 'mango illness' as it is understood within the Cambodian medical explanatory model of STDs and HIV/AIDS. Chapter 9 examines social problems (e.g., poverty, prostitution and migration) affecting the way Cambodians make medical decisions. Chapter 10 concludes the dissertation by examining its implications for international organizations and development aid programs.
CHAPTER 2: THEORETICAL APPROACHES

2.1 Introduction

This chapter discusses two theoretical perspectives that guide this research, medical decision-making and medical pluralism. Both perspectives help frame studies on health behaviors, illness patterns, and treatment choices. This followed with a discussion on alternative therapies that AIDS patients sought. This chapter discusses a variety of models within the medical decision-making approach and describes the diversity of medical practitioners that may be drawn upon within a plural medical system.

2.2 Medical Decision-Making

Most studies using the medical decision-making approach only test medical models within clinical settings (Charles et al. 1997; Kaneko et al. 2003). Only a few have examined treatment choices within specific cultures to gain insight into the relationship between cultural knowledge and medical decision-making (Frye 1989, 1990; Garro 1999). These studies have shown how people talk about illness and the actions they take to deal with it. This approach is considered an "emic" view by attempting to understand people being studied through their own observations and
experiences in contrast with an etic perspective. The underlying assumption of the latter view is that it is objective (will be discussed in Chapter 5). A review of these studies is essential for a deeper understanding of the medical decision-making perspective as it relates to both "emic" and "etic" perspectives.

2.2.1 Models within Clinical Settings

Analyses of medical decision-making are often based on testing specific models. Studies conducted by biomedical professionals in the Western world utilize one of a variety of models. Some are patient-centered (Chewning & Sleata 1996; Stevenson et al. 2000), others use the paternalistic or professional-as-agent models (Charles et al. 1997), and still others explore shared decision-making (Gwyn & Elwyn 1999; Karel 2000; Sieber & Kaplan 2000). Shared decision-making is increasingly advocated as the ideal treatment process (Charles et al. 1997: 689). A review of these models points toward a theoretical gap between studies conducted in clinical settings with patients in the West and those conducted in the field in a foreign country. These studies in clinical settings tend to be based on etic view (i.e., objectivity).
The patient-centered model focuses on the individual as decision-maker, stressing the importance of understanding patient experiences of illness and any relevant social and psychological factors. It attempts to understand the patient's point of view and expectations to work with patients in establishing a common ground regarding treatment management (Stevenson et al. 2000). It requires active listening by the doctor so that information will be provided that is important and relevant to the patient. This model assumes that the patient has adequate information about treatment options and possesses enough self-knowledge to judge efficacy and understand medical protocols. It further assumes that the patient holds a scientific worldview and recognizes that cultural beliefs about health and the causes and cures of illness result in positive or negative attitudes to suggested treatment plans. Finally, the patient is expected to be aware of the consequences of being wrong (Sieber & Kaplan 2000:237s). This limits the role of the physician to information transfer (Charles et al. 1997:683).

In the paternalistic model, the patient is irrelevant. This derives from Parson's (1951) conceptualization of the sickness role. This role of being sick is granted by the
physician to excuse patients from normal duties, but it obliges them to try to get well (Gwyn et al. 1999:438). It assumes the patient remains passive making decisions about treatment (Charles et al. 1997: 682). The physician dominates the medical encounter and uses professional skills to diagnose illness and recommend tests and treatments for the patient (Charles et al. 1997:683). This model no longer applies to the conduct of clinical medicine because informed patient consent has become the norm (Frosch et al. 1999:286).

Ideally, both patient and physician participate in the decision-making process and end up sharing treatment preferences. This model favors a personal, trusting relationship between patient and doctor (Charles et al. 1997: 689). Together, they consider available information about the illness, treatment options, and consequences, and then consider how these fit with the patient’s health preferences (Frosch et al. 1999: 285). A treatment decision is reached by mutual agreement, but several conditions must be met for shared decision-making to occur. The atmosphere must be conducive to active patient participation and the physician must make patients feel
that their contributions to the decision-making process are valued (Frosch et al. 1999: 285).

The Biomedical models focused in clinical settings measure disease processes as the outcome, assuming an etic view, while some alternative models such as those used by medical anthropologists (Garro 1999) emphasize quality of life and life duration instead of disease process (Sieber et al. 2000:234s) with an emic perspective. Alternative models have been developed in response to the observation that not all patients actually adhere to the recommendations offered by medical providers, even if they were part of the decision-making process (Sieber & Kaplan 2000: 235s). An emic view takes into account cultural and social factors. Cultural, religious, and emotional factors contribute to decision-making process, as do life experiences and health status (Karel 2000: 404). Such models emphasize identifying the non-medical factors as they influence decisions about treatment (Mckinlay et al. 1996: 773). Non-medical factors are divided into three categories: 1) characteristics of the patient (e.g., age, sex, socio-economic status, race or ethnicity, presence and type of health insurance, personality characteristics, and physical attractiveness); 2) characteristics of the doctor
(e.g., medical specialty, level of training, length of clinical experience, geographical location, and age, sex, race, ethnicity, and personality); and 3) features of the practice setting (e.g., organization of the practice and cooperativeness of the physician) (Mckinlay et al. 1996: 769). All these characteristics influence the way patients make medical decisions. Health decisions are also made based on cultural themes such as language, beliefs, and kinship systems (Frye 1991). Individuals also make decisions about treatment based on personal explanatory models guided by previous responses to particular illness episodes (Stevenson et al. 2003). Recognition of the importance of the role of the individual in making treatment decisions is therefore essential. What people believe and the actions they take in dealing with illness are an important part of the process of how medical decisions are made.

2.2.2 Descriptive and Normative Approaches to Medical Decision-Making in Anthropological Literature

Medical anthropologists have broken away from testing specific medical models in the clinical setting to debate normative and descriptive approaches to understanding
decision-making. Both the normative and descriptive treat individuals as rational decision-makers, but diverge with respect to the role of the individual in the decision-making process.

The normative approach predicts human behavior by assuming that people rationally evaluate all alternatives and make the best choices following a mathematical model (Mathews 1982:173). This implies that the process by which individuals reason should and does emulate mathematical calculations. The optimal decision generated by the normative model is supposed to reflect the decisions that people make in the real world (Mathews 1982:173).

The descriptive model takes more account of what individuals actually say and do. This approach arose as a reaction against the normative approach (Mathews 1982:173). Anthropologists following this model pay greater attention to the day-to-day actions of people confronted with illness and attempts to gain insight into the relationship between cultural knowledge and specific treatment actions (Garro 1999: 319). The descriptive theory assumes that people in the real world do not often make the optimal choices predicted by normative modeling (Mathews 1982: 173). Instead, it attempts to account for actual choices people

Related to this approach are two studies on decision-making by Frye (1989, 1990) that involve Cambodian refugees in the United States. Her research seeks to understand why Cambodian Americans do not seek health care more aggressively. Frye claims that their decisions regarding health care depend on the nature and type of illness and whose sickness the family is dealing with (e.g., a child or a parent) (Frye 1989: 116). Decisions about health care are affected by characteristics of household members, including gender, sex, and age. In general, mothers play the central family role in making more of the decisions concerning their children's health, and accessing health care services (Frye 1989: 117). Following the Buddhist
ethic of selflessness, women may also be called upon to deal with the mental health of family members, including supporting men emotionally when they are under a lot of stress (Frye 1989: 117). On the other hand, fathers play more active roles when illness is chronic and severe. Frye states that there were individual patterns of decision-making among Cambodian adults who seek health care services (Frye 1989: 117).

Frye suggests that the Khmer (Cambodians) seek health care options that provide a comfortable fit with culture and language. Although the Khmer (Cambodians) have great respect for foreign care experts, they prefer a combination of traditional Khmer medicine and biomedicine. Superficially, it appears to Western medical professionals that Cambodians accept medical advice without questioning their authority. On the contrary, what they actually do is often different from the advice given. Cambodians tend to blend different medicines. Frye focuses on cultural themes driving this behavior, including beliefs about disease causation, the pragmatics of the situation, familism, language, and other factors (Frye 1991: 134). An earlier study of a Mayan population also reveals that the decision to seek biomedical care is often based on beliefs
about disease causation (Frye 1989-1990: 34).

Furthermore, Frye claims that although traditional Mayan remedies are considered efficacious, given the choice, respondents select biomedicine because of the perception that it works more quickly (Frye 1989-1990:35).

Cambodians also consider accessibility and cost in making healthcare decisions. For example, illnesses specifically identified within the Cambodian medical system, including tors (a postpartum condition), khasoi baedoung ('soft heart'), khasoi suort ('soft lung') or ort satech aram (loss of consciousness due to 'thinking too much') requires traditional Khmer therapy (Frye 1989-1990). Similarly, traditional Khmer medicine or a combination of biomedicine and traditional Khmer medicine are used to treat mental illnesses (Frye 1989-1990).

Traditional Khmer medicine and biomedicine are usually blended when treating infants, children, or adolescents (Frye 1989: 39). For example, when children are ill they may be 'coined' (couk kchall), given traditional herb teas to drink, and receive antipyretics and antibiotics simultaneously. Biomedical care for serious illnesses is sought before traditional Khmer medicine, including cases of febrile convulsion in an eight-month old infant with
measles, spontaneous abortion in a grand multipara, and chest pain in an elderly woman (Frye 1989: 39).

In short, various factors influence how decisions are made about health care. Cultural beliefs about disease causation, availability of treatment options, and language all play a significant role. By examining these factors, we can better understand people’s responses to the occurrence of illness.

2.3 Medical Pluralism

Medical pluralism refers to the simultaneous occurrence of two or more ways of understanding health, particularly approaches to prevention and treatment (Beckeleg 1994; Muela et al. 2002; Reeve 2000:97). Pluralism may involve a combination of two or more aspects of a single medical system or a blending of different kinds of medical systems (Knuaf 2002: 81). Pluralism characterizes health care in many parts of the world. Explanatory models of diseases and their etiologies are embedded in people’s beliefs. They reflect cultural theories of illness and treatment. The experiences, exposure to various systems, beliefs, values, and education
of specialists also influences the type of medical services they provide.

All health care systems share two goals: 1) alleviating pain and suffering; and 2) promoting good health and protecting people from illness. Despite these shared goals, striking differences exist. The most widely influential medical system is biomedicine. Only recently has biomedicine begun to acknowledge ayurveda and other indigenous medical systems as having some efficacy within the biomedical setting. The World Health Organization launched a global plan for including traditional and complementary medicine in healthcare services (WHO 2003:1). The goal of WHO's plan is ensure safety for all users of alternative medicine. This initiative was a response to growing concern among patients and practitioners over the safety, efficacy, and effect of traditional and alternative medical approaches (WHO 2003:1). In the West, alternative therapies are already being used to complement mainstream biomedicine (Engebretson 2003: 177).

Allopathic medicine dominates most Western health care systems, yet patients often seek out complementary and alternative medicine (CAM). CAM includes any health interventions not normally taught in medical school or
available in most hospitals (Ernst 2003). Alternative medicines have become widely available in developed countries from venues such as health food stores.

Traditional healing practices replace CAM in developing countries. Like CAM, traditional medicine is not available in the hospitals, clinics, or health centers dominated by allopathic medicine. Traditional medicine can usually be obtained from a variety of people, however, including healers, pharmacists, and vendors.

Regardless of how allopathic medicine is controlled or managed, patients seek medicine from a variety of sources. This section discusses medical plural practice around the world, as well as indigenization of biomedicine, and diverse medical practitioners. This section discusses CAM use among AIDS patients, with broader implications for understanding medical pluralism around the world.

2.3.1 Use of CAM

CAM includes health maintenance regimes (e.g., diet and exercise) and home remedies (Stevenson et al. 2003). Herbs, vitamins, dietary supplements, physical exercise, meditation, phytotherapy, homeopathy, and psychotherapy all fall under the CAM rubric. In Western countries, herbal
home remedies have mostly been replaced by manufactured pharmaceuticals (Kelner et al. 2004). There has been a systematic effort in the U.S., U.K., and Japan to professionalize and legitimize CAM by shifting how medicine is classified. Pharmacists now supply alternative medicines that were previously only available outside of the formal health care system.

Seeking out CAM is usually motivated by the desire to heal oneself. A strong healing motivation can contribute to a patient's psychological and physical well-being, and thus lead to improvement in the patient's health (Bilia et al 1999). Patients actively participate in deciding what kind of treatment to seek (Stevenson et al. 2003). Treatment usually follows the advice of professionals, family members, or friends. These individuals play an important role in how patients manage illness or maintain health (Gray et al. 2003). Treatment decisions are influenced by explanatory models of illness and health and beliefs about different types of therapies. For example, Italians believe that the body is permeable and therefore vulnerable to atmospheric insult, microbial infection, or modern miasmas such as pollution or food additives (Whitteaker 1999). Such beliefs affect what they do to
maintain good health and what they see as appropriate therapy in times of illness.

Patients usually start with self-treatment, that is, therapy undertaken without a prescription or direct recommendation by a health care professional (Stevenson et al. 2003: 516). Patients turn to the professional sector when their problem cannot be solved at home (Stevenson et al. 2003: 521). They continue to resort to different kinds of treatment only if the one they are using proves ineffective (Garro 1999; Stevenson et al. 2003). Within the U.S. context, patients only discuss self-treatment with medical workers if the remedy is generally perceived as legitimate (Stevenson et al. 2003: 515). Treatment is thus negotiated between patients and medical professionals who may have different beliefs about medicine.

Financial constraints also influence treatment decisions among some patients. One study shows that cost considerations are included in decisions to self-treat using over the counter drugs or CAM (Stevenson et al. 2003: 523). The issue is more apparent in developing countries, where patients often have to make decisions between food or health care (Xu et al. 2003). The poor in developing countries spend more on health care as a percentage of
household income than the rich (Grant et al. 2003). Most of these expenses are in the private sector or in unofficial user fees in the public sector (Grant et al. 2003). The biggest source of finance for the health sector is out of pocket expenditures on medicine (Grant et al. 2003).

2.3.2 CAM and Biomedicine

Studies show that patients use multiple health care systems and pharmaceuticals (Petal et al. 2002). CAM is an integral part of healing in some countries (Aksoy 2001; Allen 2003; Mills 2003; Petal et al. 2002; Sharma 2001). In China, traditional and modern medical systems have operated in tandem for some time (Nie 2000). Ayurveda remains a vital part of the Indian medical system, which also includes spiritual practices in its formal medical training curriculum (Allen 2003). The Yup'ik and Cup'ik Eskimo of Southwest Alaska have developed a health care program that incorporates traditional healing (Mills 2003). There has also been increased recognition of the necessity for allopathic medical professionals to be culturally competent and take a more holistic approach to medical therapy (Betrancourt et al. 2003; Kubsch et al. 2004;
Savage et al. 2000; Uehara 2001). CAM is considered holistic because it accepts all perspectives, embracing the varied beliefs and values that influence treatment decisions (Tsoneva et al. 2004; Omonzejele 2003).

Although the Cambodian medical system is dominated by biomedicine, the use of traditional medicine persists. Cambodian highlanders still use medicinal herbs to induce abortion, for example (Asia Week 1993). Outsiders sometimes misinterpret Cambodian ethnomedical practices in a negative light. For example, abdominal pain is treated by burning the skin, which can leave visible scars after the treatment (Urbani et al. 2002:160; bunchwald et al. 1992). Dermabrasion therapy is perceived in Western countries as a form of abuse rather than a legitimate traditional medical practice (Davis 2000).

Biomedicine is commonly reinterpreted according to local explanatory systems. Contraceptive pills or injectables are believed to generate heat in the body and alter the balance of bodily elements, causing the womb to dry up (Sadana et al. 1999: 348). Side effects from contraceptive pills, such as weight gain, are associated with good health (Sadana et al. 1999: 351). Blood loss is considered permanent (Sadana et al. 1999).
Studies on the indigenization of biomedicine show that the wrong drugs are often taken or the right drugs are taken in the wrong amounts or for the wrong duration (Chareonkul et al. 2002). Another concern is the excessive and continuous use of multiple pharmaceuticals at the same time (Soeters et al. 2003). It must be understood, however, that people in different countries use or interpret medicine according to their own rationale. When it comes to healing, patients seek all available medical options. AIDS patients are a good example of this.

AIDS patients actively manage their health through the use of complementary alternative medicine. CD(4) count, educational status, year of HIV diagnosis, and marital status are not effective predictors of CAM use (Duggan et al. 2001). Another study reveals that the young, highly educated individuals and those suffering from the most debilitating symptoms are most likely to seek complementary medicine in conjunction with HIV/AIDS medication (Vanable et al. 2000).

AIDS patients generally look to CAM for ways to alleviate the side-effects of highly active antiretroviral therapy (HAART), but do not necessarily seek specific treatments from trained alternative healers (Agnoletto et
AIDS patients incorporate a variety of alternative medicines in addition to allopathic therapy (Ernst 2003). These include multivitamins, acupuncture, Chinese herbs, and other botanicals. Traditional medicine and ritual remedies prescribed by Buddhist monks are frequently used among Southeast Asians with HIV/AIDS (Hathirat 1983).

Some AIDS patients show considerable improvement following CAM therapies (Power et al. 2002). In the 1990s, medical professionals in Western countries began examining alternative treatment modalities for AIDS. Vitamins are most commonly used by AIDS patients (Nokes et al. 1995). In one experiment, AIDS patients were given 200mg of SAM-e twice a day. SAM-e is a naturally occurring molecule present in almost every tissue and fluid in the human body. Vitamins that maximize the activity of SAM-e were also taken daily, including 100mg of vitamin B12 and 800mg of folic acid (Ernst 2003). The SAM-e supplement appears to reduce symptoms among HIV patients, improving their mood and quality of life without adverse effect (Ernst 2003). Acupuncture appears to improve neuropathy (Agnoletto et al. 2003). There is an association between time of diagnosis with HIV and positive results from the use of herbal...
products (Colebunders et al. 2003). Minerals are reported to improve overall health of AIDS patients (Furler et al. 2003). Other studies present similar findings (Furler et al. 2003; Kirksey et al. 2002). In short, combining alternative and allopathic treatment modalities seems to be both beneficial and increasingly favored. In many parts of the world, overlapping medical services are the norm. This includes incorporating both Western and indigenous medicines. Western medicines are often interpreted in accordance with the local explanatory model, however.

Medicines are often classified under two categories: Western pharmaceuticals and indigenous medicine. Indigenous medicines are those taken in natural or raw form. For example, Ghanaians divide medicines into the categories of "blofo tshofa," or white man's medicine and "modin tshof,a" African medicine, which is also called "shikpon tshofa," literally 'medicine of the earth' (Senah 1994: 91). The amaXhosa people in the Eastern Cape of South Africa refer to indigenous medicines as those derived from animals and plants. Herbal medicines are described as those derived from plants. Medicines imported from Asia are considered 'modern' (Moller 2002: 388). Filipinos also
distinguish between *gamut botika*, or drug store medicine, and *halamang gamut*, or medicinal plants (Tan & Etkin 1994: 74).

2.3.3 Indigenization of Biomedicine

The local medical practices that Western medical professionals perceive as irrational are always derived logically from a coherent belief system (Etkin 1994:26; Etkin and Tan 1994; van der Geest 1989). This becomes quite apparent when examining indigenous interpretations of pharmeceuticals, including cultural understandings of drug efficacy (Kodjo 1994; Tan 1992) and the use of prescription medications for preventive or other measures (Etkin 1997; Ferguson 1988). Western pharmaceuticals are re-interpreted to fit indigenous explanatory models based on physiologic action, taste, texture, and color (Cosminsky 1994; Etkin 1992, 1994, 1997:285).

In sub-Saharan African societies, for example, the advent of globalization and the introduction of biomedicine have created alternatives to existing indigenous medical systems (Etkin 1997: 285). Africans have begun using pharmaceuticals, but often interpret them based on how they understand their botanical ethnomedicines. For instance,
Ga villagers in Ghana evaluate efficacy of a pharmaceutical based on its visible action on the body, size (if it is a tablet), taste, color, and origin instead of its pharmacologic properties (Senah 1994: 90). In the Philippines, efficacy is evaluated in terms of speed of effect, which determines how strong a medicine is (Tan 1994: 73).

Another issue with the indigenization of biomedicine is side effects. Side effects are not interpreted congruently with manufacturer statements. They are re-interpreted as primary rather than side effects (Etkin 1997: 285). Local explanatory models view these side effects differently. For example, in Hausa therapeutics, "side and other effects" are negotiated as part of the broader strategy of treatment that embraces the meaning of medicine (Etkin 1992). Side effects are also expected to have both primary and secondary physiologic effects (Etkin 1992, 1994).

Self-medication is most prevalent issue concerning Western pharmaceuticals in developing countries. Studies tend to focus on drug misuse, overuse, or inappropriate use (Abosede 1984; Ferguson 1988; Greenhalgh 1987; Hardon 1987; Shimada et al. 1995) rather than on local contexts of
distribution and use of pharmaceuticals (van der Geest 1987). For example, antibiotics are used indiscriminately in many parts of the world, such as to prevent or treat a cold (Levy 2002). In Colombo, Sri Lanka, antibiotics are used in single-dose injections or mixed into native potions and "holy" healing water (Abodsede 1984: 702). There is a similar lack of control over other dangerous drugs such as sedatives, hormones, and analgesics (Abodsede 1984: 702; Hardon 1987: 287). In India, nutritional supplements, anti-infectives, and analgesics are ubiquitous but not always used as intended by manufacturers (Greenhalgh 1987: 308).

2.3.4 Diverse Medical Practitioners

Health care practitioners may have received either formal or informal training in a variety of health systems. In the developing world, practitioners often select different aspects of medical systems to incorporate into their practice. Some healers use botanical medicines while others combine supernatural healing with Western pharmaceuticals. Individuals become medical practitioners either through divine selection or by entering training. 'Divine selection' means that a person has a dream that
indicates he or she must become a healer (Rubel & Hass 1996: 124-25). There is also a diverse group of medical practitioners in Cambodia (see chapter 5.4 discussion on the case of kru Khmer).

Another kind of divine selection happens when a person who has recovered from a serious illness feels that he or she has been chosen to become a healer in turn (Rubel & Hass 1996: 125). Alternatively, some people feel compelled to become healers after one of their family members has died of a serious disease. People who choose to become medical practitioners often go through a period of apprenticeship. A master healer may teach didactically and allow the apprentice to observe healing practices. Some students assist the healer and his or her family by way of compensation for the training while others pay for the teaching (Rubel & Hass 1996: 125). In some societies, individuals who wish to embark on a career as a healer can expect to have their abilities tested by different people, usually family members. Subsequently they are allowed to expand their practice to non-relatives.

Medical practices may also be learned in a formal educational system. In the West, practitioners of biomedicine undergo rigorous training in an allopathic
medical system that begins with four years of general education, followed by four more years in medical school, several years of internship and residency, and finally an examination before a practitioner is permitted to embark upon a medical career. Chinese and Ayurvedic doctors undergo similar training. In India, the student enters into a spiritual relationship with a guru, learns to diagnose illness through observation, and memorizes Ayurvedic texts (Leslie 1969a; Lieban 1977: 23). Chinese medicine, which dates back to the fifth century, requires seven years of training.

Diverse practitioners and medicines are found in many places in the world. In the town of Asuncion in Western El Salvador, medical practitioners include biomedical doctors, indigenous healers (sabadores, curanderos), midwives, and faith healers in the Protestant churches, but all of them use prepackaged pharmaceuticals at least some of the time as a healing strategy (van der Geest & White 1988: 23-24). Kalutara, Sri Lanka has a high number of biomedical practitioners and approximately eighty traditional Ayurvedic doctors (Abosede 1984: 699). Even in the United States, where biomedicine dominates the health care system, a third of respondents in one study reported the use of
non-conventional therapies (e.g., acupuncture, chiropractic, massage); one in three respondents had used an alternative therapy at least once in the previous year (Eisenberg et al. 1993: 246).

Healing methods also vary considerably. The health care system of Sri Lanka has been recognized as highly pluralistic. Both professionalized (university trained) and traditional or non-professionalized (apprentice-trained) practitioners co-exist (Nordstrom 1988: 480). Traditional healers, who may or may not be officially recognized as medical practitioners, sometimes integrate biomedicine with Ayurvedic and Sinhalese medicines (Nordstrom 1988: 479).

2.4 Summary

This chapter discussed two conceptual approaches to examining health beliefs and illness patterns, known as the medical decision-making and medical pluralism models. Some of the diversity of practitioners and healing methods used worldwide were described, focusing on AIDS patients, and healers and their practices.

Chapter 3 examines AIDS and AID in Cambodia with an emphasis on technical assistance and other social problems affecting development programs. This chapter discusses how
development aid linked to the HIV/AIDS epidemic, and the
effect of social problems such as poverty, prostitution and
migration on medical decision-making.
CHAPTER 3: FOREIGN ASSISTANCE AND THE EFFECT OF SOCIAL PROBLEMS ON MEDICAL DECISION-MAKING

3.1 Introduction

Foreign assistance directly influences every aspect of a society in a developing country. This impacts on medical pluralism and medical decision-making. This chapter discusses foreign assistance and the health care system in Cambodia. This chapter discusses the decision-making model, which takes into account social and other constraints that force people to make choices that may affect their health and well-being negatively. This chapter, however, summarizes the kinds of social problems that prevent people from having control over their own lives and thus limits their decision-making potential such as poverty, prostitution, and migration. This chapter discusses implications of these findings as it relates to development and foreign assistance.
3.2 AID and AIDS: Foreign Assistance and the Health Care System in Cambodia

This section examines the conceptual framework of foreign aid, development aid models, and foreign aid allocation. It discusses how socio-political instability and corruption affect aid flows and technical assistance.

3.2.1 Development Aid

Rich, developed states give foreign aid to poor countries for various reasons, not all of which are altruistic. Some analysts believe that wealthy nations give aid to others to suit their own economic and political self-interests or induce cooperation on the part of recipient states (Opeskin 1996:21; Rao 1997:947). Other reasons for rendering financial and other assistance to poor countries include promoting the political ideology and economic values of donor states, maintaining political and economic stability in recipient states to prevent an influx of refugees to developed states, and supporting economic growth in recipient countries (Opeskin 1996:21).

Foreign aid includes direct financial assistance, but it can also come in the form of export of goods and services at below market prices (Dewald & Weder 1996: 551;
Tavares 2003: 100). A variety of approaches are used to analyze data on development aid and how the foreign aid budget is used by each donor country.

3.2.1.1 Conceptual Framework for Development Aid

This section reviews development aid research and theories about why donor countries continue to give foreign aid. These theories include demand and supply approaches, the comparative advantage model, and the moral model.

The demand approach assumes that foreign aid should be spent wherever it generates the highest marginal utility (Dewald & Weder 1996: 549). In this approach, the needs of the poor are center stage. The supply-oriented approach focuses more on the donor, who is expected to provide goods and services at the lowest possible cost to itself (Dewald & Weder 1996: 549). The combined theories explain why foreign aid is critical to both recipient and donor states. The comparative advantage model is borrowed from international trade theory. It states that worldwide allocation of resources can be improved if countries specialize in certain goods and services and trade them internationally at a low cost in order to free up consumption from domestic production (Dewald & Weder 1996: 549).
551). For example, if two countries provide aid to a third country, the home country has a cost advantage relative to the foreign country in providing agricultural projects. The home country has greater knowledge and experience in producing agricultural goods and its official development assistance agencies (ODAA) provide that expertise to other countries (Dewald & Weder 1996: 551). One country has to specialize in the production of aid projects in order for it to have a comparative advantage.

Moral theory holds that rich states and their inhabitants have a moral obligation to assist poor states and their people by transferring resources to them, regardless of state or national boundaries (Opeskin 1996:22). Attention focuses on the moral relevance of states and national boundaries to conceptions of justice and humanity (Opeskin 1996: 21). However, in practice, developed countries show a preference for granting aid to developing states when it is in their national interest to do so (Opeskin 1996: 21). President Nixon admitted that the purpose of American aid was not to help poor countries but to help the United States (Opeskin 1996: 21). A moral basis for aid is overly idealistic. Rich states actually
offer assistance to promote their own political ideology or prevent a future influx of unwanted refugees.

The self-interest of donor states is apparent in the conditions they put on aid. Over the past two decades, international donors have been committed to using aid to promote specific political and social arrangements and economic development (Williams 2000:557). Their emphasis has been on governance, which entails improving public sector management, restructuring legal systems, decentralizing administration, improving accountability, encouraging transparency, and providing information (Williams 2000:570). That these concerns have become the foci of aid projects suggests that donor countries assume that recipient governments are corrupt, inefficient, and prone to mismanagement. Wealthy, developed states therefore feel justified in stipulating conditions on development assistance to poor countries.

3.2.1.2 Modeling Aid Flow

Various models have been proposed to evaluate the efficiency, quality, and quantity of foreign aid. These models rank foreign donors by scale and equity in giving aid (Rao 1997), test the corruption of foreign aid (Tavares
2003), or assess the impact of aid on recipient countries (Azam & Laffont 2003). These models examine aid flow, assuming that foreign aid is given conditionally to minimize aid-related problems and allow donor states to maintain control over the disposition of donated funds.

The equity index ranks donor countries according to how well donor's allocate aid according to recipient needs (Rao 1997:948). It measures the generosity and fairness by which aid is distributed. Need is measured by realized per capita income (Rao 1997:948). As of 1997, the rating had dropped for the United States, which was ranked at the bottom of the index. The scores for Canada and Australia had also fallen, but Italy, Germany, and the Netherlands had improved (Rao 1997:948). The equity index does not indicate how much poor people in recipient countries benefit from foreign aid, however.

Another model examines the impact of aid flow and corruption among recipient countries (Tavares 2003:100). This model includes factors such as GDP per capita, political rights, ethno-linguistic fractionalization, oil export, total population, government expenditures, whether the country had previously been colonized, and so on. The model indicates that foreign aid reduces corruption in
recipient countries by: 1) setting up conditions that limit the discretion of recipient country officials to use the funds; 2) alleviating public revenue shortages; and 3) increasing salaries for public employees (Tavares 2003: 104). Although the model shows that aid can have a beneficial impact, it cannot be inferred that more aid will further reduce corruption.

The contract model is another way of evaluating foreign aid flow. This model assumes that people are responsible administrators and that altruism is the only motivation for states to provide assistance to other states. This model focuses on the amount of income and buying power that people who are not in power in the recipient country end up receiving as a result of aid and how much aid is necessary to increase these amounts (Azam & Laffont 2003:28). It assumes that complete contracts supervised by donor agencies actually eliminate individual benefits (Azam & Laffont 2003:28). Instead, contracts should be tailored to meet the needs of poor countries and benefit the population as a whole. It is uncertain whether or not conditional aid can reduce the transfer of funds to those in power in recipient countries (Azam & Laffont 2003:28).
All of these models imply that recipient governments only partially care for the general welfare of their people. It is assumed that at least some of the aid ends up in the coffers of the ruling elite (Azam & Laffont 2003). None of these models are able to accurately gauge aid flow in recipient countries because the administration of aid is too complex.

3.2.2 Provision of Foreign Aid

The four dominant donor countries providing government to government bilateral aid are Japan (20%), the United States (17%), France (14%), and Germany (12%) (Dewald & Weder 1996:551). Together they supply 63% of the world's foreign aid, competing not only with each other but also with smaller countries such as Sweden, Italy, the United Kingdom, Spain, Norway, Australia, Switzerland, and so on (Dewald & Weder 1996:551). Official development assistance (ODA) among donor states is based on sectoral distribution. For example, some donor countries focus on social and administrative infrastructure (e.g., Australia, France), while others show a strong tendency to support economic infrastructure (e.g., Japan, the United Kingdom) (Dewald & Weder 1996: 550). Japan, Sweden, and Switzerland tend to
put more aid into agricultural projects (Dewald & Weder 1996:551).

The United States usually puts serious conditions on any foreign aid, whether distributed bilaterally or multilaterally via the U.N., IOs, or NGOs. It also allocates aid according to the political structure of recipient countries. Aid is allocated to countries in Southeast Asia for very specific purposes. Between 1998 and 2002, Indonesia received the most overall development aid, but the Philippines received the most foreign military financing, and Laos and Thailand got the most anti-narcotics assistance (CRS Report 2002:5). The most non-proliferation, anti-terrorism, and de-mining programs were funded in Cambodia, Vietnam, and Laos (CRS Report 2002:5). Human rights provisions were put on aid to Myanmar, Cambodia, Indonesia, and Laos (CRS Report 2002:6). The State Department also provided economic support funds (ESF) for regional programs intended to accelerate economic recovery, support environmental initiatives, increase democracy and security, and assist women (CRS Report 2002:5-6).

Table 3.1 summarizes restrictions put on foreign aid for human rights purposes in Southeast Asia. Foreign aid
allocation can change rapidly if the political situation changes in these countries. Human rights abuse and anti-democratic activities generally result in greater restrictions on U.S. foreign aid.

Table 3.1: Foreign Aid Restrictions

<table>
<thead>
<tr>
<th>Country</th>
<th>Restrictions</th>
<th>Policy Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>Bilateral assistance Non-basic-human needs loans from International Financial Institutions</td>
<td>Encourage democratic change in response to the CPP's anti-democratic activities since 1997</td>
</tr>
<tr>
<td>Indonesia</td>
<td>International Military Education and Training Foreign Military Financing</td>
<td>Build democratic institutions in response to human rights abuses committed by Indonesian armed forces in East Timor in 1999</td>
</tr>
<tr>
<td>Laos</td>
<td>Bilateral Assistance</td>
<td>Encourage democratic change in response to human rights abuse in Laos</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Bilateral Assistance Debt Reduction Assistance Other assistance may be provided to support pro-democracy groups and displaced people in Myanmar</td>
<td>Encourage democratic change in response to Myanmar's military junta's anti-democratic activities since 1988</td>
</tr>
</tbody>
</table>

Source: CRS Report for Congress, April 10, 2002 by Thomas Lum of the Foreign Affairs, Defense, and Trade Division.

When Premier Hun Sen assumed power by non-democratic means in 1997, the United States stopped providing bilateral aid to Cambodia (CRS Report 2002:8). Instead,
U.S. assistance went to American, international, and Cambodian NGOs. U.S. funded programs focused on monitoring elections and human rights, child and reproductive health services, HIV/AIDS education, medical care, rural credit, and assistance for war and mine victims (CRS Report 2002:8). The U.S. objected to loans from multilateral development banks (MDB) if they were for other than humanitarian purposes. This policy remains intact, since U.S. foreign policy only reacts slowly to positive change in the political system of recipient countries. On the other hand, sanctions take place immediately when anti-democratic activities or human rights abuses are documented.

3.2.2.1 Foreign Aid and Socio-Political Instability

The number of civil wars increased from 7% in 1960 to 28% in 1994 (Sambani 2000). Bilateral and multilateral aid remains constant during periods of civil war (Chauvet 2002:34). On average, however, more stable countries receive more foreign aid (Chauvet 2002). There are two ways to measure political instability. In the first, political instability is defined as the propensity for change in executive power (Alesina et al. 1996; Londregan & Poole
The second approach constructs a composite index of political and social events within the country (Alesina & Perotti 1996; Gupta 1996; Venieris & Gupta 1986). Political protests, riots, armed attacks, government sanctions, and changes in who holds executive power are all included, making this a more meaningful index of political instability (Taylor & Hudson 1972). Some researchers add in violence against, within, and by the regime in question (Gupta 1991). Violence against the regime includes riots, political strikes and demonstrations, armed attacks, and political assassinations (Chauvet 2002:36). Violence within the regime refers to coups d'état and violence by the regime is execution for political purposes (Chauvet 2002:36). Altruistic donors sometimes respond positively to socio-political instability by providing more aid in an effort to stabilize the country and protect their own commercial, security, or geopolitical interests (Chauvet 2002: 40-41).

Donor ties to recipient countries seem to be a key factor in aid flow. Generally, aid allocation from donors is based on the needs and merits of the recipient country, the recipient country's reactions to external shocks, and the interests of the donor country (Chauvet 2002: 39).
3.2.3 Corruption and Foreign Aid

The issue of development and foreign aid is obviously very complex. It is worth the attention to discuss it briefly in this section, however. Foreign aid is usually perceived as good for developing countries. Any problems the countries have are blamed on their own fragile and corrupt bureaucratic systems. Recently, however, criticism has been leveled against foreign aid as, perversely, increasing corruption and poor governance (Tavares 2003:99). One study shows a correlation between high levels of corruption and low economic growth (Mauro 1996). Another study finds that the more corrupt a country is, the more aid it actually receives (Alesina & Weder 2002). Others have pointed out that, over the long term, aid erodes bureaucratic quality and local political systems (Knack 2000). Meanwhile, there is no evidence to suggest that foreign development assistance actually reduces poverty or increases standards of living among the populations of recipient countries.

Corruption is usually believed to stem from the low salaries government employees receive in most developing countries (Azam et al. 2003; Gollogly 2002). Government
workers have to be creative in making ends meet, whether by extortion or by hiding exemption schemes from the poor. Some NGO, IO, and bilateral or multilateral agencies try to deal with this problem by developing incentive or task-based schemes. Strategies for supplementing salaries include setting up product-related or translation payments, training allowances, per diems, workshops, and consultancies. Unfortunately, this creates convoluted descriptions of payments.

Development aid increasingly focuses on capacity development, that is, encouraging individuals, organizations, institutions, and societies to develop the abilities they need to perform functions, solve problems, and achieve objectives (Godfrey et al. 2002:356). The four inter-related dimensions of this process are increasing individual skills, establishing effective organizations, strengthening interrelationships between entities, and creating an environment that enables objectives to be reached (Godfrey et al. 2002:356). Capacity development often comes in the form of technical assistance (TA). The role of TA is to facilitate and supervise resource flows in order to establish an environment in which the government will eventually be able
to take over all the projects. Technical advisors ideally work themselves out of a job, but in practice some technical advisors attempt to actually undermine the projects in order to maintain their jobs. Thus, corruption cannot always be blamed on recipient countries; nor are funding agencies necessarily free from corruption.

Cambodia has been subject to the abuse of TA. TA makes up over 80% of overhead costs in some projects. For example, in July 2000 the ADB and World Bank agreed to fund the rehabilitation of about 600 kilometers of National Roads 5, 6, and 7 (Adams 2002:1). After lengthy negotiations, the Ministry of Public Works and Transport signed a contract with two Australian companies, Worley International and SMEC International Pty, Ltd., to carry out the work. Consulting fees totaled to $4,697,790 (Adams 2002:1). The salaries for consultants ranged from $4,272 to $14,044 per month, additional $2,700 for per diem, $1,500 for housing allowance, and with some consultants receiving additional $2,700 for "one-time settling-in allowance," (Adams 2002:1). This totaled to $782.95 per kilometer of road (Adams 2002:1). Programs funded by foreign aid from the U.S. not only benefit the general managers of the programs, but sometimes also their spouses, who often teach
English courses to the staff at the international standard rate of $350 to $500 per day. Since technical assistance is often provided by the same agencies that fund the projects, there is little accountability for project expenditures. It is assumed that the organizations that receive such funds are altruistic and free of corruption.

It is important to point out that the UN considered the case of Cambodia a success. The reason is that the operations in Somalia and the former Yugoslavia were such a failure (Prasso 1995:1). One particular author wrote a compelling report on ineffectiveness of United Nations programs (Suttora 2003). It is worth citing him heavily in this section. The U.N. has 65,000 employees with an annual budget of US$ 2.6 billion (Suttora 2003:43). Many people think the U.N.'s role is to find solutions to international crises, but historically the U.N. was proven not so effective in solving any of the world's social problems (Suttora 2003:43). The U.N. Office on Drugs and Crime has spent 5 years attempting to eradicate drug cultivation, but production has only soared (Suttora 2003:43). The overhead costs for UNESCO take up 80% of its budget, leaving little for the programs it is supposed to be funding (Suttora 2003:43).
Some U.N. programs have remained in recipient countries since the 1940s without ever effectively solving a political dispute. For instance, the U.N. has been in the Palestinian territory since 1948, but conflict persists to this day (Suttora 2003:43). There has been minimal solution to the Cyprus problem after 30 years of U.N. involvement. Similarly, the U.N. has not been that effective in Bosnia for 8 years and Kosovo and East Timor for 4 years (Suttora 2003:43). In Cambodia, the U.N. did little to create political stability. After the national elections, additional funding was giving to UN High Commissioner for Refugees (UNHCR) for the repatriation program. UNHCR ran a logistical success story in Thailand shortly after the National Elections. The border refugees who left Cambodia with horror stories of the Pol Pot regime in 1979 went home and were no longer a burden on the Thai government. A year later, UN evaluations of the status of these refugees reported a high rate of poverty, infant mortality, and diseases (Prasso 1995:6). Two years after the U.N.-sponsored national elections, a military force ended two-party rule.

The problem of foreign aid is obviously complex, and it is beyond the scope of this dissertation to discuss its
full implications and provide detailed analyses. Various
studies suggested that there is no improvement with foreign
aid. For example, it does not promote democracy, encourage
economic growth, or foster political stability in recipient
countries. However, it does create jobs for the few who
work for international organizations, bilateral or
multilateral agencies. Corruption continues unabated among
both those giving assistance and those receiving it.

3.3 The Effect of Social Problems on Medical
Decision-making

The decision-making perspective is grounded on a
common understanding of how such choices are made (Garro
1999: 318). In clinical settings, medical decisions are
immediate and based on available treatment options. The real
issue, however, is how accessible such options actually are
to the people who have to make choices, that is, patients,
family member, and other decision-makers. This study draws
on Garro's (1998) decision-making model in examining the
cultural rationales that underlie medical and other
decision-making processes. It also attends to the social,
cultural and personal constructions of meaning conferred on
the occurrence of illness (Garro 1999). AIDS is closely
associated with social problems such as unemployment, poverty, and prostitution. These factors affecting the decision-making process within the developing world context.

3.3.1 Social Problems in Developing Countries

In poor, developing countries, the medical decision-making process is influenced by a number of larger social issues, including prostitution, migration, and poverty. This section analyzes how these problems generally contribute to the HIV/AIDS epidemic by constraining options and forcing people to make life choices that compromise their health.

3.3.1.1 Poverty

Poverty is the most pressing moral, political, and economic issue in developing countries today (Padmanabhan 2001). Although poverty is measured in terms of employment, income, and consumption, poverty is not only about money. The poor are usually also deprived of education, health, and human and civil rights (Hulme 2003: 407). Throughout the world, the poor tend to fall into specific groups such as rural farmers and ex-farm workers, female-headed families, disabled people, and migrant workers (Aliber 2003: 483). Poverty is closely related to high rates of
unemployment in most developing countries (Majid 2001). Overcrowding is also implicated in unemployment.

The working-poor population declined in many middle-income countries between 1986 and 1997. Low-income countries, however, experienced both decreases and increases in poverty during the same period (Majid 2001). The governments of some developing countries have made an effort to monitor the economic and social situation of their populations and analyze the impact of poverty-alleviation policies and projects (Aliber 2003; Mukherjee 2003). For example, China has actively pursued a strategy of rural industrialization since the late 1970s (Liang et al. 2002). This has provided employment to surplus agricultural laborers. In developing countries that lack systems to monitor poverty, many people work at the survival level and do not have the time or energy to improve their employment opportunities.

The United Nations has stated that a major goal is eradication of poverty (Hulme 2003). Developed nations donating aid to developing countries similarly state that it is with the intention of alleviating poverty. Unfortunately, poverty is a complex problem that involves a multitude of factors. Thus far, there is no correlation
between poverty reduction and foreign aid to developing countries (Arvin, et al. 2002). The primary reason for this failure is incompatibility between the macro policies driven by globalization, liberalization, and privatization and the goals of individual projects (Padmanabhan 2001). If donors would promote wage-employment through feasible micro-enterprises, instead of self-employment through micro-finance, it would help millions to get out of poverty (Padmanabhan 2001). Putting greater purchase power into the hands of the poor would also give them greater self-respect. Unfortunately, donors view recipient countries as incapable of delivering funds or implementing projects without corruption and other problems interfering. The International Labor Organization (ILO) tries to employ poor people in various countries, but this has so far only been a temporary solution (ILO Website, May 26, 2003). Each project never lasts more than a few years at a given location. Thus far, most poor people have been left to fend for themselves in any way they can.

Poverty and AIDS operate together in a vicious cycle. If one of the employed members of a poor family contracts HIV and succumbs to AIDS, he or she will no longer be able to work. Medicine and health care services for AIDS
patients is usually more expensive than for other diseases. The family quickly becomes destitute. As adults die from AIDS, more children are orphaned and go on living in poverty. At the same time, poverty limits the opportunities of people in developing countries. Desperate for employment, they may acquiesce to working under conditions that threaten their health. Women, in particular, are left behind in times of economic hardship. The work they take on may make them exceptionally vulnerable to diseases such as HIV/AIDS, as is discussed in the next section.

3.3.1.2 Prostitution

Both social and economic factors contribute to high levels of prostitution in developing countries (Bamgbose 2002). Rural poverty drives young women from their villages. There is also a great disparity between earnings for commercial sex and for unskilled labor (Wawer et al. 1996). Commercial sex work offers better financial resources than any other profession for young, uneducated women in poor countries. Sometimes prostitution is the only means of livelihood for women of low socio-economic status and without any employable skills.
In many parts of Southeast Asia, women are the sole providers for their families. Research on Thailand and neighboring countries emphasizes the role of women in the household economy, and the responsibility of women and older daughters to earn enough income to support the family and send the younger children to school (Muecke et al. 1992; Wawer et al. 1996). A study conducted in Thailand found that 79% of the commercial sex workers sent money to parents, siblings, or other relatives (Wawer et al. 1996: 457). Lack of economic development and employment opportunities reduced the ability for young women to fulfill these obligations if they remained in their rural homes (Wawer et al. 1996: 455). Cambodian women are also responsible for supporting their families. The scarcity of opportunity in rural villages forces them out of the traditional domestic sphere to working outside the home, often traveling to urban areas, where they may enter prostitution.

The effects of the economic crisis (late 1990s) in Malaysia, Thailand, and South Korea have spread well beyond their borders to other Asian countries. There has been a strong tendency during this time of financial hardship for women to be priced out of the job market (Lund et al.
Women who originally migrated from rural areas to seek work in urban areas found themselves unable to maintain regular employment. They usually then had only two options. They could return to the rural villages they originated from, only to become an extra burden on the limited resources of their families, or enter sex work (Tchoudomirova et al. 1997). Women who had been working in establishments such as hair salons, bathhouses, and karaoke bars are most likely to turn to sex work to make ends meet (Roger et al. 2002). Similarly, when Cambodian women migrate to the city looking for work, they usually end up either as garment factory workers or sex workers. Since factory wages are insufficient for meeting the costs of living in the city, factory workers also often engage in sex work part time to supplement their income.

Women sometimes enter sex work for other reasons. In Ghana, for example, women engage in prostitution as a means for seeking husbands (Ankomah 1999). In countries that have recently experienced civil war, women are often forced into prostitution or slavery by traffickers. In Myanmar, because of the long-standing civil conflict in the Shan states, young women are at especially high risk of being trafficked into prostitution (Beyrer 2001).
Whether women make the decision to enter sex work on their own or are forced into it by traffickers, their knowledge of HIV/AIDS and STDs is usually very limited (Rogers et al. 2002). Many do not know that sex plays a role in the transmission of HIV. Even when prevention programs are set up to educate them about the risks, they remain vulnerable to the clients they serve when the only other option is poverty. Men often pay extra to have unprotected sex and perceive condom use as unusual (Gomes et al. 2003). Many men low in the socio-economic scale do not recognize the need to use condoms during intercourse to prevent STDs (Gomes et al. 2003). The prevalence of HIV thus remains higher among both direct and indirect female sex workers than in the general population in many developing countries (Gomes et al. 2003; Sedyaningsih-Mamahit 1999; Wawer et al. 1996).

Prevention and education programs do have an effect on prostitution. For example, prostitution has changed significantly in Thailand since the beginning of the HIV epidemic in 1988. Economic and demographic factors coupled with the fear of AIDS has led to fewer Thai women practicing prostitution (Henenburg et al. 1999). Men have been patronizing brothels less often and the price of
commercial sex has risen (Henenburg et al. 1999).
Unfortunately, foreign women from Vietnam, Myanmar, Cambodia, and the Philippines have migrated to Thailand to take the place of Thai women no longer willing to engage in commercial sex work.

3.3.1.3 Migration

A variety of economic and social factors drive migration, whether internal or external. For example, the civil war in Mozambique created a large numbers of refugees (Girdler-Brown 1998). The conflict in Sudan displaced large numbers of people in the region. In Angola, a similar situation led to huge populations being displaced to various other countries. Natural disasters and landlessness are other factors that push migration. In Bangladesh, poverty and landlessness in rural areas led to migration (Lein 2000).

When rural people experience loss of land and have few opportunities to earn an income, they are forced to seek a livelihood and housing in urban areas (Lein 2000). Rural to urban migration is common in most parts of the world. In the Mekong region, the number of transnational migrants is very high, as some locations have undergone
unprecedented economic growth, while others have remained in dire poverty (Bain 1998). In the past decade in Thailand alone there have been an estimated one million illegal economic migrants from Myanmar (Bain 1998). Another 100,000 Chinese nationals are staying in the country (Bain 1998). In addition, one million people enter the country legally every year (Bain 1998). Migrants also move in and out of Cambodia freely. No system has been set up to monitor the number of migrants that enter the country annually. Research into a broad range of migrant labor issues and worker legal status appears to have had some influence on government policy in Cambodia and Thailand, however.

Since this kind of mobility is not planned in advance, migrants do not normally have any social networks set up in the communities they move to (de Bruijin 2003). This leads to a host of social and health problems. Migrants are at high risk for exploitation as cheap labor and female migrants are more likely to enter prostitution, whether voluntarily or involuntarily. Indeed, thousands of young women in Southeast Asia migrate to other countries deliberately to enter the sex trade. At the same time, young male migrants are more likely to turn to alcohol and
commercial sex to deal with the loneliness of displacement. Freedom of movement combined with a general tolerance towards men seeking commercial sex exacerbates the spread of HIV in Cambodia (UNAIDS Country Profiles 2001).

High mobility also creates more opportunity for disease to travel from person to person. In sub-Saharan Africa, for example, migration to urban areas is associated with a general rise in ill health (Molyneux et al. 1999). This compounds the other social problems associated with migration, including alcohol use, prostitution, and multiple sexual partners, all risk factors for HIV. Other risk factors include unprotected sexual intercourse and injection of drugs (Bronfman 1998; Girdler-Brown 1998). Migrants, especially young adults, are therefore known to be at high risk for STDs and HIV/AIDS (Byass et al. 2003). HIV in the Mekong Region (including Cambodia, China, Laos, Myanmar, Thailand, and Vietnam) is especially serious among cross-border migrants (both legal and undocumented), internal migrants, sex workers, and mobile occupational groups such as truck drivers, fishermen, seafarers, and cross-border traders. Hot spots for HIV/AIDS in the Mekong region tend to be found along river trade routes on the
Thai-Lao border and fishing ports in Thailand and Cambodia (Bain 1988).

The health and education systems in most of these countries are inadequate to deal with the special needs of migrants. Responses to the HIV epidemic range from very limited approaches in Laos, Vietnam, and Myanmar to fairly wide-ranging programs in Thailand and, more recently, China (Bain 1988). Thailand displays the most diversity of research among the Mekong countries, including AIDS vaccine trials. The Asian Research Center for Migration (ARCM)'s project on Trans-national Population Movement and HIV/AIDS, based at Chulalongkorn University in Thailand, has studied migrant fishermen in six countries, migrant women from Myanmar in Thailand, and other migrant populations in the Thai-Myanmar border regions (Bain 1998). The Coordination of Action Research on AIDS and Mobility (CARAM), which began as a partnership between the Malaysian NGO Tenaganita and the Free University of Amsterdam, now involves eight Southeast Asian countries in a range of research projects by NGOs (Bain 1998).

3.4 Chapter Summary

There is a link between foreign aid and the HIV/AIDS epidemic. This chapter discussed aid and AIDS. Particular
attention was given to conceptual framework for development aid, aid flow, provision of foreign aid, and corruption and aid. This chapter discussed the social problems that influence the decision-making process. Poverty, prostitution, migration, and unemployment are common problems through the world, particularly among poor, developing countries.

The next chapter explores the larger Cambodian context of medicine with an emphasis on geography, economy, and sociopolitical history. The next chapter also addresses factors contributing to the HIV/AIDS epidemic in poor, developing countries, taking Cambodia as a case study.
CHAPTER 4: THE LARGER CONTEXT OF MEDICAL CARE IN CAMBODIA

4.1 Introduction

This chapter describes the geography, demographics, economy, and sociopolitical history of Cambodia as they pertain to the medical system. The political and social transformation that took place during the Pol Pot Régime has created substantial socio-economic and political discontinuities. Recent political events along with changing subsistence patterns, industry, and infrastructure are all having an impact on health care.

4.2 Geography

Cambodia is a relatively small country located on the peninsula of mainland Southeast Asia in the Mekong sub-region. It borders Thailand in the west and north, Vietnam in the east and southeast, and Lao PDR in the north. It covers about 181,000 square kilometers, with a coastline of 440 kilometers (see Figure 4.1 below). Most of the country’s interior is an alluvial plain. Some rolling hills run along the coast not far above sea level. The plain breaks into plateaus and mountains that form natural boundaries to neighboring countries. Cambodia only has two
mountains, called Cardamom and Elephant located within a few miles of the gulf of Thailand.

To the northeast of Cardamon is Tonle Sap, the largest freshwater lake in Southeast Asia. Two major waterways run diagonally across the landscape. The Mekong River runs from Laos into the eastern part of Cambodia and connects to the Tonle Sap River in the west.
FIGURE 4.1: CAMBODIA

From May to June, as the snow melts from the Himalaya, the Mekong River swells and runs off into the Tonle Sap. Six months later, the run-off subsides and the Tonle Sap River begins to flow in the opposite direction. During this period, Tonle Sap Lake grows about eightfold, submerging large vegetation, which turns into fish food. Tonle Sap is the world's greatest source of freshwater fish; it has underpinned the Cambodian economy for centuries (Chandler 1983).

The Mekong and Tonle Sap rivers, along with their many tributaries, are approximately 3,700 kilometers in length and are navigable throughout the year (Sharma 1994). In some provinces west of the Mekong River and north of the Tonle Sap, villages depend entirely on these waterways for transportation and communication. During the wet season, 8,000-ton ships can travel up the Tonle Sap river, carrying goods inland. Phnom Penh, the nation's capital, stands at the junction of the Mekong River, the Tonle Sap River, and the Bassac River (another branch of the Mekong). In addition, Cambodia has two major ports (Kampong Som and Phnom Penh) and two small ports (Kampot and Koh Kong). The country has six airfields, but only the international airport in Phnom Penh is fully functional.
4.3 Demographics

Cambodia has a population of about fourteen million people (UNFPA 2004:76). Administratively, the country consists of twenty-four provinces and three municipalities. Phnom Penh has a population of 1.2 million people and the highest population density (3441 people/km) in the country. The population is young, with 42.8% less than 15 years old in 2000 (UNAIDS Country Profile 2001:7). Females comprise 51.8% of the total population (Cambodian Population Census 1998).

More than 90% of Cambodians are ethnic Khmer (World Fact Book 2002:1). The remaining 10% of the population include Vietnamese, Chinese, Muslims, and tribal groups (World Fact Book 2002:1). There has been a steady increase in the number of Chinese and Vietnamese people migrating to the country since 1998, following the last national elections. In the late 1990s, creating an autonomous Chinese community was discussed, but dismissed by some politicians. Due to the history between Cambodia and Vietnam, the Vietnamese are not as visible as the Chinese. In the case of intermarriage between ethnic groups such as the Khmer and Chinese, the family is usually absorbed into
one of the communities and over successive generations loses the secondary ethnic identity.

Approximately 95% of Cambodians are Theravada Buddhists (USAID Report 2001:8). The other 5% are made up of Muslims, Christians, and animists (Bureau of East Asian and Pacific Affairs April 2004:1). Mormons actively recruit Cambodians door-to-door, offering English courses along with religious conversion. Other Christian groups are not as visible as the Mormons. The small Cham Muslim community has remained relatively stable politically and socially. To the mainstream Khmer, Muslims are not normally seen as a threat (as Vietnamese people often are), but during the Pol Pot regime they were targeted for execution. Indifference characterizes their relatively peaceful coexistence with the Buddhist majority.

Cambodian society is characterized by a large rural peasantry and small middle-class and elite groups. Only 15% of Khmer live in urban areas (UNAIDS Country Profile 2001:7). The rural population cultivates wet rice crops and fishes, sell crafts, or works in unskilled manual labor. The middle class includes educated professionals, small business owners, low ranking government and military officials, doctors, teachers, and other urban 'white-
collar' workers. Many of the educated professionals received advanced training abroad and now work for international and non-governmental organizations. The elite class includes royal families, high-ranking officials, Buddhist religious leaders, the 'newly rich', and wealthy business professionals. Many of the most politically influential Cambodians went into exile during the Pot Pot regime and have now returned to become politicians or business owners. The middle and elite classes mostly reside in Phnom Penh or in urban areas in the provinces.

Not all repatriation goes so smoothly. Since 2002, the US has been 'repatriating' Cambodian Americans (some of whom were as young as one month old when they arrived in the US) who have committed crimes in the US (Lefferts 2002). These often-petty criminals face language and identity problems as they try to acculturate into Cambodian society.

4.4 The Cambodian Worldview

Most Cambodians believe religion is the foundation of human existence. Their belief system gives them reason for hope and continuing to live (Becktimirova 2002). The
Cambodian worldview is based on a mix of religious beliefs from Buddhist, Hindu, and indigenous animist traditions (Ebihara 1968:363). Cambodians do not make much distinction between folk religion and Buddhism. Their recognition of both ghosts and Buddha, praying at the temple and conducting invocations to spirits, going to monks and accaa (pagoda leaders) are all part of an interconnected worldview embedded in daily life.

The animist folk religion, the oldest religion of the Khmer, includes belief in numerous malevolent, benign, or beneficial supernatural beings (Ebihara 1968: 363; Moniroth 1995; Pang 1970). Ancestral guardians and demon-like spirits have the power to protect or harm the living (Ang 1986). Cambodians catalogue such as spirits in detail. Only a few people possess the ability to see them, but many people have symbols or figurines representing them. Some spirits are seen as protective, including nature spirits such as Neak ta teuk (spirits of the water), Neak ta dei (spirit of the land), and Neak ta prei (spirit of the forest). More dangerous spirits include preay, ghosts that retain emotional attachments to the living world because they were unable to fulfill their wishes. Animistic beliefs offer an explanation for individual misfortunes and
physical suffering, while magical rituals counter illness brought on by the actions of supernatural beings (Ebihara 1971: 423). Cambodians alleviate misfortune, suffering, and illness by making offerings to the spirits in rituals at home or at a temple, performed by monks or shamans.

Theravada Buddhism suffuses Cambodian lives with meaning and provides solace in times of trouble (Kalab 1994). It also gives the majority of Cambodians a sense of identity and self-worth. Buddhist monks represent an ideal way of life. They also perform necessary rituals and provide Buddhist laypeople with opportunities to gain merit (Kalab 1994; Pang 1970; Rithisen 1986; Yang 1997). Buddhist rituals, long the center of Cambodian culture, mark important life transitions from birth to death. Buddhism is seen as a way of maintaining social order and restoring balance to life. Buddhist beliefs play a critical part in Cambodian conceptions of health, illness, and treatment. Buddhist doctrine teaches that certain misfortune is inevitable, but that people can learn to cope with suffering (Ang 1986; Boehnlein 1987). Individuals must accept and endure pain as part of human existence. However, they can also reorient their actions to secure a better life in the next incarnation.
4.5 Resources and Economy

number of arrivals was around 5,000 per month, but by 1996, the number had jumped to 22,000 per month (IMF Report 1997:6). Tourism was hit by the SARS outbreak in 2003 (ADB 2004:1).

Wet rice agriculture has dominated the economy since the Angkor period. One of the few significant changes made while Cambodia was a French protectorate was the introduction of new rice farming technology in the northwestern part of the country (Chandler 1983:138). Elsewhere, rice continues to be grown in small, family-oriented plots as it has been for centuries. Given the importance of agriculture, it is no surprise that land use and ownership has been a complex issue in Cambodia since the seventh or eighth century. Angkor period inscriptions describe quarrels over access to land (Chandler 1983:16). Land ownership as understood today does not seem to have existed in Cambodian history. For example, land left fallow for three years reverted to state control. Today, although people can obtain titles to land, land must still be bought through second or third parties and high officials generally have more access to land than the average Cambodian. Official documents proving ownership do not necessarily stand up in court against aggressive
officials attempting to take over land. In 2001, the National Assembly passed a new land law designed to combat the problem of seizing land from the poor (UK Report, Economic Intelligence Unit 2001:16).

The ethnic Khmer control most traditional economic activities such as gardening, farming, maintaining fisheries, and silk weaving. Rice is the major export crop, but natural rubber, tobacco, soybeans, corn, and timber are also traded to neighboring countries. Other goods traded along the Cambodian borders include freshwater fish and seafood, elephant tusks, baby crocodiles, and gemstones. Currently, the Sino-Khmer (Khmer Chinese) dominate the commercial and industrial part of the economy. Industrial activities concentrate on processing agricultural commodities such as rice, fish, wood, and rubber (Chandler 1983; Sharma 1995:113). Most manufacturing plants are very small, producing goods such as soda, cigarettes, and packaged food. Most manufacturing plants are located in Phnom Penh, including textile, soft drink, tobacco, and ferroconcrete factories and power plants. Industrial activities in the provinces include rice mills, tile factories, power plants, oil refineries, a tractor assembly plant, and cement and phosphate factories. Warehouses,
automobile and equipment repair shops, and weaving operations are also scattered about the country.

The first nine foreign-owned factories were established in 1994, employing 2,270 people (IMF Report 1997: 6). By 1998, 89 factories employed 54,000 Cambodians (IMF Report 1997: 6). Foreign businesses such as garment factories now employ about 170,000 female workers (UNAIDS Profile 2001). The British-American Tobacco Company has been particularly successful in Cambodia.

The country faces problems such as illegal logging and gem mining (Bottomley 2002; Le Billon 2002). Since the incorporation of the Khmer Rouge into the military in 1999, illegal gem-mining activities have become more aggressive. Private companies purchase villagers' houses for a small price so they can mine their land.

4.6 Sociopolitical History

This section provides a brief historical background of the country since independence as a context for understanding current sociopolitical circumstances. Particular attention is given to the last four decades in Cambodia's history, including the political struggle for independence (Chandler 1983, 1991; Tully 1996), the near
demise of the country under the Khmer Rouge (Chandler 1991; Shawcross 1984), the Vietnamese invasion, and UN Peacekeeping Operations (Curtis 1998; Haas 1994).

4.6.1 Political Struggles

For nearly one hundred years, France had occupied an area between India and China, known to the West as 'Indo-China'. In the early 1950s, the Khmer Issarak had joined forces with Ho Chi Minh's Viet Minh to oppose the French (Chandler 1983). They were prepared to engage in an armed struggle, but did not have much support inside Cambodia (Chandler 1983; Kiernan & Boua 1982). Meanwhile, Prince Norodom Sihanouk had gained international support for Cambodian independence from France. In 1954, France surrendered control over Cambodia to the young prince, a man who would continue to exert a strong influence on Cambodian politics for the next four decades (Chandler 1991). Sihanouk was unable to establish Cambodia as a neutral territory until the 1991 Paris Peace Agreement was signed, however (Chandler 2000; Haas 1990). Instead, the decade that followed independence was a period of war, civil unrest, and political struggle (Chandler 1991; Vickery 1984).
4.6.2 Cambodia under the Khmer Rouge

In 1969, during the Vietnam War, the U.S. began bombing within Cambodian borders in an effort to disrupt North Vietnamese supply routes. These bombings had the unintentional result of increasing support among the Cambodian people for a group of communist insurgents nicknamed the Khmer Rouge (Red Khmer). The Khmer Rouge were seeking to overthrow the Cambodian monarchy (Shawcross 1981:272; Steinberg 1987:378). Before they could do so, Prince Sihanouk was deposed by his own National Assembly, led by General Lon Nol, with the support of the United States government. Subsequently, the Khmer Rouge insurgency erupted into full-scale civil war, with the United States providing massive aid to the new Cambodian government (Shawcross 1981). The exiled prince Sihanouk, still popular with the majority of Cambodian peasants (Kiernan & Boua 1982), then joined his former enemies, the Khmer Rouge, in an attempt to regain political power (Chandler 1991:249). By 1975, the Khmer Rouge had taken control of the Cambodian capital, forcing millions of people to flee to the countryside (Kiernan 1993; Shawcross 1987). In 1976, Khmer
Rouge leader Pol Pot became Prime Minister of Cambodia, now called Democratic Kampuchea (DK).

The nationalistic, xenophobic Khmer Rouge ruled the country with brutal force (Heder 1997; Jackson 1989; Kiernan 1996). They attempted to rid the country of all foreign influences, eradicate the former political structure, install a collectivist economy, and destroy all social institutions, including the health care system. Particular groups of people were singled out for execution, including former political leaders, government employees, and soldiers, college students and intellectuals, medical doctors, and other professionals, religious leaders, merchants, ethnic Vietnamese and Chinese, and the Cham Muslims. The result was a rapid and radical change in Cambodian society (Chandler 1991; Kiernan 1993). Education and religion were abolished and all social traditions were banned. People were forced to live in labor communes where family members were separated by age and sex, working long hours for starvation rations. The result was widespread disease and malnutrition. Cholera, malaria, tuberculosis, pneumonia, and dysentery were common. In the few years of Khmer Rouge rule, an eighth of the population – over one
milllion people - died from execution, starvation, or over-
work (Ablin & Marlowe 1990; Chandler 1991; Deac 1997).

4.6.3 The Vietnamese Invasion

In 1978, Vietnam responded to constant border violations by invading and defeating the Khmer Rouge army. The Khmer Rouge fled to Thailand along with a good number of other Cambodians seeking asylum. A new political party, the People’s Republic of Kampuchea (PRK), stepped in, promising to reorganize Cambodian society (Chandler 1991; Haas 1990; Kiernan 1993). Most PRK government officials were recruited from the People’s Revolutionary Party of Kampuchea (PRPK), which included members of the former Communist Party of Kampuchea (CPK) (Ablin & Hood 1990; Ashley 1992; Haas 1990; Kiernan 1996). This group later became known as the Cambodian People’s Party (Kiernan 1996; Tarr 1996). They used their old communist party network to strategically position themselves in the new regime. Many of these people lacked any administrative credentials; they got work in the new government by claiming to be people who had actually been killed by the Khmer Rouge. These administrative personnel tried to make sure that none of the former royal elite would return to power.
Over the next decade, it became apparent that the new regime was only a little better than the Khmer Rouge. The PRK paid little attention to constructing a functional economic system. The army looted or destroyed most of the harvest around the country. Human rights abuses were also recorded, but the PRK did stop the killing of people who had acted against the establishment of the regime (Kiernan 1985, 1996; Tarr 1996). The PRK also tried to normalize social organization and family structure based on pre-war standards. The agricultural cooperatives known as *Krom Samaki* were dismantled and the household-based peasant farming system put back in place (Chandler 1996). The PRK also attempted to revive households centered on kinship ties, but its efforts were limited by the fact that many family members had become widely scattered across the country or were in Thai refugee camps. Furthermore, Cambodians were forbidden from traveling to rejoin family members. Finally, a large part of the male population had been killed during the Pol Pot regime, so reestablished households were largely made up of women (Sonnois 1990:1).

Nevertheless, political and social life gradually returned to normalcy. Schools and other social institutions were reopened in Phnom Penh and other urban centers. The
few professionals who had survived the Khmer Rouge were asked to take on the task of rebuilding society. Urban life soon resembled pre-Khmer Rouge times.

As the 1980s progressed, the new regime embraced a market economy, presaging the Paris Peace Agreement (IMP Report 1997: 4). By late 1989, the Vietnamese withdrew from Cambodia (Chandler 1996; Haas 1990). Former prime minister Hun Sen moved back into a position of power and began renewing relations with some of the people from the nationalist movements. By 1991, the country was able to open its door to the international community (Gottesman 2003; Riddle 1996). Cambodians were allowed to travel outside of the country for the first time (Curtis 1998).

4.6.4 UN Peacekeeping Operations in Cambodia

The United Nations Transitional Authority for Cambodia (UNTAC) went to Cambodia in 1992 (Curtis 1993; Riddle 1996). In accord with the 1991 Paris Peace Agreement, war among the various factions vying for power was halted and the first steps were taken toward holding UN sponsored national elections (Haas 1990). Over seventy countries contributed over 16,000 troops and 6,000 civilian personnel to ensure a “free and fair election” (Haas 1990:3). The
Royal Party won the elections. The Cambodian People’s Party, which had lost by a small margin, threatened to fight the new government unless it was recognized as an equal coalition partner (Findlay 1995: 91). In 1993, the country was renamed the Royal Government of Cambodia (RGC), with the Cambodian People’s Party and the Royal Party (FUNCINPEC) sharing power. Prince Sihanouk was reinstated as head of state. The new government officially declared Cambodia a full-fledged democratic society operating under a free-market system (Curtis 1998; Haas 1994).

Although reconciling the political factions, promoting human rights, reconstructing the country, and establishing foreign relations were worthy objectives, these peacekeeping operations came with a huge price tag of US$1.6 billion dollars (UN Yearbook 1992:248). Refugee repatriation and rehabilitation programs cost another $92.5 million (UNHCR, Information Bulletin 1993:3-4). UNTAC represented a goldmine for both non-Cambodians and Cambodians (Riddle 1996; Curtis 1998; Muscat 1989; Ledgerwood 1994). Many non-Cambodians were given tax-free salaries and allowances that allowed them to earn in six months what it would have normally taken them several years to earn in their native countries. Cambodians who normally
earned about 30,000 to 50,000 riels (US$12 to $18) a month now earned between US$150 and US$450 in less than six months. This sudden influx of wealth had a down side, however. Young unmarried and married women from rural areas migrated to the cities searching for work. Some of them entered sex work, serving male UN personnel. The infusion of UN peacekeepers from all over the world along with US dollars therefore stimulated Cambodia’s sex industry and led to the rapid spread of HIV into the population. (Chapter 5 discusses the impact of HIV/AIDS on Cambodia).

During the mid-1990s, the CPP gained control over rural Cambodia and in 1997 took over the country in a military coup (Curtis 1998). It started a series of campaigns to win the people's trust. Meanwhile, most of the leaders of the Royal party were assassinated. The CPP won the elections the following year and Hun Sen became Prime Minister. The international community turned its back on the new government and halted aid to the country. Nevertheless, Cambodia has remained relatively stable since the CPP came to power.
4.7 Impact of Sociopolitical and Economic Discontinuities

The Pol Pot regime destroyed most of Cambodia's infrastructure. The PRK encouraged entrepreneurial, family-run economic activities. An inheritance law introduced in 1989 allowed Cambodians to own and inherit property and to build on private land (Than 2001:481). Foreign firms then began submitting applications to start businesses in Cambodia (Than 2001: 481). After the 1992 elections, both governmental and non-governmental organizations began working toward economic reconstruction. Organizations such as the United Nation High Commission for Refugees (UNHCR), Food and Agriculture Organization (FAO), European Commission (EU), and USAID have been instrumental bringing about economic rehabilitation. The lifting of the US economic embargo in 1992 also helped bring in foreign investment. Nevertheless, rebuilding the infrastructure has progressed very slowly.

Some of the country's infrastructure appears to be partially functional. By the late 1980s, only 13,350 kilometers of road were left, compared to 19,500 kilometers in 1969 (Sharma 1994). Currently, about 20% of roads and highways are asphalt; 50% are made of crushed stone or
The only good road outside of Phnom Penh is the road to Kampong Som (National Road 4), financially sponsored by the US government in the early 1990s. Streets in Phnom Penh are also being rebuilt, but are generally of poor quality due to corruption. Two railroads built while Cambodia was a French protectorate are functioning again after decades of having been disrupted by heavy fighting.

In the early 1980s, a national radio station, the Voice of the Kampuchean People, broadcast regularly from Phnom Penh. By 1984, a television channel had been added. Under the Ministry of Communications, the postal, telegraph, and telegram services were restored in the 1990s. A satellite communications station was established in 1987 in Phnom Penh and there are now numerous radio stations, television channels, and newspaper agencies. Cambodia has a free press, but some of the media companies are owned by specific political parties. There is also a countrywide mobile phone network.

International aid makes up a significant portion of the country’s national budget. In 1993, right after UNTAC, the European Commission granted about forty-five million ECU (1 ECU=US$1.2) for rehabilitation, human rights, and
humanitarian assistance (EC 1995:1). Total aid (excluding UNTAC) between 1992 and 1998 amounted to US$2.754 billion. Bilateral aid accounted for 62% of the total budget, multilateral organizations 31%, and NGOs 7% (EU Overview 2002: 2). The main bilateral donors are Japan, France, Australia, Germany, the United States, and Sweden. Total external financial assistance was 508.1 billion riels in 1998 (IMF Report 1998: 38). Between 1999 and 2000, foreign financial assistance represented about 61% of the national budget (CDRI, 26/2/02 internet access date). In 2002, the EU announced a €68.7 million package would be granted over the next three years to finance priority sectors (EU Overview 2002: 2).

By 2003, Cambodia ranked 130 out of 175 countries in the United Nations Human Development Index (HD Report 2003). 1 is the highest level. This is not bad rating for Cambodia. Overall, Cambodia seems to be making general progress.

4.8 Health Impact of Sociopolitical Discontinuities

The disruption of social services and education, the erosion of the public sector, and the near destruction of the health care system have been severe consequences of the
sociopolitical discontinuities of recent decades. Today, Cambodia also faces some of the social problems prevalent in the Western world, especially drug use and trafficking (e.g., human, drug) and gang violence (Lintner 1997; Lintner 1998; Oppenheimer 1997; Oppenheimer 1997; Schloenhardt 2001).

Although the government allocates 8% of the national budget to education, and 97% of young girls are enrolled in primary school, the adult literacy rate is still only 79% for men and 57% for women (UNAIDS Country Profile 2001: 8). Given this low level of education, finding work outside of agriculture has been difficult for women, who make up 52% of the work force (World Bank Atlas 2002: 28). Daughters are obliged to provide for their family members, most of whom remain in rural households (Nishigaya 2002).

Frustrated by meager factory wages, some garment factory workers have turned to sex work, a business usually run by Koreans, Chinese, or Japanese (ITM Report 2001). Sex work and drug abuse are both related to increased risk of HIV/AIDS. Increasing numbers of men are having sex regularly, further adding to the incidence of STDs and HIV/AIDS (UN Country Profile 2001:13).
In the near future, Cambodia will face the challenges of both infectious disease and diseases of affluence as lifestyles change. People are already becoming more sedentary, with family members watching television every evening instead of partaking in a more active social life. Other threats to health are industrial accidents and the unexploded landmines and bombs still strewn about the countryside (Davies 1997). These problems could easily overburden the fragile health care and other social systems in the country.

4.9 Chapter Summary

This chapter focused on some of the sociopolitical and economic issues facing contemporary Cambodian society. The health impact of historical sociopolitical discontinuity cannot be underestimated. The rise of urban problems such as street gangs, drugs, and prostitution contributes to the current healthcare situation, especially as related to HIV/AIDS. Social issues directly related to Cambodia.

The next chapter focuses more specifically on health care in Cambodia. Cambodia is faced with an HIV/AIDS epidemic. This will be discussed in the context of the health infrastructure and the relationship between NGOs,
IOs, and Cambodian health care programs. The next chapter discusses social problems affecting the process of decision-making. AIDS is closely associated with social problems such as unemployment, poverty, and prostitution.
CHAPTER 5: HEALTH AND HEALTH CARE IN CAMBODIA

5.1 Introduction

From 1999 to 2001, at the time this field research was conducted, Cambodia’s health care system was under reconstruction. Delivering health services to the average Cambodian living in remote rural areas of the country remained a problem. This chapter provides an overview of the health care system in Cambodia since the Angkor period. It examines the major health problems faced by Cambodians today, the availability of health care, and other issues related to STDs and HIV/AIDS.

5.2 General Health Profile

At the time of this fieldwork, a report released by the UN Development Program stated that Cambodians are making progress toward better lives (Cambodia Daily, 12 July 2001). In a 2003 UNDP human development report examining education, life expectancy, and health care, the UNDP ranked Cambodia in the bottom quartile (130th) of 175 countries. According to the 2004 report, on the average, Cambodians can live to 57.4 years compared to 53.5 years in 2000 (UNDP 2004:1). Mainland Southeast Asian countries had
approximately the same population growth rate between 1990 and 1997 of 2 to 3%, with Cambodia at the high at 2.5% (MoH 2000; World Bank 1999; UNDP 2004). As Table 5.1 below shows, other general health indicators vary greatly (Table 5.1 showed latest data/most updated health statistics in Southeast Asia are generally based on 2000 or earlier data). In 2000, Cambodia had the second lowest life expectancy among five Southeast Asian countries, at 56.53 years (MoH 2000; NHSR 1999; World Bank 1999; Nationmaster.com 2002-2004). At the same time, Cambodia had the second highest maternal mortality rate in Southeast Asia. According to a 2000 estimate, there were 440 maternal deaths per 100,000 live births.

Cambodia has the second highest total fertility rate; in 2000, it was 4.82 children born per woman. This compares to Lao PDR's rate of 5.21 per woman and Vietnam's 2.53 per woman (MoH 2000; World Bank 1999; Nationmaster.com 2003-2004).

Table 5.1: Key Health Indicators in Southeast Asia (2000)

<table>
<thead>
<tr>
<th>Country</th>
<th>Total Fertility Rate (children born per woman)</th>
<th>Maternal Mortality Rate</th>
<th>Ave. Life Expectancy at Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>4.82</td>
<td>440</td>
<td>56.53 years</td>
</tr>
</tbody>
</table>

Children under the age of 5 are likely to face a number of illnesses in Cambodia, including acute respiratory infection (ARI), diarrhea, tuberculosis (TB), malaria, and other infectious diseases. Vitamin A deficiency is one of the main causes of child mortality (MoH 2000, section I: 3).

In 2001, the incidence of stillbirth was 12 per 1,000 births, and infant mortality was 64 per 1,000 live births (CDHS 2000; MoH 2000). Children under the age of 5 died at a higher rate in 2004 than 1999. For example, children under the age of 5 died at a rate of 138 per 1,000 in 2004 (UNDP 2004:01) compared to 1999 at a rate of 125 per 1,000 (CDHS 2000; MoH 2000).

Malnutrition is also high. Eighteen percent of babies are born with a low birth weight in Cambodia, roughly the same as in Vietnam and Lao PDR (MoH 2000). Malnutrition also results in stunted growth. Fifty-six percent of Cambodian children under 5 had a height-for-age of more than two standard deviations below international standards.

<table>
<thead>
<tr>
<th>Country</th>
<th>Under 5 (%)</th>
<th>Infant Mortality</th>
<th>Under 5 Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lao PDR</td>
<td>5.21</td>
<td>650</td>
<td>53.22 years</td>
</tr>
<tr>
<td>Vietnam</td>
<td>2.53</td>
<td>95</td>
<td>69.27 years</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2.61</td>
<td>380</td>
<td>67.97 years</td>
</tr>
<tr>
<td>Philippines</td>
<td>3.48</td>
<td>170</td>
<td>67.48 years</td>
</tr>
</tbody>
</table>


* Per 100,000 live births.
in 1997 (MoH 2000, Section I: 2-3). This was higher than both Lao PDR (47%) and Vietnam (44%) (MoH 2000, Section I:2).

Cambodia's major health challenge is communicable disease. According to a 1999 National Health Survey, almost one fifth of consultations at public health facilities were for acute respiratory infection (ARI) (MoH 2000 Section I: 3). The main reasons for admission to a hospital are usually ARI (>8%), tuberculosis (16%), or malaria (>13%) (MoH 2000, Section I: 3). These diseases were the main cause of in-patient mortality (MoH Section I: 3 2000). Dengue fever and other infectious diseases made up only 4% of hospital mortality (MoH Section I: 3 2000).

Another critical health problem is the HIV/AIDS epidemic in the country, as will be discussed in more detail. These illnesses are exacerbated by the fact that only 29% of the total population has access to safe drinking water and only 15% of households have electricity and proper toilet facilities (NCHADS, January 2000:6). Seventy percent of the population is without sustainable access to improved water source in 2001 (NIS 2003).

In addition to these problems, Cambodia has one of the lowest rates of utilization of health services in the
world. One study indicated that the average Cambodian only contacts organized health service providers once in three years (UNAIDS 2001:8). A major reason for this is the scarcity of medical services in rural areas relative to urban centers such as Phnom Penh. Another reason for this low rate of usage may be the expense of health services compared to income. According to the Cambodian Socio-Economic survey conducted by the National Institute of Statistics, in 1997 Cambodians were spending about US$29 on health care per year with a per capita income of US$249, or nearly 12% of their income (MoH 2000). By 2000, this had gone up to 22% on average, with the lowest quintile putting 28% of their income into health care (UNAIDS 2001:8).

5.3 The Formal Health Care System

This section provides an overview of the history of health care in Cambodia. The Khmer have been aware of the importance of health care since at least the 12th century (Chandler & Mabbett 1995:129). During the Angkor period, health care services were provided fairly systematically, but it was not until the colonial period that the biomedical model was introduced. It now dominates the formal health care system.
5.3.1 Early History

The earliest evidence of some kind of systematic health care system in Cambodia can be found in inscriptions at Sambor Prei Kuk temple in Siem Reap Province. Carved following the death of a doctor in 639 A.D., they exhort hermitages to "provide medicine and food for the sick" (Pym 1968: 153). A centralized health care system had almost certainly developed in Cambodia by the 12th century, when hospitals were constructed by King Jayavarman VII (Mabbett & Chandler 1995:129). Inscriptions at Ta Prohm describe 102 hospitals being maintained during his reign (Groslier 1957; Mabbett & Chandler 1995:129). Outside of the walls of Angkor Thom are the remains of four chapels that doubled as hospitals. Other hospital chapels are located outside of the east and west gates, the Prasat Tonle Sngout and Ta Prohm Kel (Groslier 1957; Pym 1968: 154). These hospitals probably included medical personnel such as doctors, pharmacists, and their assistants.

The account of Chou Ta-Kuan, a Chinese envoy who visited in 1296, and inscriptions and sculptures at Angkor Wat provide further evidence of health care practices during the Angkor period (802 - 1432 A.D.), (Chandler
1996:4). The Angkor Khmer apparently took great care of those who were ill. Bas-reliefs at the Bayon inner south gallery (dated late 12th to early 13th century A.D.) show a man lying upon cushions surrounded by people he knows, one of whom appears to be a doctor feeling his brow (Giteau 1976:44). Another bas-relief shows a man dictating a prescription to a scribe, while behind him another assistant conveys his instructions (Giteau 1976:42).

Chou Ta-Kuan noted that the Khmer bathed at least twice daily (Chou Ta-Kuan 1951 [Ta-kuan Chou fl. 1297]:33). Maintenance of good health and overall well-being appear to have been important to the Khmer at the time, but such practices also suggest preventive strategies. Cleanliness is one type of prevention for dysentery and plunging oneself into water may have been a cure for skin diseases such as leprosy.3 Food was used as medicine by providing daily bodily nourishment, but this does not imply that food and medicine were viewed as one and the same (Pym 1968:155). The Khmer probably had treatments for specific diseases (Chhem 2001: 14). We know that they valued and used plants for food, medicine, and as tools (Jacob 1978:112). If some kinds of plants that were used for

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3 Chou Ta-Kuan also noticed that lepers were not isolated from the rest of the population (Groslier 1957)
nourishment were also used for medicine, it suggests that health prevention was as important to the Khmer as treating specific diseases.

Their approach to health was probably influenced by Chinese and Ayurvedic medical systems that had been adopted throughout Southeast Asia; this would have included the dichotomy between hot and cold and the notion of equilibrium (Akira 1996:109; Chhem 2001: 13). Animistic traditions were also an important part of the Khmer health belief system. Historically, Cambodia has often integrated foreign cultural practices while retaining some indigenous values and practices.

5.3.2 Later History

The pre-European period from 1431 to 1864 might be considered a dark age in Cambodian history, with what considered the darkest period in the 18th century (Chandler 1983: 95). At that time, Cambodia struggled to maintain political autonomy against aggressive neighbors intent on usurping much of its territory and ensuring that those on the Khmer throne were under their control (Ebihara 1968:35-36). Dynastic instability, foreign invasion, and civil war were frequent (Chandler 1983:95).
Little is known about the country's health care system during this time. One account written by San Antonio, a Spanish missionary at the end of the 16th century, describes Cambodian products made from rhinoceros (Chandler 1992:87). Rhinoceros horns, skin, blood, and teeth were used as antidotes for a number of illnesses, especially those associated with the heart (Chandler 1992:87).4

Meanwhile, Europeans were entering Southeast Asia with trade and colonial interests. The French were drawn into Cambodia's defensive struggles and ended up colonizing the country (Ebihara 1968:35-36). As a French Protectorate, in 1864 Cambodia was given certain rights and powers over its domestic and foreign affairs in return for aid against its neighbors (Chandler 1983:157). At this time, Cambodia, Vietnam, and Laos came to be known as French Indo-China (Ebihara 1968:36).

Under the French administration, Cambodia's political, economic, and social institutions changed radically. Taxation, jurisprudence, communications, transportation, and education were restructured to follow the French model. At this time, Cambodia came under the influence of the

4 This use of rhinoceros medicine may have been derived from the Chinese belief that rhinoceros by-products are effective aphrodisiacs (Chandler 1992:87).
Western biomedical system, although healing beliefs and practices from India remained intact (Chandler 1983: 157). Improved health facilities aided the suppression of epidemic diseases and increased the longevity of the population as a whole (Ebihara 1968: 47). The French trained a high number of Cambodian health professionals over the next hundred years. Some Cambodians received technical and medical education in France and other Western countries. The health care system therefore greatly improved until the abolition of all social welfare systems during the Pol Pot regime in the late 1970s.

As described in Chapter 3, the three years the Khmer Rouge were in power resulted in the death or disablement of thousands of people along with the destruction of the entire health care system. By 1979, only 45 medical doctors had survived, but 20 of them left the country (McGrew 1990:77). The entire population of health professionals in 1979 included the remaining 25 doctors, 3 staff members from the Ministry of Health, 26 pharmacists, 28 dentists, and about 728 medical students (Mam and Key 1995:311; McGrew 1990:77).

In 1979, the PRK made improving health care one of its five top priorities (McGrew 1990:77). A large number of
health workers were trained in a short period of time, but their skills were not up to international standards (Mam and Key 1995: 311). Furthermore, doctors working for the government were vastly underpaid, less than $30 a month in 2003. Most of them turned to private practice to supplement their incomes; they also preferred to remain in urban areas (Mam and Key 1995: 311).

5.3.3 Contemporary Infrastructure

The Cambodian Ministry of Health (MoH) has been restructured a number of times. Before 1993, local health units were responsible for budget allocation and sector development. After restructuring, these functions were transferred to the MoH, but external finances continue to flow to the local health units, especially at the provincial and district levels (MoH 2000, Section II: 1). In 1996, the MoH established a policy of providing health services through both Minimum and Complementary Packages of Activities (MPA/CPA). Following the Second National elections in 1998, Cambodia received greater technical and financial support from the international community (EU Report 2002:2; IMP Report 1999:38). The Ministry of Health (MoH) was again restructured. The MoH is now organized
into three different Directories: Inspection, Health Services, and Finance and Administration. The directories come under the control of the Senior Minister and his Cabinet.

The MoH is currently decentralizing its organization and returning some of its control to the provincial and district levels. Its main objective is to give budget centers greater control, which should direct resources toward health priorities, make more coherent use of external aid, and provide a better ratio of physicians to population (MoH 2000, Section II: 1).
Figure 5.1: Organizational Chart of the Ministry of Health

Senior Minister &
Minister of Health

Cabinet

Secretary of Health

Under Secretary of State

Under Secretary of State

Under Secretary of State

Under Secretary of State

Director General for Health

Director General Of Inspection

Office of Secretariat Health

International Relations Bureau

Dept. of Health Planning & Information

Dept. of Human Resource Development

Dept. of Drug, Food & Medical Materials

Dept. of Hospital Services

Dept. of Preventive Medicine

Dept. of Communicable Disease Control

National Centers, Hospitals & Institute

Provincial Health Departments

Source: Health Situation Analysis, MoH 1998
The MoH aims to ensure access to health care for all segments of the population, including people living in remote rural areas. The MoH manages the following programs:

1) The National Malaria Center
2) The National Center for Maternal and Child Health
3) The National Tuberculosis Control and Leprosy Elimination Program
4) The National Center for Health Promotion and Primary Health Care
5) The Center for HIV/AIDS, Dermatology and STDs.

These programs provide specific health services and support the health facilities throughout the country. Health services are distributed among 73 "Operational Districts" (ODs). In principle, each OD includes a Referral Hospital (RH). Six national hospitals (Calmette, Norodom Sihanouk, National Pediatric, Kossamak, Ang Duong, and Kunthia Bopha) in Phnom Penh provide tertiary care (MoH 2000, Section II: 1). An additional 963 Health Clinics (HCs) were supposed to have been distributed around the country according to the population of each district (MoH 2000). However, by the end of 2000, only 565 had actually been constructed. There are no current data in terms of the number of health centers being built or future plans on its progress.

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5 Operational districts do not coincide with administrative districts. Cambodia is divided into 24 provinces and municipalities that are further divided into 184 administrative districts.
Table 5.2: Total Health Centers Open Annually (1996 -2000)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Health Centers</td>
<td>59</td>
<td>157</td>
<td>280</td>
<td>402</td>
<td>565</td>
</tr>
</tbody>
</table>

Source: Ministry of Health Planning Unit 2000

Unfortunately, in most cases, there are no trained health staff on hand to provide health services to those who come to the health centers (MoH 2000, Section II: 2). Table 5.3 shows that although the Ministry of Health staff increased by 39% between 1996 and 2000, there has been relatively little increase in number of health personnel. 6

Table 5.3: Health Personnel Deployed by the Ministry of Health

<table>
<thead>
<tr>
<th>Year</th>
<th>1996</th>
<th>1998</th>
<th>2000</th>
<th>% Increase from 1996 to 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Personnel</td>
<td>15,594</td>
<td>16,593</td>
<td>16,952</td>
<td>9</td>
</tr>
<tr>
<td>Other Personnel</td>
<td>2,639</td>
<td>2,283</td>
<td>3,660</td>
<td>39</td>
</tr>
<tr>
<td>Total</td>
<td>18,253</td>
<td>18,876</td>
<td>20,612</td>
<td>13</td>
</tr>
</tbody>
</table>

Source: Health Workforce Development Plan, 1996-2005

Distribution of health care professionals is another major concern. In urban areas such as Phnom Penh, there are higher ratios of health professionals to population

6 The lack of trained health personnel suggests that medical services for people with HIV/AIDS are increasingly limited, considering the increase in the number of AIDS cases between 1991 and 2000 (see Table 4.6).
than in rural areas and isolated provincial capitals (MoH 2000). Health personnel want to stay in Phnom Penh so they can maintain private practices and their families want to be close to educational and recreational facilities. Employment opportunities for their spouses are also greater in urban areas. This produces overstaffing in Phnom Penh and understaffing in other provinces, particularly in the northern provinces such as Prey Vihear, Banteay Meanchey, and Odar Meanchey. For example, in 1998, the ratio in Phnom Penh was 1 physician per 1,280 people, compared to Banteay Meanchey, where it was 1 to 11,791. Current data are not available.

Table 5.4: Distribution of Government Physicians in Cambodia as of 1998

<table>
<thead>
<tr>
<th>Province</th>
<th>Population</th>
<th>No. of Physicians</th>
<th>Ratio of Physician to Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bantey Meanchey</td>
<td>577,772</td>
<td>49</td>
<td>1:11791</td>
</tr>
<tr>
<td>Battambang</td>
<td>793,129</td>
<td>90</td>
<td>1:8813</td>
</tr>
<tr>
<td>Kampong Cham</td>
<td>1,608,914</td>
<td>113</td>
<td>1:14238</td>
</tr>
<tr>
<td>Kampong Chnang</td>
<td>417,693</td>
<td>29</td>
<td>1:14403</td>
</tr>
<tr>
<td>Kampong Speu</td>
<td>598,882</td>
<td>48</td>
<td>1:12477</td>
</tr>
<tr>
<td>Kampong Thom</td>
<td>569,060</td>
<td>44</td>
<td>1:12933</td>
</tr>
<tr>
<td>Kampot</td>
<td>528,405</td>
<td>42</td>
<td>1:12581</td>
</tr>
<tr>
<td>Kandal</td>
<td>1,075,125</td>
<td>89</td>
<td>1:12080</td>
</tr>
<tr>
<td>Koh Kong</td>
<td>132,106</td>
<td>24</td>
<td>1:5504</td>
</tr>
<tr>
<td>Kratie</td>
<td>263,175</td>
<td>22</td>
<td>1:11963</td>
</tr>
<tr>
<td>Mondokiri</td>
<td>32,407</td>
<td>5</td>
<td>1:6481</td>
</tr>
<tr>
<td>Phnom Penh</td>
<td>999,804</td>
<td>781</td>
<td>1:1280</td>
</tr>
<tr>
<td>Prey Vihear</td>
<td>119,261</td>
<td>9</td>
<td>1:13251</td>
</tr>
<tr>
<td>Prey Veng</td>
<td>946,042</td>
<td>39</td>
<td>1:24258</td>
</tr>
<tr>
<td>Pursat</td>
<td>360,445</td>
<td>5</td>
<td>1:72089</td>
</tr>
</tbody>
</table>
5.3.4 Biomedical Health Care Services

Overall, the health care system in Cambodia has yet to meet international health care standards (Santini 2002; Kudo 2002; Pilsczek 2001). Nevertheless, biomedical services are available from a variety of venues, including the public health care system, non-governmental organizations, and private practice. Governmental medical services are not very good because of the poor quality of medical education in Cambodia (Santini 2002). The Faculty of Medicine reopened in 1980 after the Pol Pot regime had destroyed medical education in the country (Santini 2002). The new curriculum included training for different, clearly defined positions (e.g., doctors, medical assistants, nurses, midwives). There was no system in place to ensure quality training, however. Corruption further hindered the likelihood of turning out knowledgeable medical
professionals. Instead of recruiting qualified students, the medical school accepted anyone who could afford to pay off an administrator. Students also paid their teachers to pass them on exams. In some cases, a medical degree could be bought without the student ever attending medical school (Soeters et al. 2003). Despite corruption and lack of technical skill and training facilities, Cambodian medical school enrolls a large number of students each year (Kudo 2002; Santini 2002).

Since medical workers are poorly paid by the government, they often go into private practice (ranging from basic health care to cosmetic surgery) to supplement their salaries (Pilsczek 2001). It is not difficult to obtain private medical care if one can afford the high fees. Patients can also seek health care with non-governmental organizations or go to public hospitals that receive external financial and technical support (Gollogly 2002). Non-governmental organizations generally provide better care than the public health care system.

Although costly, Western pharmaceuticals ranging from aspirin to antibiotics are readily available throughout the country (KHANA 2003). They are sold in the marketplace and by traveling salespeople, schoolteachers, and traditional
healers (Gollogly 2002; Pilsczek 2001). Even though certain pharmaceuticals are supposed to be prescribed by a doctor, in practice almost anything can be purchased directly from a pharmacy. Pharmacies are legally required to obtain a license to dispense Western pharmaceuticals, but these laws are not enforced (KHANA 2003). Pharmacy owners buy licenses from pharmacists who are no longer working. Pharmacists or people who work in pharmacies often dispense medical advice as if they were doctors (Pilsczek 2001).

5.4 The Case of Kru Khmer

Kru consist of a diverse group of traditional medical practitioners. Traditional Cambodian healers, called kru Khmer, learn their skills in an oral tradition passed on by a parent or master healer (Biacabi 1993). Generally, the term kru referred to any teacher including schoolteachers. However by adding the word Khmer after the term kru that the phrase becomes specific (e.g., traditional healer). Kru Khmer made up a wide range of practitioners depending on one’s beliefs, values, educational level, and other external influences such as witnessing a dramatic event.
There are a variety of Cambodian medical practitioners; many of them integrate a various practices, including plant medicines, religious and supernatural healing, and biomedicine (Cheung & Spears 1995:258). The traditional Cambodian medical system is based on humoral theory, or the belief that good health is a matter of balancing between opposites such as hot and cold or wet and dry. Traditional healers (kru Khmer) may read palms, draw up astrological charts, or enter trance to conduct diagnosis.

Spirit mediums, who may or may not be considered kru, are another kind of healer in Cambodia. Spirit mediums are not allowed by their spirit helpers to ask for payment for their services, but can receive symbolic gifts of food, goods, or money. As in many parts of Asia (Beckford & Suzara 1994; Lepowsky 1990; Wilber 2002; Woodward 1985) and elsewhere (Beckerleg 1994; Dumont 1992; Muela 2002; Risberg et al. 1996), religious beliefs play a part in medical practices. Spiritual leaders and monks consider spirits and sorcerers to be at the root of most serious physical or mental disturbances (Cheung & Spears 1995: 258). They are sought out to consult on diagnosis and cure and may be involved in healing ceremonies. They usually turn to
exorcism as a principle therapy for spiritual or supernatural illnesses. Their repertoire includes incantations and rubbing blessed oils or powders on the patient’s body. After the exorcism ritual, food and water are blessed and consumed. They may also explain that an illness has origins in incorrect moral behavior and recommend a correct code of conduct as part of the path to recovery. Since monks play such a key role in healing, they are sometimes also considered a kind of kru. Traditionally, monks are also not allowed to ask for payment, but most patients provide symbolic gifts when their expectations regarding treatment have been met (Biacabi 1993).

Cambodians therefore have a number of options whenever seeking medical treatment. Their choices depend on the cause and severity of a particular illness and the availability and acceptability of different medical services (Biacabi 1993: 8). Home remedies and traditional medicine are generally used for minor injuries, illnesses assumed to have natural causes, and symptomatic relief (Biacabi 1993: 8; Cheung & Spears 1995: 258). According to one study, 80 to 90 percent of all treatments are self-administered at home (Biacabi 1993: 8); patients switch to
alternative treatment depending on diagnosis. For life-threatening conditions or supernatural illnesses, patients usually seek biomedicine or turn to a traditional healer. Patients are increasingly turning to private practitioners, especially when they seek injections, which are believed to have certain magical values and be more efficacious in alleviating pain quickly and restoring the body back to equilibrium (Bicabi 1993).

Cambodians choose kru Khmer healers by a process of elimination (Biacabi 1993). There are many kru in most villages in the country, but their experience, knowledge, and credibility vary widely and it is not unusual to find kru prescribing more than one therapy at a time. Some kru only deal with mental health problems, reading horoscopes to discover the severity of an illness and foretell its future course (Biacabi 1993). Other kru treat illnesses inflicted by spirits and demons. These tend to be more specialized, but their status is somewhat precarious because they can use both white and black magic to cure or harm a person (Biacabi 1993). Monks who are suspected of practicing black magic are blamed for failing their moral obligations to Buddhism. However, monks who possess
supernatural power combined with knowledge of medicinal plants are highly sought after (Biacabi 1993).

_ Kru_ who treats illnesses that result from natural causes are also considered specialists. Medicines are made of plants or animal remains, including bones, skin, hair, organs, and bones, and may be given in the form of infusions, decoctions, pills, powders, ointments, or plasters (Biacabi 1993). Preparing remedies often follows a ritual process: for example, infusions are always prepared in three bowls and then boil the water until it remains for about one cup (Bicabi 1993: 10). Since exceeding the right dosage can harm the patient, good kru try the remedy on themselves before giving it to others.

5.5 National Health Budget

Ever since the UN sponsored national elections of 1992, public health care funds have come from international donors. According to the USAID/Cambodia Draft report on Population, Health and Nutrition Assessment (June, 2001), multilateral and bilateral organizations contribute the majority of financial support to Cambodia’s health care services. For instance, the Asian Development Bank spent US$6 million on basic health services from 1997 to 2002,
focusing on the construction and rehabilitation of health centers and hospitals and the provision of essential drugs. Bilateral organizations such as AUSAID, DFID, French AID, GTZ, JICA, and USAID have committed to providing annual support of more than US$10.7 million from 1997 to 2005 (USAID Report, 12 June 2001:114, 120).

In 1997, the Cambodian government contributed approximately 30% to the total health care budget (World Bank 1999). This amount has increased annually. For example, in 1994, total funding from all sources was 87,793 million riels (US$34.5 million); 30,079 million riels (US$11.8 million) came from the government. By 1997, funding from all sources was 181,916 million riels (US$60.9 million), of which 54,689 million riels (US$18.3 million) was from the government. Although between 1995 and 1997 the national budget went down, government funding for the health sector increased.

<table>
<thead>
<tr>
<th>Year</th>
<th>1995$^a$</th>
<th>1996$^b$</th>
<th>1997$^c$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total National Budget</td>
<td>369.8</td>
<td>375.3</td>
<td>336.2</td>
</tr>
<tr>
<td>Total Government Expenditure</td>
<td>487.7</td>
<td>511.7</td>
<td>424.2</td>
</tr>
<tr>
<td>Government Funding to Health Sector</td>
<td>10.7</td>
<td>16.5</td>
<td>18.3</td>
</tr>
<tr>
<td>Official donor aid</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$^7$ The exchange rate in 1994 for US$1 was 2,543 riels.
$^8$ The exchange rate in 1997 for US$1 was 2,989 riels.
Health funding is allocated to the following components: sector policies and planning, primary health care, disease control and family planning, hospitals, drug supply and training, construction, equipment, and counterpart (subcontractor). In 1996, although the total government budget for the health sector was 43,178 million riels (US$16.5 million), only 2.4% percent was allocated for disease control and planning and 2.7% for primary health care (MoH 2000, Section III: 12). The majority of funds was spent on sector policy and planning (44%) and training (43%) (MoH 2000, Section III: 12). The 2002 actual budget was $43 million (US) (UNDP 2004:1). The government set itself the target of increasing budget expenditure in social services from 2.1% of GDP in 1999 to 3.3% in 2003 (UNDP 2004:1). The total costs of the Government’s planned development programs, both on-going and new programs, from 2002 to 2004 is estimated to be around US $1,388 million

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<table>
<thead>
<tr>
<th></th>
<th>22.6</th>
<th>47.4</th>
<th>32.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGOs</td>
<td>n/a</td>
<td>9.3</td>
<td>10.5</td>
</tr>
</tbody>
</table>

Sources: MoH, 2000; World Bank, 1999.

a. In 1995, the exchange rate for US$1 was 2,462 riels.

9 The exchange rate in 1996 for US$1 was 2,624 riels.
The total budget for health programs was $309,353, with the government committed US $112,342 for 2002-2004 (CDC 2004:2).

5.6 The HIV Profile in Cambodia

The rate of increase in HIV/AIDS in Cambodia was alarming in the 1990s (see Table 5.6). Up until the 1990s, Cambodia was relatively isolated from the outside world. Due to this, it was only in 1991 that the first HIV case was detected, during a serological screening of donated blood at the National Blood Transfusion Center in Phnom Penh (NCHADS, 24 March 1999:1). By late 1993 and early 1994, the first 15 cases of AIDS had been diagnosed (STI/HIV/AIDS Surveillance Report, Special Edition, No. 14, October 1999:8). Since then, the number of people infected with HIV has grown exponentially. By 1998, 3.6% of the adult population in Cambodia was estimated to be HIV positive. It was predicted then that by 2000 it would go as high as 5.1% of the population (Sentinel Surveillance 1998). However, the rate of increase has actually declined. Between 1999 and 2002, the number of infected remained roughly stable. Adult prevalence rate was at 2.6% in 2002 (UNFPA 2003).

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>3</td>
<td>91</td>
<td>205</td>
<td>660</td>
<td>2611</td>
<td>4541</td>
<td>4674</td>
<td>7646</td>
<td>170,000</td>
</tr>
<tr>
<td>AIDS</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>14</td>
<td>91</td>
<td>300</td>
<td>572</td>
<td>7,107</td>
<td>21,619</td>
</tr>
</tbody>
</table>

Sources: ITM/EU Report, June 2001; MoH 2000;

Table 5.6: Continue

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>169,000</td>
<td>160,000</td>
<td>157,500</td>
<td>170,000</td>
<td>157,500</td>
</tr>
<tr>
<td>AIDS</td>
<td>8,712</td>
<td>8,248</td>
<td>19,000</td>
<td>----</td>
<td>----</td>
</tr>
</tbody>
</table>

Sources: ITM/EU Report, June, 2001; MoH 2000; UNAIDS 2001; UNAIDS 200; NCAHDS 2004

A number of factors have contributed to the slowing rate of increase of HIV in Cambodia. One is simply that many people have died or are dying of AIDS and HIV is not being passed on as rapidly. For instance, 39,539 new cases of HIV infection were reported to National Center for HIV/AIDS, Dermatology and STDs (NCHADS) by the end of 2000, but between 1999 and 2000, people with AIDS had declined from 21,619 to 8,712 (UNAIDS, May, 2001:10). One reason for this low number compared to 157,000 HIV cases reported in the table for 2002 is due to under reporting, different diagnosis, or misdiagnosis. The other reason is that the 157,000 HIV cases is based on a formula predicted using mathematical calculations, not actual numbers. One thousand two hundred and fourteen AIDS deaths were reported to the government during 2000. It is estimated by 2005 that a
total 29,743 Cambodians will have full-blown AIDS (UNAIDS, May, 2001:10). Most will die in the next five years of AIDS-related complications.

Another reason for declining HIV prevalence is the introduction of STD prevention campaigns by both governmental and non-governmental organizations. These campaigns have been quite effective. For example, in 1996, the prevalence rate for syphilis among sex workers was 15%, but by 1999 it had dropped to 1.4%. The rate for Trichonomas in 1996 was 7.2%, but again by 1999 was down to 0.3%. Latest statistics for STDs are not yet available.

Table 5.7: STD Prevalence Rates from 1996 to 1999

<table>
<thead>
<tr>
<th>Year</th>
<th>Syphilis [RPR+]</th>
<th>Trichonomas (1st)b</th>
<th>Trichonomas(^c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996(^a)</td>
<td>16%</td>
<td>7.2%</td>
<td>-</td>
</tr>
<tr>
<td>Nov.-Dec.,1998</td>
<td>9.2%</td>
<td>5.5%</td>
<td>-</td>
</tr>
<tr>
<td>Jan.-Mar.,1999</td>
<td>2.7%</td>
<td>5.3%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Apr.-Dec.,1999</td>
<td>1.4%</td>
<td>0.3%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

Source: ITM/EC Report, June, 2001:20
\(^a\)Data from sex workers in Sihanoukville during National STI Prevalence Survey conducted in 1996.
\(^b\)"Microscopic examination of a fresh vaginal smear for Trichonomas vaginalis infection is carried out systematically at the 1st visit" (ITM/EC Report, June, 2001:20)
\(^c\)Testing for Trichonomas on return visit to the clinic.

Since many of the measures taken to prevent STDs are effective against HIV transmission, it is not surprising
that HIV is also declining, at least among those groups targeted by such campaigns. The government sero-prevalence report of 1999 shows that HIV/AIDS prevalence rates have dropped among some high risk-groups (NCHADS 1999). For instance, in 1995, the rate of HIV infection among direct sex workers in Cambodia was 37.93%; by 1999, the rate had dropped to 33.2%. The 1995 HIV prevalence rate among police was 8.07%. Police are a high-risk group because they visit sex workers frequently; by 1999 this had been cut nearly in half, to 4.70%. Among indirect sex workers such as so-called 'beer girls', the 1995 rate of 24.71% also dropped, to 19.80% in 1999. Some provinces show increasing HIV among these high-risk groups, however, possibly due to the high mobility of sex workers in the country (see Table 5.8). The average time a sex worker remains in one province is usually about a month. They tend to move to wherever demand is highest, particularly to major provinces or municipalities such as Phnom Penh, Kampong Som, Kandal, Koh Kong, or Poipet.10

Table 5.8: HIV Rates Among Direct Sex Workers by Province (1995-1999)

10 It is not easy to compare HIV prevalence rates across provinces from one year to the next, since sero-prevalence reports are not always consistent in terms of number of years surveyed, sites chosen, or groups tested. Table 5.8 is based only on provinces that have collected HIV/AIDS statistics for a consistent five-year period.
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bantey</td>
<td>45.75%</td>
<td>54.49%</td>
<td>58.08%</td>
<td>53.96%</td>
<td>50.70%</td>
</tr>
<tr>
<td>Meanchevy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Battambang</td>
<td>48.00%</td>
<td>58.33%</td>
<td>47.06%</td>
<td>53.33%</td>
<td>35.40%</td>
</tr>
<tr>
<td>Kandall</td>
<td>13.64%</td>
<td>13.33%</td>
<td>19.13%</td>
<td>21.36%</td>
<td>31.70%</td>
</tr>
<tr>
<td>Koh Kong</td>
<td>39.16%</td>
<td>52.10%</td>
<td>52.00%</td>
<td>41.04%</td>
<td>41.70%</td>
</tr>
<tr>
<td>Phnom Penh</td>
<td>30.47%</td>
<td>41.62%</td>
<td>44.44%</td>
<td>61.33%</td>
<td>47.40%</td>
</tr>
<tr>
<td>Rattanakiri</td>
<td>21.43%</td>
<td>35.00%</td>
<td>34.21%</td>
<td>21.21%</td>
<td>46.90%</td>
</tr>
</tbody>
</table>

Source: NCHADS, 1999

As of 2004, there are no data available. All current or updated reports are based on 2002 or data from earlier years such as data at the peak of the epidemic in 1999. The Cambodian government has identified high-risk groups using the Behavioral Surveillance System (BSS) and HIV Sentinel Serological Surveillance System (HSS). Both programs are conducted every 12 to 18 months, but not all groups are consistently surveyed. For instance, the last round examined sex workers, motorcycle-taxi drivers, and beer promoters, but not indirect sex workers such as karaoke girls, fruit shake vendors, waitresses, or cigarette promoters. Direct sex workers are easy to identify since they work in brothels or bars that cater to locals, tourists, and expatriates. Sex work is primarily done by young females (ITM Report 2001:16). The numbers of male sex workers and transvestites in Phnom Penh are fairly small (ITM Report 2001:16). Indirect sex workers are
difficult to identify, since they include people working in a wide range of occupations whose sexual behaviors do not necessarily overlap (ITM Report 2001:17). They generally include young women with jobs in the thriving entertainment business, such as nightclubs, bars, and massage parlors (ITM Report 2001:17). 'Beer girls', cigarette and alcohol promoters, waitresses, night-time fruit vendors, factory workers, and karaoke singers are classified as indirect sex workers if they occasionally sell sex to supplement their income. Other high-risk groups include policemen, cyclopeddlers, motorcycle taxi drivers, military personnel, frequent blood donors, and college students. These groups are being targeted by the Cambodian government’s campaigns to raise awareness, education, and prevention of HIV.

Table 5.9 below lists HIV prevalence rates among selected groups in 1999. The rates varied from 33.2% for direct sex workers to 1.2% among women who head households. Among TB patients, the HIV prevalence rate was 7.9%. Among hospital patients, it was up to 11.1% (only those diagnosed with AIDS).

<table>
<thead>
<tr>
<th>Target group</th>
<th>HIV Prevalence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
By 2000, the prevalence rate among many of these groups had declined slightly, as seen in Table 4.10.

### Table 5.10: HIV Rate by Target Group (2000)

<table>
<thead>
<tr>
<th>Target Group</th>
<th>HIV Prevalence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct sex workers</td>
<td>31.1%</td>
</tr>
<tr>
<td>Indirect sex workers (e.g., beer girls, bar girls, etc.)</td>
<td>16.1%</td>
</tr>
<tr>
<td>Police</td>
<td>3.1%</td>
</tr>
<tr>
<td>ANC</td>
<td>2.3%</td>
</tr>
<tr>
<td>TB Patients</td>
<td>6.7%</td>
</tr>
<tr>
<td>Hospital Patients</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: UNAIDS, 2001

The HIV/AIDS prevalence rate in 1997 for the general adult population aged 15-49 years was 2.4% (MoH 2000:2). Estimates for 1998 varied from 3.6 to almost 4% (MoH Oct./2000:5). HIV prevalence in 1999 went down again to a little over 3% (MoH October, 2000:5). This decline continued in 2000, when an HIV surveillance report estimated that 2.8% of adults were living with HIV in
Cambodia (ITM Report 2001:15). Since then, it is relatively stable.

The 2000 BSS revealed some interesting information in terms of high-risk sexual behavior. Most men's sex partners are either their own wives or commercial sex workers. Twenty-five percent of Cambodian men engage in social activities that put them at high risk for HIV infection (UNAIDS 2001:13). Cambodian men tend to marry in their late 20s, so younger men have more sex partners and go to more sex workers. About 16% of Cambodian men are mobile; those that travel are more likely to have sex with direct sex workers than those who do not (UNAIDS 2001:13).

5.6.1 Government Reporting

Currently, the government uses the HIV Sentinel Serological Surveillance System (HSS) established in 1994 and the Behavioral Surveillance System (BSS) established in 1998 to keep track of HIV/AIDS in Cambodia. These behavioral surveillance systems cover the five major provinces that have the highest population density (e.g., Phnom Penh, Sihanoukville, Kampong Cham, Battambang, and Siem Reap) (UNAIDS 2001:12). A few small, remote provinces
with low populations are not included in the surveillance programs (MoH 2000:10).

The Cambodian government identifies areas of priority for surveillance based on geographical location of high-risk groups. The high-risk group for the central southern area - consisting of Phnom Penh, Kampong, Kampong Chhnang, Kampong Cham, and Kampong Speu - is sex workers. The government is more concerned about migrant workers along National Road Number 5 in the northern part of Cambodia, including Banteay Meanchey and Battambang, (both bordering Thailand) Siem Reap and Pursat. The highest-risk group in the southwest area is sexual partners of sex workers, found in Koh Kong (bordering Thailand), Sihanoukville (a port town), and Kampot (bordering Vietnam). The government focuses most on people who already have HIV/AIDS in the central eastern part of Cambodia, including Kandal, Prey Veng, Svay Rieng, and Takeo.

5.6.2 Factors in the Spread of HIV/AIDS in Cambodia

Although Cambodia is in many ways similar to neighboring countries, it has experienced the worst

11 That is, Mundolkiri (population 32,407), Kep (28,660), and Otdar Meanchey (68,279).
HIV/AIDS epidemic in Southeast Asia. HIV infected the Cambodian population in half as much time as in Thailand (Tia et al. 1998:S13). By 1998, at between 3 to 5% (depending on the reporting agency), Cambodia had the highest HIV/AIDS rate in Asia (USAID 2001). This section examines the source of HIV/AIDS in Cambodia and some of the factors, which may have contributed to such rapid rates of infection.

Controversy has emerged about how AIDS developed in Cambodia. The 2000 Danish documentary, (UN Blamed for Bringing AIDS to Cambodia), blames the spread of HIV/AIDS in Southeast Asia on United Nations peacekeepers (see Chapter 3) (National Post, Canada, August, 2000). Agencies that supplied generators to UNTAC in Cambodia also provided sex workers to its male personnel (Tarr 1996:19). Many UNTAC peacekeepers were away from home for the first time. They may have frequented nightclubs when they felt lonely and isolated. The documentary implies that their appetite for sex launched the AIDS epidemic in Cambodia.

Commercial sex is hardly new to Southeast Asia, however. In Thailand, for example, prostitution dates back

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12 The documentary also accuses UN peacekeepers of fathering and leaving behind untold numbers of children who are now teased and bullied by other youngsters for being of mixed race (National Post, Canada, August 2000).
at least to the 15th century, when women were sold as concubines and wives (Wawer et al. 1996:454). In the 17th and 18th centuries, Chinese migrants created a striving market for brothels in Thailand's Chinatown (Wawer et al. 1996:454). Demand for commercial sex increased in the 1960s and 1970s when United States soldiers entered Thailand during the Vietnam War, followed in later decades by tourists. Similarly, sex work was exacerbated by demand from foreigners in Cambodia.

The spread of HIV in Cambodia cannot be entirely blamed on UNTAC personnel, however. Cambodia had its own sexual culture prior to the UN presence (Tarr 1996:20). For example, Cambodian men tend to engage in sexual activities outside of marriage. Most young males report having their first sexual encounters with paid sex partners or women with whom they have only short-term relationships before moving on to the next partner.

Regardless of origin of the virus, UN peacekeeping operations intensified the spread of HIV/AIDS by stimulating the Cambodian economy. UNTAC allowed Cambodians and non-Cambodians alike to make a lot of money within a

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13 Another factor was the development of economic policies that promoted industrialization and provision of services in Bangkok at the expense of the agricultural sector. Today, more Thai women are in commercial sex work than any other occupation (Wawer et al. 1996: 454-455).
short period of time. People were suddenly able to buy more goods and pursue pleasures they would not otherwise have been able to afford. With economic prosperity came further expansion of the commercial sex industry.

Meanwhile, many rural women had begun migrating to urban centers in search of work. In 1993, there were no factories for them to work in yet, so many of them entered brothels or took jobs in bars. A year later, nine factories were established in Phnom Penh, mostly employing women (IMF Report 1998: 6). Since factory wages were low, some of them turned to sex work to supplement their incomes (Nishigaya 2002). The overwhelming availability of sex workers and the government's indifference to prostitution further exacerbated the spread of HIV. By 1995, the overall HIV prevalence rate among direct sex workers was 37.93%; this increased to 42.6% by 1999 (NCHADS 2000). In some provinces such as Pursat, the HIV prevalence rate in 1995 was already as high as 44.19%, increasing to 64.12% in 1998. Other provinces showed similarly high figures: 61.33% in Phnom Penh, 57.33% in Sihanoukville, and 38% in Siem Reap (NCHADS 1999).
5.6.3 Responses to AIDS in Cambodia

Two distinct patterns of response to the HIV/AIDS epidemic have emerged. The government focuses on establishing national policies to deal with HIV/AIDS and STI prevention, including education, awareness raising, and support as well as long-term intervention, surveillance systems, and research. NGOs and religious organizations have more immediate objectives in dealing with the day-to-day problems of those who have been affected by the epidemic. They focus on setting up hostels, hospices, support groups, and home-based care programs.

The first governmental response to the threat of an HIV epidemic was in 1991, when the National AIDS Program (NAP) was established by the Ministry of Health. The NAP was set up independently from the existing National STD Center. It was intended to implement HIV prevention activities, including conducting prevalence and risk behavior surveillance. In 1993, the government created the National AIDS Committee (NAC) and National AIDS Secretariat (NAS), involving representatives from different ministries and provinces. The NAC's mandate was to review the HIV/AIDS situation, inform the council of ministers, develop sector policy regarding AIDS prevention, ensure
cooperation between the various parties involved, and monitor and evaluate their effectiveness. The Provincial AIDS Council (PAC) and Provincial AIDS Secretariats (PAS) were then established in 1994. Members of the PAC and PAS are representatives of different provincial departments. PAC sets policy and PAS implements it.

In 1998, NAP and the National STD Center were merged to create the National Center for HIV/AIDS, Dermatology and STDs (NCHADS). NCHADS oversees implementation of MoH policies and provides technical support to other government agencies and national partners (UNAIDS Country Profile, Feb.2000:16). NCHADS also provides technical support to three units of Provincial AIDS Offices (PAOs): 1) Program Management, Evaluation and Research; 2) Multisectoral Unit, STD Control, STDs and Dermatology Clinic; and 3) AIDS Care and IEC.
Figure 5.3 NCHADS Administrative Structure

Source: UNAIDS Country Profile, October 1999.
A key issue has been lack of cooperation among the different units of the government, particularly between the health staff from the Ministry of Health and those from NCHADS. Although the central government's Ministry of Health and Provincial Health Departments have proven most effective in combating HIV/AIDS, most of the responsibility for doing so lies with NCHADS and the Provincial AIDS Office (PAO) (MoH October, 2000: 8).

In 1999, the NAC and NAS were replaced by the National AIDS Authority (NAA). All their functions and responsibilities were incorporated into the NAA. In 1999, the NAA developed a five-year plan, identifying the following priorities: 1) educating various groups in the population about HIV/AIDS; 2) establishing a program to promote 100% condom use; 3) ensuring access to prevention and care services; and 4) strengthening health information systems, including research (MoH October, 2000:6). In early 2000, the NAA shifted focus to include the following areas: 1) HIV/AIDS and STI Awareness and Education, including both Information, Education and Communication (IEC) and Outreach activities for high-risk groups; 2) STI services; 3) Blood Safety; 4) Preventing Mother-to-Child Transmission (PMTCT); 5) AIDS Care, including home-based
Figure 5.4 NAA Administrative Structure

Source: UNAIDS Country Profile of Cambodia, October 1999.
It should be pointed out that the Cambodian government probably would not have responded as aggressively to the HIV/AIDS epidemic if the UN had not been present in the country. Thanks to rapid action, Cambodia controlled the epidemic in a short time. At 2.2%, the current HIV prevalence rate is only 0.4% higher than in Thailand (NCHADS 2002). The government is also drafting a law to outlaw discrimination against people living with AIDS and ensure the privacy of those who take HIV tests (Cambodia Daily, 18 July, 2001). Modeled after Philippine law, it calls for jail time and fines those violating the rights of people infected with HIV.

Unfortunately, the government has put much less effort into supporting people already living with AIDS. Only two public hospitals care for AIDS patients, Calmette and Preah Norodom Sihanouk in Phnom Penh. Medicins Sans Frontieres France (MSF) provides technical and financial support to the latter. AIDS patients are housed with patients who have other infectious diseases. Provincial hospitals also take AIDS patients, but they do not provide treatment specifically for AIDS-related complications. Furthermore, there is no indication that the government is planning to provide anti-retroviral therapy. There is concern over the
misuse of AIDS drugs, which are widely available in most urban pharmacies in the country.

In 12 July 2001, the Chief of Mission for Medecins Sans Frontieres, Catherine Quillet, announced that a trial program to treat AIDS patients had been initiated in Cambodia (Cambodia Daily, 3 July 32001). When I talked to Dr. Francois Crabbe, a technical advisor to NCHADS two months after the announcement, he was not aware that the MoH had approved the trial. He noted, however, that if Medecins Sans Frontieres plans to provide AIDS therapy throughout the duration of AIDS patients' lives, the government would not object to such a trial program.

Currently, Medecins Sans Frontieres-France, Medecins Sans Frontieres-Belgium, Medecins Du Monde and Center of Hope provide ARV treatments to a limited number of people with AIDS in Phnom Penh, Takeo and Siem Reap (KHANA September 2003). These pilot programs are encouraged by the government (KHANA September 2003).

The first NGO set up to respond to the HIV/AIDS problem was the Khmer HIV/AIDS Alliance (KHANA). It is technically and financially supported by the International HIV/AIDS Alliance based in England. Other NGOs that have taken an active role in raising awareness of HIV/AIDS among
high-risk groups include WHO, World Vision, CARE International, various UN programs (e.g., UNAIDS, UNICEF, UNFPA, UNDP, and UNESCO), and the World Bank. In 1996, the World Bank was the first NGO to open an office in Cambodia, intending to coordinate the programs of these diverse multilateral agencies, provide technical backstopping, and help mobilize resources. In the beginning, these organizations were mainly involved in preventing HIV/AIDS through education and awareness, but the WHO was interested in setting up a care program for people with AIDS.

The Fonds d'Aide a la Cooperation (FAC) implemented HIV testing at the start of the epidemic. The FAC-funded Pasteur Institute opened the first voluntary testing center in Cambodia. From 1997 to 1999, FAC provided technical and financial support to five national testing centers. About 70% of its budget went to equipment, rehabilitation, and furniture (French Cooperation Report, January 2001:18). The other 30% was for staff training, reagents and other products, supervision, and quality control systems (French Cooperation Report, January 2001:18). Today, there are six national testing centers, two in Phnom Penh and one each in Battambang, Kampong Cham, Siem Reap, and Sihanoukville.
provinces. All testing is free of charge, anonymous, voluntary, and confidential.

The HIV/AIDS Coordination Committee (HACC) was set up to coordinate the various NGOs. It is supposed to promote cooperation, but despite its efforts, little exchange of information takes place between the government and NGOs. The only project on which the government and NGOs have collaborated is when NCHADS, WHO, and several other NGOs started a home care pilot project for AIDS patients in Phnom Penh in 1998. Home care is an alternative to hospital care; it is cheaper, more convenient, and less likely to expose patients to infection. Patients prefer to remain home if they can still receive professional care and many would rather die at home surrounded by family than go to a hospital. The pilot project was a success, so NGOs and the government established mobile health teams to provide support for people living at home with HIV/AIDS. They also developed guidelines for adult and childcare at home. More than twenty home care teams now operate within the capital. One is run by an international organization, while the others are overseen by local organizations with support from KHANA and World Vision. Home care teams are
being established in the provinces of Kampong Speu, Battambang, Banteay Meachey, and Kandal.

Local NGOs are also being established to help people with AIDS. People with HIV/AIDS are in charge of running some aspects of NGOs such as the Cambodian Organization of Persons with HIV/AIDS and Ponleu Chivit (Light of Life). Some local NGOs receive support from various sources such as the HIV/AIDS Alliance, bilateral agencies, and other international organizations. The Cambodian Organization for Persons with HIV/AIDS gets financial support from UNICEF. Other clubs and support groups have also been established. Religious organizations provide some of the most effective care, even though they usually accept only a few AIDS patients. The Missionary of Charity hospice outside of Phnom Penh can only house ten AIDS patients at a time. Maryknoll's hostel is similarly limited. Furthermore, most HIV/AIDS support services remain limited to urban centers with high population densities (e.g., Battambang, Kandal, Kampong Cham). Those living in remote areas still have to travel far distances to find medical care.

Traditional healers have become involved in the fight against HIV/AIDS. Traditional healers require AIDS
patients to live with them and consume medicinal teas prepared by the healer (see Chapter 8). Food and shelter are extra expenses, which makes traditional Khmer treatment very costly for the average AIDS patient. Some of the more sought-after healers charge as much as US$500 per treatment, prompting accusations by government officials that they are cheating their patients. The Minister of Health, Hong Sung Hout, asked skeptically how one traditional medicine could be used to treat a hundred different kinds of diseases (Cambodia Daily, March 14, 2001). In 2000, traditional healers in Kampong Cham province attempted to establish a formal organization to respond to such skepticism. They aim to maintain traditional healing methods and preserve the use of botanical medicines. At the time I was writing this dissertation, two traditional healers had decided to work with the local organization in hope that it would help provide them with a voice and credibility.

5.7 Cambodian Health Beliefs

In general, Cambodians believe that they can determine the causes of illnesses, but these causes are not isolated from religious beliefs and cultural knowledge. The
Cambodian health belief system is syncretic, combining Buddhist, animist, Ayurvedic, and biomedical traditions (Cheung & Spears 1995, Frye 1991, Sargent et al. 1984). Cambodians use both personalistic and naturalistic etiologies. Foster defines a personalistic medical system as "one in which disease is explained due to the active, purposeful intervention of an agent who may be human (a witch or sorcerer), nonhuman (a ghost, an ancestor, an evil spirit) or supernatural (a deity or other very powerful being)" (Foster 1998: 112). A personalistic component to a medical system can be recognized when illness is perceived as the result of intended action by some medium-humans such as witches, sorcerers, superhuman deities, or nonhumans with human characteristics. (Etkin 1997: 284). The ill person is a victim of their willful aggression or punishment.

Personalistic disease etiology is found in Theravada Buddhist and animist folk beliefs, which form the basis of Cambodian religion. Cambodian folk religion gives reasons for and means of coping with the incidental misfortunes of existence (Ebihara 1968: 442). Theravada Buddhist beliefs concerning the state of earthly existence and the

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14 Witches inherit their ability to do bad magic, whereas sorcerers acquire such knowledge and power.
continuous cycle of rebirth suggest that the nature of life is suffering. The alleviation of suffering depends on individual adherence to proper moral conduct. The accumulation of Buddhist merit may provide a better rebirth in the next life, but in the meanwhile there may be problems such as illness, unrequited love, or drought that need attention (Ebihara 1971: 442). Since an individual's present circumstances are the result of past life actions, some health conditions are considered the result of karmic destiny. In this case, illness is personalistic in that a person 'causes' his or her own sickness by making the wrong choices in the past.

Most of the time, however, ghosts, spirits, or sorcery are blamed for ailments. In animist folk tradition, the physical body is endowed with numerous spirits and ghosts and spirits permeate the surrounding environment. They may cause minor, serious, or chronic illness to people in the area, especially those who live near a forest. Spirit possession can result if: 1) a person's own spirits are weak; 2) a person has forgotten to make an offering; or 3) a person has violated a taboo (Price and Bith 1993). Ghosts or angry spirits can cause fatigue, anxiety, eating disorders, weight loss, insomnia, chronic headaches, body
aches, or any other kinds of pain not associated with a particular illness.

If the ghost, ancestral spirit, or person who cursed the patient can be identified, then it is relatively easy to cure the patient. It is more difficult to find the appropriate therapy when the precise source remains unknown. Specialists then diagnose the disease and prescribe therapy by a process of elimination.

In contrast to a personalistic system, naturalistic medical beliefs define illness in impersonal and systemic terms (Etkin 1997: 284). Disease is thought to derive from natural forces or conditions (mae-rook in Cambodian) such as heat, wind, cold, dampness, upset in the balance of the basic bodily elements, or even microbes (Foster 1998: 112). Cambodians believe that an illness caused by a spirit or ghost is more difficult to treat than illness caused by such physical agents.

In the Cambodian system, good health is described as an equilibrium of bodily states, a concept derived mainly from Ayurvedic humoral (dosha) theory. Humoral models are generally expressed in binary oppositions such as hot-cold, sweet-sour, and wet-dry (Etkin 1997: 284). Health requires maintaining the hot-cold balance appropriate to the age and
condition of a person in his or her environment (Foster 1998: 112; Sargent et al. 1984:7). Illness can be caused by upset to this balance or may itself cause the loss of equilibrium (Foster 1998: 112). Treatment may involve a dietary regime designed to bring the body back into equilibrium (Sargent et al. 1984:7). For example, an excess of heat results in a 'hot' disease that must be treated with 'cold' food and medicine (Etkin 1997: 284). 'Hot' and 'cold' do not refer to temperature in this case, but rather to the symbolic power of a condition or substance. For instance, Western pharmaceuticals are said to have hot properties, so are therefore effective for treating cold conditions. Neither the personalistic nor naturalistic etiology dominates Cambodian health beliefs. Many ailments are understood to result from combining two different kinds of causative factors. Indeed, the dichotomy between personalistic and naturalistic is artificial; Cambodians unify both in conceiving of the healthy body (Price & Bith 1993).

5.8 Social Issues Unique to Cambodia

Cambodia shares many of the problems of other developing countries, including poverty, unemployment,
illiteracy, prostitution, rural-urban migration, and recent civil war. Cambodia's recent political history presents some unique problems, however. Cambodia was isolated from the international community prior to the advent of the HIV/AIDS epidemic. At the same time, the previously sustainable agricultural system broke down and almost a third of the population was killed in less than three years (Chandler 1996). These factors have contributed to the way HIV/AIDS has affected the Cambodian population.

Before the war in the 1960s, rural families were able to sustain a living farming their own land and working for other families as needed (Kiernan 1982). The Pol Pot regime forced people off their land to live in commune-like compounds (Kiernan 1985). After the Pol Pot regime came to an end, Cambodians snatched up land on a first-come basis, since the real owners were no longer in residence (Shawcross 1984). Those who were in power locally or regionally ended up claiming most of the land, despite governmental policies intended to protect the poor from losing their land (Country Report 2001:14, Economist Intelligence Unit). Today, the elite own most of the land,
and there is a great disparity between the economic situation of rural farmers and the elite class (Than 2001).

Whereas women previously could work on neighboring farms to bring in an income, they are now being forced out of the rural labor force altogether. Combined with the fact that many more men than women were killed by the Khmer Rouge, this has resulted in a wide gender imbalance in the work force. As yet there has been no systematic study to assess the numbers of women in various occupations, but urban women do occupy a variety of traditional occupations other than prostitution. For example, women rather than men usually work in the markets as vendors. Selling and buying goods is a traditional responsibility of women in the family. Although men are perceived as decision-makers and negotiators, women actually control family finances and conduct most small trade transactions. It is therefore difficult to say how much loss of land has contributed to increased prostitution in Cambodia.

A more significant factor is probably the period of self-indulgence that followed a long period of deprivation, isolation, and ignorance. Most educated and upper class citizens and foreigners in Cambodia were executed during the Pol Pot regime. Contact with foreigners and travel
abroad was forbidden. As a result, the country was left with an emotionally traumatized population with no educated Cambodians left to run the country. When the three years under the Khmer Rouge came to an end, Vietnam colonized the country, but perpetuated a similar isolationist policy for another decade. Cambodians were still forbidden to travel or train overseas. There was no infrastructure and no health system. Since so much knowledge had been lost and there was no new information filtering in, Cambodians before the advent of UNTAC were completely naive about the new disease (AIDS) that had been afflicting other nations for over a decade.

The first case of HIV was recorded in Cambodia in 1991, which also marked the first year that foreign aid became available (Tia et al. 1998). The presence of UNTAC, as described in chapter 4, overwhelmed the Cambodian society. A staff of 50,000 foreigners appeared overnight (Riddle 1996). Cambodians employed by UNTAC received huge sums of money in a short time (Riddle 1996). Many people had money for the first time in their lives and could buy whatever they wanted. By 1992, material goods were being imported to meet the high demand. Tourists also started coming to Cambodia (IMF Report 1997:6). New international
and non-governmental organizations began to establish bases in Phnom Penh, employing even more Cambodians (Jennar 1998). By 1999, there was one IO or NGO per every 3000 people in Cambodia (CAMDEV List 1999). The Cambodian government was preoccupied with setting up policies and programs to deal with foreign investment, landownership, and new entrepreneurship, and was unable to control foreign aid (Haas 1995; Than 2001: 481). No system was set up to help Cambodians deal with the rapid pace of change.

The period of repression was followed by a period of indulgence, perhaps as compensation for so much time lost. Self-destructive practices such as alcohol use and prostitution increased. Extramarital sex, particularly commercial sex, was not a new phenomenon, but Cambodians were suddenly allowed a freedom that they had been denied for three decades. Brothels in Phnom Penh mushroomed. Imported sex workers from throughout the Mekong region became a normal part of the local sex culture. The rate of HIV/AIDS increased exponentially in a very short period of time.

The government has not been able to mount an adequate response to the spread of HIV/AIDS. It recently closed all the brothels in Phnom Penh, but the sex trade continues to
flourish in other establishments such as beauty salons, bath houses, and karaoke bars (Roger et al. 2002). This makes it difficult to monitor the prevalence rates among high-risk groups. The HIV/AIDS epidemic lingers on, although the government believes it has done its part to combat the problem.

Cambodian society continues to operate on a system of cronyism among the elite Khmer network, ensuring that the 'haves' continue to control resources. Poverty is chronic and widespread. The educational system is improving, but slowly. Education is also improving, but at a pace too slow to keep up with the needs of the people. Employment opportunities remain limited. Young, uneducated, or unskilled women remain trapped in a system where sex work is often the only means to gain an income. These on-going problems greatly limit the choices Cambodians are able to make to improve their lives.

5.9 Chapter Summary

This chapter focused on the history of the health care system in Cambodia from the Angkor period to present day. Social issues related to the spread of HIV/AIDS were discussed, along with responses by various interest groups, including the government, local and international non-
governmental organizations, and traditional healers.
Cambodia's recent history of land loss, isolation, and sudden freedom has also contributed to the HIV/AIDS epidemic.

The next chapter outlines the study site, including the physical characteristics of Sdaov village and the demographics of its population. It discusses some illnesses affecting Sdaov villagers, as well as change that they are inevitably facing.
CHAPTER 6: SDAOV VILLAGE

6.1 Introduction

This chapter describes a typical Cambodian village, Sdaov, the field site for this research. Its physical configuration, residential units, subsistence patterns, demographics, daily activity patterns, and health care practices are summarized to give a deeper understanding of rural life in contemporary Cambodia, and change that they are facing.

6.2 Selection of the Study Site

Several criteria determined the choice of Sdaov as a study site. First, conducting research in the northern provinces was ruled out because of safety concerns. The north had until recently been under the control of the Khmer Rouge. Second, it was necessary to avoid being perceived as partisan. Some villages would not accept strangers who were suspected of belonging to the wrong political party. Third, since this research focuses specifically on what the Khmer call "mango illness," a cultural construct that covers both STDs and HIV/AIDS, the field site had to be located in a village in which people were actively dealing with the HIV/AIDS epidemic. This is
most likely in a province with a high population. The province chosen, Kampong Cham, includes 1.6 million people, the highest population in the country. Two neighboring provinces have the next highest populations. Sex workers have been identified by the Ministry of Health as a high-risk group in Kampong Cham.

Another criterion was that the village be typical of Cambodia in depending upon wet rice cultivation and other rural economic activities for subsistence. It should have access to a waterway, since villages that are located deep in the countryside and away from regular water sources tend to be quite resource-poor. Finally, the village should be close enough to Phnom Penh to allow frequent contact, since this is likely to affect the rate of HIV/AIDS. Kandal village was first choice because of its close proximity to Phnom Penh, but local authorities refused permission to conduct research there.\(^{15}\) The field site chosen, Sdaov, is located on the Mekong River a half-day from Phnom Penh by motorcycle.

\(^{15}\) Administratively, a village chief is responsible for all official activities conducted within a village, particularly during election periods. Village chiefs can give permission to conduct a study or implement an NGO project. If a village chief does not have the authority to make a decision, permission is sought next from the commune chief and then provincial provincials.
6.3 Physical Configuration of the Village

Cambodia is subdivided into provinces (*khet*), districts (*srok*), communes (*khum*), and villages (*phum*). Sdaov is a small village located in Sdaov Commune within the Korng Meas District of Kampong Cham Province. Kampong Cham is surrounded by six other provinces: Kampang Chhnang (to the east), Takeo, Svay Rieng, and Prey Veng (to the south) and Kampong Thom and Kratie (to the north). Kampong Cham also shares a border with Vietnam. Sdaov is neither remote nor inaccessible. Some Sdaov villagers commute back and forth to Phnom Penh on a daily basis. Small trucks and oxcarts bring products from the city every day.

Villagers divide Sdaov into two parts, lower Sdaov, considered to have full village status, and upper Sdaov, a village segment. The village chief of lower Sdaov is also in charge of upper Sdaov, but there appears to be little distinction between residents of the two subdivisions. Residents of both villages interact with one another on a daily basis. The division is mainly for administrative purposes since upper Sdaov village is small to be considered its own village. Fieldwork was conducted in lower Sdaov. For simplification, lower Sdaov will be referred to as Sdaov village, since the inhabitants did not
themselves refer to their village as 'lower'. They called their village Sdaov, but referred to the other village as 'upper' Sdaov.
FIGURE 6.1: LOCATION OF STUDY VILLAGE
Source: USAID/Cambodia Report 2001
6.3.1 Residential Demographics

In 1999, the total population size of the village was approximately 816, of which 404 were female (see Table 6.1). The residents belong to 163 households, divided into 10 teams. The average number of children per household is 3.5. One family had only 1 child, while the largest had 8.

Table 6.1: Village Demographics

<table>
<thead>
<tr>
<th>Age</th>
<th>Total Population</th>
<th>Total Number of Females</th>
<th>Percent of female pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 5 years</td>
<td>195</td>
<td>45</td>
<td>23%</td>
</tr>
<tr>
<td>6 to 17 years</td>
<td>239</td>
<td>115</td>
<td>48%</td>
</tr>
<tr>
<td>18 to 64 years</td>
<td>315</td>
<td>216</td>
<td>69%</td>
</tr>
<tr>
<td>Over 65 years</td>
<td>55</td>
<td>28</td>
<td>51%</td>
</tr>
<tr>
<td>Total</td>
<td>804</td>
<td>614</td>
<td>Ave. 48%</td>
</tr>
</tbody>
</table>

Kampong Cham, Korng Meas District Health Center 2000

As is true throughout Cambodia, there are more females than males among adults over 18 years old. Out of 135 married women, only 2 were 'widowed'. The word 'poas-mai', meaning 'absent partner', refers to any family with a single parent, so there is no linguistic distinction between divorce and widowhood. It is possible the 'widowed' women were actually divorced, but the other
villagers did not seem to know what had really happened to their spouses.

The total area in the village is about 56 hectares, with 55 hectares available for farmland. Villagers share 4 fishponds. A main road cuts across the village, intersected by a small dirt road. At the end of the main road is a primary (first to sixth grade) public school. A Buddhist temple is located next to the school, where the main road intersects the dirt road. Across from the temple is a small village market where fish, fresh vegetables, and meat are sold daily. Occasionally, fermented palm wine is sold in the market, usually in the afternoon when older men gather to talk over the daily news. A small multi-purpose shop nearby sells produce, household cleansers, over-the-counter Western drugs, soft drinks, and local as well as imported beer. Another small shop sells traditional Khmer medicine and medicinal alcohol. Another shop re-charges old car and motorcycle batteries that villagers use in their homes to operate their electric appliances.

Residential houses are located along both sides of the two roads, but villagers prefer to build homes along the dirt road. This is unusual in Cambodia, where most homes are located along main roads. In Sdaov, however, the dirt
road provides better access to the Mekong River. Most villagers fish to supplement their income. In addition, the land around the Mekong is common property, used on a first-come, first-served basis. Houses that are closest to the river have better access to irrigable land and villagers plant crops along the Mekong River during the season when the water recedes.

Some houses are situated only a few feet away from each other, while others are relatively isolated. Most residential units are separated by a small chamkar (multi-crop field). Boundaries are maintained with fences made out of tree branches and wire and framed by kapok trees. Scattered among the dwellings are other trees and herb and vegetable gardens.

Sdaov is similar to Svay village, where Ebihara did her fieldwork in the late 1950s. Even the materials that are used to build houses today are similar to those described by Ebihara (1968). They are made from materials that are easily available in the village, such as grass, palm leaves, bamboo, or concrete piles. Sixty-seven of the houses have ceramic tile roofs, 46 use zinc tiles, and 50 are roofed with grass and palm leaves.
Houses are usually rectangular and elevated on top of wooden or concrete poles that vary in height from 6 to 8 feet. House interiors include a large room partitioned by hanging cloth, thatch, or wood to give some privacy at night. Houses usually include an indoor kitchen area, but most people cook outside, beneath or beside the house. Most homes contain few belongings. A trunk or armoire is used to store clothes, mats are unrolled for sleeping or to seat guests, and there is usually a small altar before a picture of Buddha. Miscellaneous household goods include kerosene lamps and kitchen utensils. Sometimes pictures of Cambodian royalty, King Sihanouk and Queen Monineath, are hung on the walls. Forty-eight households own televisions. Farm implements include 24 plows, 16 oxcarts, 4 rice mills, and 24 harrows.

6.4 Subsistence

Subsistence primarily depends upon wet rice farming. Each family owns or leases a plot of land (Mabbett & Chandler 1995: 140). Sdaov residents today own less land less than the average Cambodian did before the 1920s (Kiernan & Boua 1982:4). In the 1920s, 80% of Cambodians owned about 5 hectares of land (Kiernan & Boua 1982:4). By
the 1950s, fourth-fifths of rural Cambodians owned less than 2 hectares (Kiernan & Boua 1982:4). Currently, the average family in Sdaov owns a third of a hectare. However, it requires a full hectare to supply enough rice for a family of three or four (Devert 1960: 370). Rural households therefore undertake diverse economic activities to sustain themselves. Villages along the Mekong River have better soil than those away from the river, so Sdaov villagers cultivate multi-crop fields called *chamkar* in which they raise cash crops such as banana blossoms, green papayas, sugarcane, Chinese broccoli, and lettuce. Other vegetables and herbs are grown in the common-use land along the river, including jackfruit, sugar palm, betel, bananas, lemon grass, bell pepper, Thai basil, turmeric, yams, potatoes, galanga, ginger, cucumbers, squash, eggplant, watermelons, and chili. They also raise pigs, ducks, and chickens. Fruit trees such as coconut, guava, tamarind, orange, mango, bamboo and kapok trees grow around residential units or along property lines. Bitter melon, ivy gourd, and winter melon vines also grow in the village. The leaves of ivy gourd and bitter melon are eaten or sold in the village market.
As noted earlier, fishing provides additional income. Villagers complain that fishing was better before the Pol Pot regime. The size of fish they catch has decreased and they have quarrels with local authorities over the right to fish in the river. Some parts of the Mekong River are said to belong to top government officials. Villagers who want to fish in these forbidden areas have to pay bribes to do so. Their catch is either sold in village or provincial markets or made into prahok (fermented fish paste). Prahok is one of the main ingredients in Cambodian cuisine. It is an important part of the local economy, since people from other provinces or the city travel to Sdaov to buy its prahok. Almost all Sdaov villagers manufacture it during fishing season. The amount of fermented fish paste produced by a family depends on the family's primary occupation, resources (e.g., fishing nets, size of boat, family size), and experience in making prahok. One family that lives close to the Mekong River specializes in prahok. The family makes deals prior to fishing season with other fishermen to supply them with fish. Both sexes are involved in prahok production, from fishing to gutting, to soaking, storing, and fermenting the fish.
Of the two schoolteachers in the village, one sells Western pharmaceuticals to supplement his income. The wife of the other teacher plants vegetables and fruit to sell in the village market because his income is insufficient to support the family. A few families grow a type of grass used to weave baskets and mats to sell in Phnom Penh. One man grows rice in the dry season in the marshlands. Growing dry rice still requires irrigation, so this is difficult, but it enables him to obtain extra rice in an otherwise lean season.

One couple works irregularly in Phnom Penh as construction workers. When the husband works he is paid about 8,000 riels (a little over US$2) per day. His wife earns less, about 5,000 riels (about US$1.50) per day. During the period of this fieldwork, the couple spent more time looking for work than actually working. They occasionally had to lease or farm their field to supplement their income.

6.5 Daily Activities

At the first call of a rooster, a grandmother builds a fire underneath the house and set a pot filled with water and rice to boil. The rising steam wakes up the rest of the
family. They roll up their mats and change into work clothes. One by one, they climb down the stairs to have hot tea and rice porridge. She then packs lunch for rest of the family as the first ray of light appears on the horizon. When the sun provides enough light to see but the air is still cool, the family leaves to walk to the rice fields. Grandmother stays behind to feed the pigs and chickens while the children who are not attending school help with house chores. Older children collect water from the river to irrigate vegetables while younger ones walk ducks to the pond and guard them from running wild in the rice field. Thus begins a typical Sdaov day.

How far the family has to walk to the fields depends on whether they are cultivating common-use marshland near the river or own land closer to the village. The village chief and his family have a small field within the village bounds. A few families work in their own back yards growing betel, peppers, herbs, and other crops to sell at the provincial market. One woman who sold produce in the village market made enough money to support the entire family. After a family finishes farming their own land, they usually go to the marshland areas to clear weeds and shrubs and grow corn and peppers. The marshlands are
about an hour's walk from the village. During fishing season, almost all the families participate in fishing activities, including cleaning fish, supplying fishing nets and rods to fishermen, or making pottery to store the fish for fermenting.

6.6 Overall Health

I have categorized illnesses in Sdaov as either 'emic' or 'etic'. 'Emic' illnesses mainly exist in the Cambodian medical system, while 'etic' illnesses fit biomedical/clinical definitions. In Sdaov, two categories of illness largely match biomedical/clinical definitions: 1) common ailments; 2) infectious/communicable diseases. Common ailments are considered more a nuisance than life threatening. Almost everyone from Sdaov suffers from common ailments such as fever, coughing, chill, indigestion, headache, numbness, nausea, tense or achy muscles, throat irritation, or dysentery. Other minor illnesses included stomachache, broken legs, pink eye, runny nose, sinus infection, exhaustion, swollen limbs, thinness, flu, or itchiness. Villagers describe hunger as an illness. A few individuals complained of abdominal pain and bleeding nose. One man had a blind right eye. One
woman complained of hunger. Another older man stated that he had a swollen penis, but he emphasized that his condition was different from those who suffered from sexually transmitted infections.

Infectious/communicable, or other diseases include typhoid, cholera, measles, tuberculosis, malaria, pneumonia, acute respiratory infection (ARI), and life-threatening fevers. A few individuals had been diagnosed with uncommon diseases affecting the village and were being monitored regularly by government medical workers. An older woman suffered from stomach cancer. She had been diagnosed by a hospital in Phnom Penh, but could not remember where she had gone for treatment. A medical doctor from the government health center confirmed her diagnosis. Another person had tuberculosis and two individuals had hemorrhagic dengue and were hospitalized in the city. One small boy had epilepsy and another young boy had asthma.

6.7 Change and Continuity

One main issue affecting village life is employment opportunities for young unmarried women in the city. At the time when this study was conducted, young unmarried women
preferred to stay in the village to help the family. Almost two years later, some young women expressed an interest in seeking work in the city and planned to leave the village. Living in the city also means understanding and recognizing fashion and other Western materials. Proof is seen mostly with migrants returning home with new clothes and other material goods. There is a major contrast between rural and urban life. Contemporary urban life represents Cambodian modernity that forms political and economic organization, particularly that associates with industrial capitalism with such features as an economy oriented toward production for commodity markets, reliant on complex technologies, and industrial labor. At the same time, for villagers, urban life symbolizes diseases, deaths, and other disasters that are bound to happen.

While the city can offer villagers the opportunity for employment, it also means that it is a frightening place for those who may not be able to adapt to the new environment. Returnees, particularly women whose reputation may be in question for involving in sex work, talked of city life as being glamorous. The contradiction in their descriptions often lied in their physical appearance. Most
returned home because they were too ill to work. Some might have contracted HIV and would eventually die of AIDS.

Since 1992, after the National Elections, the demand of female workers from garment factories was very high. Parents were willing to go against the tradition with the belief that their daughters would bring home money to support the family. This phenomenon represents a sharp departure from established Khmer patterns of feminine behavior and notions of appropriate activities for women, especially unmarried daughters. Traditionally, young unmarried daughters were forbidden to travel or live alone in the city. Currently, due to the demand from factories for young female workers, female migrants made up the majority of garment factory labor force. Consequently, as women are leaving their village to seek employment in the city, they and their families confront changing understandings of gendered roles and traditional values.

In the traditional role in Cambodia, young women would be expected to provide for the family in time of need, particularly when there is a sickness in the family. Historically, women's mobility has been more restricted than that of men. For example, women worked for someone else in the village to earn money to pay for expenses. They
would not leave home to seek employment outside of the village. To do so would risk losing the family’s face (e.g., reputation). Toward the end of this fieldwork, more young unmarried women were recruited from the village to work in the garment factories in Phnom Penh. It is this type of change that causes great concerns for older parents who are left behind in the village.

In terms of crime rates in the village, there is no current data. One interesting problem is truancy. Students are cutting classes to play video games at the only arcade in the village. Some parents turn to the village temple to rectify the situation by forcing their sons to become monks during their teen years. Arranged marriage is slowly disappearing because young adults are moving away from their traditional spaces to new common ground such as school or training center. They would meet in these new spaces, which allow them to interact socially.

Most villagers realize that their traditional way of life is inevitably changing. There are more material goods being imported such as television, cameras, arcades and karaoke. At the same time, more young people are leaving to seek work or pursue higher education in the city. Sdaov village is an example of a typical Cambodian village that
is forced to accommodate change as Cambodia moves toward progress, growth, and advancement, and perhaps slowly becoming a part of the global economy. It is Cambodian modernity that affects village life.

6.8 Chapter Summary

This chapter presented general characteristics of Sdaov village, the site of this research project. The demographics and residential configuration of the village were described, along with daily subsistence activities and a brief picture of health in the village. This chapter also examined changes that occurred in the village as a result of external influence.

The following chapter summarizes the methodology used in this research.
CHAPTER 7: RESEARCH METHODOLOGY

7.1 Introduction

Methods used during the course of fieldwork included both unstructured and structured interviews, participant-observation, and focus group discussions. Questionnaires used in interviews were revised in the field to reflect changing circumstances and an expanding knowledge base.

Interviews were conducted among residents in Sdaov village as well as with people working for government health programs and international NGOs. AIDS patients, sex workers, and traditional healers were among the people interviewed. Care was taken throughout the research to maintain confidentiality and show sensitivity, particularly in interactions with AIDS patients. Altogether, 338 people in 5 provinces were interviewed between 1998 and 2001.

Although the major portion of fieldwork took place from November 1998 to September 2001, two earlier trips to Cambodia inform this study. In 1997, I spent three months in Battambang, Pursat, Siem Reap, and Phnom Penh assessing health circumstances in Cambodia. At that time, I determined some of the problems that could be explored further. I also contacted local authorities to ask for
permission to conduct research and identified traditional healers who were still alive after the Pol Pot regime. No formal interviews were conducted during this trip.

In 1998, I was hired for the summer by an international organization (IO), Reproductive and Child Health Alliance, to assess health facilities in the provinces of Pursat, Siem Reap, and Kampot. As a result of this project, I established contact with local and expatriate health professionals who later assisted during field research.

Between 1998 and 2001, I lived in Cambodia and worked for the Center for Advanced Study in Phnom Penh, a non-profit research NGO. I began collecting data for this dissertation while working there by interviewing AIDS patients, sex workers, and health professionals in Battambang, Pursat, Banteay Meanchey, Kampong Cham, and Phnom Penh. From May 1999 to September 2000, I collected data in Sdaov village, where I also participated in social and religious events. Sdaov villagers represent the experiences of the majority of Cambodians who live in rural areas.
7.2 Unstructured Interviews

For these interviews, 205 people were selected for in-depth, unstructured interviews (Pelto and Pelto 1996: 309). These people were chosen based on snowball sampling (Bernard & Bernard 1995: 73, 94, 97-98). Snowball sampling was a quick way to identify key individuals in the health care field, including those who needed health care and those who were familiar with the restructuring of the health care system. I interviewed 83 adults and 3 children living with HIV/AIDS. The children were with their parents who acquired the virus from their parents. People working to care for those with HIV/AIDS or prevent the spread of HIV in Cambodia included 25 governmental officials, 90 NGO personnel, and 4 nuns and monks.

Table 7.1: Unstructured Interviews (1998-2001)

<table>
<thead>
<tr>
<th>Category of People</th>
<th>N= 205</th>
<th>Age Range (years)</th>
<th># Female</th>
<th>% Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with HIV/AIDS</td>
<td>86</td>
<td>25 to 55</td>
<td>43</td>
<td>50%</td>
</tr>
<tr>
<td>NGO Personnel</td>
<td>90</td>
<td>25 to 55</td>
<td>26</td>
<td>29%</td>
</tr>
<tr>
<td>Government Officials</td>
<td>25</td>
<td>25 to 55</td>
<td>13</td>
<td>52%</td>
</tr>
<tr>
<td>Buddhist Nuns/Monks</td>
<td>4</td>
<td>Over 50</td>
<td>3</td>
<td>75%</td>
</tr>
</tbody>
</table>

In general, Cambodians respond vaguely to questions about age. Being older (over 50) is positively valued as
implying wisdom, so people tend to reply to demographic questions with answers such as "I am almost 50" or "I am in my late 40s." Therefore, I estimated ages within a range, as shown in Table 7.1 above. Overall, about half the respondents were female. The exception are NGO personnel. These often come from international organizations dominated by men.

All government officials interviewed were mostly based in Phnom Penh. Representatives of the following departments and ministries were interviewed: National Blood Transfusion Center, National AIDS Authority (NAA), Ministry of Social Affairs, Labor, Vocational Training and Youth Rehabilitation (MoMSALVY), National Centers for HIV/AIDS, Dermatology and STDs (NCHADS), Fonds d'Aide a la Cooperation (FAC), Ministry of Education, Provincial Department of Women's and Veteran's Affairs, Provincial AIDS Office (PAO) Battambang, Bantey Meanchey Police Commission, (PAC) Third Provincial Governor, and PAO Bantey Meanchey. Interviews with government officials included medical personnel from public hospitals such as Sihanouk, Calmette, Municipal, Provincial, Thmar Puok, Mongkol Borei, and Battambang Military and health centers in Battambang and Poipet.
Representatives of international and non-governmental organizations constituted the largest group of interviewees. International organizations included WHO, CARE International/Cambodia, United Nations Program on HIV/AIDS (UNAIDS), Missionaries of Charity, Maryknoll, Khmer HIV/AIDS Alliance (KHANA), Family Health International (FHI/Impact), Medecins Sans Frontieres (MSF)-France, Quaker Service Australia (QSA), Servants' to Asia's Urban Poor-Cambodia (SERVANTS), United Nations Children's Fund (UNICEF), Social Environment Agriculture Development Organization (SEADO), Catholic Relief Services (CRS), Pharmaciens Sans Frontieres (PSF), Social Service of Cambodia (SSC), Goutte d'eau, Health Net International, MSF-Holland/Belgium/Sweden, Norwegian AID, International Committee of the Red Cross (ICRC), World vision International (WVI), Pasteur Institute, Japanese Hospital, Medicam, World Bank, European Union (EU), and Medecins Sans Frontieres (MSF). Local organizations include: Women Organization for Economy and Nursing (WOMEN), Women’s Room, Health Teams 1-8, Indradevi Association, Reproductive Health Association of Cambodia (RHAC), Catholic Office for Emergency Relief and Refugees (COERR), Squatter and Urban Poor Association (SUPF), Cambodian Women’s Development
Association (CWDA), Homeland, Chivit Thmey, Khmer Buddhist Association, Cambodian Families development Services (CFDS), Operations Enfants de Battambang, Cambodian Association for Assistance to Families and Widows (CAAFW), Action Against Hunger, STD Clinic Poipet, Khmer Buddhism for Development, Mith Samlanh/Friends, Cambodian Children and Handicap Development Organization, Nuns and monks from Wat Norea and Wat Kampheng were also interviewed.

7.2.1 Government Officials

A total of 25 government health officials were interviewed. Permission was granted to take notes during each interview. A former mentor (Dr. William Collins), who had left the U.S. to work in Cambodia referred me to government officials from Battambang, Pursat, and Phnom Penh who were in charge of health care. These officials then referred me to other key government personnel for interviews. These interviews took place between May 1998 and September 1999. The average interview lasted about one and a half hours. The objective of these initial interviews was an overall assessment of Cambodia's health needs and health care system. Unstructured questions aimed
at eliciting general information about accessibility of health care services, including availability of pharmaceuticals, health care expense, training, and technical and financial support. Given the reconnaissance nature of these interviews, they were not directed at collecting specific data on STDs and HIV/AIDS.

7.2.2 NGO Workers

A total of 90 NGO workers were interviewed between May 1998 and November 2000. Interviews took place in Phnom Penh, Pursat, Battambang, and Banteay Meanchey, usually during lunch break or after work. Permission was granted to take notes during each interview. Each interview lasted about one and a half hours.

The primary objective was to understand how both the governmental and non-governmental sectors have dealt with the rapid increase of the HIV/AIDS in Cambodia. Given this narrow focus, individuals were selected from a wide range of health professionals, including personnel from international organizations and local NGOs, staff from various hospices, hostels, and youth shelters, and workers at various religious organizations that provide services to people with HIV/AIDS. General questions included:
• Do you have a support system for people living with HIV/AIDS?
• What is the immediate plan for these people?
• What are the long-term goals?
• What services are available for them?
• Do you need technical assistance? What kind?
• How do you go about getting technical assistance?
• Do you depend solely on international technical assistance?
• What criteria do you use in selecting patients to work with?
• How many patients or people living with HIV/AIDS do you serve per month or per year?
• Do you plan to expand your services, particularly by providing shelters to accommodate AIDS patients who reside in Phnom Penh?
• What are your funding sources?
• Do you explore local/indigenous resources?
• How are you going to deal with the overwhelming need for health care services, considering the limited resources of Cambodia?

For workers in hospices and shelters, further questions were directed at admissions processes and patient recovery, since only a few people with AIDS are usually admitted.

These questions included:

• What is your approach to treating patients?
• Do you have adequate support system for these patients?
• Do you make referrals?
• What kinds of policies or guidelines do you have for patients?
• If patients show signs of recovery, do you send them home?
• What is your policy with regard to those patients who recover, but get sick again?
• Do you readmit them?
• Do you refer them to other agencies?
• Do you allow patients to date each other?
• Do you allow them to leave the compound and interact with the community?
• How do you deal with patients who die?
• Do you contact their family?
• Do you provide funeral services?
• Do you contribute financially to funeral services?

These questions were drafted in advance and were used to guide the interview.

7.2.3 People Living With HIV/AIDS

In total, 144 people living with HIV/AIDS (Table 7.2) were interviewed throughout the course of fieldwork between 1999 and 2001. These people were selected through snowball sampling, based on recommendations from NGO and government workers. Interviewees are grouped in Table 7.2 according to occupation, except in the case of patients living in hospice. Age ranges reflect the responses of interviewees in each group.

<table>
<thead>
<tr>
<th>Occupations</th>
<th>N=86</th>
<th>Age Range (years)</th>
<th>#Females</th>
<th>% Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Patients</td>
<td>10</td>
<td>23 to 50</td>
<td>5</td>
<td>50%</td>
</tr>
<tr>
<td>Government</td>
<td>38</td>
<td>23 to 50</td>
<td>14</td>
<td>37%</td>
</tr>
<tr>
<td>Gardeners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>3</td>
<td>Under 10</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Sex Workers</td>
<td>30</td>
<td>18 to 31</td>
<td>30</td>
<td>100%</td>
</tr>
<tr>
<td>Head of Household</td>
<td>5</td>
<td>30 to 40</td>
<td>5</td>
<td>100%</td>
</tr>
</tbody>
</table>
The approach used for interviewing people with HIV/AIDS was a little different than the standard one to two hour long interview of government and non-government personnel. Rather, I first interviewed people briefly if they had enough energy to answer questions. Then I spent time observing their lives, often simply sitting with them watching mango trees grow or helping them water the garden. Often I listened as they told me whatever was on their minds or answered questions they asked me. The objective was to understand what was happening inside the minds of the patients, their perceptions of life, their knowledge, attitudes, and beliefs about AIDS, and what they feel and need on a day-to-day basis. It is difficult to describe encounters with people with HIV/AIDS. I became something other than an anthropologist whose primary purpose was to elicit research data. A truer description would be a student trying to understand a vulnerable group of people.

Interview venues were chosen based on recommendations from NGO workers. The first place was a hospice located about 40 minutes by car Phnom Penh. The hospice was situated in the middle of a rice field and had a garden filled with vegetables and flowers. It was divided into two wards, one for TB patients and the second housing AIDS
patients. The AIDS ward was located at the back of the property. TB and AIDS patients were not allowed to visit each other due to fear of infection. Likewise, I was told to keep my distance from the AIDS patients I interviewed. In reality, the close proximity of the beds and daily interactions made this difficult. Since most hospice patients have full-blown AIDS, they were too sick to answer questions for more than five minutes at a time. In-depth interviews were impossible with this group, although I visited many of the patients repeatedly.

Another group of people living with AIDS were gardeners who worked for the government and their family members who had tested positive for HIV. Most of the gardeners had been sex workers, truck drivers, or motorcycle taxi drivers. They became gardeners after contracting HIV. It was a government program to keep HIV positive people employed. They recruited each other; it was one of the means to create a support system among themselves. Another group included five women whose husbands had died of AIDS. Two of the women had children who were also infected through breast-feeding and/or giving birth. They had been recruited to speak on behalf of
people living with HIV/AIDS by a local NGO that provided home care service.

Generally, the questions asked of these groups included:

- What are your views about the HIV/AIDS epidemic?
- How do you view your present situation?
- What are your plans for the immediate future?
- If you had choices, what would you like to do in life?
- Do you share your experiences with the community? Or with your family? Or with your close friends? Or other loved ones?
- Are you embarrassed for being sick?
- Are you angry with your partner?
- Do you have a support system?

I also interviewed twenty HIV-positive female sex workers from brothels in Tuol Kork, a red light district in the northern section of Phnom Penh. The district is also known as Kilometer 11 or Svay Pak, and is frequented by expatriates and tourists. Questions directed towards this group included:

- How long have you been involved in sex work?
- What is your perception about sex work?
- How do you feel about the owner of your brothel?
- How did you learn about this brothel?
- Do you make enough money to support yourself?
- Do you send money to your family?
- Do you miss your family?
- Do you go home to visit your family?
- How often do you visit your family?
- Do you tell your family about your work?
- What do you say to them?
- Do you have other plans for yourself in the near future?
- What do you do for fun when you are not working?
- Do you have friends?
- Are you married?
- Do you have children?
- Do you have a boyfriend, husband, or lover?
- Is there anything else you would like to share with me?

7.3 Structured Interviews

Three groups of people were selected for structured interviews: government officials (N=25 people), traditional healers (N=13), and Sdaov villagers (N=at least 120) (see Table 7.1. The first group was scattered throughout the country. Healers came from the provinces of Kampong Cham, Battambang, Bantey Meanchey, and Poipet. The last group was all residents of Sdaov village (see Chapter 5).

Structured interviews were conducted between November 1999 and September 2000. Questions were developed and tested prior to interviews (Bernard 1994: 210).

7.3.1 Government Officials

Government officials from the Ministry of Health and other related government units were interviewed between May 2000 to September 2000. They were selected from among the first group with whom I had conducted unstructured interviews, based on expertise as defined by academic training and years of professional experience with health
care and HIV/AIDS. Officials who had been involved in a variety of ministries, programs, and working committees were preferred.

Interviews took place at various locations including the National Center for STDs, Dermatology and HIV/AIDS (NCHADS), the Ministry of Health (MoH), Ministry of Social Affairs, and Labour Vocational Training and Youth Rehabilitation, as well as at public and provincial hospitals, government and national health centers, and police departments.

The structured interview focused specifically on the meanings and contexts of HIV/AIDS and STDs, availability of health care services, and funding for HIV/AIDS and STD education, intervention, and treatment. Some questions addressed the government's role and response to the HIV/AIDS epidemic and problems with STDs among high-risk groups. These questions included:

- When were the national HIV/AIDS and STDs education, prevention, and awareness-raising programs established?
- What kinds of services are available for patients? What are the criteria used for patient selection?
- Are there fees for services? Are fees based on income?
- Who funds each program?
- How many staff members does each program employ?
- How many patients do you serve per month?
- What are the main problems encountered with patients and with the system?
• Is there a referral system for patients who need special care or other services?
• What kind of support programs are available for patients?

Other questions focused more on collaboration and coordination between programs:

• Is there a network system or working committee creating nation-wide policy?
• What are these coordinating bodies?
• Who make up the coordinating bodies?
• What are their roles, tasks, and responsibilities?
• What are the immediate plans?
• What are the long-term plans?

Additional questions examined immediate and future policy and strategy development, particularly in establishing national guidelines regarding STDs and HIV/AIDS. Particular attention was given to the most recent responses from the government, since by late 2000 there were many cases of AIDS in Cambodia. These questions included:

• Will the government provide anti-retroviral therapy for AIDS patients in the near future?
• Will it object if NGOs and IOs establish a trial program for AIDS patients using cheap AIDS drugs?
• Will the government continue to require traditional healers to register with the MoH if they wanted to treat patients?
• Will a 100% condom-use policy be applied to all provinces in the near future, after the completion of the pilot program in Sihanoukville?
• Will a 100% condom-use policy be part of a national strategy to reduce transmission of HIV and STDs?
• What is the next five-year plan in response to the HIV/AIDS epidemic?
7.3.2 Traditional Healers

Selection of traditional healers (THs) began in 1997, during the first trip to Cambodia. These were also based on referrals, leading to a snowball sampling. Six of the healers were from Kompong Cham province, 3 from Battambang, and 2 each from Pursat and Phnom Penh. All the traditional healers interviewed were between 35 and 60 years old and all but one were male.

Interviews started in May 1998 and continued until September 2001. A semi-structured questionnaire was used. It was modified throughout the course of the interviews to reflect particular problems that arose. The average interview lasted about one and a half hours. Permission was granted to take notes during each interview. Two healers were interviewed a second time after they were recruited to work with a local NGO, providing treatment to AIDS patients in Phnom Penh.

All of these traditional healers were actively engaged in finding effective treatments for patients with AIDS between 1997 and 2001. Full-blown AIDS cases began to emerge in 1999. Most people were still having a hard time grasping what was happening. Interviewing THs was difficult for several reasons. First, they took the exposure
received from involvement with this research project as an opportunity to promote themselves. Second, they preferred to talk to Western researchers, but classified me as 'foreign' Cambodian, having lived in the U.S. for twenty years. At the same time, since I was born in Cambodia, I was expected to know certain unwritten rules of conduct. When my behavior reflected what they perceived as lack of understanding about the culture, they did not excuse me as they would have a foreigner. After some awkward initial experiences, I conducted the remaining interviews in English with translators. This actually allowed the exchange to go more smoothly. The translator carried on the interview under my guidance, while I listened, observed the interaction, and took notes. This reduced the likelihood of misunderstanding and, in some situations, made it easier to obtain sensitive information.

I began with questions regarding their training and skills as healers:

- How did you become a Khmer traditional healer?
- Did you learn your skills from your father, mother, or someone else?
- Do you continue to learn new ways to treat people?
- If so, how do you learn? From other traditional healers? Through books? Other ways?
- How do you feel about being a traditional healer?
- How do you diagnose and treat an illness?
- Are there particular treatments for particular illnesses? If so, what are they?
• How do you obtain your medicine? Do you grow your own medicinal plants? Gather them in the field? Buy them from the market? From other traditional healers?
• Do you treat only with medicinal plants? Traditional Khmer medicine? Other medicines?
• Do you prescribe Western pharmaceuticals to patients? If so, can you name some of the Western pharmaceuticals you have prescribed? And for what illness?

I then asked questions regarding how AIDS patients were treated with traditional therapy, including the cost involved, types of medicine, and length of time for treatment. I also gathered information on the demographics of AIDS patients treated by traditional healers and their chances for recovery. Some questions were:

• When you provide therapy to patients, what are your expectations?
• How many patients have you treated so far in your life?
• Do you maintain a relationship with your patients?
• How do you recruit patients?
• How do you charge patients? What are your fees?
• Do you explain your fees and services before you treat patients?

Some questions were specifically about 'mango' illness. These included:

• Are you familiar with 'mango' disease?
• Can you tell me what 'mango' disease is?
• What do you think is the cause of 'mango' disease?
• Can you describe the symptoms of 'mango' disease?
• What are mango illnesses? Can you name all the 'mango' illnesses? How are these different from each other?
• Why do you think people call the disease 'mango'? How do you think people came up with the name 'mango'? Does the name have anything to do with the fruit? If so, why?
- When people refer to 'mango' disease, what is the first characteristic symptom you think of?
- How do you treat 'mango' disease?
- Can traditional Khmer medicine treat 'mango' disease? What kind of traditional Khmer medicine can treat 'mango' disease? Is there a particular type of 'mango' illness that needs a particular type of traditional Khmer medicine?
- Do you think Western medicine can cure 'mango' illnesses?
- Do you think 'mango' illnesses can be cured permanently?
- Are there certain types of 'mango' illnesses that are more easily treated? Which ones?
- Is there a serious type of 'mango' illness? If so, what is it?
- How do you describe serious 'mango' illness? What makes it serious?
- What medicine do you use to treat the serious type of 'mango' illness?
- Is there a different fee for 'mango' illness?

7.3.3 Sdaov Villagers

Structured, in-depth interviews were conducted in all the households of Sdaov village. Interviews were tape-recorded. Because of the length and extensive approach to these interviews, I had two research assistants help conduct interviews and transcribe and translate the data. It quickly became apparent that interviewees were uncomfortable answering questions on sensitive topics when the interviewer was not the same sex. Therefore, my male assistant interviewed men in the village. Sometimes more than two people were present at the interviews.
Approximately 120 homes were selected with the assistance of the village chief, who identified separate households. Since each living unit included both nuclear and extended family members, it was not always clear when one family home ended and the next one began. We mapped each home prior to conducting interviews.

In Sdaov, people do not reckon their age according to precise years, but tend to provide an approximate decade. Table 7.3 below shows how many villagers in each age range were interviewed. Approximately as many men as women were interviewed in almost all age ranges.

<table>
<thead>
<tr>
<th>N= 120</th>
<th>Age Range (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>20 to 29</td>
</tr>
<tr>
<td>39</td>
<td>30 to 39</td>
</tr>
<tr>
<td>24</td>
<td>40 to 49</td>
</tr>
<tr>
<td>21</td>
<td>50 to 59</td>
</tr>
<tr>
<td>21</td>
<td>Over 60</td>
</tr>
</tbody>
</table>

For safety reasons, I resided in Phnom Penh throughout my fieldwork. During this period, I commuted daily to Sdaov by motorcycle. Given the mode of transportation and lack of telephones, scheduling appointments for interviews was not possible. Interviews were therefore conducted at the convenience of the villagers. We started at one end of the village and continued until almost all the households were
represented. Since most villagers traveled every day to farm their fields, we interviewed those who usually stayed home. These included women who were still breast-feeding their children, people who were too sick or old to work in the rice paddy, and people with unusual occupations that kept them in the village. For example, there was a small group of fishermen who remained at home since it was off-season for fishing in the Mekong River. Another group of healthy young men were waiting for construction jobs in the city or had no transportation to get to work.

The primary purpose of interviewing someone from every household in the village was to get representative data about village health beliefs and practices. We followed Young and Garro's (1982; 1999) suggested method for conducting interviews on medical decision-making.

Initial questions aimed at gathering demographic data:

- What is your name?
- How old are you?
- How many people are in the family?
- How many children do you have?
- What is your primary occupation?
- Do you make enough to support the family?
- How do you supplement your income?

The first objective was to assess the criteria used to evaluate medical choices and discover who the decision-maker was in each family. An initial fifteen-minute
assessment included: 1) describe the level of illness in general as well as most recent illness in the family; 2) identify the decision-maker; 3) describe possible medical treatments; 4) describe the process of evaluating medical options; and 5) Asking what kind of medical practitioner was consulted the last time someone in the family was sick. Specific questions were asked about health and healthcare, including:

- Has anyone in the family been sick recently?
- What kind of medicine was used?
- Who did you consult first?
- Did you choose a Western-trained medical doctor or a traditional Khmer healer?
- What is your opinion about public or private hospitals?
- If someone were to get sick, who would be the decide what to do?
- What criteria are used to evaluate who in the family should be the decision maker?
- Have you personally gotten sick in the last year?
- How did you choose therapy?
- How much did you pay for the last treatment?
- What made you choose one particular therapy over another?

Questions were about STDs and HIV/AIDS were very sensitive. These questions were phrased in second person to avoid stigmatization. For example, people were asked if they knew of a friend, neighbor, or stranger who was sick from AIDS or STDs.

- Have you heard about 'mango' illness?
Why do they call it 'mango' illness?
Is there more than one type of 'mango' illness? If so, what are they? What are their symptoms? What about treatment?
Which treatment (Western medicine or traditional Khmer medicine) is most effective for 'mango' illness? Why do you believe in such treatment?
Could you personally treat your friend if he/she were to have an STD?
What is AIDS?
Is AIDS a kind of 'mango' illness? If it is different, how so? If it is the same, can you explain why you believe it is a kind of 'mango' illness?
What kind of medicine do you prefer for the treatment of STDs or AIDS?
Do you prefer Khmer or Western medicine in general? Why?

7.4 Focus Group Discussions

The purpose of facilitating focus group discussions was to gain information from people who were too sick to be interviewed individually. Focus groups were made up of people living with HIV/AIDS and patients with full-blown AIDS. Approximately ten people attended each of eleven sessions, for a total of 110 participants. Seventy-seven (70%) of the participants were female. Each session lasted between 50 and 60 minutes. The discussions took place from May to September in 2001 in Phnom Penh. Unless the group requested some guidance, they steered their own discussions into whatever topics they wanted to talk about, while I observed, listened, and took notes (Coreil 1995:194). Some of the topics they discussed included lack of basic
understanding about the illness, lack of resources (support system), and lack of financial support from family members.

7.5 Participant Observation

Participant observation was useful in observing people interacting in their natural contexts. Taking notes while observing was usually possible, except for when I was required to be an active participant at a social event (Bernard 1994:144-153). For example, at one point I sponsored a wedding and was required to be present and attentive the entire time. I usually spent evenings reflecting and writing or typing up the day's activities. Fieldwork involving participant-observation took place from November 1999 to the end of 2001.

7.5.1 Participant Observation in Sdaov Village

Most of the daily activities observed in Sdaov Village centered on children and old people at home. I also went on fishing trips with fishermen and excursions with traditional healers. On most of these occasions, it was possible to take notes while observing. Observing children walking cows or ducks to the pond was more effective when
children were not aware of my presence. When they noticed me, they usually wanted to have a conversation, which disrupted their daily routine and the anthropologist’s opportunity to observe them in their natural environment. Familiarity with street language was useful in eliciting information from children, however.

Observing older people cooking or cleaning the house made it possible to construct a picture of daily domestic life in the village. Occasionally, I took a tour around the chamkar (multi-crop fields) to observe the many plants old people picked for food.

Important ceremonies required active participation and were the best ways to gain insight and information into people’s relationships with one another in the community. It was difficult to take notes during these occasions. During a wedding, for example, all those who were invited were involved in the whole process, including throwing palm blossoms for good luck. Ceremonies were normally accompanied by loud music, eating, and dancing.

Donations were an essential part of participation in any event. I filled all requests for donations, including buying pigs for celebrations. The only exception was when it was not possible to purchase some of items that had been
requested following a flood in 1999 that had cut off transportation.

7.5.2 Traditional Healers

Observing the preparation of traditional Khmer medicine by a kru Khmer was also informative. In most cases, traditional healers preferred being observed to being interviewed. Observation was necessary because traditional healers sometimes assumed what they were preparing was so basic as to require little explanation.

Some traditional healers grew their own botanical plants. One traditional healer in the village both grew his own plants and took excursions to rice fields to gather other plants.

It was not always possible to take notes during observations. A second traditional healer in the village entered trance to diagnose a patient and did not permit note-taking at that time.

7.6 Critique of the Methods

Several methodological issues came up during this research. First, the role of an anthropologist studying her own 'culture' was somewhat complicated. As noted
earlier, some of the traditional healers were uncomfortable being interviewed by someone who was simultaneously Cambodian and foreign (American). Other people assumed that as a 'native' anthropologist, I was knowledgeable about certain issues, and therefore did not feel it was important to discuss them with me. It is also possible that as a partial insider, I might have taken for granted or overlooked some aspects of the culture (e.g., issues concerning beliefs and practices).

Other problems arose from working with assistants. Some information may have been lost in the process of transcription or translation or both. Furthermore, interview strategies were not perfectly consistent since I changed from conducting interviews directly to working with intermediaries. In some cases, this made interpreting data difficult.

7.7 Chapter Summary

This chapter focused on research methodology. A number of methods were used, ranging from casually talking to people to unstructured and structured interviews. Focus group discussions made it possible to obtain sensitive
information from people living with HIV/AIDS.

Participant observation was most useful in studying a village life.

The next chapter presents some of my research findings. A local explanatory model of illness is discussed. Particular attention is given to decision-making and treatment choices.
CHAPTER 8: ILLNESS CATEGORIES AND TREATMENT ALTERNATIVES

8.1 Introduction

This chapter presents findings from research in Sdaov village on local models of illness, concepts of potency, perceptions of treatment alternatives, and traditional and biomedical treatment modalities. This chapter provides a deeper understanding of how some Cambodians use and perceive health care options.

8.2 Indigenous Illnesses in Cambodia

This section examines local explanatory models of physiological and psychological illnesses that are specific to the traditional Cambodian medical system. Some illnesses, such as 'falling white' or 'weak heart' (see below) are considered legitimate. People with these illnesses may seek formal or informal medical care. Mental illness, however, is stigmatized. People claiming to have psychological problems such as depression are labeled crazy and considered disabled and useless to society. It is more difficult for them to seek care within the Cambodian medical system.
8.2.1 *Khasoi Suort* (Weak Lung) and *Khasoi Baedoung* (Weak Heart)

Cambodian illness theory treats the heart (chhiet) as the center of emotion and sensation and the focal point of the soul. All psychological or emotional experiences are expressed through the heart. If the heart becomes 'soft' or 'weak' (*khasoi baedoung*), it is said to upset the balance of wind in the body, such that illness results. 'Heart' problems may describe as suppression of the heart, tightness of the heart, suffocation, or lack of motivation, implying loss of feeling from the heart. Other descriptions include numbness, lack of regulation, and lack of wind.

Some of Cambodia's folk illnesses such as *khasoi suort* (weak lung) or *khasoi baedoung* (weak heart) are considered "illnesses of the rich." Some of these conditions match biomedical/clinical definitions of diseases of affluence such as heart disease, diabetes, high blood pressure, and so on. Symptoms of 'weak lung' and 'weak heart' include fainting, pain in the chest, dizziness, shakiness, difficulty breathing, or rapid heartbeat. Villagers associate these symptoms with people who have money and live in the city, especially wealthy, high status women who
do not exert themselves physically and eat a lot of meat and fatty foods. One of the physical characteristics of these conditions is obesity. Since obesity is interpreted in terms of class in Cambodia, it is not really seen as a health problem. Cambodians perceive 'rich' people (people they perceive to have excessive materials goods, such as cars, houses, boats, etc.) as those are more likely to be fat, so fat people are assumed to be rich and generally healthy.

8.2.2 Kus Mebar (Offending Ancestral Spirits)

*Kus mebar* is another emic illness. It is highly stigmatized because of the presumed cause. Since *kus mebar* is the result of having offended one's ancestral spirits, the victims of such disorders are blamed for having brought the problem on themselves. A *mebar* (ancestral spirit) may be offended by, for example, having a secret love affair. Since young people are still expected to follow the dictates of their parents in accepting an arranged marriage, if they have a boy or girlfriend of their own, it offends their ancestors. A young woman is only allowed to be in the company of family members or the to whom she is betrothed or married.
Symptoms of *kus mebar* vary from psychological to physiological. Physiological symptoms include fever, seizures, and weight loss or inability to eat. Chronic headaches result if the mind is 'too full' with memories of the past (equivalent to psychological depression), which can hinder participation in daily activities. Both men and women can suffer from this illness.

One method for diagnosing *kus mebar* is to put a chicken egg in the middle of a round plate and then assign seats around the plate to family members of both lovers. The egg symbolically connects the human and spirit worlds. The person performing the ritual asks questions while looking at the egg. Questioning is almost always directed at spirits from the girl's family first, since it is assumed the girl has violated the female code of conduct. If the egg stands up straight after a question is asked, then they are satisfied that a diagnosis has been reached. If the egg does not move, then questions are directed toward the spirits from the boy's family. If the egg still fails to move, then a fortuneteller with more experience is sought to determine what other spirits the couple has offended.
Once the cause is determined, the couple performs a propitiatory ritual. They then wait for a positive physiological outcome. If nothing happens, then traditional healers with greater religious knowledge (e.g., monks or shamans) are sought for advice. Even if the cause of the illness is known from the first ritual, if the outcome is not satisfactory to the patient, the search for appropriate therapy continues until some form of relief occurs. Sometimes, this process cycles from a traditional Khmer healers to monks or shamans to Western health care professionals, then back to a traditional healers. *Kus mebar* can be interpreted either as simply being 'crazy' or fits in as a legitimate illness. It can be highly stigmatized and suggests craziness such as depression.

8.2.3 Tors (Postpartum Disease)

Another illness specific to the Cambodian context is tors, a postpartum condition. A postpartum woman is believed to be in a highly precarious state; if proper care is not taken she may become seriously ill or die. The postpartum period is considered a 'cold' time, rendering women susceptible to blood clots. These are numerous regulations in behavior and diet that a woman must follow.
in order to return to a balanced state and avoid future problems. A woman must first keep her body warm by ang pleung. Ang pleung, also known as 'mother roasting', is the indirect application of heat through having the postpartum woman lie on a raised bed underneath which a small fire burns. The ang pleung period lasts between three to seven days after parturition. Ang pleung restores proper blood circulation to the woman's body.

Some women drink wine in which medicinal plants have been soaked to increase and restore the heat in the body. Eating cold food is avoided. If the woman does not follow these preventive measures, she may suffer from tors later in life after she has finished childbearing. One woman in the village explained that her current health problems were a result of not having adhered to these strictures because she had to work right after giving birth to her last child.

8.2.4 Tleksaw (Falling White)

The signs of tleksaw, a 'woman's disease', seem to fit with biomedical descriptions of some STD symptoms. In the Cambodian medical system, the term refers to white vaginal discharge, known as 'falling white' (tleksaw). It commonly occurs among women who are sexually active. STDs
are normally treated as men's diseases, however. Cambodian medical practitioners focus on finding out how men were infected and can be cured. Women are seen only as incubators and transmitters of STDs. 'Falling white' is therefore not interpreted in Cambodia as symptomatic of 'mango' illness.

Cambodian women with children tend to be affected by chronic vaginal inflammation, accompanied by discharge of various colors and odors (Eisenbruch 1997:7). 'Falling white' can refer to other symptoms as well. One woman's tleksaw symptoms included chronic headache, abdominal pain, and genital irritation and itchiness. She had experienced these conditions ever since she had had her last child, but had not been able to find the right medicine. She complained that her condition worsened when her husband traveled more frequently and spent more nights away from home. She consulted many health specialists, including Western-trained health care workers, traditional healers, and monks. She went to see a fortuneteller and was told that her 'falling white' was a result of kus mebar rather a 'woman's disease'. 'Falling white' is therefore a symptom rather than a causative disease in its own right.
Other illness results from 'thinking too much' or ort satech aram. The person's mind is said to be 'too full' or 'overloaded' to function properly and loses his or her mind or conscience, one's moral sense, or 'consciousness', mental awareness. Loss of consciousness implies fainting, going unconscious. Loss of conscience implies social pathology, an inability to discern right from wrong. Symptoms include headaches, insomnia, loss of appetite, and restlessness. Ort satech aram occurs when a person succumbs to the pressures of daily life and can no longer deal with reality.

An illness caused by 'thinking too much' requires a traditional healing specialist. Since psychological problems are rarely discussed or considered illnesses that require medical treatment, such conditions are difficult to diagnose, however. When psychological problems are interpreted in terms of physiological discomforts instead, patients can seek medical attention without stigmatization.

This applies to psychological conditions such as stress, depression, anxiety, or post-traumatic stress disorder (PTSD) as well. So long as they are conceived in biomedical terms, they may go untreated, but when they are
framed as symptoms of 'soft' or 'weak' heart, then help can be sought. For example, stress is understood as the inability to release the wind in the body. It is also described as the heart being pressed so tight that it causes imbalanced emotions. Similarly, anxiety is described as the wind in the body having become so suppressed that the body is no longer able to function normally. Depression is explained as lack of motivation or lack of emotion and the heart is said to have fallen into a pit. Post-traumatic stress disorders are described as resulting from shocks to the body. By rendering illness in physiological rather than psychological terms, albeit through an emic understanding of causative factors, social stigma is removed and treatment becomes possible.

8.3 Illnesses in Sdaov Village

Cambodians suffer from infectious diseases such as typhoid, malaria, dengue, cholera, measles, acute respiratory infection, and tuberculosis. In Sdaov, five individuals reported that they had had typhoid, one-third of all the villagers (but mostly men) had suffered from malaria, and almost all the children had contracted chicken pox. In addition, there had been one case each of cholera,
hepatitis, measles, and pneumonia within memory. Men tend to contract infectious diseases more often than women because they travel more often and spend more time in the forest, where malaria is prevalent. Women seem to suffer more from 'emic' illnesses such as weak heart, falling white, postpartum condition, and offending ancestral spirits, however. Table 8.1 discusses diseases contracted only during the fieldwork period.

Table 8.1: Illness in Sdaov Village (1999-2000)

<table>
<thead>
<tr>
<th>Category of Illness</th>
<th>N=131</th>
<th>% of Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Ailments</td>
<td>97%</td>
<td>65%</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>43%</td>
<td>30%</td>
</tr>
<tr>
<td>Culturally Defined Illnesses</td>
<td>21%</td>
<td>48%</td>
</tr>
</tbody>
</table>

Approximately 97% of villagers reported suffering from common ailments (see Chapter 6). A third suffered from infectious diseases. Twenty percent had culturally defined illnesses during that period. The two most common 'emic' problems were tors (postpartum 'cold' condition) and kus mebar (sickness resulting from offending an ancestral spirit). Almost 43% suffered from infectious diseases. These infectious diseases include: typhoid, cholera,
measles, tuberculosis, malaria, pneumonia, acute respiratory infection (ARI), and life-threatening fevers.)

8.4 Local Healing Modalities

Cambodian healing methods fall within two main modalities: 1) the infliction of external pain as a substitute for internal pain, forcing regulation of the body or 2) the consumption of botanical medicines that restore the body to a state of equilibrium. Results from fieldwork in Sdaov indicate that many Khmer still practice traditional healing. Almost all of those interviewed have used traditional Khmer medicine at least once at some point in their lives and approximately 70% have combined traditional Khmer medicine with Western pharmaceuticals. Dual treatment is usually employed for serious illness.

Some people go to a fortuneteller (specialized kru) to seek advice or ask for information about the cause of an illness before seeking out a traditional healer who specializes in medicinal plants or supernatural/religious healing. Some of this kind of kru treat clients themselves.

Two traditional healers lived in Sdaov. The female healer made all diagnoses during trance and then combined supernatural power, religious ritual, botanical medicines,
and Western pharmaceuticals in her treatments. The other healer preferred traditional Khmer medicine, turning to Western pharmaceuticals only as a last resort or when patients requested them. He had a small shop that dispensed both medicinal alcohol and pre-packaged Khmer medicine for a variety of ailments.

Some traditional healers only sell one herbal compound to treat all illnesses. Other healers use various recipes, with one package for common ailments and another for serious problems such as diabetes, TB, or dengue fever. Still another may be used to treat AIDS. Generally, the number of plants used in a given preparation depends on the severity of the disorder it is meant to treat. Packets of prepared herbal compounds are also sold by mobile vendors.

Patients can also gather plants themselves and prepare their own compounds. Six people in the village recognized medicinal plants growing in the fields and had gathered them to boil and drink as tea, the usual way to ingest traditional medicine. Plants are combined in a big pot, with about 3 cups of water with herbs and boiling it to 1 cup. Medicinal teas usually taste slightly bitter.

A variety of plants, animals, and minerals are used in traditional Khmer medicine (Chhem 2001). Coconut juice is
important for the treatment of diarrhea or fever. Black sugar cane, rusted nails, and corncobs are some of the ingredients for the treatment of STDs. Pulverized squirrel skin is rolled into balls and taken for headache. Pills made of tree bark and animal remains are used to treat a number of ailments including chronic body ache, insomnia, and stomachache. During the Pol Pot regime in the late 1970s, earthworms were used as one of the main ingredients for the treatment of measles and chicken pox.

More often than not, healers combine a variety of therapies, including the use of objects such as coins or cups and religious ceremonies. Villagers also use home remedies to treat common ailments such as headache, stomachache, diarrhea, and body aches (see Table 8.1 below). Remedies such as moxibustion may be used when the disorder is more severe. Healers and patients alike thus maintain these traditional practices.

<table>
<thead>
<tr>
<th>Home remedies</th>
<th>English Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couk kchall</td>
<td>Coining</td>
</tr>
<tr>
<td>Chap kchall</td>
<td>Pinching</td>
</tr>
<tr>
<td>Prors</td>
<td>Spitting</td>
</tr>
<tr>
<td>Ksea Keithaa</td>
<td>Magic belts</td>
</tr>
<tr>
<td>Kansieng yon</td>
<td>Magic scarves</td>
</tr>
<tr>
<td>Oich</td>
<td>Moxibustion</td>
</tr>
<tr>
<td>Phlom baley</td>
<td>Blowing the wind</td>
</tr>
<tr>
<td>Sak</td>
<td>Religious tattoo</td>
</tr>
</tbody>
</table>
Cupping (couk kchall) and pinching (chap kchall) are the most common home remedies. Couk kchall literally means 'to scrub the wind in the body'. Coining involves rubbing a coin vigorously on water or oil on any area of the body where there is pain, until the skin turns red. If an individual has a stomachache, the lower back will be coined. An afflicted individual can perform this treatment for him or herself if the place to coin is in reach. Chap kchall means 'to pinch the wind from the body'. Pinching is an alternative to coining. The first and second fingers are soaked in water then used to pinch the skin repeatedly. For example, the skin between the eyebrows will be pinched to relieve headache and tension.

Spitting (prors) is used for minor injuries such as a sprain or aching joints. Six people responded that they had received spitting from a monk, traditional healer, or an aacha (religious leader/elder who is highly respected in the community).

Other remedies involve religious rituals. Amulets are used both metaphorically and physically. Adults wear amulets around their waists, while children wear them around their ankles, necks, or wrists. Most amulets are
made from silver or gold, tied to the body with a cotton thread. Amulets serve as protection against supernatural beings who have the power to harm the living. They may also attract supernatural beings who can protect the bearer from injury from shrapnel, bullets, fire, and so on. Other magic tools include scarves (kanseing yon) or magic belts (ksea keithaa). These items have been woven during a religious ritual. Like amulets, they protect an individual from illness or injury during warfare (Moser 1983).

Other healing methods can be quite painful, but are considered efficacious. These include phlom baley (to blow sacred wind), oich (moxibustion), and chope (cupping). In a phlom baley ceremony, a kru Khmer 'blows wind' over a painful area. On this wind, the healer recites religious scripts in the Pali language of Theravada Buddhism (Marcucci 1994). These words are carried by the wind to heal the individual. Phlom baley usually includes moxibustion (oich). After a kru healer asks the inflicted individual about the illness, candles are lit and kapok pellets are placed on the skin of the chest or back. Both the healer and the patient begin chanting Buddhist precepts. The pellets are lit and burn the skin of the patient. Then the healer blows over the area, intending to
blow the wind away from the body. The pain starts the process of healing, but the treatment leaves scars. The pain inflicted by moxibustion symbolizes the Buddhist belief in suffering as a constant part of life. Oich also creates an external hot condition intended to draw out or release the internal cold that is causing illness (Moser 1983).

Another healing method is cupping or chope (literally, 'to suck wind'). Chope is commonly used to treat headache. A small candle is lit over the area where the patient feels pain. Then a glass is upended over the candle. For instance, if an individual is experiencing a headache, a small candle is lit and placed inside the glass against the forehead. When the glass is put over the candle, the oxygen is used up, causing the skin to be pulled up into the glass. The result is a circular red bruise that lasts a few days.

Sak or tattoos of religious symbols are used to either heal or prevent illness. Such tattoos are considered sacred objects that have the magical power to protect individuals from supernatural power or physical injury. Sak designs do not vary much. They are usually Buddhist precepts or a depiction of an animal known to have magical power. Sak
became popular during the revolutionary period. Men recruited to join the guerrillas or military got tattooed as protection against bullets and any supernatural beings that resided in the forests. The religious tattoos allowed them to engage in battle courageously, without fear of being killed. Such tattoos are also common in Thailand.

Chun arak is no longer used in Sdaov village. It refers to 'stepping on a ghost' to determine the case of illness. Villagers said this healing practice has been used by their grandparents, but no longer played a part in contemporary healing practices. Older people claimed to have seen chun arak performed before Cambodia collapsed under the communist regime. They could not remember why it had been discontinued, however. One theory they put forth was that all those who possessed supernatural power and knew how to interact with ghosts had been killed during the war. Villagers continue other animistic traditions, however. About 66% of the people interviewed mentioned that they made regular offerings to the ancestral spirits (neak ta) to avoid being afflicted with sickness.

Traditional healing thus continues to play a critical role in the lives of people who live in small villages such as Sdaov. Home remedies and botanical medicines are used
either as a supplement to other healing methods or for immediate alleviation of minor ailments, especially when biomedicine is not accessible. Traditional healing also provides a low cost alternative to costly Western health care.

8.5 Perceptions of Biomedical Treatment

Although biomedicine dominates the current Cambodian health care system, local perceptions of Western medicine underlie medical decision-making. Cambodians incorporate Western medicine into their explanatory model, valuing certain biomedical practices over others. Treatments such as injections are preferred, while others, such as radiation and chemotherapy, have yet to be incorporated into the formal health care system. Cambodians clearly prefer treatment choices that conform to their health beliefs, although the high cost and low availability of many biomedical options also affect choice.

Findings from Sdaov provide statistics on villagers' preferences regarding biomedical treatment (see Table 8.3 below). About 86% of Sdaov villagers have taken tablets. Tablets such as aspirins, Tylenol, and other stomachache related medications are affordable and readily obtained, so
they are used most widely. Injections such as serum are preferred, however, not only because they are believed efficacious but also because they are associated with class. 'Rich' people are known to ask for injections for every ailment. Seventy-nine percent of those interviewed have used injections. The serum is believed to quickly restore any bodily imbalance. Another favorite, especially among older married women, is injections or using saline serum. Serum or injection is believed to cure exhaustion, insomnia, weakness due to overwork, headache, diarrhea, and so on. Approximately 34% of Sdaov villagers have taken serum.

Only a small percentage (3%) have been hospitalized, because of distance and high cost. Furthermore, villagers avoid surgery because of the threat of blood loss. They believe that loss of blood has a permanent effect on bodily balance and that the body can never be restored to its original equilibrium after surgery. Most villagers believe that dying is better than undergoing surgery.

Table 8.3: Use of Biomedicine in Sdaov Village

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>N=120</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tablets</td>
<td>86%</td>
</tr>
<tr>
<td>Injections</td>
<td>79%</td>
</tr>
<tr>
<td>Serum</td>
<td>34%</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>3%</td>
</tr>
<tr>
<td>Surgery</td>
<td>0%</td>
</tr>
</tbody>
</table>
8.6 Factors in Choosing Treatment Alternatives

Treatment in Cambodia falls into five categories, determined by the kind of medicine dispensed and the type of practitioner: 1) traditional Khmer medicine dispensed by healers, vendors, or prepared by patients themselves; 2) remedies such as cupping used by patients at home; 3) biomedicine disseminated by untrained practitioners; 4) biomedicine practiced by peet (anyone trained in the formal, biomedical, health care system); and 5) combinations of traditional medicinal plants, religious/supernatural healing, Western pharmaceuticals, and home remedy techniques, dispensed by traditional healers. Various factors influence which alternatives will be chosen, including cost, availability, and kind and severity of illness.

8.6.1 Expense of Treatment Alternatives

Medical alternatives vary significantly in cost. Packets of traditional Khmer medicine cost as little as 1,000 to 2,000 riels (US 25-50 cents), whereas treatment by peet can run as high as one million riels (US$263). Since some medicinal plants can be gathered and compounded by the
villagers themselves, traditional herbal treatment can be free. One patient in the village spent an average 1,372 riels (US$0.35) for traditional Khmer medicine per illness. The most anyone had spent on traditional Khmer medicine for an illness was 45,000 riels (US$11).

By contrast, a patient can expect at least to pay 1,500 riels (US$0.38) for Western pharmaceuticals. The cost of Western pharmaceuticals depends upon the country of origin. For example, pharmaceuticals from France generally cost more than those from any other country, regardless of the type of medicine. The average spent on biomedical options, including injections, tablets, serum, and in a few cases hospitalization was about 78,210 riels (US$20) per illness. Hospitalization is normally out of reach for the average person living in a rural, remote area, but not for urban, middle or upper class Cambodians. Some wealthy people even travel to Vietnam, France, or the U.S. for medical treatment. The highest cost for treatment per illness in the village was reported at almost six million riels (US$1,500).

Generally, cost considerations have the greatest effect on decisions regarding common ailments. Home remedies, traditional medicine, and basic pharmaceuticals
(e.g., aspirin, paracetomol) are easily available and affordable, so they are usually used first. In cases of serious illness, cost becomes a secondary issue. Family members will then do their best to borrow money from relatives, friends, or employers to pay for a patient’s medical expenses.

8.6.2 Access to Treatment Alternatives

Both Western pharmaceuticals and traditional Khmer medicine were readily available in Sdaov. People selling basic Western pharmaceuticals in the village included a small vegetable shop owner, a schoolteacher, and traditional healers. Antibiotics, pain relievers, and other drugs were easy to purchase without prescription in every pharmacy in Phnom Penh. Toward the end of the field research period, the government issued a policy banning sale of antibiotics and other prescription drugs without a license. This policy had little effect on villagers, who knew trusted individuals from whom they could obtain these drugs. A few villagers claimed to have stored antibiotics at home to sell to other villagers.

There was no government health center in the village, but one about ten kilometers away provided basic health
care services, including treating minor injuries and infectious diseases and providing birth control and other limited reproductive health care. The only supplements provided by the center were iron pills and Vitamin A. A major problem with health centers has been lack of staff. Most medical workers have private practices elsewhere. Making appointments with them was not an option for villagers.

Some unlicensed and untrained individuals provided biomedical services to the villagers. Mainly, they gave injections or dispensed serum and pharmaceuticals for various ailments. Drugs were often removed from their original packaging and dispensed in small plastic bags labeled by hand with the name of the drug or the ailment it was meant to treat. Usually the labels were illegible and the bags sometimes contained more than one kind of tablet. For example, a bag labeled as treatment for menstrual cramps included an iron pill, a tab of paracetamol, a Vitamin C pill, and two unrecognizable tablets (one yellow and the other white).
8.6.3 Potency of Treatment Alternatives

Cambodians evaluate the effectiveness and potency of traditional and biomedical treatments differently. Sdaov villagers believe that biomedicine helps a patient recover quickly, but only on a superficial level. It is assumed that symptoms will reappear at a later date. Traditional Khmer treatment is perceived as ultimately more effective in defeating disease for good. Traditional medicine has to be consumed for a longer period of time, which Khmer believe allows the medicine to penetrate more deeply into the body. Effectiveness is therefore equated with level of saturation in the body. This is measured by the slow process of recovery while drinking medicinal tea.

Cambodians judge the potency of Western pharmaceuticals based on the country of origin. French pharmaceuticals are both most expensive and considered most potent. Medicine made in India is considered less strong, but better than the cheap drugs originating from Vietnam. Pharmaceuticals from the United States fall between India and France in potency. This evaluation is strictly based on relative cost: potency = high expense.
8.6.4 Choosing Among Alternatives

Not all Cambodians agree on which kind of treatment to seek or whether traditional medicine is preferable to biomedicine. Cambodians include potency and availability in making their evaluations, but also whether or not a medicine helps a patient eat and sleep well and gain weight while recovering. Although most Sdaov villagers preferred traditional Khmer medicine, a few families only used Western pharmaceuticals. They claimed that Khmer traditional medicine had not been scientifically proven to be effective and might actually harm the body. Preferences in treating STDs make this diversity of opinion clear. Five percent of the villagers interviewed believed that Western pharmaceuticals were more effective than traditional Khmer medicine in treating STDs, while 35% thought traditional Khmer medicine would be more appropriate. Twenty-one percent responded that both kinds of medicine could produce a satisfactory outcome. The other 39% chose not to respond to the question.

In the case of severe illness, expense is not as important as diagnosis in deciding what kind of treatment to pursue. Emic illnesses will usually be treated by traditional healing specialists, while biomedical options
are often sought for life-threatening new diseases such as AIDS. The first person to have full-blown AIDS always seems to be the breadwinner of the family, so family members seek treatment aggressively to give the patient a chance to recover. However, in AIDS cases, family resources are essentially exhausted by the time a patient dies.

Over time, patients and their families learn more about the various choices available to them in the community. If they try biomedicine and it doesn't work, they usually return to traditional Khmer medicine as a last resort. Patients often learn to gather, prepare, and gauge the dosage of medicinal teas. They take over that chore themselves, while their family members return to their daily tasks. If the patient's condition deteriorates, the patient then turns to religious practices to prepare for the afterlife, as the family waits for his or her death.

8.7 Chapter Summary

This chapter presented research findings on Cambodian health beliefs and knowledge. Local or 'emic' illnesses were discussed as well as treatment alternatives. Criteria used to choose appropriate treatment were summarized,
including expense, availability, potency, and effectiveness.

The next chapter analyses perceptions of 'mango' illness, including symptoms and transmission. How AIDS fits into this indigenous model of illness is also examined. The chapter discusses foreign aid as it relates to development. This follows a conclusion chapter by providing a summary of dissertation.
CHAPTER 9: MANGO ILLNESS

9.1 Introduction

This chapter discusses the Cambodian ethnomedical disease known as 'mango' illness or svay. It emphasizes an empirical understanding of health beliefs and practices in Cambodia, specifically focusing on how Cambodians structure their knowledge of illness, beliefs about contagion, classification of diseases, and illness metaphors and symbolism. Although scholars have begun to acknowledge the importance of medical beliefs and practices around the world (Green 1999), health beliefs based on personalistic ethnomedical models have yet to be fully accepted within the biomedical domain. Cambodian models of STDs and AIDS provide a good example of this problem.

9.2 Medical Anthropology and Intervention

I need to examine related programs and address why some worked and others failed for a full understanding of government and community responses to the HIV/AIDS epidemic. Western medical intervention programs in Cambodia are bound to fail without adequate understanding of indigenous beliefs regarding illness, health, and
treatment. Anthropologists have long understood that any effort to change human behavior rests on studies that address questions of why people behave as they do. Such studies should place an emphasis on the social, cultural and psychological aspects of human health and illness, particularly beliefs about etiology, diagnosis, and efficacy. Programs intended to combat infectious disease can be met with resistance if indigenous explanatory models are ignored.

Some intervention programs in Cambodia have failed due to the attitudes and behaviors of health care providers. Most Western medical professionals or locals trained in biomedicine perceive local beliefs and practices as irrelevant to policy and program development. Intervention programs are designed based on the beliefs of these health care providers instead of on the beliefs of those they are intended to reach. Several cases can be cited in Cambodia. For, a local NGO (which will remain unnamed) had set up a program to provide iodine supplements to isolated villages along one of the main rivers in the country, where iodine deficiency is common. Iodine was added to well water. The program was unsuccessful because Cambodians thought the discolored well water was contaminated. It did not taste
normal and they refused to cook with it. Some villagers even claimed that the NGO was performing some witchcraft intended to inflict pain on them via water contamination. Another program aimed at reducing iron deficiency among women of child-bearing age was met with resistance by local Cambodian women. This time problems arose because public health officials failed to explain the side effects, such as black feces and indigestion, of taking iron pills. Most of the women quickly discontinued taking the supplements.

Anthropological studies have provided important insights and information to public health programs (Inhorn & Brown 1997). For example, it took an anthropologist to show how kuru disease in Papua New Guinea was being caused by a particular cultural practice (Johnston & Low 1984:223). Ethnomedical beliefs about diseases are not always congruent with the biomedical paradigm, as several scholars have shown (Green 1999: 225; Kandall et al. 1984; Menegoni 1996:391). In Pakistan, some 35,000 children died of measles each year due to differences in medical beliefs (UNICEF/Government of Pakistan 1988:44). Local beliefs can also interfere with accurate diagnosis, such as when measles are mistaken for smallpox (Inhorn & Brown 1997:
303, 341). An effective health program requires the ability to understand local knowledge and beliefs.

Two aspects of indigenous health systems can be analyzed. First, societies actively change the local ecology to increase or decrease the risk of particular diseases (Inhorn & Brown 1997: 54). Second, culture provides a theoretical system for understanding and attempting to manipulate through medicine the diseases that cause human suffering and death (Inhorn & Brown 1997: 54). By understanding both aspects, medical anthropologists can provide data that improve the effectiveness of intervention programs, particularly for HIV/AIDS prevention programs.

9.3 Research on STDs and HIV/AIDS in Cambodia

There is a great deal of diverse literature on STDs and HIV/AIDS in Cambodia. None of these studies provide an in-depth analysis of Cambodian beliefs about treatment efficacy, or the etiology, prognosis, and nosology of STDs and AIDS within the Cambodian ethnomedical system, however. Governmental and NGO documents are primarily descriptive epidemiological reports. For example, the NCHADS report on HIV Seroprevalence in 1999 described HIV rates among at-risk target groups by province (NCHADS, MoH 2000). Other
documents record the progress of the epidemic and estimated impact of AIDS on the economy (Bunna & Meyers 1999; Heng et al. 1999; Tia et al. 1998; MoH October 2000; MoH Census Workshop Report March 1999; MoH Joint Health Sector Review December 2000). Other documents such as the USAID/Cambodia Report (June 2001), the ITM/EU Report (June 2001), and the French Cooperation Report (2001) are more concerned with quantifying services to funding agencies.

Some NGO studies have focused on cultural knowledge and beliefs about HIV/AIDS. For example, CARE International (1993) reports that Cambodian men and women perceive Vietnamese sex workers as the main cause of HIV/AIDS. The report also states that more men than women have heard of AIDS and that some call AIDS the "king of ghosts" because no kru (traditional healer) could destroy the disease (CARE International 1993:5). Other studies have dealt with perceptions of sexuality among certain groups in Cambodia (Tarr 1996:92).

In one of the most important studies, Eisenbruch (1997) explains how STDs and AIDS are viewed in Cambodia, the role of sex work in spreading these diseases, and men's vulnerability to 'mango' illness. He provides detailed
descriptions of modes of transmission and types of STDs, relying on traditional healers and male patients as his informants. It is for this reason that a close examination of the cultural construction of "mango illness" is critical in understanding HIV/AIDS prevention programs in Cambodia and how Cambodians reacted and responded to the epidemic.

9.4 Cambodian Disease Etiology

Eisenbruch's (1997) and Green's (1999) research is particularly relevant to discussions on beliefs regarding STD and HIV/AIDS transmission in Cambodia. Green provides an overview of ethnomedical methods and discusses indigenous contagion theory. Many communicable illnesses such as tuberculosis (TB), acute respiratory infections (ARI), dengue fever, diarrhea, and STDs are conceived within an indigenous interpretive framework in many parts of the world (Green 1999:225).

Eisenbruch (1997) explains a cultural concept, mee rook, that forms the basis of Cambodian contagion theory and illness classification.16 It cannot be understood in isolation from the Cambodian cosmological order and worldview. Mee rook includes all beings, whether

16 Mee means 'chief' in Sanskrit; rook is derived from roga, meaning 'illness' (Eisenbruch 1997:10).
supernatural beings living in the forest or living things in the local environment, that cause disease. Mee rook can refer to almost anything small and invisible that could cause harm, and is often translated as 'microbe' (Eisenbruch 1997:10). Eisenbruch claims that the average Cambodian patient or Khmer healer has no idea what a virus is, but labels the cause of all transmissible diseases as mee rook. He stresses that mee rook does not imply microbes at all, and that such translations are in error (Eisenbruch 1997:10).

Eisenbruch is correct, but only in the context of the original meaning of mee rook. He fails to take into consideration that words borrowed from another language (Sanskrit) do not necessarily retain their original meaning. The average Cambodian applies mee rook to different health contexts, encompassing a wide range of beliefs about disease etiology. Sickness can be attributed to either naturalistic or personalistic causes. Furthermore, any disease may involve an amalgamation of causative agents, including sorcery, witchcraft, wind, cold, heat, water, fungus, bacteria, virus, or yeast. Illness may result from getting wet from rain or bathing, general failure to look after oneself properly, poor
nutrition, or exposure to ashes or tiny dirty animals (Green 1998: 233). Other naturalistic beliefs focus on promoting general good health, including eating cold food in hot weather and vice versa, getting enough sleep, quarantining the sick, and maintaining good hygiene. Cambodians interpret contagion and disease causation holistically.

9.5 Classifying AIDS and Svay (Mango) Illness in Cambodian Ethnomedicine

There are two meanings for the word ‘svay’ in the Khmer language. The first is 'mango', meaning the fruit. The second is a slang expression referring to sexually transmitted infections. This term is in common use among ordinary Cambodians, but there have been arguments about it within the formal health system. Medical professionals generally prefer 'kama rook' and view 'svay' negatively.

Classifying STDs has had political implications in Cambodia, particularly during the Khmer Rouge regime. In the decades before Pol Pot, when Norodom Sihanouk and Lon Nol were in power, STDs were called kama rook (illnesses of sexual desire) by medical professionals (Eisenbruch 1997: 2). This phrase reflected men's nighttime activities
in urban centers. Dancing, singing, drinking, and visiting sex workers dominated nightlife before the war. Pol Pot leaders viewed the term as suggestive of the contamination of the West. They renamed STDs the more politically correct rook sangkum (illnesses of the community), implying that the community had been corrupted by Sihanouk and Lon Nol (Eisenbruch 1997: 2). During the Hang Samrin era, the old system was revived. Medical professionals returned to calling STDs 'kama rook'. The term 'svay' has remained in common currency among ordinary people throughout these political changes, however.

Svay illnesses tend to be attributed to natural rather than supernatural causes. They are usually understood to be the result of human actions or secretions and environmental factors, rather than ghosts or spirits. AIDS may or not may be considered a kind of svay kraap (mango illness), depending on what is believed to be the original mee rook. Different Cambodians therefore classify AIDS differently, depending on their beliefs about mee rook. If the mee rook for svay is considered different from that of AIDS, then AIDS is not classified as a kind of svay kraap. However, if both are believed to have the same mee rook, then AIDS symptoms are perceived and treated as svay.
Medical professionals tend to overlook *mee rook* and indigenous interpretations of illness classification, contagion, and disease progression. International and local NGOs claim that Cambodians misunderstand the differences between AIDS and *svay kraap*, but this reflects their own failure to comprehend Cambodian ethnomedical conceptualizations. *Mee rook* is an ambiguous, broad, flexible term. Its meaning changes to reflect new beliefs and values as new illnesses emerge. For the average Cambodian, classifying AIDS as *svay kraap* is a logical extension of their disease etiology.

9.5 The Mango Metaphor for Sexually Transmitted Disease

Metaphors and euphemisms are often applied to socially stigmatized diseases. As Nations and Monte (1997) point out, diseases such as cholera-like tuberculosis, leprosy, and HIV-AIDS are mysterious infectious diseases that are not only acutely feared but are felt to be morally as well as literally contagious. These illnesses are treated as crimes and sick people as deviants deserving punishment (Inhorn & Brown 1997: 469). Metaphors are one way to protect individuals from negative social sanction (Inhorn & Brown 1997: 279). In the Philippines, for example, 'weak
lung' can refer to tuberculosis. Whereas TB is a sign of poverty and uncleanliness, however, 'weak lung' applies to "states of ill health in which a child experiences recurrent or prolonged cough and cold, loss of weight and lack of appetite, fatigue and restlessness, and low-grade 'inside fever'," which carries no social stigma (Inhorn and Brown 1997: 272). Some diseases are so frightening that people construct deities they believe must be propitiated to prevent pestilence or cure disease (Inhorn and Brown 1997: 103). In India and China, people describe smallpox as a goddess worshipped out of fear of her displeasure (Inhorn and Brown 1997: 104).

There are a number of possible explanations for the mango metaphor for STDs. According to some traditional healers, the term 'mango' illness has to do with the mango season from March to April, when children tend to get contagious infections characterized by skin eruptions (Eisenbruch 1997: 2). Before the Pol Pot regime, smallpox, chicken pox, and measles were also called 'svay' (Eisenbruch 1997: 2). Chickenpox is actually called 'mango smallpox' in the Khmer language. Men who get syphilis show pustular lesions that migrate along the body, rather like the pattern among children with contagious diseases
(Eisenbruch 1997: 2). Furthermore, unripe mango sap produces an itchy sensation. Cambodians may associate the 'itchy' sensation from mango sap with the season that produces itchy skin problems and extended it to other diseases with common symptoms. Such a metaphor provides a deeper understanding of how indigenous people structure their knowledge in the biological world.

Eisenbruch (1997) presents another hypothesis. The 'mango cashew' (svay chantii) is so strong that it can cause chronic, serious damage to the body. Its rotten flesh induces itchiness in the throat and skin (Eisenbruch 1997: 2). Furthermore, the cashew nut hangs outside, underneath the fleshy fruit. It is seen as so strong that it penetrates the flesh, devouring the 'penis' that symbolizes male virility (Eisenbruch 1997: 2). It is perhaps no coincidence that fermented noni fruit, one of the medicines for cancer, TB, diabetes, malaria, dengue, and even AIDS, smells very like ripe cashew fruit. The odor of cashew might therefore have played a role in naming the svay category of illness.

Another possible origin of the metaphor may be in the flowers of mango. According to CARE International (1999),

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17 Although it has no bioscientific importance, Hawaiian people have long used fermented noni to treat a number of ailments (Dixon & Etkin 1999).
syphilis symptoms include brownish, cauliflower-like growths. Two or three weeks after blooming, mango flowers turn brown, and stand up in spiky clumps reminiscent of syphilis growths on the skin. Perhaps the appearance of these brown mango flowers stirred associations with syphilis. Dr. Var Chivorn, Associate Executive Director of the Cambodian Reproductive Health Association, explained that Western-trained Cambodian medical professionals often identify diseases according to their physical appearance as well as by symptoms that match clinical biomedical definitions. Perhaps medical professionals actually initiated the term 'svay' to refer to syphilis, then expanded it to include a number of STDs and other chronic or serious illnesses that include skin lesions (e.g., smallpox, measles, leprosy). Later they preferred the term kama rook as a more precise term, but svay remained in circulation in the common parlance. Although there is no way to know for certain the origin of the metaphor, it is clear that it refers to socially stigmatized diseases.

9.6 Emic Classification of 'Mango' Diseases

Cambodians classify disease holistically, based mainly on etiology and symptoms and partly on treatment. There
appear to be four kinds of 'mango' illness, but Eisenbruch (1997) points out that these emic classifications are not necessarily in line with biomedical definitions based purely on etiology. Each emic class may not be a distinct etic illness. For example, different stages of an illness sometimes fall into different emic categories as the symptoms change. Sometimes one category encompasses multiple illnesses if they all share the same mee rook (causative agents). For example, the illness category 'krun' is applied to a variety of flu-like symptoms, including high temperature, sweat, convulsions, shakiness, dizziness, cold, and chills. Krun encompasses pyrexia (krun), malaria (chumgii krun chan), scarlet fever (chumgii krun kdai), typhoid (krun pueh-wien or krun santum), dengue fever (chumgii krun lueh), hemorrhagic fever (chumgii pueh-wien), yellow fever (chumgii krun lien), the common cold, and sinus problems. Despite such ambiguity when shifting between emic and etic categories, indigenous classifications of illness are rational and therefore worth some attention.

The first type of svay is premah. Svay premah generally refers to the symptoms associated with gonorrhea. The cause of svay premah is believed to be poisoned male
semen or blood interacting with the inflamed uterus of a woman to produce *premah theuk-bai*, or rice-water *premah*. The blood or semen is thought to rise up the woman’s vertebral column to the axilla, where the lymph nodes became enlarged (Eisenbruch 1997: 4). Then the mixture ascends to the nodes behind the ears and makes the person lose hearing (Eisenbruch 1997: 4). The head pulses with pain, then the mixture falls back down the woman's body and enters the man's penis, causing his symptoms (Eisenbruch 1997: 4).

There are three stages of *svay premah* in the male. In the first stage, the penis becomes swollen, tender, and inflamed (Eisenbruch 1997: 4). Whenever the man is sexually excited and has an erection, his penis becomes itchy and painful and he cannot have intercourse (Eisenbruch 1997: 4). The second stage is when the groin becomes swollen and some blisters begin to appear. The infected person has difficulty urinating. Slowly, the patient begins to have problems walking, eating, and sleeping. According to some traditional healers, the last stage is the appearance of red spots all over the body, including testicles, skin, legs, arms, even eyes. The patient can no longer urinate at all and has a high
temperature. The patient begins to lose weight until he can no longer walk, sleep, or eat. The patient is likely to die if the red spots break open into lesions. At this stage, one type of *svay* has evolved into a new type. As Eisenbruch (1997) points out, although gonorrhea and syphilis are biomedically distinct and cannot change into each other, traditional healers believe that rice-water *prameh* can turn into another form of 'mango' illness.

*Premah crop* (seed gonorrhea) differs in appearance from rice-water *premah*. It refers to the period before blisters burst, when the disease has only 'seeded' the skin. Symptoms include cold, fever, and skin irritation. Some Cambodians believe that the 'seed' form of *svay premah* is more difficult to treat because it can travel anywhere in the body and is not necessarily discernible to the eye. Once the skin blisters, the disease is called *svay chaegn* (exposed mango), a sub-category of *svay crop* (seed mango).

*Svay tiktla* is even more ambiguous in terms of symptoms and etiology. According to one traditional healer, *svay tikla* is a less serious form of another category, *svay kraap* (see below). The *mee rook* (causative agents) and symptoms are the same as for *svay kraap* and both require the same traditional Khmer medicine for
treatment. Traditional healers describe symptoms that correspond to variants of syphilis, gonorrhea, lymphogranuloma venerum (LGV), and HPV warts on male patients. Western-trained Cambodian medical professionals identify symptoms such as painful propagating abscesses around the perineum, genitals, buttocks, and other private parts as premah tiktla. Svay tiktla may be chlamydia, since Cambodian medical practitioners describe chlamydial infections as "gonorrhea with clear or serous exudates," contrasting it to the more viscous secretions usually associated with gonorrhea (Eisenbruch 1997: 4).

The third type of 'mango' illness is svay kraap. 'Kraap' means to bend or duck down. Kraap metaphorically means remaining dormant in the body, suggesting poison that lies below the skin. This is the most commonly recognized category of svay among laypeople and practitioners of bio- and traditional medicine. Most Cambodians can describe the symptoms of svay kraap.

Svay kraap is generally understood as a serious form of STD, but it is not clear whether it is simply tertiary syphilis or whether it includes a variety of diseases. In the past, svay kraap was used to refer to infectious diseases such as TB, measles, malaria, dengue, and so on.
The term is still applied to an un-prolapsed uterus (Eisenbruch 1997: 2).

The last type is AIDS. AIDS is included within the svay kraap typology, but inconsistently. Cambodian biomedical experts have not supplied Khmer words for AIDS; they borrow the acronym from Western biomedicine. Villagers class AIDS as a 'mango' illness in recognition that it is sexually transmitted, but which kind of 'svay' remains uncertain. On the one hand, AIDS is like svay kraap in that it remains dormant in the body for a very long time before the mee rook attacks the body and symptoms appear. On the other hand, AIDS symptoms (diarrhea, wasting syndrome, and other secondary infections) are not very much like the usual symptoms of svay kraap or tertiary syphilis. Furthermore, treatment is different. Most Cambodians believe that AIDS cannot be cured with traditional Khmer medicine. Since etiology (mee rook) and symptoms do not match up to old categories in this case, it is possible that AIDS is being seen as a fourth kind of 'svay'.

Superficially, this suggests that Cambodians recognize the link between HIV and AIDS. In Cambodia, however, a person is only considered sick when symptoms appear. HIV (pronounced 'hiew' in Cambodia) is therefore not understood as an asymptomatic stage of full-blown AIDS within Cambodian ethnomedicine. This cultural norm has profound implications for programs aimed at prevention of HIV/AIDS.
Eventually a new term may come into circulation that identifies it as such.

9.7 Gender Differences with Respect to STDs

A popular saying offers insight into the relative value of men over women in Cambodian society: "Men are like gold, while women are like cloth." The implication is that while a piece of cloth easily gets dirty, gold shines even in the mud. By extension, women are blamed for the transmission of diseases because they are perceived as being easily contaminated by their surroundings. Although both sexes are vulnerable to "mango illness," women are blamed for passing on the mee rook, while men are seen as victims of the disease. "Mango illness" is thus a cultural construct linked to gender.¹⁹

In order to understand why women are seen as transmitters of disease, it is important to examine the role of women in Cambodian society. According to Khmer Buddhism, women's primary role is to be the donor (donor of various things, e.g., diseases, financial support, creator of being) (Ledgerwood 1990: 36). Women's actions and thoughts affect men and the entire family (Ledgerwood 1990: 19 It is also linked somewhat to ethnicity. Since most Cambodians believe that many sex workers are Vietnamese, the Vietnamese are seen by men as the progenitors of svay diseases.

¹⁹ It is also linked somewhat to ethnicity. Since most Cambodians believe that many sex workers are Vietnamese, the Vietnamese are seen by men as the progenitors of svay diseases.
62). Women help men at the same time as they depend on them (Ledgerwood 1990: 62). Women are viewed as simultaneously nourishing and depleting. Although ideally soft and sweet, they affect the social order, especially men's social advancement (Ledgerwood 1990: 64). Khmer literature often portrays a virtuous woman marrying a lazy man who ends up becoming a success thanks to his wife. At the same time, a woman without virtue can reduce a rich man to poverty. A woman's character thus creates the environment for either success or decline. This concept carries over to health or illness in the ethnomedical model.

Figure 9.1 below shows the route of infection of "mango illness." Men are considered vulnerable from both their wives and sex workers, but sex workers are seen as the main cause of "mango illness." It is believed that female sex workers accumulate male fluids (semen and blood) in their vaginas. These fluids coagulate in the uterus and are then released to men during intercourse, causing "mango illness." It is believed sex workers themselves do not develop the disease, but instead have "falling white." However, if they are diagnosed as having too much of this
dangerous fluid in their uterus, they may receive
treatment for their disease similar to that for "mango
illness."

Figure 9.1: Male Vulnerability to "mango illness"

Sex Workers → Men (develop symptoms of svay)

Wives (develop symptoms of "falling white," a female condition)

Men who are infected with "mango illness" are never
considered at fault. They are innocent even though it is
disease to their wives. According to general beliefs,
wives can only contract "falling white." Their symptoms,
although similar to "mango illness," are considered
unrelated to svay, or STDs. "Falling white" can also be
contracted from bathing in dirty water or having sex too
frequently. It can be re-transmitted to men during sexual
intercourse. This makes men vulnerable to "falling white,"
although again they are treated for "mango illness."
Almost all patients who seek treatment for STDs are male.
In the context of this gender construction, any inappropriate contact with women may lead to harmful consequences for men. Menstrual blood and breast milk are thought especially dangerous for men (Ledgerwood 1990: 44). Menstrual blood is interpreted as black blood harboring mee rook. Women never develop disease from "black blood," but can put their sexual partners at risk. If husbands have sexual intercourse with their wives while they are menstruating, they are more likely to develop "mango illness." It is believed the "black blood" mixes with male secretions during intercourse and is then sucked up the man's urethra, passing to blood tubules to be distributed throughout his body. At this stage, he either develops svay kraap (syphilis) or the mee rook remains dormant in the body until many years later.20

The fact that men interpret themselves as victims and women as polluters provides a rational basis for male sexual and health behaviors. Men justify having sex with other women by blaming their own wives for not carrying out their wifely duties. At the same time, they blame women as being the cause of contamination, rather than acknowledging their own part in transmitting the disease to their wives.

20 This is a more recent interpretation suggestive of AIDS.
Furthermore, wives purposely describe their illness as "falling white" to protect their husbands from community speculation about extramarital activities. The ethnomedical constructs of "mango illness" and "falling white" are thus clearly gendered. 21

Although women are considered polluters, they are the decision-makers in their own homes. They are considered weak, but they are flexible at the same time. They are submissive, and yet, they are supposed to be active in caring for their children. They often have absolute control over finances, which means that they make decisions on how things should run at home. Cambodian women who work for NGOs are almost always the sole providers for their family. For example, one of the women I interviewed, who was in her forties with two children, described her daily chores to include knowing the precise whereabouts of her own husband. She worked for a local NGO and her salary alone supported the entire family, including his parents who lived with them. She explained that his government salary barely covered his morning meal expenses. She stated that when her husband claimed to be with friends after work, it meant

21 Since traditional Khmer healers do not acknowledge that women can contract svay, Eisenbruch (1997) also ignores women. He overlooks how the social construct of illness shapes gender roles and restricts freedom of movement among women in Cambodia.
something entirely different. The ability to interpret such statements can be a powerful tool. In this case, she stated that he would be with other men in a karaoke parlor or somewhere where sex would be easily accessible. While through connections and various networking with other wives, she learned to identify potential places that her husband and his friends would normally go to. When such occasions occurred, she would intervene. Being active, she suggested, was important in keeping her family healthy and safe. It also showed concerns. At the same time, she stated that losing face was intolerable. A woman should try to maintain her husband’s reputation, meaning there are many subtle ways to do it, depending on each wife’s tactics and skillful manipulations.

Another woman was in a similar professional career. She worked for an international organization on reproductive health, STDs and HIV/AIDS. She was in her fifties with three children. She was also the sole provider since her husband worked for the government. She said that she would tolerate her husband misbehaving to a certain extent, but she would not put up with him if he misbehaved too much. She believed that a woman must not act to embarrass her husband. As a woman, she believed that she
could never trust her husband completely, however. She would question his whereabouts. She claimed that the problem with some Cambodian women was that they trusted their husbands and rarely questioned their loyalty. She wanted to inspire them. She believed if the woman were to be the moneymaker, she should be in a position to influence her husband. She confessed this required a delicate balance. A woman must be intelligent to know when to act and when not to. On the other hand, a sex worker who was in her early twenties, believed it was her fate to be HIV positive. She wanted to die when she found out about her HIV status. She felt she had no control over her own body because of money. Once she paid off the owner of the brothel where she worked, she would try to take care of herself. Only then, she felt that she was in complete control.

These women are the decision-makers. They can influence the way their husbands interact with others, perhaps even prevent them from engaging in risky activities such as frequenting brothels. At the same time, a woman must be able to balance her position in society, so that she can maintain her family’s reputation. It is in this view that Cambodian women cannot be ignored in disease
prevention. They have an important role to play in protecting the family from diseases and ill health.

Another point is balancing social stigma with seeking medical care. On the one hand, an ambiguous illness category such as "mango" serves an important purpose. On the other hand, it creates difficulty in terms of diagnosis and treatment. The cultural construction of "falling white" to describe women's symptoms serves to protect them from stigma of contracting "mango illness." However, it also prevents them from receiving proper diagnosis and treatment. "Mango illness" is a socially stigmatized disease category, suggesting deviant or unacceptable behavior. If a woman were to be treated for "mango illness" and were the head of household at the same time, her condition would have serious implications. She would be judged by her community. Her role would be reduced; she would become the object of sympathy and would lose control of her family's affairs. Her husband would be reduced to being a "bad boy."

The double standards for men and women further complicate treatment. The phrase "bad boy" does not have the same connotations as "bad girl." "Bad girl" is used as a common phrase for sex workers whereas the phrase "bad
boy" does not always have sexual implications but rather means misbehaving generally. This distinction is important when a diagnosis occurs. By diagnosing a woman with "falling white," she would be less subject to public scrutiny and could seek medical treatment. A diagnosis of "white falling" may be problematic, however. If a woman is suspected of having contracted "mango illness," she would receive the wrong diagnosis, and therefore the wrong treatment.

The issue becomes whether to interpret a woman’s symptoms "falling white" to maintain her reputation or as "mango illness" in order to provide her with the right treatment. There is no answer. It is equally important to safeguard her reputation, as it is to treat her for the right disease. Sensitivity to her well-being is an important part of providing proper care. Careful discussion of her condition is essential. A compromise could be made between her and doctor in terms of true condition and what she needed to explain to loved ones. She should be able to make the right choice for herself. Since the domestic sphere belongs to the female headed-household, a woman can influence how she deals with medical care and diseases. The
decision should be up to her with consultation from the health care professional.

9.8 Local Knowledge about 'Mango' Illness

About 72% of Sdaov villagers stated that they have heard of 'mango' illness. A third of these know of two types, svay premah and svay kraap. Only 6% considered AIDS a form of svay kraap. Over 60% believed that svay illnesses are curable, but that AIDS is not, showing that they make a strong distinction between AIDS and more familiar STDs.

The majority of villagers considered men more susceptible than women to STDs, because men were more likely to engage in social activities that increase risk. At the same time, about 30% responded that both sexes were susceptible. Nobody stated that women were at more risk. The average Cambodian woman was not perceived as being at risk for infection unless her husband worked outside of the home. Infections were seen as springing from 'bad' women located far away.

Villagers believed that sexual intercourse was the primary, but not only, mode of transmission (see Table 9.1 below). Kissing, contact with urine, and close contact
with infected people (e.g., by giving or receiving a pedicure or manicure) could lead to transmission.

Table 9.1: Transmission of STDs

<table>
<thead>
<tr>
<th>Mode of Transmission</th>
<th>N=120</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>39%</td>
</tr>
<tr>
<td>Urine</td>
<td>23%</td>
</tr>
<tr>
<td>Sitting next to/touching an infected person</td>
<td>2%</td>
</tr>
<tr>
<td>Kissing</td>
<td>2%</td>
</tr>
</tbody>
</table>

Villagers recognized the symptoms of STDs as including a swollen groin, painful urination, and pus coming from the penis. A few also mentioned abdominal pain and defecation with blood.

Table 9.2: Symptoms of STDs

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>N=120</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swollen groin</td>
<td>21%</td>
</tr>
<tr>
<td>Painful urination</td>
<td>12%</td>
</tr>
<tr>
<td>Pus from penis</td>
<td>6%</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>1%</td>
</tr>
<tr>
<td>Defecate with blood</td>
<td>1%</td>
</tr>
</tbody>
</table>

Approximately 7% of Sdaov villagers knew of treatment protocols for svay illnesses (other than AIDS). They emphasized that they had learned about this from traditional healers, but had never themselves had svay symptoms. They also claimed that it was not difficult to learn about the medicinal plants used in treating svay.
One man stated that he had put together a medicine compound for his best friend who had an STD, but that he had learned how from a healer and had never himself had the illness. Similarly, it was not considered difficult to obtain the right Western pharmaceuticals for STD treatment from any pharmacist or drug vendor.

Seventy-four percent of villagers had heard of AIDS; only 2% believed it was curable. The modes of transmission for AIDS were thought to include sexual intercourse, contact with blood or urine, injection with dirty needles, or contact through giving/receiving a manicure or pedicure.

Table 9.3: Transmission of AIDS

<table>
<thead>
<tr>
<th>Mode of Transmission</th>
<th>N=120</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>16%</td>
</tr>
<tr>
<td>Injection with dirty needles</td>
<td>6%</td>
</tr>
<tr>
<td>Blood</td>
<td>5%</td>
</tr>
<tr>
<td>Manicure/pedicure</td>
<td>4%</td>
</tr>
<tr>
<td>Urine</td>
<td>4%</td>
</tr>
</tbody>
</table>

Villagers stated that nobody in their own village had ever been infected with STDs or AIDS, and that they had learned the symptoms of AIDS from government medical workers who frequented the village and broadcast public awareness announcements. They considered thinness a sign of AIDS, perhaps because they had seen skeletal AIDS patients on televised public advertisements. Villagers
interpreted their bony appearance as lack of food. Other symptoms included spots, blisters, and itchiness of the skin, fever and chills, feeling faint, and fragile bones. A common symptom of AIDS that was not mentioned was diarrhea.

Table 9.4: Symptoms of AIDS

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>N=120</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thinness</td>
<td>11%</td>
</tr>
<tr>
<td>Red/black spots</td>
<td>5%</td>
</tr>
<tr>
<td>Itchiness</td>
<td>4%</td>
</tr>
<tr>
<td>Blisters</td>
<td>4%</td>
</tr>
<tr>
<td>Rotting bone</td>
<td>4%</td>
</tr>
<tr>
<td>Fainting</td>
<td>2%</td>
</tr>
<tr>
<td>Chill</td>
<td>2%</td>
</tr>
<tr>
<td>Fever</td>
<td>2%</td>
</tr>
<tr>
<td>Hunger</td>
<td>2%</td>
</tr>
</tbody>
</table>

These responses show fairly widespread about STDs and AIDS at the village level. These findings may be representative of the level of knowledge in rural Cambodia in general.

Table 9.5: The Villagers' Understanding of the Etiology of "Mango Illness"

<table>
<thead>
<tr>
<th>Etiology of Mango Illness</th>
<th>N=120</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male secretions after sexual intercourse</td>
<td>54%</td>
</tr>
<tr>
<td>Male secretions mixed with menstrual blood</td>
<td>31%</td>
</tr>
<tr>
<td>Using restroom after an infected male</td>
<td>8%</td>
</tr>
<tr>
<td>Having sexual intercourse during menstruation</td>
<td>4%</td>
</tr>
</tbody>
</table>
Table 9.5 presents the most interesting responses about the villagers' understanding of the etiology of mango illness. The majority responded that they thought that exposure to male secretions after sexual intercourse was the main cause of "mango illness." The villagers believed that when released into the woman's womb, these male secretions caused "mango illness." They claimed the woman was at fault for accumulating a lot of male secretions in her womb and re-releasing these secretions to her male clients. The other main cause mentioned was male secretions mixed with menstrual blood, particularly right after a menstrual cycle. Less than five percent provided various other causes of "mango illness" (see table 9.5). None attributed the cause to spirits or ghosts.

Upon further questioning, I discovered that villagers were suspicious of male secretions. They believed that many types of mee rook were embedded in these secretions. The release of these secretions implied a detachment of the mee rook from the male's body. Men could contract "mango illness" the next time they visited a sex worker. Villagers
explained that men could avoid mango illness simply by staying away from sex workers, particularly during their menstrual cycles. The chances of married women contracting "mango illness" increased during menstruation. At the same time, women should stay away from their husbands when they are menstruating. They needed to eat warm food and avoid public restrooms. They said that their full understanding of the cause of "mango illness" had nothing to do with people in their village. They emphasized that they were not aware of anyone who lived in the village that had contracted "mango illness."

The villagers' claims are congruent with responses from traditional healers. The two traditional healers from Sdaov village responded to have treated only people from other villages. Out of 13 traditional healers interviewed, 75% responded to have treated Cambodians with "mango illness" from another village or "the city." The city, referring to the capital Phnom Penh, is considered the main place harboring "mango illness" in Cambodia due to the overwhelming number of sex workers. Less than 15% have treated people in the province. Two other traditional healers had treated AIDS patients in Phnom Penh. These AIDS
patients came from all over the country. None of them were from the village where both traditional healers lived.

The responses from traditional healers were similar to those of Sdaov villagers in that they also believed the mixture of male secretions and menstrual blood was the main cause of "mango illness." The female traditional healers further claimed that the additional urine from the infected male combined with bathing in cold dirty water caused women to contract "mango illness," particularly married women.

In addition, unlike all the others, one male traditional healer described a specific mee rook as being responsible for "mango illness." He further elaborated that this particular mee rook was not from environment—that is, it was not from the dirty water or soil; it was an entity, alive and continuously multiplying in the womb of a woman. This is significant because his explanation somewhat fits the biomedical definition of a microbe and disease etiology.

Among Cambodian health professionals, it was not surprising that the majority of responses (over 80%) matched the biomedical definition of a microbe as the cause of "mango illness." What is more interesting was the small percent who responded differently, however. About 10%
believed that syphilis and AIDS shared the same mee rook, depending on the level of severity of the disease. On the one hand, this response seems appalling. On the other hand, there is rational basis for this response. A mee rook encompasses a wide range of things and can transform itself—its definition is fluid and constantly changing.

Sex workers provided vague answers as to the cause of “mango illness.” While they all agreed that sexual intercourse caused some of the symptoms such as itchiness and painful sensations in their vaginal areas, they could not elaborate further. One woman, the leader of the Union of Sex Workers, in her late twenties, suggested that perhaps male secretions poisoned the woman’s body, which in turn, caused “mango illness.” This view was shared also among AIDS patients whether they were male or female. The only difference was that the male AIDS patients tended to blame sex workers, while female AIDS patients blamed their husbands for the disease. Most female patients resented that they had contracted the virus when they had been loyal to and trusted their husbands. Generally, all these people responded that a mee rook was the cause of mango illness. When further questioned to the actual cause, none could specify what it was.
While the Cambodians' rationale for the cause of "mango illness" may not fit the biomedical definition precisely of disease etiology, it serves an important purpose. It provides a frame of reference in terms of how people understand diseases and ill health.

9.9 Decision-making and Treatment of 'Mango' Illness

Choosing treatment alternatives for STDs and AIDS involves more than trial or error or fusing two separate medical systems to get the best result. Cambodians adhere to certain traditions that have been proven to work over time, at least to the extent that people are satisfied with the outcome of the therapy. My findings reveal that, like many medical systems in other cultures, healing in Cambodia is not a singular event, but a process in which decisions are made each step of the way.

Cambodians actively participate in choosing among alternative treatments for 'mango' illnesses. The decision-maker in the family is generally chosen based upon education and income rather than age or gender. The family decision-maker can be a mother, father, brother, sister, husband, or wife, as Table 8.5 below illustrates. The decision-makers among the families in Sdoav were generally
well respected for their accomplishments. Other villagers described them in terms of financial and educational success.

Table 9.6: The Decision-Maker in the Family

<table>
<thead>
<tr>
<th>Decision-Maker</th>
<th>N=120</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wife</td>
<td>26%</td>
</tr>
<tr>
<td>Both husband and wife</td>
<td>11%</td>
</tr>
<tr>
<td>Educated Children</td>
<td>8%</td>
</tr>
<tr>
<td>Husband</td>
<td>6%</td>
</tr>
<tr>
<td>Active Older Parents</td>
<td>5%</td>
</tr>
<tr>
<td>Educated Siblings/Neighbors</td>
<td>1%</td>
</tr>
</tbody>
</table>

The decision-makers in my study shared similar characteristics. They all had at least a high school diploma and were considered knowledgeable about medicine, society, world events, and technology. Older parents asked their children for advice if their children were old enough to be perceived as having adequate knowledge. Neighbors also acted as decision-makers if they were judged by the family to be sufficiently knowledgeable.

Second, decision-makers are usually those who contribute significant financial support to the family. Parents were the decision-makers if they were still working and earning enough money to support the family. All family members acknowledged that they had financial obligations to care for a patient faced with a life-threatening disease.
In that case, everyone who contributed financially became part of the decision-making process.

9.9.1 Treating 'Mango' Illnesses and AIDS

The treatment of STDs is based on local beliefs and understanding of traditional therapy. My findings reveal that traditional Khmer medicine is preferentially used to treat svay illnesses. If the outcome is not satisfactory, other alternatives are then discussed.

Thirty-five percent of Sdoav villagers stated that they would use traditional botanicals for the treatment of STDs. Plants considered essential for treatment include black sugar cane, local bamboo, wild bamboo, and corn (the cob). Rusted nails are also used. Duration is an essential component of Khmer medicine. It must be taken for a long time in order for the medicine to penetrate deeply into the body and restore its equilibrium.

Twenty-five percent of Sdoav villagers favor Western pharmaceuticals, especially tablets and injections, because they are believed to 'dissolve' quickly into the body and promote rapid healing. Those infected with disease are expected to feel better immediately, but Cambodians believe that their symptoms will reappear at a later date.
Therefore, for a complete cure, many Cambodians use Western pharmaceuticals initially, followed by a long course of consuming traditional medicinal tea. A few individuals knew that antibiotics were the correct treatment for some STDs, but none could specify which antibiotics. They explained that the peet (medical worker) would know.

Another reason for preferring Khmer over Western medicine is privacy. Most pharmaceutical sellers live in the local community. Going to them for treatment of STDs meant risking that the whole village would find out that had contracted svay. Generally, seeking treatment outside the village is preferred. One of the traditional healers in the village claimed that the patients with STDs who came for treatment were all from distant villages and strangers to the Sdoav community.

Treating AIDS is considered more complex than normal svay illness. Most traditional healers admit that they cannot cure a patient with AIDS. Instead, they hope to alleviate some of the symptoms. The first step in treatment is to evaluate the patient’s condition. The healer examines the body closely for 'signs of life', especially the joints, eyes, fingers, and toes. The absence
of color ('whiteness') in the eyes again suggests that the disease is too advanced for treatment. They also check movements of the eyes to determine whether the patient is alert. They generally reject a patient who shows the 'etic' symptoms of full-blown AIDS as defined in biomedicine. A patient with a skeletal appearance is disqualified. The first signs of AIDS, particularly diarrhea and skin problems, are considered more treatable. The patient should also have enough strength to drink medicinal tea, eat, and sleep.

In almost all cases, patients are asked to live with traditional healers while receiving treatment. The cost of being cared for by a traditional healer is often too high for AIDS patients, however. Those who can afford it will drink between 3 to 10 liters a day of medicinal tea, depending on the healer. Effective treatment is measured by three outcomes: 1) resumption of appetite and water ingestion; 2) regular sleep cycles; and 3) weight gain. The first or second sign of recovery is not as important as the last. Gaining weight is perceived to be an absolute measure of improvement. Sufficient weight gain implies that the patient's body has returned to equilibrium.
This section focused on the emic identification of svay illness category and some possible reasons why STDs are referred to as 'mango' diseases. The causes, symptoms, and alternative treatments of various svay illnesses were discussed, as well as the role of gender in beliefs about transmission of svay. Perceptions of treatment efficacy are embedded in cultural models of illness and health. Specific diseases are said to require certain kinds of treatment, whether Western pharmaceuticals or traditional botanical medicines. Cambodians are less sure how to identify and treat AIDS compared to other STDs, and AIDS is not usually considered curable.

9.10 Chapter Summary

This chapter focused on the emic identification of svay illness category and some possible reasons why STDs are referred to as 'mango' diseases. The causes, symptoms, and alternative treatments of various svay illnesses were discussed, as well as the role of gender in beliefs about transmission of svay. Perceptions of treatment efficacy are embedded in cultural models of illness and health. Specific diseases are said to require certain kinds of treatment, whether Western pharmaceuticals or traditional
botanical medicines. Cambodians are less sure how to identify and treat AIDS compared to other STDs, and AIDS is not usually considered curable.

The next chapter concludes this dissertation by providing an overview of Cambodia's recent history and the impact of foreign aid and the HIV/AIDS epidemic.
10.1 Introduction

This chapter concludes this dissertation. The impact of foreign AID and the HIV/AIDS epidemic in Cambodia needs to be addressed by providing an overview of Cambodia’s recent history and this impact on medical decision-making and medical pluralism. AIDS is a complex social problem, and it is directly linked to foreign aid. Development and developing countries are interconnected with little separation, meaning that developing countries depend heavily on foreign aid. And in turn, the impact of foreign aid is not always positive. The next section will highlight some of these points. This chapter concludes with an overview of this dissertation.

10.2 The Impact of Foreign AID and HIV/AIDS Epidemic in Cambodia

The reality is that foreign aid affects every aspect of a society. It is important to understand how foreign aid is tied to the HIV/AIDS epidemic in Cambodia. As described in Chapter 4, by the end of the Vietnam War, the U.S. government was ready to let go of mainland Southeast Asia. When the United States pulled out of Vietnam, Cambodia fell to communist rule under the Pol Pot regime.
The regime was given a seat in the United Nations, which supported its legitimacy. By late 1978, over a million people had been executed by the Khmer Rouge or died of starvation and disease.

Cambodia was neglected by the international community until the Paris Peace Agreement was signed in 1991. The United Nations immediately sponsored national elections, importing a huge number of foreign personnel to direct the elections (see section 4.6.4). Foreign aid was brought in to support reconstruction and rehabilitation of the country. One side-effect of these sudden changes was an exploding sex industry. Cambodian prostitution increased to serve the mostly male UN personnel and as a result of sudden increase in wealth in the country. In 1991, there was only one case of HIV (see section 5.5.1), but by 1995 the epidemic was spreading exponentially.

The spread of HIV/AIDS is thus linked to the flow of foreign aid. In a sense, the UN caused the outbreak of AIDS in the country. Ongoing foreign aid to Cambodia to combat HIV/AIDS suggests perhaps that the international community feels the need to help Cambodians once again. Foreign aid supports public campaigns against HIV/AIDS and long-term care plans for those living with AIDS.
It is important to emphasize a number of issues related to development. Research is essential prior to further project development. Development workers need to conduct feasibility studies to determine local needs and act appropriately. Ethnographic data provides a meaningful way to understand local people. Coordination among donors ensures that there are no wasteful overlapping services. There should also be collaboration between organizations and the governments of recipient countries. Who owns a particular project has a direct bearing on levels of corruption.

One problem is that Cambodians are having a hard time coming to grips with this new disease. As this dissertation shows, AIDS has only recently been incorporated into the 'mango' illness category. However most Cambodians are still confused about the mode of transmission, AIDS etiology, and even where to find help. People assume the worst about those infected with the virus. The findings from this research show that there is much work to be done in Cambodia. Health problems and infectious diseases are still a major concern. Foreign interventions do not solve the country’s main problems such as poverty, lack of education, corruption, and prostitution. AIDS is a complex social
problem that cannot be solved with quick-fix solutions or foreign aid solutions.

The impact of every project should be evaluated. Some projects have been harmful to local communities. Independent monitoring is essential for progress and minimizes corruption. Controlled development can minimize some of the problems currently found in development programs and help alleviate the many social problems that promote the spread of HIV/AIDS. As it is clearly shown in this dissertation, Cambodia has a long way to go in terms of growth and development. However, I am hopeful that someday Cambodians themselves will take the next step to deal with their social problems with minimal technical assistance, and eventually become more independent as they continue to engage in the global market economy, and being able to respond adequately to health problems such as the HIV/AIDS epidemic.

10.3 Conclusion

This dissertation began with an examination of health care system in Cambodia as it relates to caring for people living with HIV/AIDS. Two theoretical perspectives were discussed in Chapter 2: medical decision-making and medical
pluralism, which framed this study. Chapter 3 focused on various social problems as it linked to the spread of the HIV/AIDS in Cambodia. It addresses problems as well as solutions to the allocation of foreign aid and distribution of aid to specific sectors. This chapter discusses corruption and lack of accountability from people who are involved in providing technical assistance. Generally, foreign aid is distributed to poor, developing countries for various reasons depending on the objective/mission of donor's country. This chapter addresses AIDS and foreign AID in Cambodia and how the response from international community triggered the overall response of the Cambodian government. It was important to address the larger context of medical care in Cambodia (Chapter 4). In this chapter, I discussed the history of health care from the Angkorian period to the current medical system. Chapter 5 described the current health care system and health problems that Cambodians are facing such as HIV/AIDS and STDs, following Chapter 6 with a descriptive analysis of Sdaov village. In this chapter, I discussed overall health, village demographics, and change and continuity. Choosing the right research methodology was critical in soliciting the right kind of data for this research. This task was accomplished
in Chapter 7. Chapter 8 examined a variety of illnesses affecting Cambodians and various treatment choices. In chapter 9, I discussed illness category known as "mango" that is uniquely found in the Cambodian medical system. As this dissertation shows, the kinds of social problems that prevent people from having control over their own lives are poverty, prostitution, and migration. This bares direct link on medical decision-making and medical pluralism. This chapter concludes this dissertation by highlighting some major points about the impact of foreign aid and the HIV/AIDS epidemic. I pointed out that Cambodians are still having difficulty understanding the disease, particularly when every family member is affected this epidemic.
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