The Health Sector Strategic Plan 2008-2015 clearly stipulates that the long term vision of the Ministry of Health is “to enhance sustainable development of the health sector for better health and well-being of all Cambodian, especially of the poor, women and children, thereby contributing to poverty alleviation and socio-economic development.”; and furthermore that “A value-based commitment of the Ministry of Health is Equity and the Right to Health for all Cambodians”; and the first of its five Working Principles is “Social health protection, especially for the poor and vulnerable groups: To promote pro-poor approaches, focusing on targeting resources to the poor and groups with special needs and to areas in greatest need, especially rural and remote areas, and the urban poor.

Through the efforts of the Ministry of Health and health development partners, we have made important steps forward in recent years in expanding health services coverage across the country, and in trying to meet the health needs of the poor in particular through implementation of health financing reforms and extension of health outreach services to the most remote villages of the country. The results of those efforts have translated into overall increase in coverage of main maternal and child health care programs as well as communicable diseases interventions and a significant reduction in the child mortality rate.

However, as Demographic and Health Surveys have demonstrated, there are persisting problems of inequity of health care access and health outcomes that are related to the economic status and education backgrounds of the population. Lower levels of income and education in families means that women and children in these families are more likely to have lower access to health care and have a higher mortality risk.

Along with the fast growing urbanization in the recent years, we have seen the expansion of settlement communities in Phnom Penh which consist largely of those families with lower incomes and levels of educational attainment and poorer living conditions. These settlement communities have been the source of public health threats such as a circulating vaccine derived poliovirus in 2006. In 2010 these areas still present a high risk for further communicable disease outbreaks. Thus, better health services will not only improve the health status of these poorer communities, but also will help protect the health of the whole Cambodian population.

This study enables us to understand more clearly the challenges these communities have in keeping their families healthy and gaining access to health care services. Ministry of Health wish is that the Ministry of Health, Provincial and District health staff, relevant local authorities, international agencies and NGOs and community leaders themselves will use these findings to develop strategies to work together to reach out to these populations for both better health services and improved health for the more disadvantaged sections of our society.

Phnom Penh, July 9th, 2010

Professor Eng Huot
Secretary of State
Ministry of Health
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ACRONYMS

ADB  Asian Development Bank
AFD  Agence Francaise de Development
ANC  Antenatal Care
ARI  Acute Respiratory Infection
CAS  Centre for Advanced Studies
CBM  Community-Based Monitoring
CPA  Complementary Package of Activities
DFID  Department for International Development
DPT  Diphtheria, Pertussis and Tetanus
EPI  Expanded Programme on Immunization
FDG  Focus Discussion Group
FHD  Family Health Development
GRET  Groupe de Recherche et d'Echanges Technologiques
GTZ  Deutsche Gesellschaft für Technische Zusammenarbeit (=German Development Cooperation)
HC  Health Centre
HDI  Human Development Index
HEF  Health Equity Fund
HSP2  Second Health Sector Strategic Plan
HSSC  Health System Strengthening in Cambodia
HSUP  Health Services for the Urban Poor Project
IMCI  Integrated Management of Childhood Illnesses
KAP  Knowledge, Attitudes and Practices
MCH  Maternal and Child Health
MHD  The Municipal Health Department
MoH  Ministry of Health
NGO  Non-Governmental Organization
NIP  National Immunization Programme
NIS  National Institute of Statistics
OD  Operational Districts
PAC  Priority Access Card
RH  Referral Hospital
RHAC  Reproductive Health Association of Cambodia
RMIT  Royal Melbourne Institute of Technology
TBA  Traditional Birth Attendant
UHP  Urban Health Program
UN  United Nations
UNCHS  United Nations Centre on Human Settlements
UNDP  United Nations Development Programme
UNICEF  United Nations Children’s Fund
USAID  US Agency for International Development
USG  Urban Sector Group
WHO  World Health Organization
Health Service Access Among Poor Communities in Phnom Penh 2009
= study areas
EXECUTIVE SUMMARY

There is a long-running problem of poor health service access among populations in the lowest socio-economic quintiles throughout Cambodia. In 2005 in Phnom Penh alone, the National Immunization Program identified up to 16 per cent of villages as at risk of outbreaks of vaccine-preventable disease. One of these at-risk communities had been the source of a vaccine-derived polio case earlier in the year, which led to a nationwide immunization campaign and targeted strategies to reach the most vulnerable populations. However, despite those efforts, concerns remain that coverage has not been complete and that the health care system is inadequate to reach the at-risk populations.

To improve the quality and coverage of immunization and maternal and child health preventive programmes for the at-risk populations in Phnom Penh, the National Immunization Program and UNICEF first initiated a health access study. In collaboration, the Centre for Advanced Studies (CAS) along with the Municipal Health Department (MDOH) conducted the study from January through March 2009. The purpose was to identify how communication and health system strategies could be strengthened in terms maternal and child health care, particularly preventive care. The study's purpose was to identify the main barriers to service access and ways to overcome them. The research entailed a literature review, a household survey, one-on-one interviews and focus groups discussions with mothers (of children younger than 5 years), health centre staff and local health authorities in four very poor communities (62 per cent of the households live on US$1–$5 a day).

Although the research was not population based with a sampling methodology that allows the results to be generalized, it has provided in-depth analysis of what the local residents in a few communities think of the health service and how access can be improved for populations at risk.

Findings

This study of selected poor populations in Phnom Penh confirmed that health care access to basic preventive and curative services for women and children has relatively high coverage, considering people's capacity to pay. Immunization rates are high and antenatal services are well used. Mothers have a good knowledge of the risk factors for vaccine-preventable disease, HIV infection, dengue fever and communicable disease. There is also a wide range of market choice of health care service providers, covering traditional, private and public sector services. However, although the quality could not be confirmed, and services come at a high cost relative to income.

Despite the available access and high coverage of health services, the respondents in the study reported poor health outcomes. But they attributed their poor health primarily to the unhealthy social and environmental conditions in which they live.

The four communities selected for the study were chosen through consultations with local authorities. The communities were generally described as having poor solid and waste management as well as inadequate shelter and water supply in some locations. Some 57 per cent of the mothers who participated in the research had completed primary school. They reported their family had spent an average of $66 on health care during the three months prior to the research study. Around 53 per cent of the mothers said that they had to pay for their
child's immunizations. Despite high health care costs relative to their income, only 14 per cent of the mothers interviewed (160) held a poverty or health insurance card exempting them from certain health care fees.

Coverage for immunizations, antenatal care and birth delivery at a facility is surprisingly high, even in the poorest communities. However, 75 per cent of the interviewed mothers said they do not know staff in their local health centre very well; and only 19 per cent of mothers had used the health centre in the previous six months when their child was sick. The private sector is a mother's first choice for child curative care (50.3 per cent). Health centres and government hospitals are the first choice for preventive care (79 per cent of immunization services were provided at health centres and 66 per cent of reproductive health services at government facilities). Because of the fixed-facility strategy, outreach services have stopped.

Perceptions of quality and cost heavily influence the choice of provider. Quality is defined in terms of effectiveness of medicines, perceived skills and attitudes of the health centre staff and the cleanliness and presentation of the facility. Reproductive health services (antenatal and birth delivery) are well used at a range of providers, but especially health centres and government hospitals.

Water, sanitation, waste removal, nutrition, security and income generation were perceived to be the main cause of poor health. There are particular subgroups of the poorest families in the studied communities that are particularly at high risk of social exclusion and social isolation; these include single mothers, young school-aged children and teenagers. Social programmes should target these most vulnerable groups to provide them with a minimum level of social protection for interlinked issues of health, education and food security. Additionally, in recognition of the strong interaction among access to health, education, food security, environmental conditions and income generation, there is a need for wider health public policy implementation for the very poor that takes into account the social determinants of health.

Electronic forms of media and word of mouth are the main channels for spreading health information in communities. The study's findings indicate that where health education programmes of the government and international organizations have been active (immunization, HIV prevention and care, dengue fever) the very poor demonstrate good knowledge of the causes of illness and what is required to avoid illness. The interviewed mothers were less informed on matters relating to maternal health risks, child illness and reproductive health.

Overall, people identified poor health in the context of the social conditions in which they live rather than gaps in health service access. This highlights the need to refocus public health strategies in order to alleviate the daily health and social conditions of the very poor. In some instances, resident health care practitioners and non-government organization (NGO) networks are powerful channels for networking health information and health referrals, especially when linked to local health authorities and local government health services. Local authorities identified their role in health networking mainly in passive terms relating to the gathering of population statistics or conducting social mobilization activities for immunization campaigns. The apparent limited role of local authorities in public health networking for safe water, sanitation and waste removal was striking. All the respondents in the different research methods seemed to lack clarity on exactly who is responsible for public health functions and how to request needed public health interventions.
In Cambodia, there is no single unified health system in the urban context. There is in fact a health market with a wide range of choice of providers and types of service, even for the urban poor. A better understanding of the dynamics of this health market for the poor would guide policy makers towards improving quality health care and social protection for them. Given the scale of the market mechanism for health care, there is also a strong case for increasing the market competitiveness of government health centres through the reduction of client costs (social protection) and improvements in the quality of service. The study’s findings indicate that the very poor pay levels of cost for both preventive and curative care services that are disproportionate to their capacity to pay. Their willingness to pay by borrowing or selling personal property reflects the high priority the poor place on accessing health care.

Policies and systems interventions are needed to protect the poor from the burden of the disproportionate costs through social protection, improvements in public health functions and the health care system. Although the fixed facility strategy has been successful in maintaining coverage, there is still concern regarding pockets of non-immunized children in selected high-risk locations. More investment is required for health centres to micro plan, conduct health education outreach and build stronger partnerships with local practitioners, authorities and NGOs in high-risk communities.

Although there is some degree of clarity of role in relation to the medical service provision through health facilities, the broader functions of public health and primary health care are ill defined. This leaves communities at high risk of communicable disease outbreak. Essential functions of public health need to be defined and resourced, with clear lines of accountability for the Ministry of Health staff, local authorities and communities.

**Conclusions**

Improving access to health care among at-risk populations means improving access to healthy social conditions as well as improving access to health care services. The report notes the following primary areas of action:

- scaling up social protection measures for health care and education in collaboration with civil society and local authorities;
- implementing health care strategies that focus not only on essential medical service packages but also on essential public health functions that address the social determinants of health;
- conducting health surveillance focused on the needs of the poor and not just on their diseases.

**Recommendations**

The five recommendations that are presented in the report cut across three levels of intervention – i) service delivery strengthening, ii) public health function and iii) social protection policy – and largely derive from suggestions by local authorities, health centre staff and mothers. The recommendations speak to two prime needs: making health service more affordable and of higher quality, and making living environments more conducive to a healthy way of life.

**Recommendation 1: Community-based services for the urban poor**

Adequate resourcing of health centres should be introduced for conducting health education and service outreach to at-risk communities on a regular basis. The purpose is three-fold: i)
strengthen links among health services, community practitioners, local authorities, NGOs and communities; ii) make contact with and support local social networks for health (formal and informal); and iii) provide mobile services for the most at-risk populations.

**Recommendation 2: Community-based health monitoring of the urban poor**

The Municipal Health Department (MHD) needs to undertake a systematic approach to the surveillance of at-risk populations through support to districts and health centres. In conjunction with local authorities and civil society partners, the MHD also needs to conduct regular mapping and micro planning for at-risk populations. The mapping exercise should be built into the routine functioning of the surveillance and planning system so that surveillance focuses both on disease and on detecting health risks and health inequities.

**Recommendation 3: Health services quality improvement**

A combined health education and quality improvement strategy should be adopted so poor people can access good-quality and more affordable child-illness care at health centres, such as facility and community-integrated management of childhood illness.

**Recommendation 4: Review of the public health functions**

A review of essential public health functions for improving urban people’s health should identify the resources required and a capacity-building plan to strengthen the delivery of services, either through local authorities, NGOs, health centres or a combination of all.

**Recommendation 5: Review and scaling up the social protection policy**

Social equity funds or ‘social-safety net’ funds, based on a model of the health-equity fund, should be established in the poorest communities in Phnom Penh on a comprehensive basis to ensure very poor people’s access to both health care and education services.
1. INTRODUCTION TO THE STUDY
According to the Cambodian 2005 Demographic Health Survey (Ministry of Planning), people in the lowest socio-economic quintiles have substantially less access to health services. The National Immunization Programme (NIP) in 2005 identified up to 16 per cent of villages in Phnom Penh (109 of 695) as at risk of insufficient coverage (NIP documentation, 2008). One of the identified communities in the National Immunization Programme research was the source of a vaccine-derived polio case earlier in the year, which had prompted national immunization campaigns and other targeted strategies for populations at risk of infection from vaccine-preventable diseases.

Despite the campaigns and coverage improvements, national and municipal health managers continue to be concerned that Cambodia’s communication and health system strategies remain ineffective in reaching the at-risk populations. Thus remains the possibility of repeat outbreaks of the vaccine-preventable disease as well as inequities in maternal and child health outcomes.

To improve the quality and coverage of immunization and maternal and child health preventive programmes for the at-risk populations in Phnom Penh, the National Immunization Programme and UNICEF first initiated a health access study, incorporating both quantitative and qualitative components. In collaboration, the Centre for Advanced Studies (CAS) along with the The Municipal Health Department (MDOH) conducted the study from January through March 2009 and included observations and interviews with residents of communities in four operational districts (OD) of Phnom Penh municipality: Cheung, Lech, Tboung and Kandal.

Specifically, the respondents lived in a selected krom, which is the lowest administrative unit in the Cambodian system. The krom consists of approximately 50 families and has an identified krom leader. Each village within an operational district consists of one or more krom.

The study entailed three stages: 1) community consultations, 2) household survey and 3) interviews and focus group discussions. This report highlights the findings and responses.

A Steering Committee consisting of representatives from the four research partners (the National Immunization Program, UNICEF, CAS and MDOH) managed the study’s proceedings.

Ethics

A study proposal was submitted to and approved by the National Ethics Committee of the Ministry of Health in December 2008. Ethical considerations including obtaining consent and community participation were discussed during the training of the data collectors from the Centre for Advanced Studies in January 2009.

Objectives

The study was designed to analyse the situation in selected at-risk communities within Phnom Penh in terms of health service access. The purpose was to generate sufficient insight for recommendations on improving the communication and health access strategy for at-risk populations. Ultimately, the insight and recommendations would help improve coverage of the Expanded Programme on Immunization (EPI) as well as maternal and child health (MCH) preventative care.
In particular, the study aimed to:
- identify and describe the main barriers to access of health services, through conversations and interviews with community members, health centre staff and local authorities
- identify and describe health system delivery approaches and communication strategies to improve and sustain health service access for maternal and child health care among at-risk populations.

Research methods

The study adopted a case study approach to gain the needed in-depth understanding of the barriers and potential solutions. The study was conducted in three stages:

**Stage 1: Community consultations** (January 2009): Researchers visited the health centres in the four operational districts to identify ‘the most difficult’ or poorest populations. The researchers then travelled to the suggested villages to consult with the village leaders and explain the objectives of the study. From these consultations, four study communities were selected for stages 1 and 2 research.

**Stage 2: Household survey** (February 2009): A standardized household questionnaire was used to randomly survey 160 mothers of children younger than 5 years in the four selected communities. The questionnaire enabled the gathering of background information of respondents and their overall knowledge, attitude and practices regarding maternal and child health care services (see annex 1 for the questionnaire).

**Stage 3: Interviews and focus group discussions** (March 2009): To gather more qualitative feedback, detailed interviews were conducted with 20 health centre staff and key informants. Four small focus group discussions (FGD) were conducted with health centre teams and mothers. The FGDs ranged in size from 8 to 20 participants and relied on open-ended questions. A questionnaire guideline was designed for use with the mothers and with local authorities and health centre staff (annex 1 provides the framework for these interviews).

The targeted at-risk population – typically categorized as ‘slum dweller’ – was characterized as living in the lowest socio-economic conditions: on open land, dikes, sidewalks, the riverbank, rooftops, along railways and rubbish sites or in clusters of densely occupied temporary or unstructured housing. The targeted secondary populations were the authorities and agency staff tasked to provide or facilitate health services to the at-risk population, primarily local authorities, health clinic managers and workers, and local NGO staff.

The four communities were selected by the following criteria:
- area identified by health managers and municipal authorities as the poorest or ‘most difficult’ in terms of accessibility and coverage
- willingness of community leaders (head of village and/or krom) to participate in the study.
Table 1: Study communities*

<table>
<thead>
<tr>
<th>Health centre (HC) catchment and operational district (OD)</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tec Tlar HC, Lech OD</td>
<td>Trabeng Chuuk</td>
</tr>
<tr>
<td>Mean Chey HC, Tboung OD</td>
<td>Dam Charn and Dam Slaeng</td>
</tr>
<tr>
<td>7 Makara HC, Kandal OD</td>
<td>Borey Kaylah</td>
</tr>
<tr>
<td>Samdach Ov HC, Cheng OD</td>
<td>Tuol Sangkhie</td>
</tr>
</tbody>
</table>

*These areas are highlighted on the map on p. ii of this report.

Stage 1: Community consultations

The researchers and the national and municipal health authorities visited each operational district office to identify the health centres with the most difficult to access or poorest populations. The researchers then travelled to those identified health centres to target the areas in their catchment that were the poorest or the most difficult to reach. Then the researchers headed to those villages to meet with the village chief and explain the purpose of the research. The village chief identified the *krom* with people considered the poorest economically. The researchers then moved to the *krom* to meet with the *krom* leader to explain the objectives of the research and the survey’s timeframe and make observations of the area based on their guidelines.

Stage 2: Household survey

Eight researchers from the Centre for Advanced Studies conducted the household survey, with supervision by municipal and national health authorities, a UNICEF consultant and senior CAS researchers. A two-day orientation with the researchers and one-day testing of the questionnaire took place to ensure good-quality data collection.

A two-day training with the eight researchers and a testing of the questionnaire in Boeung Kak community was conducted prior to the beginning the household survey.

In three of the four communities, the *krom* leaders did not have a tabulated list of all households or family names. In one village, the chief had an outdated list (according to the *krom* leader). There were also inconsistent estimates provided on the numbers of families residing in each *krom*. The researchers decided to divide the targeted poorest village areas into three or four blocks, with 10–15 mothers with children younger than 5 years selected from each block; the researchers moved from house to house in each block until 40 mothers had been interviewed. The researchers made their own maps when necessary to ensure that they were sampling the poorest areas.

Figure 1: Hand-drawn map of Dam Charn community (poorest *krom* labelled in black, at the top along the Bassac River)
Table 2: Communities included in the household survey

<table>
<thead>
<tr>
<th>Health centre catchment and operational district</th>
<th>Community</th>
<th>No. of families</th>
<th>Sample household survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tec Tlar HC, Lech OD</td>
<td>Trabeng Chuuk</td>
<td>300–400</td>
<td>40</td>
</tr>
<tr>
<td>Mean Chey HC, Tboung OD</td>
<td>Dam Charn &amp;</td>
<td>250</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Dam Slaeng</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>7 Makara HC, Kandal OD</td>
<td>Borey Kaylah</td>
<td>2,341*</td>
<td>40</td>
</tr>
<tr>
<td>Samdach Ov HC, Cheng OD</td>
<td>Tuol Sangkhae</td>
<td>89</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>160 mothers</strong></td>
<td></td>
</tr>
</tbody>
</table>

*The sample was selected from all the groups in Borey Kaylah. There are 30 groups in the village, and one group consists of 75–80 households. Dam Charn and Dam Slaeng are treated as one community in this report.

Stage 3: Interviews and focus group discussions

For the qualitative survey, the researchers were asked to identify mothers and/or key informants during the community consultations and household survey who could articulate the social context and barriers to health service that they and their neighbours experience. Thus a majority of the interviewees were purposefully selected for the in-depth interviews. For the remainder of the sample, the researchers followed the same process as the household survey, randomly selecting mothers according to the criteria of having a child younger than 5 years and living in the community.

For the FGDs with mothers, one group was selected from each community. In every case, a key informant (local authority, resident practitioner or community leader) assisted in the selection of eight mothers, all with a child younger than 5 years and from a very poor household. However, the focus groups ultimately ranged in size from 8 to 20 mothers because they were conducted in an open area and other residents joined the discussion.

The FGDs with health centre staff were conducted in the health centre closest to each of the four communities. Participation was limited to the workers with employee status of the health centre, with a specific request for the health centre manager, an immunization specialist and an MCH provider. The FGDs ranged in size from 6 to 12 participants, depending on the size of the facility and the staff’s willingness.

The interviews and focus group discussions were conducted by the Khmer researchers in Khmer. Permission was requested from the participants for recording each conversation. Representatives from the National Immunization Programme and UNICEF observed the process.

Given the limited scope of the survey, men (aside from the local authorities) were not purposefully targeted for interviews, although discussion took place with women on the role of men in seeking health care (see annex 1 for more details on the research instruments, methods and content).
### Table 3: Study sample for interviews and focus group discussions

<table>
<thead>
<tr>
<th>Health centre catchment and operational district</th>
<th>Community</th>
<th>In-depth interviews</th>
<th>Focus group discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tec Tlar HC, Lech OD</td>
<td>Trabeng Chuuk</td>
<td>Mothers, local authorities, health centre staff</td>
<td>Mothers Health centre staff</td>
</tr>
<tr>
<td>Mean Chey HC, Tboung OD</td>
<td>Dam Charn &amp; Dam Slaeng</td>
<td>Mothers, local authorities, health centre staff</td>
<td>Mothers Health centre staff</td>
</tr>
<tr>
<td>7 Makara HC, Kandal OD</td>
<td>Borey Kaylah</td>
<td>Mothers, local authorities, health centre staff</td>
<td>Mothers Health centre staff</td>
</tr>
<tr>
<td>Samdach Ov HC, Cheng OD</td>
<td>Tuol Sangkhae</td>
<td>Mothers, local authorities, health centre staff</td>
<td>Mothers Health centre staff</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>8 focus groups</strong></td>
</tr>
</tbody>
</table>

### Data analysis

Following the collection of data through the household survey in stage 2, debriefing meetings were conducted in the CAS office. Responses to the few open-ended questions were recoded before the data was entered into the SPSS program (statistical analysis software). Interpretation of the findings was further debated and validated with the team of researchers at a follow-up meeting. The data was analysed again in the SPSS program and entered into the Excel format for graphic presentation.

*Interviews and focus group discussion analysis*

Following the interviews and focus group discussions in stage 3, the researchers recorded the summaries into thematic areas. The summaries were recorded in Khmer and were typically five pages in length. Following those interviews and FGDs, the researchers met to discuss the main findings and the implications for recommendations.

The outcomes of the analysis were organized into three sections, based on the three stages of research. The findings from the three research method were cross-referenced for consistency in themes. Finally, the overall findings were compared and contrasted with analysis in national and international literature to arrive at a representation of the situation and the recommendations on strategy for improving health service access.

### Study limitations

The research is not a population-based survey with a sampling methodology that produces generalised results regarding health status, knowledge or behaviours which is representative of at-risk populations in Phnom Penh. Rather, it provides an in-depth analysis of four communities in terms of how community members, health staff and local authorities perceive their access to health services and their opinions on how to improve that access among marginalized populations. Further, the research is not a quality assessment of health service provision, although it seeks to understand community members’ perceptions of the quality of the service available to them.
2. COMMUNITY
CONSULTATIONS
FINDINGS
Community profile 1: Trabeng Chuuk

Trabeng Chuuk is located in the catchment area of Tec Tlar Health Centre, in the Lech Operational District. The community members originally resided near a lake a short distance away. However, ten months prior to the study research, a large fire destroyed their housing and the residents relocated to Trabeng Chuuk, which is an empty building site about 1.5 h in size. Different estimates were given for the number of families residing here, ranging from 300 to 500 families.

The environmental conditions are very poor. According to interviews and observations, there is one toilet for the entire community – at least 300 families. Because of the recent relocation due to fire, most of the families are still living in plastic shelters; others are living under coconut palm- or tin-roof structures. Liquid and solid waste are visible in most pathways and roadways, with uncollected rubbish heaped in one corner of the site. Drinking water is piped to the site, and large water containers are available.

Various NGOs are helping the community. Hope Hospital provides a once-weekly service for medical curative care. CARITAS brings water supplies. World Vision provides for home-based care for people who are HIV-positive. The staff of the Tec Tlar Health Centre comes to the area if called, but there is no consistent mobile health service.

Some of the community members work as builders and market sellers. But incomes are very low. Families do not have health insurance or ‘poverty exemption cards’, which exempt them from certain health care fees. Many children are not attending school. Many of the families reported that they were waiting for the local authorities to permit them to return to the original housing site, which was being redeveloped. But the community members are unclear on the timing of the return or if there will be any compensation if they are unable to return.

A mother’s story in Trabeng Chuuk

“My father had many wives and children. My mother was from a remote province. She was very beautiful. My father drove the boats up and down the river and was away a lot…. I have no education. I came to Phnom Penh to work in the garment factory. But then I started also working in the beer halls and karaoke clubs. Then I met my husband; he was a much older man. And he was a drug [addict]. The [police] caught him, and now he is in prison for two years. I do not want to see him again. I [was pregnant]. I tried to drink a lot of alcohol so the baby would abort. But this did not happen. They said that they would take my baby for $100. But after I delivered the baby, I loved the baby and now I am keeping him. It cost me $100 to deliver the baby at the hospital. I cannot return to my mother. I am too ashamed. I am alone now and I have nothing. I work for $2 a day washing the clothes of the people who live by me. I receive no help from the outside – but the people who live nearby me, they help. I have nothing.” – the young mother was living with her newborn under a tarpaulin in a space 2 x 2 m
Community profile 2: Dam Charn and Dam Slaeng

Dam Charn is a village in the catchment area of Mean Chey Health Centre, in Tboung Operational District. The community was established here in the early 1980s. A large fire several years ago destroyed most of the community, but the people recently returned to live along the bank of the Bassac River. The community is of mixed Vietnamese and Khmer ethnic origin. There is a Khmer village chief and a Vietnamese community leader. One NGO provides on-site bilingual education programme for the children.

Dam Charn’s population is unclear. No one had any accurate figure or household listing. Many children were observed at home with elders while the parents were away working. The researchers reported there is no waste removal system or system for managing liquid waste for people living closer to the river. There are no toilets or safe water supplies in the area.

Dam Slaeng village was originally part of Dam Charn village until they were separated in 2007. According to the local authorities, some of the poorest residents in Dam Slaeng (in krom 8, located in the cemetery) had recently migrated from other provinces (such as Prey Veng and Takeo). The krom consists of approximately 50 families. Six families are living in an unused building. Here also the environmental conditions are very poor, with crowding and lack of solid waste disposal. As well, many children seemed to be not attending school.

Due to the proximity of these two communities to each other and their historical connections, for the purpose of this study, the communities were studied jointly using one sampling frame.

Community profile 3: Borey Kaylah

The Borey Kaylah community is located in the catchment area of 7 Makara Health Centre, in Kandal Operational District. The residents began moving here in the early 1980s, setting up temporary homes. In 1993, the community received official status, and the district (sangkhat) authority appointed a village chief. Between 2003 and 2007, formal building structures were established in some spots, and a total of 30 krom were recorded. The groups in total entail some 1,779 families and a population of 9,979 people. The krom leader was unclear on the number of residents or families but said that the village chief’s list was probably outdated. Each krom in this location contains 79–80 families. Three health volunteers cover the population. Some of the families live in high-rise tenement blocks, while others reside in more temporary single-level dwellings.

The standard of living is very low. According to the village chief, people do not live day to day but moment to moment. The residents typically earn money as construction workers, rubbish collectors and market sellers.

There are many health service outlets near the community. These include the referral hospital, the 7 Makara Health Centre, Hope Hospital (an NGO) and other government hospitals. The staff at the health centre report that they are unclear on current service use by Borey Kaylah community members because they are so mobile and there is no structured outreach health service programme. The researchers verified that many of the community members have health insurance cards.
Community profile 4: Tuol Sangkhæ

Tuol Sangkhæ is a village in the Samdach Ov Health Centre catchment area, in Cheng Operational District. The community members live alongside a narrow gauge railway track with a train running through twice daily to transport fuel to a nearby depot.

Tuol Sangkhæ consists of 19 krom, with a total of 367 families. Of them, 153 women have children younger than 5 years. This is also a mixed community, with people of Khmer and Vietnamese ethnicity. Most of the population are factory workers, builders and motorcycle taxi drivers. A few better-off families live further away from the railway track, having moved here since 1988; some have been selling land at the railway site to others and moving on. This area has formed its own community association.

The houses appear to be temporary and are crowded close to the railway track. There are obvious problems with solid and liquid waste and mosquito control. A private doctor operates a clinic along the track and assisted the researchers in contacting households for the study. Some community members reported experiencing economic hardship associated with the recent closure of factories. Community members said they are using the health centre for vaccination services. For other health services, they go to private providers and government hospitals.

A migrant’s story in Tuol Sangkhæ

“I have been here for two years. I moved from another temporary location after [the authorities] wanted to relocate the homes. Where I was staying was too crowded. There was no room. So we moved here. I had my baby one month ago. The birth was quick – it took only ten minutes so I delivered the baby myself. [Someone] contacted the private doctor and he came quickly and cut the cord.

I left my province ten years ago. My family’s land is in the higher country. There the soil is dry and sandy. Without a well you cannot make a garden – you cannot make a living there. So we came here to earn income. But now the factories are closing, and it’s harder to find money. If I stay here long enough, maybe we can get some money … and we can go back to the province and make a well.” – the woman and her family live in a space 2 x 3 m, roughly 8 m from the railway track.
3. HOUSEHOLD SURVEY FINDINGS AND OBSERVATIONS
Figure 2 provides a snapshot of the household survey findings and observations the researchers made during their visit to the four targeted communities and the 160 households.

**Figure 2: Summary of household survey findings**

<table>
<thead>
<tr>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>A total of 160 mothers with children younger than 5 years were randomly selected from the four communities.</td>
</tr>
<tr>
<td>In most cases, there was no household list; so the random selection was done by dividing a community into ‘blocks’, with ten mothers selected randomly from each block.</td>
</tr>
<tr>
<td>The communities were identified by operational district officers and health centre staff as the ‘most poor’.</td>
</tr>
<tr>
<td>The questionnaire of mostly closed but also open-ended questions covered family socio-economics, health knowledge and communication and service coverage and use.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Socio-economics and environment (survey and observation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All respondents reported a low income (62 per cent had an income of $1–$5 per day from the main income earner) and a low education level (57 per cent had not completed primary school).</td>
</tr>
<tr>
<td>There are high health costs, with families spending on average of $66 in the previous three months on health care costs.</td>
</tr>
<tr>
<td>The communities suffer from poor solid and liquid waste management.</td>
</tr>
<tr>
<td>In some cases, there is inadequate shelter.</td>
</tr>
<tr>
<td>The respondents noted a lack of social mobility; they had been in the four communities on an average of 7.6 years.</td>
</tr>
<tr>
<td>The respondents also cited lack of social protection; despite being the four poorest communities identified by health district officers, only 14 per cent of the respondents have health insurance of any kind.</td>
</tr>
<tr>
<td>The respondents reported a sense of physical insecurity, especially at night.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Health communication and knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers have good knowledge of EPI.</td>
</tr>
<tr>
<td>The mothers retain their children’s yellow immunization card (63 per cent) despite their difficult housing conditions.</td>
</tr>
<tr>
<td>Electronic media (TV) seems to be effective in reaching mothers.</td>
</tr>
<tr>
<td>Knowledge on danger signs in pregnancy and warning signs for child illness is limited.</td>
</tr>
<tr>
<td>Local health educators/communicators are not very visible.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Service coverage and use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage for EPI, antenatal care and birth delivery at facility is good, even in the poorest communities.</td>
</tr>
<tr>
<td>The population prioritizes health care.</td>
</tr>
<tr>
<td>Health centres are used for prevention programmes, such as EPI and reproductive health awareness.</td>
</tr>
<tr>
<td>Outreach services have stopped, and 75 per cent of the survey respondents said they do not know staff at the health centres very well.</td>
</tr>
<tr>
<td>Some 19 per cent of the 160 mothers had used the health centre in the six months prior to the survey for a child health consultation.</td>
</tr>
<tr>
<td>The private sector is the first choice for child curative care (50.3 per cent) and Kantha Bopha hospital (20.8 per cent).</td>
</tr>
<tr>
<td>Health centres/government hospitals are the first choice for preventive care (EPI: 79 per cent and reproductive health: 66 per cent at government facilities).</td>
</tr>
<tr>
<td>Some 53 per cent of the mothers said they have to pay for immunizations.</td>
</tr>
<tr>
<td>The use of provider is driven by perceptions of quality, cost and trust.</td>
</tr>
</tbody>
</table>
Of the 160 survey respondents (women with a child younger than 5 years), the mean age is 29 years. The mean size of household is 5.8 persons. Some 84 per cent of the respondents are Khmer and 13 per cent are Vietnamese; 93 per cent are Buddhist. The Vietnamese respondents resided predominantly in the Dam Charn community.

Around 71 per cent of the respondents identify themselves as migrants, and 29 per cent identify themselves as ‘mobile’ (respondents were requested to self identify as mobile – this commonly means that they are frequently coming and going and also residing in other locations). On average, the respondents have lived in the community for 7.6 years. Some 38 per cent of them moved to their current location from another area in Phnom Penh; 55 per cent came from other provinces. Figure 3 highlights the primary reasons the respondents moved to the community.

Figure 3: Main reason survey respondents moved to the community

Environmental conditions: Observations made during the community consultation and household survey detected immensely poor environmental standards. Trabeng Chuuk, in particular, resembles a humanitarian emergency community. Most shelter here is plastic sheeting or makeshift materials. There is one pit toilet for at least 300 families. There are open drains and waterways and no collection of rubbish. Mosquitoes and dengue fever were mentioned as common problems. Although the average household size of 5.8 persons is similar to the national average, in slum conditions this represents overcrowding. The researchers observed that many families live in 2 x 3 m living spaces.

Social problems: Other problems noted during interviews in the community include physical insecurity at night, social isolation of single mothers, gambling and alcohol consumption, non-school attendance and increasing unemployment due to the economic crisis (specifically, loss of work at garment factories).

Socio-economics: Most professions of the main income earners in each respondent’s family are construction (22 per cent), home or market selling (19 per cent) and motorcycle taxi driving (17 per cent). Other work includes carpentry and electrical repair (11 per cent), secretarial (8 per cent) and government jobs (7 per cent).
Only 57.5 per cent of the respondents had completed primary education. Given the low education levels, it is not surprising that the income levels in the families surveyed are also low. Some 62 per cent of the respondents stated that the household income is between $1.25 and $5 per day\(^1\) (figure 4). Although this is in line with the gross national income for Cambodia (at $591), these respondents need to support an urban cost of living. City costs tend to be higher than in rural areas, particularly for health care. In the three months prior to the survey, the mean expenditure by households on health care was $66. Some 25 per cent of the respondents’ households spent $100 or more.

When balanced against the income and other family necessities of education and food, the health care costs are clearly very high.

Some 53 per cent (148) of the mothers surveyed reported that they paid for their child’s previous immunization, although no specific information was collected on how much each paid. Only 14 per cent had a ‘poverty card’ or ‘insurance card’, which exempted them from fees for certain health care services; those having a poverty card all lived in Borey Kaylah where an NGO operates (and manages) a health equity fund.\(^2\)

**Figure 4: Income of main income earners (4,000 riel = US$1)**

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\(^1\) US$1 is equivalent to approximately 4,000 riel (Khmer currency)

\(^2\) A Health Equity Fund is a pro poor health insurance scheme for hospital care services and for a selection of primary care medical services (see Annear et al, 2007)
Health communication and health knowledge

**Health communication:** Some 77 per cent of the 160 mothers reported hearing or seeing a media message on immunization within the previous three months. Of those who heard or saw the information, 84 per cent picked it up through television. Based on the responses, obtaining information on the importance of routine immunization or an immunization campaign seems limited beyond the television. Government health workers (who the mothers said they do not know very well) are the main source of information outside of television (40 per cent). Around 82 per cent of the survey respondents reported hearing or seeing a media message/programme on women’s health within the previous three months. Of those who heard or saw the information, 89.4 per cent picked it up through television. Outside television, government health workers (20 per cent) are the next largest source of information for women’s health, followed by friends and neighbours (at 15 per cent) and then parents or relatives (at 5 per cent). This data, combined with the service coverage data indicates the effectiveness of television in its reach. However, the survey results also suggest poor social networks for health information, especially women’s health.

**Health knowledge:** The majority of mothers could state three major diseases prevented by immunization. This finding is reinforced by the fact that 63 per cent of mothers had the government immunization yellow card in their household possessions. This is a high retention rate, considering the insecurity and crowded living conditions of the households.

**Figure 5: Mothers’ knowledge of diseases preventable by immunization**

The respondents were also questioned on their knowledge of child and maternal health danger signs. As shown in figure 6, 46 per cent of the 160 mothers identified bleeding as a danger sign in pregnancy, and 27.5 per cent cited swollen hands and feet. These responses link with the finding that only 40 per cent of mothers reported hearing from government health
workers about maternal health issues. It also links with the finding that only 60 per cent of respondents reported hearing information on danger signs from a health worker during their last antenatal care visit.

**Figure 6: Mothers’ knowledge of maternal danger signs**

![Mothers' Knowledge of Danger Signs in Pregnancy (N = 160)](image)

For child health, only 26 per cent and 25 per cent of mothers identified fast and difficult breathing, respectively, as reasons for immediately seeking a health facility.

**Figure 7: Mothers’ knowledge of child health danger signs**

![Mother's knowledge of child health symptoms requiring referral (N= 160)](image)
Health service coverage and use

**Immunization:** Immunization coverage in the poor communities is satisfactory. As figure 8 shows, the third dose of diphtheria, pertussis and tetanus, and the hepatitis B vaccines was verified by cards for 88 children of an eligible population of 139 (63 per cent). A further 41 children (29.5 per cent) had been vaccinated, according to the oral history from the mothers. Only 10 of 139 children (7 per cent) were reported by the mothers as not vaccinated.

**Figure 8: DPT-Hepatitis B coverage**

Of the 160 children, 148 received vaccinations as scheduled. The main reason given for the child not being immunized was that the mother was ‘busy’ (9 of the 12 responses). Of the vaccinations provided, 68 per cent were provided at the health centre, 11 per cent at the government hospital and 7 per cent at Kantha Bopha hospital. Only 2 per cent were provided through the private sector. Some 53 per cent of the mothers reported paying for the previous vaccination. The main reason for not vaccinating at the health centre was that some mothers did not know the staff at the health centre (33 per cent) or preferred to vaccinate at another place (23.5 per cent).

The Government stopped funding immunization health outreach services to communities two years ago. The survey results confirm the health outreach services have stopped. When asked how often an EPI team visited their area, 35 per cent of the mothers replied they were unsure, and 15 per cent said not at all. Around 34 per cent indicated there were six monthly visits from an EPI team. As stated earlier, 53 per cent of mothers reported paying for the last immunization provided. However, only 10 per cent of those who did not attend the health centre for a vaccination indicated that the cost was the barrier, suggesting that costs for immunization services are not a significant barrier or are sufficiently low. However, the fact that 9 of 12 mothers who did not receive vaccination at all indicated they were busy does suggest competing economic priorities with immunization programmes that might not exist if the service was free.
**Figure 9: Reasons for not receiving immunization at the health centre**

<table>
<thead>
<tr>
<th>Reason</th>
<th>% Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother doesn't know or trust staff</td>
<td>33.3</td>
</tr>
<tr>
<td>Vaccinated at other place</td>
<td>23.5</td>
</tr>
<tr>
<td>Mother busy</td>
<td>11.8</td>
</tr>
<tr>
<td>Cost of immunization</td>
<td>9.8</td>
</tr>
<tr>
<td>Other</td>
<td>5.9</td>
</tr>
<tr>
<td>Do not care</td>
<td>5.9</td>
</tr>
<tr>
<td>Poor quality</td>
<td>5.9</td>
</tr>
<tr>
<td>Distance</td>
<td>3.9</td>
</tr>
</tbody>
</table>

**Child health:** Respondents were asked to identify the last child illnesses experienced by their child (younger than 5 years) within the previous six months. A total of 149 children of 160 had had an illness, with the different conditions shown in figure 10. The most common childhood illnesses experienced were acute respiratory infection (ARI) (40 per cent), fever (37 per cent) and diarrhoea (13 per cent).

**Figure 10: Previous childhood illness**

<table>
<thead>
<tr>
<th>Illness</th>
<th>% of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARI</td>
<td>40</td>
</tr>
<tr>
<td>Fever</td>
<td>37</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>13</td>
</tr>
<tr>
<td>Not sick</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>
When mothers were asked if they had used the nearest government health centre for a child health consultation in the previous six months, 19 per cent (31) of the 160 replied affirmatively. When mothers were asked how well they know the health centre staff, 75 per cent replied that they do not know them very well, 16 per cent said they know them a little bit, and 9 per cent know the staff very well. If their child had been ill in the six months prior to the survey, the respondents were asked to identify their first provider of choice. Private clinics (27 per cent) and local pharmacies (23 per cent) were the main providers of choice; some 21 per cent said they used Kantha Bopha hospital, and 9 per cent used the health centre.

**Figure 11: First choice of provider for treating child illness**
Figure 12 outlines main reasons for choice of provider. Perception of quality is the main reason for the first choice of provider (49 per cent), followed by cost factors (19 per cent) and distance (12.2 per cent).

**Figure 12: Reasons for first choice of provider to treat child illness**

Reproductive health: Unlike for child health care, the findings for reproductive health care indicate a higher level of use of government facilities. Some 61 per cent of respondents had three or more antenatal care visits for their previous pregnancy. As shown in figure 13, the majority of the mother respondents stated they received most of the recommended antenatal care services, although information provided on warning signs and vitamin A had lower coverage.

**Figure 13: Services provided during antenatal care**
Table 4 indicates that the vast majority of previous deliveries were facility based, with the majority taking place in public hospitals (48 per cent) and health centres (31 per cent).

**Table 4: Location of previous delivery**

<table>
<thead>
<tr>
<th>Delivery location</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital</td>
<td>76</td>
<td>48</td>
</tr>
<tr>
<td>Health centre</td>
<td>49</td>
<td>31</td>
</tr>
<tr>
<td>Home</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>Private clinic</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>160</td>
<td>100</td>
</tr>
</tbody>
</table>

Consistent with previous responses regarding choice of health care provider, the majority of the mothers perceived quality as the main factor (40 per cent) in choosing a reproductive health provider, with distance (21 per cent), economic reasons (19 per cent) and staff attitude (10 per cent) as additional factors.

In terms of delivery location, the first choice was driven by economic factors (24 per cent), distance (20 per cent), trust (19 per cent), quality (19 per cent) and attitude (14 per cent). If trust, quality and attitude are combined, then clearly quality factors are more important than economic factors in health care-seeking behaviours.
4. INTERVIEW AND FOCUS GROUP DISCUSSION FINDINGS
Social context for health service access

Social structures and health care-seeking behaviour

To obtain a deeper understanding of health care behaviours and family capacity to access health services, the study’s researchers looked at social structures in the four communities, in particular:

- the history of the community
- any differences between the village and the community
- the main source of family employment
- how families manage competing resource demands for health, nutrition and education.

In most cases, the communities were established directly after the overthrow of the Khmer Rouge rule, which took place in 1979. Thus they have a relatively long history of multigenerational entrapment in poor living conditions. The communities appear to be continuously growing; there was a particularly strong growth period around 2000. The exception is Trabeng Chuuk, from which many families had been dispersed because of fire.

It is not apparent that these communities are homogeneous economically, although without doubt the majority of the populations are very poor. However, most of the communities appear to have a visible social hierarchy. This is often evident in the way the communities are physically structured. For example, at Tuol Sangkhae, the poorest community members live closest to the railway line, and slightly better off households are situated further from the track. At Dam Charn, the poorest communities live closest to the river banks, with more established families in better housing located further up the river banks. At Borey Kaylah, some families have been relocated into apartment blocks, in contrast to poorer groups who are still residing in temporary housing. At Trabeng Chuuk, residents are classified as those who have procured land and those who are renters.

**Finding 1: Social class and health**

Poor communities are long sustaining, and the poverty found in them is multigenerational. However, not all members of each community are very poor. This makes a case for sustained and targeted social support in order to break the cycle of multigenerational poverty entrapment.

The researchers observed that community members often differentiated between administrative structures (village) and ideas of ‘community’. Most understood the term ‘village’ in an administrative sense, such as in reference to the village leaders. Village leaders make the final decision on key issues and are social mobilizers, but they were not identified with the
term ‘community’ (saharkum). This was reserved most often for local agencies, groups or NGOs that assisted with networks for health service or credit or security of land tenure. In one community, a private medical doctor was identified as the community leader, and this was different to the role of the krom leader or village leader. In another location, the community was identified as within a social protection health network.

In a third location, the community was identified in terms of defending land tenure for the poor. Up to 12 subcommunities were identified within one of the four communities, with the local authority in this case expressing some dissatisfaction with the lack of communication and vested interests among so many subcommunity groups. An ‘ethnic community’ was identified as parallel to the Khmer local authority system in one community.

In most cases, the collaboration between community substructures and administrative structures appeared to be positive. In particular, the local authority in Borey Kaylah cited the collaboration between the NGO Family Health Development (FHD), local authorities and the population as being the best model of relationship between community subgroupings.

Beneath these administrative and community layers, families and neighbours form the basic social structure. In times of social stress (such as needing funds to cover high health care costs), it is to family and neighbours that people turn first for help.

**Finding 2: Social structure and health**

Poor communities are complex in structure and do not rely solely on the administrative leadership for social cohesion or social action. Community members often identify more closely with community subgroups, NGOs and even resident health practitioners and are primarily reliant on their own family and neighbours for assistance. This supports a case for a health promotion strategy to work locally with community subgroupings and families and their networks rather than relying on the administrative organization and procedures.

**The different dimensions of social insecurity among the very poor**

Many of the focus group participants expressed feelings of insecurity, which very much relates to their social context rather than individual behavioural constraints. Physical insecurity was expressed in terms of night-time disturbances, assaults and abuse of alcohol and drugs. But it was social and income insecurity that was the most predominant theme in the discussion of social context.

Social insecurity was expressed in terms of insecurity of land tenure. “We don’t know what will happen to us” and “we don’t know when we will have to move” were common statements from community members in two of the communities.

Income insecurity was often expressed in terms of irregularity of income of the main earners in households. Motorcycle taxi drivers, construction workers, hairdressers and markets sellers are all subject to the vagaries of the market place. For most income earners in society, variation in income can be managed through savings or borrowings. But for income earners of US$1–$2 per day, their family lives in a chronic state of insecurity – uncertain of the income that will come, especially for daily nutrition and education needs for children. This is especially the case when income is irregular.
The researchers found that in many cases, the income insecurity led to restrictions on food purchases and indications of under-nutrition. Notably, families will borrow or sell household items when they need to pay for health services, but the daily education costs are often deemed non-affordable. There were frequent reports of children dropping out from school or attending irregularly due to lack of family income.

Health insecurity was surprisingly not often expressed in terms of not being able to afford health care services (although this is sometimes the case). Access to water and sanitation and the absence of any institutional or social mechanisms for waste management was the most dominant theme in the discussions. Community members, local authorities and health workers consistently identified poor waste management, water supply and sanitation as the main threats to the health of families. Most childhood illnesses and even adult illnesses were attributed to uncleared rubbish, lack of toilets, standing water and mosquitoes. Sometimes the problems were attributed to personal and household behaviour, but more often, they were identified as community characteristics that people – even the local authorities – felt powerless to resolve. "The words of the poor are cheap," explained one long-term resident.

Given these conditions, it is hardly surprising that there is a heightened sense of ‘living for the moment’. It is difficult to undertake or envision long-term community or household planning in this chronic state of daily insecurity and powerlessness. Frequently, the researchers heard community members say they are “living for the day”. One local authority member indicated that many community members do not even live for the day but live from “moment to moment” in order to cope with each day’s needs.

Finding 3: Social insecurity

There are many aspects of social insecurity in communities that impact on health and well-being. These include physical, income and health insecurity. This social context for health and well-being indicates that the primary determinants of poor health in these communities can best be understood in structural rather than behavioural terms. This supports a case for a more comprehensive social policy approach to address the structural factors rather than a reliance on health education strategies for individual behaviour change.

Exclusion and social isolation

Participants in both the in-depth interviews and focus group discussions talked of exclusion and social isolation, mostly related to the structural determinants of income capacity, education access and powerlessness previously noted.

Single mothers in particular are at high risk of exclusion due to absolute income poverty. In one case, a single mother was completely dependent on her neighbours for income and social contact. Because they dropped out of school, many young adults are exposed to risks of drug abuse and prostitution.

The researchers found limited examples of community activities or structured gathering locations for young people. In one community, an NGO was active in providing therapy for injecting-drug users, and in other communities, home care visits were conducted by an NGO supporting people who are HIV-positive. Overall, services or social activities are not in place for young people in the four communities.
The process of social exclusion starts very early.Repeatedly, community members highlighted the daily income demands of education as a major strain on family income and on social participation. In some cases, NGOs provide education programmes for young children within the community. In other cases, NGOs provide income support for children to attend schools. Local authorities try to help the children of poor families through the provision of a letter to the school teacher exempting them from paying school fees (as is the case with certain health care services). There was one example of children being transported to the local pagoda for education classes where children in a community could not afford the government school.

The dynamics of social exclusion are structural rather than behavioural in nature. Although, there were reports about negative attitudes among health clinic workers who look to see what a patient is wearing to decide who will be treated first – “You have to have money. If you do not have money, they won’t pay much attention to us,” explained one resident. Community members also reported that they are “looked at” by health staff to determine whether they can pay or not.

In all four communities, health centre staff indicated that they exempt the very poor from payment for certain health services. However, those health workers also indicated that in the absence of a poverty card or a letter of exemption from the local authority, they will look at the clothing or personal items of a patient to make an on-the-spot poverty assessment.
The absence of systematic social protection mechanisms increases the risk of a mistrustful relationship between health professionals and clients. This equally applies to the relationship between the education sector and community, with some people indicating that children are “afraid” of the teacher if they do not have enough money to pay for school expenses.

The daily struggle to manage family food, education and health care costs with a low income was a consistent theme spoken of throughout the research.

According to one local authority official, “Health is a big problem here. When people get sick here they go to the private health care provider first and buy medicine. This means they spend a lot of money on this – they spend a lot on medicine. But if they go to the government service, they would not spend so much money. Then they spend on the children for going to school. I provide them a letter sometimes to the teacher so the teacher does not take money from the poor, but the teacher still needs to take money. So if we think about it, health and education and food, they spend more on education – they have to spend on education every day…when they do go to school they often stop at level two or three…they just don’t have the capacity to send them to school.”

And one mother commented, “I have two children going to school, but one has had to stop...because we have no money for the teacher. Our family is spending more money than our income....our standard of living is lacking. We have no rice field or garden. For health care, we pay money every now and then, but for education you have to pay every day and for food we have to spend most of all.”

Families use various coping mechanisms for their day-to-day survival and basic needs. For health care, they typically sell household or personal property, borrow from a family member or neighbours, seek out NGO or pagoda support, or ask for assistance from the local authority (letter of poverty status to exempt them from certain fees). Health centre staff indicated that they do not ask the poorest of the poor to pay, but there were many cases in which people did not seek out health care, opting for exclusion or social restriction.

In summary, people in the four communities mentioned the following coping mechanisms:

- not sending children to school
- restricting food intake
- in some instances, not seeking health care for chronic conditions
- borrowing money or selling property to pay for health care.

**Finding 5: Social vulnerability and health protection**

Health workers assess the poverty status of their patients, and patients know they are being assessed for their capacity to pay. As a result, mistrustful relationships have developed between government health centre staff and community members. Those people with exemption cards expressed confidence in attending health facilities. This makes the case for extending the health equity fund or related health protection schemes to increase the use of health care services by the very poor.
Social networks for health

When questions regarding social networks for health care were asked in the research interviews and discussion groups, most of the participants indicated that they were not aware of any formal network (with the exception of the health equity fund scheme in one community). However, following further discussion on patterns of health service use, it became clear there are many informal social networks for health care.

Informal networks: Informal networks mostly consist of word-to-word relay of information about where to access health services that are of quality or are affordable. Many mothers reported taking their children to the Kantha Bopha Hospital for care and treatment; reasons given for this choice were quality, perceived skill of the health providers, effectiveness of treatment and the zero cost. Nearly all the mothers interviewed said they had heard about the hospital from a neighbour or family member.

The same applied to seeking abortion services Women discussed the various methods and outlets available for an abortion, nearly exclusively through pharmacy shops or through favoured private practitioners. But what they knew they had learned from other women.

For other situations, the choice of delivery was motivated by perceptions of the quality of the provider as expressed by a family member or neighbour. The women reported that within their family, they are the main caregiver and decision-maker on health issues. In fact, they were quite dismissive of the man’s role in health care decision making. The man’s role was valued more in terms of arranging transport in an emergency or in organizing the funds to cover the health care costs. But in terms of importance, women identified themselves as the primary agent, care giver and decision maker on health matters.

In terms of recommendations for improving health service access and public health in general, many of the research participants indicated that it is necessary for local authorities and community members to be active through discussion, meetings and even house-to-house awareness raising. This suggestion reflects the importance of word-of-mouth networking of health information and how it appears to be the most influential factor affecting health care-seeking behaviour.

Formal networks: The researchers identified clear NGO roles for improving health care access or in alleviating social conditions that impact on people’s health. Examples of practices already in place include agencies providing home-based care for people with HIV or AIDS (these were very visible and frequently mentioned), community schooling or subsidizing...
payments to teachers, direct health care services provided by NGOs and helping people access services through health insurance or health referral mechanisms. Both the local authorities (village leaders and group leaders) and community members were highly trustful and confident in the role of NGOs at the community level in supporting social protection and poverty alleviation. The main limitation of the NGOs was perceived to be the lack of adequate service coverage for the poor.

Local authority networks: Local authorities’ identified their own role in health networking, mainly in the passive terms of gathering population statistics or conducting social mobilization activities for immunization campaigns. However, the apparent limited role of local authorities in public health networking for safe water, sanitation and waste removal was striking. Both health workers and local authorities and community members seemed to lack clarity on exactly who were the primary organizers and responsible agents for public health care and how information and requests for public health interventions are networked. (Note: Care should be taken with this conclusion. The hesitancy of local authorities to participate in public health functions in these communities may be related to the perception that some of the communities are illegally occupying public lands.)

Resident health practitioners and volunteers: The researchers found examples of health practitioners who had been residents in the communities over a long period of time (doctor, midwife). These resident practitioners are well known and trusted members of the community as well as trusted health care providers. They are very influential in affecting the health care-seeking behaviour of the population. One resident practitioner had previously worked in a community clinic operated by the Reproductive Health Association of Cambodia (RHAC), which is a national NGO. When the RHAC support ended, the practitioner continued to refer community members to the health centre and meet with the health centre staff regularly to discuss the health status of the community. This study confirms the findings of previous urban health evaluations in Phnom Penh (such as Vickery, 2003), which advised that positioning health workers in at-risk communities is an effective way to link the population to the formal health system.

**Finding 7: Local health networks**

Resident health practitioners and NGO networks are powerful ways to spread health information and make health referrals, especially when linked to local health authorities and local government health services. Local health networks are linked to social networks through the formal and informal providers who frequently visit the communities or actually live in them.
Utilization patterns of health care services and access barriers

The health care market and the health care system

With help from local women’s groups, the researchers mapped the health care market options available to the urban poor in the four communities. The women’s group members identified the locations and types of providers on hand-drawn maps and listed out the reasons why each provider is used and the choice of service. For example, the map of Dam Charn community (figure 14) illustrates the significant range of available health service choice.

Not marked on the map (outside the map boundary) is the wide range of choices of government and NGO hospitals and clinics used for delivery care, immunization, family planning and child sickness care. An additional range of services and choice is available locally for treating sick children, such as pharmacies and shops selling medicines. What became apparent from the health mapping exercise is the lack of an overall single system or consistency in patterns of health care use – there is considerable variation based on local characteristics. These include the presence or not of resident health practitioners, the distance to facilities and the local perceptions of quality of care and cost. Thus, the health care system is a complex market system with a range of choice in terms of provider type, service type and cost.
In line with the household survey findings, the interviews and group discussions demonstrated that choice is affected by perceptions of quality, attitude and cost of services. There are also ‘preferred service providers’ for specific types of services.

Quality was often defined in terms of hygiene or technology, such as “the hospital is very clean” or “they have all the modern equipment”, or in terms of outcomes, such as “the medicine is very effective” or “the child gets better quickly”. The community members often cited the perceived skill of the provider as being critical when they were seeking health care. On the other hand, a provider with a poor attitude is viewed very dimly by clients. The poor attitude was interpreted mostly in terms of waiting longer because you are poor, being looked at to see if you are poor or not, and impolite speech. All of these quality factors seem to influence people’s selection of provider.

Additionally, specific types of facilities were preferred for having packages of quality services. Health centres are highly valued for immunization services, antenatal care, AIDS (and HIV,
including testing and counselling) services and, increasingly, birth deliveries. Government hospitals are highly valued for acute child health illness and delivery care. The private sector is highly valued for the convenience of managing childhood illness. NGOs are valued for reproductive health care and social protection (where it exists). Choice is therefore mediated by location, perceptions of quality and type of service provided. However, cost is a major issue and thus is a major factor in decision making about when and where to seek health care.

For immunization services, the household survey indicated that 53 per cent of the respondents were paying for the service. Nevertheless, costs were not high. There was no reported case of refusing any immunization service because of high cost, although, the household survey indicated that 10 of 51 mothers who did not have their child vaccinated at a health centre stated that cost was the deciding factor. It also helps that the health centres have a reputation for providing good-quality immunization services. One health centre worker commented that “even people in Land Cruisers” come to get their children immunized at the facility. But when it comes to a baby delivery, health staff reported the richer patients will use hospitals.

**Figure 15: Analysis of health care per capita costs in the four communities**

![Health care costs per capita](image)

The need for health care are intermittent and thus the poor seem to find some way to mobilize the funds needed to cover the costs. Even the poorest seem able to find $100 for birth delivery fees in a hospital. This is understandable given that it is a predictable cost. However, it does not diminish the significant impact on the poor of unpredictable or catastrophic health care costs. This study indicates that the poor in the four communities pay more than (at $43.7 per capita) for health care than the nationally estimated $33 per capita (National Health Sector Plan, 2008).

Covering the recurrent costs of education and food leaves the poor the most insecure financially. However, there were instances in which people in the research areas did not seek out health care services because of the cost. In one krom, women in one FGD stated that they

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3 For national health care per capita costs, 75 per cent of costs are out of pocket. For this study, the costs were all out of pocket.
did not seek care for female health issues because they feared the expense. Some local authorities noted that many people delay seeking health care until quite late out of fear of the expense and subsequent economic loss. There was also one case of a man who sold his house to cover medical care expenses in the family. Thus, the fact that health care costs are intermittent does not mitigate the severe impact that these expenses have on very limited family income.

Participants in the women’s group in Borey Kaylah expressed a high degree of satisfaction with the system of health insurance operating through the NGO Family Health Development (FHD), in partnership with local authorities and government health services. However, there was no evidence of any systematic implementation of financial social protection measures for the poor in any of the other communities.

**Finding 9: Health care costs and the limitation of choice**

Evidence from this study indicates that the very poor pay levels of cost for both preventive and curative care services that are disproportionate to their capacity to pay. This capacity to pay through borrowing, sale of personal goods or support from neighbours reflects the high priority the poor place on accessing health care. This being the case, policy and systems interventions are needed to protect the poor from the burden of these disproportionate costs through social protection, improvements to public health services and health system strengthening strategies.

**Gaps in knowledge**

During the focus group discussions with mothers and with health centre workers, the participants were asked to list the main health problems that arise in their family and rank them according to seriousness; they were also asked to identify causes and solutions. Both communicable and non-communicable diseases were ranked, but with childhood communicable diseases (fever, cough, diarrhoea) being the most consistently mentioned.

It is interesting that the community members and health workers consistently highlighted structural factors as the most predominant causes of ill health. This includes poor nutrition, stagnating water and poor sanitation. That is, poor health is equated with living conditions or individual behaviours rather than patterns of health care-seeking behaviour (such as promptly taking a child with fast breathing to a clinic).

The participants articulated the causes and solutions for communicable disease conditions, such as vaccine-preventable diseases, HIV infection and dengue fever, which were identified as particular problems in the communities. Although the lack of an adequate food supply was often referred to in the interviews, it was not correlated with illness – invariably, it was the living environment and personal hygiene and behaviours that were considered the main causes of the high rate of illness.

Women’s health was often identified as a problem by both men and women but it was not linked to sexual health. Rather, women’s common health problems were linked to individual behavioural risk factors of a non-sexual kind, such as poor personal hygiene.

Repeatedly, the cause of illness was linked to social and environmental conditions: dirty water, poor sanitation and waste removal, nutritional limitations, social isolation, gambling, drug and alcohol abuse, unemployment among youth, low income and insecurity (night-time violence).
Health Service Access Among Poor Communities in Phnom Penh 2009

Gaps in health care

Health services: The findings from the household survey indicate that access among the very poor to basic preventive medical services is very good in the four communities. This was confirmed in the interviews and focus group discussions in most cases, which reflected the following patterns of use:

Health centre services are trusted and relied upon for specific packages of preventive services, in particular: immunization, antenatal care, voluntary counselling services for HIV and, increasingly, birth deliveries. Government hospitals are used for treating reproductive health problems and severe illness. The private sector is relied upon for managing mild childhood illnesses and certain adult illnesses. The research participants reported that local private sector practitioners are close to the community, are well known and that visits to them do not impose any hardship on the daily income earning. This contrasts with the use of government facilities; people stated they frequently have to wait for a long time. If children are seriously ill, they are taken to a hospital (Kantha Bopha or the National Pediatric Hospital). Health centres were not mentioned in terms of treatment for a sick child. In fact, staff in one health centre reported that they had not had any formal training in the integrated management of childhood illness (IMCI).

Finding 10: Health knowledge and awareness

The findings from this study indicate that where health education programmes of the government and international organizations have been active (immunization, HIV prevention, dengue fever) the very poor demonstrate a good knowledge of what causes common illness and what is required to avoid them. However, the research participants were less knowledgeable on matters relating to maternal health risks, a sick child and sexual health. Overall, people identified ill health in the context of the social conditions in which they live rather than in terms of gaps in health services.

Finding 11: Child care for the very poor

The private sector is the first choice of care for people in poor communities in the case of mild illness; government hospitals are preferred for severe illness. Health centres are preferred for prevention services (immunization, antenatal care, HIV testing and counselling). There is a case for strengthening IMCI service provision in health centres that is then supported with the same strategy for communication applied for immunization campaigns and antenatal care. This would prevent the unnecessary and potentially costly procurement of non-essential drugs by clients through private-sector outlets.

The introduction of the fixed facility strategy for immunization through the National Immunization Program in 2006 has clearly provided some benefits to the services and to the population in terms of increasing demand, efficiency and income generation for health centres. However, during the health centre mapping exercise, it became apparent that the service providers were no longer confident on who in the community was immunized and who was not. Prior to 2007, health centre staff conducted regular outreach programmes to the
harder-to-reach areas. Thus regular contact was made with village volunteers, local authorities and the community. Now in Phnom Penh, all immunization services are provided only in health centres.

When marking hard-to-reach or slum areas on health centre catchment maps, the health centre workers demonstrated knowledge in locating them but they expressed less confidence in identifying pockets of non-immunized children. Comments, such as the following, indicated the health centre staff’s uncertainty of population coverage in high-risk areas:

- “We are not sure what is going on there now.”
- “Funding for outreach has stopped so we cannot be sure.”
- “These places are confusing – people are coming and going all the time.”

It was also not clear whether social mobilization and communication meetings were taking place regularly enough with local authorities and village volunteers. Even though it is a fixed-facility site strategy that relies on population demand, funding is still required for health education and social mobilization in communities for the fixed facility strategy to work. Staff in one health centre noted this to be a problem, and action had already been taken by the district director to develop systematic meetings with local authorities on a monthly basis in order to identify and resolve issues that health staff and local authorities could manage together. Despite this limitation, the research participants expressed a feeling that the quality and demand for services at health centres had improved in recent years. Figure 16 highlights other strategies that are working well in terms of access by the poor to health services; figure 17 summarizes findings of reactions to the fixed facility strategy of the National Immunization Program.

**Figure 16: Summary of what is working well in relation to health service access**

- Community members and health centre staff report that health centres are preferred and are increasingly relied upon for immunization services and antenatal care.
- There is a high rate of household possession of immunization cards – the population values immunization and its benefits. This is also apparent for antenatal care and birth delivery by professional providers.
- Community members and local authorities in Borey Kaylah all expressed a high level of satisfaction with the health financing scheme. It eases the financial burden of the poor, engages the local authority in health care and increases the use of the government facility where quality can be more assured, compared with the private sector.
- In some cases, there are health practitioners residing in communities who work as private providers through NGOs or as volunteers. These resident practitioners have the trust and confidence of the community and are the vital referral link to government services.
- Health messaging by the MOH and international partners is clearly having an effect – the poorest of the poor are making every effort to access immunization, antenatal care and birth delivery services despite the high costs (relative to their income and living conditions). This also reflects the high level of commitment by health workers and families to the care of women and children, despite the situation of extreme poverty.
Based on the study’s findings, however, Phnom Penh is still at-risk of vaccine preventable disease in at-risk populations in Phnom Penh. This is due to the lack of adequate financing for operational monitoring of unreached areas. This operational surveillance could be strengthened through i) systematic micro-planning and mapping in high risk areas; ii) meeting with local authorities and volunteers in high-risk areas on a regular basis; iii) scheduling community visits by health centre staff to high-risk areas; and iv) developing stronger partnerships with NGOs and volunteers and local area practitioners in these areas.

Finding 12: Reaching the hard to reach
Although the fixed-facility site strategy has been successful in maintaining coverage, health centre workers and manager are concerned about pockets of non-immunized children in selected high-risk locations. Under the outreach scheme, regular contact was made with village volunteers, local authorities and the community; this community exchange has been significantly diminished under the fixed-facility site strategy.

Public health: As previously noted, community members, health workers and local authorities (village and krom leaders) consistently pinpointed social and economic conditions as the prime determinants of poor health. Although limitations in access to health services due to the cost were also identified as an issue, it was clear the social and economic conditions of daily life represented the fundamental health and disease burden, as reflected in the following comments from the research participants:

- “Water is pooling everywhere, especially in the wet season. The mosquitoes bring dengue.”
- “The air is bad here, the community is not healthy. There is too much rubbish and water lying around.”
- “There is one toilet here for 300 to 400 families.”
- “We are afraid to ask for better drainage systems and water. This is a temporary location.”
- “We used to try and organize the rubbish to be collected in one place, but then [the government] stopped coming to collect it. So people now don’t collect the rubbish in one place.”
- “Some of the new people who come who are the renters are causing a lot of trouble at night. So after dark, we close the doors and don’t go out.”
- “There is nothing here for young people to do and parents cannot afford to keep them at school, so they just wander around. It’s easy for them to get into trouble.”
- “Education – that’s the problematic one. We have to pay for this every day. Health we pay for some times. But education we have to pay every day. It’s a big problem.”
“What we eat each day depends on our income. Sometimes we cannot eat what we want.”
“There is nothing here for the young people to do or any place for them to go. There are no programmes for them.”

Although health costs and occasionally the attitude of health workers were sometimes identified as a problem (costs were mentioned more often), it remains the case that it is the economic and social conditions of everyday life that are the main factors affecting access to healthy conditions of life, in contrast to access to health services. Figure 18 contrasts recommendations from a health centre focus group and a women’s group from a local poor community. What is interesting in the contrast of perspectives is the service delivery focus of the health centre staff and the public health care focus of the community perspective.

One of the principal findings of this study is that the main barrier to health care for very poor communities is not so much health service access but rather limited access to basic public service functions in the community. Consistently, community members and local authorities (and health centre staff to a lesser extent) cited structural determinants of poor health as the main cause of ill health rather than limited access to medical services. Sanitation, waste removal, stagnating water, poor nutrition, security and income generation were perceived to be the main drivers of poor community health. But when asked who is responsible for the environmental and social conditions in the community, the responses were not well articulated. Health centre workers hesitated to respond. In the end, the consensus seemed to be that it was a joint function of the Ministry of Health and local authorities.

**Figure 18: Contrasting perspectives on recommendations for improving health and health care access**

<table>
<thead>
<tr>
<th>Recommendations from health centre staff</th>
<th>Recommendations from a women’s group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disseminate information so people know and understand what services are available through the health centre.</td>
<td>Please ensure health centre staff speak politely to sick patients.</td>
</tr>
<tr>
<td>Communicate closely with the local authority so he can inform the population about services at the health centre.</td>
<td>Please make the cost of health services cheaper.</td>
</tr>
<tr>
<td>Inform people who come to the health centre to tell other people about the services at the facility.</td>
<td>Please ensure the health staff pay attention to the needs of the sick.</td>
</tr>
<tr>
<td>Raise awareness among people about not buying medicines from pharmacies as a first choice of treatment.</td>
<td>Please don’t let the sick patients wait too long.</td>
</tr>
<tr>
<td>Ensure an adequate medicine supply at the health centres.</td>
<td>We need to have poverty cards (bun krey kro) so the health staff do not take money (charge for service).</td>
</tr>
<tr>
<td>Ensure sufficient space for services (an additional room) in the health centre.</td>
<td>Please help the local authority provide an adequate water supply and electricity.</td>
</tr>
<tr>
<td>Provide additional technical training for health centre staff.</td>
<td>Please help the local authority prepare adequate drainage systems in the community.</td>
</tr>
<tr>
<td>Increase the salary (make more appropriate) of health centre staff; health centres should have higher salaries for a smaller number of staff.</td>
<td>From a mother</td>
</tr>
<tr>
<td></td>
<td>We have to keep our environment around the house clean and also look after food hygiene.</td>
</tr>
<tr>
<td></td>
<td>NGOs should help our children to go to school and learn, help us find work and provide loans so we can earn income to send the children to school.</td>
</tr>
</tbody>
</table>
|                              | NGOs should help us about domestic violence so to protect households from men coming home to their family when they have been drinking and using violence in the house.
When asked to define their own function in relation to health, local authorities saw their role more in terms of gathering statistics and social mobilization and less so in actually requesting or mobilizing resources for public health interventions. This lack of clarity on accountability for environmental and social conditions relates in part to insecurity of land tenure – local authorities may not want to put in place environmental infrastructure when there are legal disputes over the land. Regardless of legal or political questions, these communities are highly vulnerable to an outbreak of communicable diseases because of dysfunctional public health functions relating to safe water, sanitation, waste removal, nutrition and youth affairs. This requires urgent attention.

Finding 13: The public health function
Although there is some degree of clarity of role in relation to medical service provision through health facilities, the broader functions of public health/primary health care are ill defined. This leaves the communities vulnerable to a communicable disease outbreak. Essential functions of public health need to be defined and resourced, with clear lines of accountability for the Ministry of Health staff, local authorities and communities. Specifically, it must be clear what needs to be done and who is responsible for it.

A community leader’s story
“This community started in 1979 after the end of the Khmer Rouge time. It started with 10–20 houses. But in 2000, the numbers increased sharply. Then the people just bought and sold land from each other. About 70 per cent of the population is lacking a means for basic livelihood. There are motorcycle taxi drivers and factory workers here. But the main problem is poverty. People are short of food, especially children. There is little living space for some people. There is gambling and fighting. Children stop going to school at year 8 or 9. They start walking around in groups. What people want is what they can be provided now. It is hard for them to think beyond this time.

In 2003 we started a community association. A community is a way of negotiating on rights for people. But the words of the poor are cheap.

Local authorities can help with many health issues – environment, nutrition and hygiene, for example. But what is in it for them? I say we need a sanitation system, they say – “You got a million dollars?” The direction has to come from the central Government, otherwise they will not move. Sometimes people’s houses fall down, so they rebuild and still the police walk by and ask for money to authorize reconstruction. There has to be something in it for people.

It is not enough for one person to have commitment for things to change. So I am quiet now.”
5. RECOMMENDATIONS FOR IMPROVING ACCESS TO HEALTH SERVICES
As the study progressed, it became clear to the researchers that the social dynamics and interactions of low income, education and health care costs and food prices place significant daily pressure on poor families. More frequently than not, it is education costs that are most commonly set aside. However, it is education that offers the best opportunity for the families to escape poverty by providing the younger generation with skills and capacity to bring more income into the family at a later age. The inability to afford and secure education costs for young children is a sure way to lock families into multigenerational poverty. Families are already disadvantaged by high health care costs (relative to low incomes). But due to the dysfunction of urban public health, these families are also exposed to higher rates of illness due to environmental hazards and nutritional deficiencies. This cycle of illness and poverty is effectively excluding the very poor populations from wider social participation in the skilled workforce and in public dialogue regarding their social conditions.

The recommendations from this study derive from suggestions of local authorities, health centre workers and managers and community members. The suggestions spoke generally to two issues: making health service more affordable and of higher quality and making daily living environments more conducive to a healthy way of life. That is, it was structural and systematic factors of health systems, society and government rather than behavioural changes of individuals that were identified as the best ways to move forward. These structural or systematic strategies should target three levels: service delivery strengthening, public health functions and social protection policy.

The researchers for this study propose five recommendations that cut across those three levels of intervention. The following outlines the five recommendations and includes a list of associated priority actions for implementing them.
RECOMMENDATION 1: Community-based services for the urban poor

This study has found that health authorities and agencies have been very effective in informing poor populations of the benefits of maternal and child health care – particularly for immunization and antenatal care. But there are gaps in the service delivery generally for maternal and child care, especially for maternal health, women’s health and management of a sick child. It is also highly likely there are pockets of undetected at-risk populations that are not accessing services at all.

There is no question that the access of the very poor to health care services for a narrow band of preventive and curative services is impressive. Information from this study indicates that the communication strategies of the Ministry of Health and development partners and health centres have been effective in stimulating demand for immunization, antenatal and delivery services in particular.

Health facilities have been noted to be centres of high demand for immunization, antenatal care, birth delivery and HIV testing and counselling services. However, the researchers qualify this statement based on their observations on the scope of care; the success of the fixed facility strategy (in stimulating access for the majority) may come at a cost to a minority of the population. That is, the cessation of outreach services and lack of strong connections with local informants, NGOs and local authorities means that fixed-facility sites do not have the surveillance and resource capacity to detect and respond to the needs of small pockets of unreached populations. For this reason, a service and communication strategy needs to be developed specifically to meet the needs of the urban very poor.

Recommendation 1: Community-based services for the urban poor

Adequate resourcing of health centres is needed for conducting health education and services outreach to at-risk communities on a regular basis. The additional resourcing would i) strengthen links between health services, community practitioners, local authorities, NGOs and communities, ii) establish contact with and support local social networks for health (formal and informal) and iii) provide mobile services for the most at-risk populations.

Implementing action:

- Identify the 20 most at-risk communities in Phnom Penh in four operational districts and define an essential package of health services to be provided to each community on a monthly basis.
- Facilitate the networking of local health care practitioners, NGOs and community leaders for health communication, referral and local problem solving of priority public health issues. This can entail monthly communication meetings with formal and informal social networks (similar to fixed-site meetings) but with a wider public health agenda.
- Facilitate the formation of local community groups (mothers’ clubs or health providers groups, etc.) for linking a community to maternal and child health and other social services.
- Define clearly the adequate human and financial resources required for responsible health centres to provide additional services to the urban poor.
- Develop a detailed, costed multi-year action plan; include it in the annual operational plan for the National Immunization Program and the Municipal Health Department; the plan should identify human and material and communication resource requirements.
RECOMMENDATION 2: Community-based health monitoring of the urban poor

As noted in the findings, most surveillance focuses on disease outbreak. This is particularly the case in relation to vaccine-preventable disease. Less emphasis is placed on surveillance of health and public health. This necessitates the transition of surveillance from a current focus on ‘disease’ to a broader view – structuring a more systematic approach to health monitoring of the social and economic factors that impact on health and health access for at-risk populations, namely food security, waste management, water and sanitation and social protection for health and education.

More recent analysis and findings through the Cambodian Anthropometric Survey (2008) has highlighted high rates of severe malnutrition among the urban poor and the associated need to put in place effective community-based monitoring (CBM) of the nutritional status of children. Based on the findings of this health service access study, it is clear that such a CBM system should be extended to incorporate immunization status, school attendance and assessment of health insurance status to ensure that health practitioners, planners and policy makers have a comprehensive assessment of the situation of the urban poor and thus can structure a well-informed response plan. This will also assist with targeting the urban poor for more comprehensive social policy measures (see recommendation 5).

RECOMMENDATION 3: Health services quality improvement

Despite the high coverage of care, this study has detected limitations in the quality of care, particularly in relation to the management of a sick child. A range of other studies have indicated the dubious quality of care provided through private facilities. There is no systematic strategy for ensuring quality in this sector. Yet it is to this sector that most families turn in the event of child illness.

Operational Districts and health centres have demonstrated that they can generate a large demand for immunization, antenatal care, HIV testing and counselling, and birth delivery services. Despite these successes, the vast majority of the very poor still prefer to access...
private medical services in the first instance when a child becomes sick. This comes at a relatively high cost. This being the case, the integrated management of childhood illnesses (IMCI) services (with an associated communication strategy) should be applied at urban health centres in order to improve the quality and coverage of care for sick children in very poor families.

Given the successes of the MOH, partners and health centres in generating demand for certain services, there is definite scope for promoting public health care through the strengthening of these centres in order to provide good-quality IMCI services at an affordable cost. As well, the poor should be protected from high health care costs through the provision of health insurance or user fee-exemption systems.

**Recommendation 3: Health services quality improvement**

A combined health education and quality improvement strategy should be adopted so that poor families can access better quality and more affordable care for sick children from health centres (for example, facility and community IMCI).

**Implementing action:**

- Develop and cost a detailed plan to train and implement an IMCI strategy in urban health centres.
- Consider developing community-based partnerships for a community-level IMCI strategy (involving referral and care community practice networks of local private practitioners, pharmacists, NGOs, local community and administrative leaders).
- Support the implementation of a child sickness management strategy with a national communication campaign along the already successful lines of EPI, dengue fever and HIV prevention.

**RECOMMENDATION 4: Review of the public health functions**

With the publication of Cambodia’s National Strategic Development Plan and in light of the findings of the Global Commission on the Social Determinants of Health, along with the 2008 World Health report (WHO, 2008), there is now a strong national and international focus on widening the scope of health interventions from medical care to public health or primary health care.

However, the capacity of health centres and districts is already stretched in terms of providing medical care services. This being the case, the development of public health strategies and interventions will require strong partnerships and institutional and human resource development programmes within local authority, health and civil society structures at the village and district levels. This will mean significantly raising the level of function and resourcing of local authorities for public health functions. Further, the endeavour will require shifting roles from social mobilization and data collection to more proactive leadership and participation in the problem-solving process and in the delivery of essential public services, such as environmental health and social affairs.
The trend towards selective primary health care and health sector reform has delivered important results for population health in terms of scaling up essential service delivery packages. However, health inequities across different socio-economic groups are persisting. Although medical services are increasingly available, even for the urban poor, the accountability for performance of essential public health or primary health care functions (water, sanitation, waste management, social affairs) remains very unclear. A thorough review of essential public health functions of local administrative and health authorities should be undertaken in order to define essential public health functions, the resources required for implementation and accountabilities for performance.

RECOMMENDATION 4: Review of the public health functions

A review of essential public health functions for urban health should identify resources required; a capacity-building plan is needed to strengthen the delivery of essential public health functions, either through local authorities, NGOs, health centres or a combination of all.

Implementing action:

- Conduct a review of essential public health functions for urban health that identifies resources required, specifies accountabilities and leads to a capacity-building plan to strengthen the delivery of essential public health functions, either through local authorities, NGOs, health centres or a combination of all.
- Design the concept paper and terms of reference for the review, identify resource requirements and seek consensus from the MOH and other relevant ministries for implementing the review.

RECOMMENDATION 5: Review and scale up social protection policies

It is time to recognize the synergies in development between health, education and nutrition. Then in recognition of these synergies, consideration should be given to the implementation of a social protection policy or social safety nets with cross-sector links.

The main finding from this study is that the primary determinant of poor health and poor access to health services are essentially structural in character. ‘Structural’ refers to the social and economic constraints of daily living and how this impacts on health, income availability, education access, cost of health services, the exercise of power by local authorities, water and sanitation and social opportunities for the young in particular. This is of course not a new finding – internationally, the Commission on the Social Determinants of Health has indicated that the first of the three principles of action for reducing health inequities is to “improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age” (WHO, 2008 p. 2). Health equity should therefore be at the centre of urban planning and not on the periphery of it.
This study has found that a majority of the very poor are willing to listen to health care messages and pay for health care services to follow these messages, even though it sometimes comes at a formidable cost. The daily cost of education and food and the intermittent costs of health care means that sometimes families have to go without or self-restrict demand for basic human needs. Other studies support these findings. The Cambodian Anthropometrics Survey conducted in 2008 indicates that acute malnutrition among poor urban children has increased from 9 per cent in 2005 to 16 per cent in 2008, exceeding the threshold of 15 per cent wasting rate use, to identify a humanitarian emergency. As for the demand-side factors, poverty was confirmed as the most critical factor in determining the level of effective access to primary education in Cambodia (UNICEF, 2007).

Government and development agencies need to focus on the social determinants of health. Over-emphasis on economic growth and lack of emphasis on social development, particularly for the very poor, means that a government objective of poverty reduction is not attainable for many of the very poor. Although a health sector-specific policy can make a difference, it cannot reduce poverty when not acting in collaboration with food security, income generation and education initiatives. In this sense, there is an important distinction that needs to be made between health policy and social policy. Broader social policy initiatives (or social safety nets) that take into account the social determinants of health status and that address the needs of the very poor should be designed and implemented in high-risk communities as a first step.

Key components of such a strategy should include:
- social protection measures for health and education in collaboration with civil society and local authorities;
- implementation of health strategies focusing not only on essential medical service packages but also on essential public health functions that address the social determinants of health status;
- health surveillance focused on the needs of the poor and not just on their disease (see recommendation 2 on community-based monitoring).

These social policy developments will be critical in the coming years, given the global and national trends in urbanization. A UN Habitat report on urban slums stated that in 2001, 924 million people, or 31.6 per cent of the world’s urban population, lived in slums. In Cambodia, recently released census data indicates that the growth rate for urban areas has been 2.55 per cent and 1.3 per cent for rural areas. The population in Phnom Penh has grown 32 per cent in ten years, between 1998 and 2008 (NIS Census, 2008). These demographic facts point to the need for a long-term comprehensive strategy for urban health care for the very poor in order that public policy can anticipate and respond to the well-established social and demographic trends.

Focusing the discussion about social exclusion on structural determinants also opens up the possibility to have a more fruitful public dialogue regarding causes and solutions to urban poverty and ill health. It enables the discussion to move away from a ‘blame game’ (health workers have a bad attitude, the poor don’t look after themselves and governments don’t care) to a problem-solving exercise focusing on structural and process change.

This study has documented how activities of daily living, including income generation, food security, education and access to health care are interlinked issues in a family setting. For this reason, there is a strong case for linking policy initiatives of health, education, labour and environment into a broader and more cohesive healthy public policy (combined with social policy) that takes into account the social determinants of health status and their impact on
quality of life for families. Clearly one area where this linking could take place is social protection.

The information from Borey Kaylah community indicates the high value that community members, health centre staff and local authorities place on the operation of the health equity fund scheme. People in the other three communities, where no or very limited social protection measures are in place, also recommended the introduction of these schemes as a high priority to reduce health care costs for the very poor. Studies across Cambodia published in the international literature support the claims of residents, local authorities and health centre workers that social protection schemes, such as the health equity fund, can increase poor people’s access to public facilities (Annear, 2008; Jacobs, 2007; Noirhomme, 2007). Targeting the health sector for quality improvement is necessary but insufficient – the approach needs to comprehensively address social sector barriers to good health and not only to medical care services. This is also currently being addressed by higher level Government of Cambodia policy discussions regarding efforts to research and development comprehensive social safety net strategies for the very poor (Council for Agriculture and Rural Development, 2009).

Recommendation 5: Review and scale up social protection policies

Social safety-net equity funds, based on a model of the health equity fund, need to be established in the poorest communities in Phnom Penh on a comprehensive basis to ensure access to health care and education services for the very poor.

Implementing action:

- **OPTION 1:** Scale up existing health equity funds to all the urban poor areas of Phnom Penh (comprehensive health equity fund scheme for the urban poor).

- **OPTION 2:** Conduct a feasibility study on the development of a social safety-net equity fund model for health, education, food security, building on the already successful model of health equity funds in Phnom Penh.
6. CONCLUSIONS
This study has confirmed that, even for the very poor, health access to basic preventive and curative services for women and children is relatively good, in proportion to one's capacity to pay, in some of the poorest communities in Phnom Penh.

Immunization rates are high and antenatal care services are well utilized. Mothers have good knowledge of the risk factors for vaccine-preventable disease, pregnancy, HIV infection, dengue fever and communicable disease. There is also a wide range of market choice of health care services from traditional, private and public sector care services, although quality assurance of private and traditional care services cannot be confirmed (Rose, 2002; Ramage, 2001).

However, despite the wide access and high coverage, there is consensus across families, local authorities and health centre workers that the principle source of poor health outcomes are the unhealthy social and environmental conditions in which people live on a daily basis. The combination of barriers in access to education services, low incomes and poor environmental conditions means that families are at chronic risk of communicable disease. It is the social and environmental conditions rather than access to medical services that are the main barriers to sustaining and improving family and community health.

This being the case, this study concludes that improving the health status of at-risk populations means improving their access to healthy life conditions and not simply removing the barriers to health care services. Certainly there are immediate steps that can be undertaken to improve links to the community to identify the most vulnerable. In the short term, practical improvements to primary medical services, health management practices and in health education strategy would make a difference to health care access for the poor. In the medium term, improvements to essential public service functions and in the long term, development of healthy public policy, expressed through the extension of social protection for health care, education services and food security, presents the best prospects for breaking the multigenerational cycle of poverty in the poorest communities of Phnom Penh.
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ANNEX 1: RESEARCH INSTRUMENTS

Details of quantitative research instruments

Household surveys

The purpose of the household survey was to develop background information on knowledge, utilization and health service client satisfaction prior to conducting more in depth analysis through in-depth interviews. Topic areas centred on the following:

BACKGROUND INFORMATION. This part of the questionnaire collected information regarding population mobility, socio-economic status and cultural backgrounds of respondents.

KAP EPI – MCH. This part of the questionnaire collected information on health communication and knowledge of mothers with respect to maternal and child health care and immunization.

UTILIZATION OF SERVICES. This part of the questionnaire assessed immunization coverage and patterns of use for maternal and child care health services (delivery, management of a sick child and reasons for selecting a provider).
Household questionnaire

Section 1: Background

<table>
<thead>
<tr>
<th>No.</th>
<th>Questions</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>What age are you?</td>
<td>Years old_________</td>
</tr>
<tr>
<td>2</td>
<td>How long have you been living in this community?</td>
<td>Months_________</td>
</tr>
<tr>
<td>3</td>
<td>Are you a migrant to this community?</td>
<td>Migrant 1 Mobile 2</td>
</tr>
<tr>
<td>4</td>
<td>Before you came to this community, where did you live?</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>How many children do you have?</td>
<td>#_________</td>
</tr>
<tr>
<td>6</td>
<td>What was the main reason you /your family moved to this community?</td>
<td>1 2 3</td>
</tr>
<tr>
<td></td>
<td>CAN ANSWER UP TO THREE RESPONSE (RANKING ACCORDING TO PRIORITY)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>What education level have you completed?</td>
<td>Code __________</td>
</tr>
<tr>
<td></td>
<td>Code 0 Never learned or entered primary school</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Code 1 Completed primary school</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Code 2 Completed secondary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Code 3 Completed university</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Code 4 Post-graduate study</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Code 5 No answer</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>How many persons reside in this household?</td>
<td># Residents_________</td>
</tr>
<tr>
<td>9</td>
<td>What religion are you?</td>
<td>Buddhism 1 Catholic 2 Muslim 3 No religion 4 Other religion (please specify) 5 No response 9</td>
</tr>
<tr>
<td>10</td>
<td>To which ethnic group do you belong?</td>
<td>Khmer 1 Vietnamese 2 Cham 3 Chinese 4 Other (please specify) 5 No response 9</td>
</tr>
<tr>
<td>11</td>
<td>What is your current marital status?</td>
<td>Married 2 Divorced 3 Separated 4</td>
</tr>
</tbody>
</table>
12 What is the job of the main income earner in the family household? ________________________________

13 What is your estimated family income per day? Less than 5,000 riel per day 1
5,000–20,000 riel per day 2
More than 20,000 riel per day 3
Not regular 4
Unsure 9

14 In the past three months, what is the estimated family income spent on health? #

15 Can you understand the staff in the health centre? Yes 1
No 2

16 Are you able to read and write Khmer? Very well 1
Not so well 2
Cannot read or write 3

Section 2: KAP immunization and MCH

No. Questions Coding

17 In the past three months, did you see or hear anything on the radio, television, newspaper/magazine or loudspeaker about childhood immunization or child health? Yes 1
No 2
Don’t remember 3

18 From what source do you hear the most about the childhood immunization or child health? PLEASE SELECT ONE

   Television 1
   Radio 2
   Newspaper/magazine 3
   Loudspeaker 4
   Poster 5
   Public meetings 6
   Others (please specify) 7
   Don’t know 9

19 Apart from the sources mentioned above, from whom do you hear the most about childhood immunization or child health? PLEASE SELECT ONE

   Government health workers 1
   Drug seller or private clinic 2
   Traditional healers 3
   Heads of village/commune 4
   Parents or relatives 5
   Friends or neighbours 6
   NGO 7
   Others (please specify) 8
   Don’t know 9

20 In the previous three months, did you see or hear anything on the radio, television, newspaper/magazine or loudspeaker about women’s health (or maternal health)? Yes 1
No 2
Don’t remember 3

21 From what source do you hear the most about women’s health? (maternal or reproductive health) PLEASE SELECT ONE

   Television 1
   Radio 2
   Newspaper/magazine 3
   Poster 4
   Public meetings 5
<table>
<thead>
<tr>
<th>No.</th>
<th>Questions</th>
<th>Coding</th>
</tr>
</thead>
</table>
| 22  | From whom do you hear the most about maternal health? | Government health workers 1  
Drug seller or private clinic 2  
Traditional healers 2  
Heads of village/commune 3  
Parents or relatives 4  
Friends or neighbours 5  
NGO 6  
Others (please specify) ____________ 7  
Don’t know 9 |
| 23  | How many times did you see any health worker for antenatal care for the previous pregnancy? | Did not see anyone 1  
One to three times 2  
Four to six times 3  
Six times or more 4 |
| 24  | At an ANC visit, did you receive any of the following:  
CHECK RECORDS (CHECK PINK MOTHER CARD) IF CANNOT REMEMBER  
PROMPT WITH OPTIONS | Tetanus injection Y/N/DK  
Iron tablets Y/N/DK  
Advice on your diet in pregnancy Y/N/DK  
Information about warning signs during pregnancy Y/N/DK  
Mebendazole capsule Y/N/DK  |
| 25  | What diseases can be prevented by immunization? |  |  
|  | DO NOT PROMPT |  |
| 26  | What are the danger signs in pregnancy that require a woman to seek medical care? | Bleeding 1  
Severe headache 2  
Trouble with vision 3  
Fever 4  
Swollen hands or face 5  
Reduced or faster foetal movement 6  
Other please record__________ 8  
Do not know 9 |
| 27  | Sometimes children have severe diseases and should be taken immediately to a health facility. What types of symptoms (danger signs) would cause you to take your child to a health facility right away? | Child not able to drink or breastfeed 1  
Child develops a fever 2  
Child has fast breathing 3  
Child has difficult breathing 4  
Child has blood in the stool 5  
Child is drinking poorly 6  
Other please record__________ 8 |
<table>
<thead>
<tr>
<th>No.</th>
<th>Questions</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>Did your child receive a DPT Hep B vaccination?</td>
<td>Mother reports immunization was given 1</td>
</tr>
<tr>
<td></td>
<td>CHECK THE IMMUNIZATION YELLOW CARD AND RECORD DATES</td>
<td>Immunization date DPT3 recorded on the yellow card 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Immunization not given 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Record date of birth of child..</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Record date DPT1 provided..</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Record date DPT 2 provided..</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Record date DPT 3 provided..</td>
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<tr>
<td></td>
<td></td>
<td>IF RECEIVE ONE DOSE OR COMPLETE DOES GO TO QUESTION 30</td>
</tr>
<tr>
<td>29</td>
<td>If your child did not get required vaccination as scheduled, what were</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>the reasons?</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>30</td>
<td>Who came to tell you information about receiving immunization services?</td>
<td>Government health workers 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Head of Group/Heads of village/commune 2</td>
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<td></td>
<td></td>
<td>Village volunteer 3</td>
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<td></td>
<td></td>
<td>Neighbours 4</td>
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<td></td>
<td></td>
<td>Went by themselves 5</td>
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<td></td>
<td></td>
<td>Others (please specify)</td>
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<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>31</td>
<td>Where did your child usually have vaccination?</td>
<td>Health centre 1</td>
</tr>
<tr>
<td></td>
<td>(if 1, please go to question 30)</td>
<td>Hospital 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Private clinic 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Others (please specify)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
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<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>32</td>
<td>What are the main reasons your child did not receive vaccinations at the</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>health centre?</td>
<td>2</td>
</tr>
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<td></td>
<td>RECORD ACCORDING TO PRIORITY 1</td>
<td>3</td>
</tr>
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<td></td>
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<tr>
<td>33</td>
<td>How often does an immunization team reach your area?</td>
<td>Monthly 1</td>
</tr>
<tr>
<td></td>
<td>SELECT ONE ONLY</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 monthly 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 monthly 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not at all 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unsure 9</td>
</tr>
<tr>
<td>34</td>
<td>For the previous vaccine your child received, did you have to pay for it?</td>
<td>Pay 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not pay 2</td>
</tr>
<tr>
<td>MATERNAL HEALTH</td>
<td></td>
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<tr>
<td>-----------------</td>
<td></td>
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</tr>
</tbody>
</table>
| 35 | Where was the location of delivery of your most recent birth? | Phnom Penh 1  
Province 2  
In this community 3  
Other 4 |
| 36 | Where was the place of delivery of your last child? | Health Centre 1  
Public hospital 2  
Private clinic 3  
If answer 2, 3 or 4, skip to questions 38 and 39  
Home 4  
Other please describe_____________5 |
| DO NOT PROMPT |
| 37 | What was the main reason for choice of location for delivery? | 1………………………………………………….  
2………………………………………………….  
3…………………………………………………. |
| PROVIDE RANKING (1 – 3) |
| 38 | Who assisted with the delivery? | Midwife 1  
TBA 2  
Doctor 3  
Other please describe_____________4 |
| IF DELIVER AT HOUSE OR OTHER LOCATION |
| 39 | What was the main reason for choice of provider for your last delivery? | 1………………………………………………….  
2………………………………………………….  
3…………………………………………………. |
| PROVIDE RANKING (1–3) |
| 40 | Do have an insurance card for receiving health care services? | Yes 1  
No 2 |
| IF NO SKIP TO QUESTION 42 |
| 41 | Who provided the insurance card to you? | Local authority 1  
NGO 2  
Church 3  
Government. 4  
Other 5 |
| 42 | Do have a poverty status card (health card) for receiving health care services? | Yes 1  
No 2 |
| 43 | Who provided the poverty card (health card) to you? | Local authority 1  
NGO 2  
Church 3  
Government. 4  
Other 5 |
| 44 | How far is the nearest government health centre from your house? | #  
Do not know 6  
Not sure 9 |
| 45 | Do you know the health staff who works there very well? | Know very well 1  
Know a little bit 2  
Do not know well 3 |
| 46 | Do you know whether the staff has a daily immunization service that is provided at the health centre? | Yes 1  
No 2 |
<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td>What was the type of illness last experienced by your child in the previous six months?</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>For this illness, who was the first choice for seeking treatment?</td>
<td>Local pharmacy 1, Private clinic/hospital 2, Health centre 3, Public hospital 4, Other please describe 5</td>
</tr>
<tr>
<td>49</td>
<td>What was the main reason for the first choice of health provider?</td>
<td>PROVIDE RANKING (1–5)</td>
</tr>
<tr>
<td>50</td>
<td>Have you used the nearest government health centre for child health consultation in the last three months?</td>
<td>Yes 1, No 2</td>
</tr>
<tr>
<td>51</td>
<td>What do you like best about the government health centre?</td>
<td>PROVIDE RANKING (1–3)</td>
</tr>
<tr>
<td>52</td>
<td>What is the thing you dislike most about this health facility?</td>
<td>PROVIDE RANKING (1–3)</td>
</tr>
<tr>
<td>53</td>
<td>For the last consultation for reproductive health (delivery, women’s health, birth spacing, antenatal care), who was the first choice for seeking treatment?</td>
<td>Local pharmacy 1, Private clinic 2, Health centre 3, Hospital 4, Other please describe 9</td>
</tr>
<tr>
<td>54</td>
<td>What was the main reason for the first choice of health provider?</td>
<td>PROVIDE RANKING (1–5)</td>
</tr>
</tbody>
</table>
Qualitative research instruments

Qualitative survey

For the in-depth interviews and focus group discussions, an open-ended questionnaire guideline was designed for mothers, local authorities and health centre staff. All three contained specifics for each category and the questions followed the main topic areas:

SOCIAL CONTEXT FOR HEALTH. This topic area involved discussions about standards of living, daily living priorities of health, food and education and the history and background of the community. The purpose of this line of discussion was to gain a deeper understanding of the social context and determinants of good health and health service access.

LEARNING ABOUT SOCIAL NETWORKS FOR HEALTH. This area of discussion focused on patterns of health care-seeking behaviour and communication in the community about health and health service use. The purpose of this discussion was to gain a deeper understanding of how people learn about health services from their own community.

DETERMINANTS FOR SERVICE UTILITY. This area of discussion focused on why community members choose to use specific health services. This also enabled deeper understanding of the quality, provider behaviour and the impact of cost on access.

RECOMMENDATIONS FOR IMPROVING ACCESS. Following on from the previous discussions, participants were encouraged to provide their own recommendations on improving health care service access.

The principal approach in the focus group discussions was based on the participatory learning action (PLA) approach, which contains three main components:

1. Facilitators’ behaviours and attitudes (being sensitive to who controls the collection and use of information).
2. Methods that combine visuals materials (such as mapping, modelling, diagrams) and working with small groups.
3. Sharing (encouraging practices and behaviours that empower through local creativity and ownership of study process and findings).

In the context of this study, participants were encouraged to lead the discussion through a range of PLA techniques, such as:

1. Mapping of health service access by community members and health centre workers – participants were encouraged to physically map the community, its main features as well as health access points (whether traditional, private or public).
2. Listing and ranking of main health problems (either through writing or pictorial representation).
3. Making recommendations for improvements to health care access.
1. Focus group discussion with community members

1. Facilitator describes objectives
2. Listing main health problems and locate on map. Use poster with the following throughout the focus group discussion (FGD):

   List with symbols and detail the following:
   - frequency
   - seriousness
   - causes
   - solutions

3. Discussion of seriousness – put a star against the most serious health problems
4. Discussion of reasons for main health problems
5. Mapping
   - physically map the community with local community members
   - map important locations
   - map where people go for health services, especially MCH-related services

6. Suggested solutions
   Select four topic areas for problem solving health improvement or improvement to health service access, especially for MCH.

2. Focus group discussion with health centre staff

1. Mapping
   - physically map community
   - map important locations
   - map where people go for health services, especially if MCH related

2. Listing and rank main health problems and locate on map
   - discussion of main health problems in the slum areas
   - discussion of reasons for main health problems
   - ranking of health problems in slum areas specifically

3. Suggested solutions
   Select four topic areas for problem solving health improvement or improvement to health service access, especially for MCH in slum areas.
## ANNEX 2: LITERATURE REVIEW

### History of urban health service delivery in Phnom Penh

<table>
<thead>
<tr>
<th>Year</th>
<th>Detail</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979–1990s</td>
<td>At the end of the Khmer Rouge rule, returnees to Phnom Penh were able to occupy buildings on a first-come first-serve basis. They were mainly public officials and the few remaining professionals after the mass killing of all educated people in Phnom Penh. The scarce professionals were allowed to occupy any vacant dwellings close to their new place of employment. The new owners appropriated many centrally located buildings in the city, which they then subdivided and started to sell, with no formal titles. In 1990, the first year of the Human Development Report, Cambodia’s Human Development Index (HDI) was calculated at only 0.501, placing the country at the “low human development” status. After the Paris Peace Accord in 1991 and the establishment of the new government in 1993, the national reconciliation policy allowed about 200,000 displaced people who had lived in the refugee camps along the Thailand and Cambodia border and also in Thailand territory to repatriate.</td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td>The Urban Sector Group (USG) is a Cambodian NGO established in 1993 that works in 48 poor communities in Phnom Penh. USG was originally established by a group of local and international NGOs working in Cambodia with the aim of helping squatter communities to address issues of poverty, including land ownership, housing, basic infrastructure services, water, sanitation and solid waste disposal.</td>
<td></td>
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<tr>
<td>1996</td>
<td>Introduction of the Health Financing Charter by the Ministry of Health, legitimizes and attempts to regulate user fees for health services, additionally through the introduction of exemption schemes for the poor.</td>
<td>Socio Economic Survey 1997, quoted in D. Thomas, Social Development Priorities in Health Sector Reform Options, August 1999 439/99/DFID</td>
</tr>
<tr>
<td>1997</td>
<td>As far back as 1997, a supplementary study of the Socio-Economic Survey concluded that “health care costs are simply unaffordable for the poor. Even a single outpatient visit….takes up one third of all non food expenditure for a year for a typical person in the poorest quintile”.</td>
<td></td>
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<tr>
<td>1998</td>
<td>Back in 1998, bilateral agencies started to become interested in urban health. One of the outcomes of the health sector reform project in the 1990s was the establishment of the Urban Health Project. A</td>
<td></td>
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</table>
baseline demand survey was conducted in 2000 in five urban slums. It was mostly a qualitative study, with data on access, quality and affordability. After the study, the Urban Health Project set up ‘urban health rooms’. These were small facilities based in the slums. They provided basic treatment free of charge for slum dwellers. Staff at these facilities (who received incentives) also assisted in referring patients to the municipal hospital. The staff also assisted to administer the health equity fund. The first (or one of the first) health equity funds was established in the period 2001–2002. The health equity fund became independently managed by the Urban Sector Group. Due to management issues internal to the organization, the health equity fund function of the USG was then taken up by Apiwat Krusaa (Family Development – a local NGO). At the time of the health equity fund and health rooms, the Municipal Health Department lobbied hard for financing and official status of the health rooms. But this strategy was not ever integrated within the health sector strategy.

2000

“In Phnom Penh, the term ‘squatters’ describes people living on land and in buildings over which the government claims ownership. However, because squatters translates as ‘anarchists’ in Khmer, the word is usually avoided in official documents. The term ‘urban poor’ is used to describe families who claim some form of occupancy rights but who are economically poor, who live in inadequate housing conditions, poor environment and lack of access to basic services.”


2001

The Urban Health Project was officially started in 2001 with funding through the UK Department for International Development (DFID) and Options consultant services. The aim was to explore alternative models of service delivery for health care for the urban poor. A demand-based baseline survey was conducted in two communities in 2001 (Tonle Bassac and Boeung Kak). The main findings were:

- Poor people felt that government staff ignored their needs.
- The cost of health care is the most common cause of poverty and homelessness.
- The richest of those living in the two communities estimate they can spare a maximum of 5,000 riel per day for health care.
- The poorest of the poor have no money for healthy care.
- Fee exemption schemes did not work in the communities, with high levels of unofficial charges.
- The private medical sector is the first choice of treatment source for the population of Phnom Penh but is largely unregulated and of dubious quality.

2001

An Urban Health Project Management Unit was based in the Municipal Health Department, with services provided through government health staff supervised by the MHD.

2001

Some of the strategies applied in the program implementation were as follows:

- Establishment of ‘health rooms’ in communities as primary care

C. Vickery, Review of Health Services for Urban Poor
and referral points, staffed by municipal health employees with performance payments.

- Development of ‘user group’, mostly in the form of mothers’ club to advocate for and promote community health.
- Establishment of local financing schemes (health equity funds) with poverty identification schemes.

2001 An economic evaluation of the Urban Health Project (health services component) established the following:
- Health rooms are heavily used by a predominantly poor population. Population served by the two health rooms was making about 1.8 visits per person annually, compared with the city wide average of 0.16 to all public health facilities in 1999.
- A target population of 200,000 was identified for health equity funds, with scale-up costs over a three-year period estimated at $320,228.
- Benefits of the equity fund were noted: increased access to treatment, prevention of poverty and prevention of cost of $1,000 per capita of government expenditure on poverty alleviation schemes.

A final evaluation indicated that health rooms became the first choice of health provider for 66 per cent of residents (who previously used private practitioners).

2001 An assessment of the status and numbers of the poor in 2001 established the following: “About 35,000 families (180,000 people) live in 502 low-income settlements within Phnom Penh’s seven municipal districts. Five per cent of these families live along railway tracks, 5 per cent along roadsides, 9 per cent on rooftops of downtown buildings, 26 per cent on river banks and along canals, and 40 per cent on open land. In addition, there are growing numbers of poor tenants who rent makeshift shacks around the factories or who live in crowded sub-divided rooms in the city centre or in isolated but insecure circumstances. Adding these would raise the total to about 450,000 people or about 40 per cent of the city’s 1.1 million population.” (p. 63)

2002 DFID approved a 12-month extension to Health Services for the Urban Poor Project (HSUP) in 2002. A final evaluation raised ethical implications of creating highly subsidized services and then withdrawing all support at the end of project. In 2002, the Urban Sector Group took responsibility for implementing the equity fund of the Urban Health Program (UHP), in partnership with the Municipal Health Department of Phnom Penh. In October 2003, University Research Co Ltd. provided USG’s equity fund with a grant, funding it for one year until September 2004.

2003 In 2003, the UN released a report on urban slums. In 2001, 924 million people, or 31.6 per cent of the world’s urban population, lived in slums. The majority of them were in the developing regions, accounting for 43 per cent of the urban population, in contrast to 6 per cent in more developed regions. Eastern Asia (36.4 per cent), Western Asia (33.1 per cent), Estimates for Phnom Penh range from 20–30 per cent. It is further projected that in the next 30 years, the global number of slum dwellers will increase to about 2 billion if no concrete action is taken. The urban population in less developed
regions increased by 36 per cent in the past decade. Slums are not homogeneous — “Slums and poverty are closely related and mutually reinforcing, but the relationship is not always direct or simple. On the one hand, slum dwellers are not a homogeneous population, and some people of reasonable incomes live within or on the edges of slum communities. Even though most slum dwellers work in the informal economy, it is not unusual for them to have incomes that exceed the earnings of formal sector employees. On the other hand, in many cities, there are more poor people outside slum areas than within them.”

2003 An final evaluation of the Urban Health Project identified the following service features/strategies that worked:
- providing services at hours that allow the poorest to attend
- involving users in the management of services
- establishing affordable charges and eliminating unofficial payments
- providing exemptions for those who cannot afford the fees
- improving access to second-level care by removing finance, transport and institutional barriers to care.

2002–2003 UNCHS provided supplementary funds to the Municipal Health Department to extend project activities to relocation sites (Extension of Health Services to the Urban Poor 420/99/DFID 2002) for populations from Tonle Bassac and Chbar Ampeu, following fires that destroyed the settlements. Project activities continued at Boeung Kak Health Room and despite funding shortages. The MHD opened a new health room at Anglong Kngan with the support of UNCHS and also to the Samaki relocation site.

2003 The health equity fund has been operated by a local group who formerly worked under an NGO called Urban Health Sector Group; now they go by the name of Family Health Development and from October 2003 until June 2008 they operated with funding from the USAID-HSSC project. Through the proposed project, poor households, identified either through the pre-identification process or through a post-identification process followed by a field verification visit, will be provided with a Priority Access Card (PAC). The card can be used by any member of the family listed during the identification process to access services at the Municipal Referral Hospital, CPA1 referral hospital or health centres that have a contract to provide services with the health equity fund.

2004 An Urban Health Task Force was also established under the chair of MHD. Evaluations of the Urban Sector Project was conducted in 2004. There have always been difficulties accessing financing for the health equity fund, health rooms and municipal health staff. User groups and mothers’ clubs were also established. The US Agency for International Development, through the University Research Council, still supports the health equity fund through local NGOs, such as Apiwat Krusaa (Family Development). Although health posts have been set up, the health rooms could not be financially sustained despite the documented successes in use and coverage. The main barriers to sustaining the programme include lack of financing and inability to convince decision makers of the need to integrate the health room into the health system. Financing therefore remains project dependent.
2005 The Municipality of Phnom Penh Conducts a statistical survey of the population.

Municipality of Phnom Penh


Ministry of Health

2007 In 2007, the National Immunization Program, in partnership with the World Health Organization and other partners developed an at-risk strategy for slum areas of Phnom Penh and other parts of the country. This followed the detection of a vaccine derived polio case (and documented lower EPI coverage) in the slum area of Tonle Bassac, which required a nationwide campaign to reduce the risk of further transmission. In the process of this campaign effort and implementation of at-risk strategy, 347,000 in 109 villages of Phnom Penh were identified as high risk. Criteria for high risk was not clearly identified, although the following criteria for classification were identified in interview – i) low coverage; ii) unstructured housing developments; iii) the very poor; iv) minority groups (Vietnamese, Cham).

Consultation Notes

2007 “Officially, poverty stands at 12 per cent of the city population. The poorest areas include a total of 22 different recognized squatter settlements, including six in which HEF is provided (Anlong Kngan, Anlong Kong, Beoung Kak, Bori Kila, Samake, Tonle Bassac).”

The Phnom Penh Municipal Hospital is the referral hospital for the four Operational Districts of Kandal (with four health centres), Cheung (with five health centres), Tboung (with six health centres) and Lech (with six health centres) and a total of 21 health centres.

Sky Health Insurance (initiated by GRET with support from GTZ) established a pilot project at one site in 2005. The SKY Health Centre is located within the Municipal Hospital. Funding provided by AFD (Agence France Development) from 2007. “Monthly premiums are charged pro-rata according to family size: single person at 16,000 riel, 2–4 persons at 20,000 riel, 5–7 persons at 24,000 riel, and 8 and more persons at 28,000 riel.”

2008 As part of the programmes for child survival and immunization, UNICEF and the NIP (National Immunization Program) partner with the MHD will undertake a study of health service access in selected communities as well as identifying strategies for improving communication and access between at-risk communities and government health services.

Family Health Development designs are a new proposal for extension of health equity fund system (USAID HSSC). Main characteristics: Poor households are identified, either through the pre-identification process or through a post-identification process followed by a field verification visit, are provided with a Priority Access Card (PAC). The card can be used by any member of the family listed during the identification process to access services at the Municipal Referral Hospital, CPA1 referral hospital or Health Centres which have a contract to provide services with the health equity fund. The initiative also involves the establishment of village user groups.

Proposal, Apiwat Krusaa, 2008

2008 Cambodia had experienced three years of double digit economic growth, but still an estimated 30 per cent of the population lives below the poverty line. The international economic crisis, leading to sharp rises in fuel and food prices, has pushed many families below

Consultation notes and literature sources.
the poverty line status. The Asian Development Bank recently announced a $30 million food security fund for the slum areas of Phnom Penh. In some cases, slum areas are still being relocated. In other cases, some populations are moving out of slums. But new rural migrants sell land and are replacing populations that leave the slums.

2008 The 2008 census in Cambodia indicated that the proportion of urban population in Cambodia was 19.5 per cent. Growth rate for urban areas is 2.55 per cent and rural areas 1.3 per cent (Phnom Penh, specifically 2.82 per cent). The population has grown 32 per cent in Phnom Penh in ten years, between 1998 and 2008. Urbanization has increased over the past decade. The proportion of urban population according to the new definition of urban areas has increased from 17.4 per cent in 1998 to 19.5 per cent in 2008. Average household size in Phnom Penh is 5.1 people. The provinces of Phnom Penh and Kandal, particularly their urban areas, have been attracting a large number of young women who take up jobs in garment factories. This is contributing to very low sex ratios in the urban parts of Phnom Penh (88.2) and Kandal (88.0). Urban Phnom Penh and urban Kandal with their large female populations, depress the sex ratio of urban Cambodia as a whole. Subject to confirmation by age and migration data, the possible reasons for the large numbers of females in these two areas in the de facto count could be: i) Large-scale migration of younger women to work in garment factories in Phnom Penh, Ta Khmou etc.; ii) sizeable out migration of men to provinces like Battambang, Oddar Meanchey, Stung Treng, Ratana Kiri, Mondul Kiri, Preah Vihear, etc.

2008 About 20 per cent of the poor now live in Phnom Penh and other urban areas. By 2035, the proportion is projected to reach 50 per cent. Most of the urban poor live in slums and squatter settlements, without adequate access to clean water, sanitation, and health care (Urban Health Project 2002).

National Immunization Program = 16 per cent (NIP, 2008)
Municipality of Phnom Penh= 20 per cent (Municipality, 2005)
Urban poor =12 per cent (Annear et al, 2007)
Urban poor = 19.7 per cent (241,000) (UN Habitat, 2002)

General Population Census of Cambodia 2008
Provisional Population Totals
National Institute of Statistics, Ministry of Planning Phnom Penh, Cambodia, August 2008