A unique blend of historical anthropology and contemporary ethnography.

At face value, this book is about medicine in Cambodia over the last hundred years. At the same time, however, it is an historical and contemporary anthropology of Cambodia, in that ‘medicine’ (in the sense of ideas, practices and institutions relating to health and illness) is used as a prism through which to view the colonial and post-colonial society at large.

Rich in ethnographic detail derived from both contemporary anthropological fieldwork and colonial archival material, the study is an account of the simultaneous presence in Cambodia of two medical traditions: the modern, biomedical one first introduced by the French colonial power at the turn of the twentieth century, and the indigenous Khmer health cosmology. In their reliance on one or the other of the two traditions, the Khmer people have continually been concerned to find efficient medical treatment that also adheres to norms about the morality of social relations.

The authors trace the articulation of these two traditions from the French colonial period via the political upheavals of the 1970s through to the present day. The result is more than a medical anthropology; this is a key text that makes a significant contribution to the anthropological study of Cambodian society and will be an important resource for scholars as well as for development planners and aid workers in medical and related fields.

‘This is a compelling, persuasive study of the “indigenization” of global bio-political knowledge in Cambodia from colonial to modern times. Rigorously researched, balanced in interpretation and cautionary rather than idealistic, scholars and policymakers alike will derive much benefit from this insightful assessment of the human condition in Cambodia today. It is benchmark, interdisciplinary social science for showing us how social order and everyday survival are continually shaped and reshaped by successive models of governance.’ – Laura Summers, University of Hull

The authors are associate professors of anthropology at Uppsala University in Sweden. They have been engaged in the study of Cambodian society since 1995.
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Cambodians and Their Doctors

A Medical Anthropology of Colonial and Postcolonial Cambodia

Jan Ovesen and Ing-Britt Trankell

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Preface

This book is about medicine in Cambodia over the last hundred years. It is at the same time an effort to provide a historical and contemporary anthropology of the nation of Cambodia. We use ‘medicine’ – in the sense of ideas, practices and institutions relating to health and illness – as a prism through which we view Cambodian society more generally.

Our anthropological involvement with Cambodia goes back to 1995 when we were asked by the Swedish International Development Cooperation Agency (Sida) to do a study of social organization and power structures in rural Cambodia, as part of the agency’s planning of a country strategy for Swedish development assistance. Despite the very limited time allotted for the study (one month in Cambodia and a couple of weeks to read up on existing social science and development literature), we found the assignment attractive for several reasons. It was only very recently that anthropological field research had again become possible, for the first time since the 1960s. Even by then, studies of the daily life of ordinary people in Cambodia were rare. After the devastations that Cambodian society had suffered in the 1970s and 80s there seemed to be a pressing need for basic anthropological and other social science research. At the time, the prevailing atmosphere among both social scientists and development actors was one of optimism. Thanks to the mission of the United Nations Transitional Authority in Cambodia (UNTAC) that culminated in the parliamentary elections in 1993, it was felt that Cambodia was now about to ‘emerge from the past’ as it was pushed onto the world stage and expected to find its place among the world’s budding democracies. The Cambodian population was seen as no longer just unfortunate victims of past political disasters, but as empowered with agency to actively shape their society in conformity with the international aid organizations’ goals of liberal peace and socio-economic development. In our report to Sida (Ovesen, Trankell and Öjendal 1996) we
cautiously questioned the social science basis for the prevailing development optimism. 

A decade later, political developments in the country give even less cause for optimism. In the meantime we have had occasion to learn more about Cambodian society. A grant from Sida’s research council (SAREC) enabled us to do fieldwork intermittently from 1996 to 1999, mainly with a Cham (Muslim) community in Kampong Chhnang and with Khmer communities in Siem Reap. Since 1996 we have spent on average one or two months a year in Cambodia, with some longer periods for community studies. We embarked on the present study, on ‘the indigenization of modern medicine,’ in 2000, thanks to a three-year grant from the Swedish Research Council, which allowed us to do research part-time and which is gratefully acknowledged. Subsequent field trips were made possible through travel grants from the Margot and Rune Johansson Foundation (Ing-Britt) and the Swedish School of Advanced Asia-Pacific Studies (Jan) in 2004/05 and from our home department at Uppsala University in 2006. Finally, the Faculty of Arts, Uppsala University generously relieved Jan of his teaching obligations for three months during 2007 to work on the manuscript.

The study was carried out with the kind permission of the Ministry of Health, Royal Government of Cambodia. We are grateful to His Excellency Professor Sau Sok Khonn, Undersecretary of State, for the Ministry’s official acceptance of our research proposal. Part of the fieldwork has been carried out in Phnom Penh – since this is where most of the ‘medical establishment’ is concentrated: the Ministry of Health, major hospitals, the university faculties of medicine and pharmacy, the pharmaceutical companies and larger pharmacies. But most of the fieldwork has been focused on sites outside the national capital. We have worked in provincial towns and rural areas in the provinces of Kandal, Takeo, Kampong Chhnang, Kampong Cham, Kampong Thom, Pursat and Battambang, and in Pailin Municipality.

We are indebted, naturally, to all informants in the field. Among them, members of the medical establishment include His Excellency Professor My Samedy, His Excellency Professor Ly Po, Professor Tea Sok Eng and Dr Lim Rathanak. Our gratitude also goes to all other informants – hospital personnel, pharmacists, medical and pharmaceutical students, private practitioners, village doctors, pharmacy/drug shop keepers, pharmaceutical company representatives, indigenous healers, monks, spirit mediums, former Khmer Rouge medics and, of course, ordinary people – all of whom are too numerous to be acknowledged individually. By conveying their voices we have attempted do them justice. For the sake of individual integrity, the names of informants given in the text are
Preface

pseudonyms, except of those who are sufficiently well known locally that the use of pseudonyms would serve no meaningful purpose.

During fieldwork we have always worked with Cambodian research assistants-cum-interpreters. For their linguistic, intellectual and practical assistance as well as companionship during various phases of this study we are grateful to Pon Kaseka, Ly Vanna, Lath Poch, Chen Sochoeun, Chea Bunnary and, most particularly, Heng Kimvan. We have been institutionally affiliated with the Center for Advanced Study in Phnom Penh and we thank its director Dr Hean Sokhom for his insightful advice and comments. We also thank Dr Kong Bun Navy, Dr Meng Huot and Ms Pam Gantley for facilitation in the field, and Mel Sophanna, Hun Thirith and Men Chean Rithy for helpful input. The staff of the Cambodian National Archives in Phnom Penh deserves our gratitude for facilitating our archival research.

We have had fruitful exchanges and conversations with a number of fellow Cambodia scholars. Very special thanks to Laura Summers, Anne Guillou and Henri Locard. Ever since we first embarked on Cambodia studies, Laura has generously shared her profound knowledge and analytic powers, and her detailed comments on the manuscript were invaluable. Anne kindly shared her unpublished thesis and provided perceptive comments on several chapters. When in Phnom Penh we have enjoyed stimulating conversations with Henri Locard, who also made valuable comments on parts of the manuscript. Thanks also to Ang Chouléan for friendship and scholarly generosity and to William Collins, Annuska Derks and Eve Zucker for good intellectual company. The (post-anonymous) reviewers’ comments by David Chandler and Maurice Eisenbruch helped us improve the shape of the manuscript and sharpen some of our arguments; Eisenbruch’s comments on indigenous healers were particularly valuable. Various parts of the study have been discussed with colleagues and doctoral students at the Uppsala Department of Cultural Anthropology and Ethnology, especially the Department’s Medical Anthropology Seminar Group; thanks to Claudia Merli, Sten Hagberg and Sandro Campana Wadman. Hedvig Ekerwald kindly let us use a couple of her rare photographs, and Kristina Weiland helped with last-minute information. Thanks, finally, to Gerald Jackson and Leena Höskuldsson at NIAS Press for making the book materialize, to Dayaneetha De Silva for editorial improvements, and to the Swedish Research Council for financially supporting the publication.

Our wish that this study be first and foremost an empirically grounded anthropology of Cambodian society seen through the lens of medicality has imposed some limitations, also dictated by considerations of space. The vast
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scholarly literature on medical anthropology, on historical anthropology in general and the anthropology of colonialism in particular has been very rudimentarily discussed. We have also refrained from detailing the many obvious points of comparison with medical conditions and health cosmologies in other Southeast Asian societies, and we have excluded reference to the extensive literature on health conditions among Khmer diaspora communities. These are sins of omission but not of ignorance.

Some fragments of this study have appeared in earlier versions in a couple of places. Parts of the ethnography presented in Chapter 3 was published in *Anthropology and Medicine*, vol. 11, 4, 2004 (Trankell and Ovesen 2004). Material from various chapters, on the use of pharmaceuticals and indigenous medicinal substances, formed a contribution to an edited volume on *Medical Identities* by Kent Maynard, published by Berghahn (Trankell and Ovesen 2007). Quotes from French sources are translated by the authors. Photos are by the authors unless otherwise indicated.
Glossary

achaa lay Buddhist functionary. An achaa is a respected elder, usually a former monk, familiar with ceremonial procedures. Apart from his Buddhist ceremonial duties, he often acts as diviner, and sometimes healer, in the community

ang pleung fire lit under the bed of a new mother to restore her body after the strains of pregnancy and childbirth

Angkar ‘organization’. In Democratic Kampuchea the word was used for the Communist Party of Kampuchea. Current usage signifies ‘NGO’

Angkar loeu Central Committee of the Communist Party of Kampuchea

arogyasala halls of ‘diseaselessness’; Angkor period

barang foreigner, European. Versions of the word (farang, ferenghi…) have been diffused over many parts of Asia by Muslim traders. Its etymology has been traced to ‘Franks’, the name North European crusaders used for themselves (Thion 1993: 239–241)

boramey divine power, the spirit by which a medium is possessed. The spelling adopted here reflects the Khmer pronunciation; in the literate Pali tradition it is spelt parami

bray spirits of women who had been childless or had died while giving birth and are therefore jealous of the better fortune of others

chedi stupa, memorial edifices where the ashes of deceased family members are kept

chhmob indigenous midwife, sometimes specified as chhmob boran, ‘traditional midwife’, in contradistinction to medically trained midwives

chol rup ‘enter body’, a spirit medium

CPP Cambodian People’s Party, the ruling political party. Its name was changed from the People’s Revolutionary Party
Cambodians and Their Doctors

of Kampuchea in connection with the withdrawal of the Vietnamese occupation forces and the party’s abandonment of Marxist-Leninist ideology in 1989

DK
Democratic Kampuchea: the official name of Cambodia during the Pol Pot regime, 1975–1979
devaraja
divine king, particularly of the Angkor kingdom
khamaphibal
communist party cadres in DK
Khmer
the ethnic majority of Cambodia; Khmer language
Khmer Rouge
(‘Red Khmer’) expression first used by Norodom Sihanouk in the 1950s as a blanket term to discredit his political critics on the left. It eventually came to denote (members of) the revolutionary political movement that held power in Democratic Kampuchea, but which existed as an active political force from the late 1960s to the late 1990s
khsae
cotton thread, string, or line; the family line of a person; the clients of a patron; the spiritual lineage of a teacher (kru)
khum
commune, an administrative unit created by the French in the early twentieth century and revived a century later. The first commune elections after independence were held in 2002
kong youthea
soldier group, platoon, in DK consisting of 32 persons (male or female). Three such groups (i.e. 96 people) formed a vireak
krae
the low and wide wooden dais used as a bed or for entertaining
krama
checkered cotton scarf worn by most Cambodians, particularly in the countryside
krob sleng
poisonous plant, particularly the species Strychnos nux vomica, the seeds of which contain strychnine and are used in herbal medicine
kru
teacher, master, medical practitioner
kru khmae
practitioner of Khmer indigenous healing
kru pet
practitioner of modern medicine (irrespective of his/her formal medical education)
mekhum
commune chief
mesrok
district chief
munti pet
‘medical office’, hospital, or health clinic; mainly DK usage. Munti means a place where official business is conducted
neak ta
‘ancestral person’, a territorial guardian or ancestral spirit.


Glossary

okhna
originally a high-ranking official in the pre-colonial Cambodian state. After independence the title, like a knighthood, was bestowed by the king on people who had distinguished themselves in the service of the nation. Today, the title is mostly acquired from the Prime Minister’s Office by business tycoons.

padevat
revolution, revolutionary (Khmer Rouge terminology)

pay si
ornamental offering constructed from gold-coloured paper, banana leaves, and flowers

pet
medicine, person with medical education. Nowadays the word relates to modern medicine

phum
village

pralung
the 19 vital spirits which animate the human body

prey
forest, wilderness

PRK
People’s Republic of Kampuchea: the official name of Cambodia during the Vietnamese-backed socialist regime, 1979–1989

Renakse
short for Renakse samaki samkru cheat kampuchea, the ‘Solidarity Front for the Salvation of the Nation of Kampuchea’, the Cambodian political front for the Vietnamese political and military occupation

riel
Cambodian currency (at the time of writing, 4,000 riel equalled US$1).

sahakor
production cooperative in Democratic Kampuchea

Sangha
the Buddhist congregation, the community of monks

Sangkum
the period 1955–1970 during which Prince Sihanouk’s political movement Sangkum Reastr Niyum, ‘People’s Socialist Community’, was in power

sangkumakech
‘base people’ trusted by Khmer Rouge cadres to oversee distribution of foodstuffs and medicine in the sahakor, and exempt from hard agricultural work

sasay
body conduits

sima
ritual border, in ritual healing temporarily demarcated, for example, by a cotton thread or a chalk line. Permanent sima stones are placed to mark the boundary of a wat

srok
homeland, place of belonging. In the contemporary state administration the word denotes the administrative level of district (within a province), but in everyday parlance it may be anything from one’s native area to Cambodian soil (srok khmae)
Cambodians and Their Doctors

*thnam*  
medicine, medicinal substance, used both of herbal medicine and pharmaceuticals

*toah*  
a condition that includes headache, diarrhoea, abdominal cramps as well as post-partum depression

**UNTAC**  
United Nations Transitional Authority in Cambodia: the UN mission in 1991–1993 that led to the general elections in May 1993 and the promulgation of a new constitution in September

*vihear*  
sanctuary, hall of worship in a *wat*; also non-Theravada Buddhist temple

*vireak*  
military company during DK consisting of three *kong youthea*, i.e. 96 persons

*wat*  
Buddhist temple-monastery complex, in Cambodian English rendered as ‘pagoda’; a *wat* consists of a *vihear* (sanctuary), *sala* (communal hall and refectory), and *kuti* (monks’ dwellings). The *wat* grounds usually accommodate a number of *chedis* (stupas). Some also include a crematorium.
Figure 0.1. Map of Cambodia
CHAPTER ONE

Introduction

This is an anthropological study of ‘doctors’ and ‘patients’ in Cambodia. These two categories include the actors within the separate but coexisting medical traditions in Cambodia – the biomedical and the indigenous. Doctors in the biomedical tradition generally seek to cure the physical body, while indigenous medical practitioners seek to heal the social person. Ideally, both strategies for regaining health should be complementary, but medical doctors and indigenous healers have rarely collaborated. This book traces the social, historical, and political circumstances under which these two medical traditions have evolved and the opportunities and constraints which Cambodians have faced and still face when seeking healthcare.

Our study spans the colonial introduction of biomedicine into Cambodia in the late nineteenth century to the present. By anthropological standards this is a rather longue durée, also given that our own observations of Cambodian society go back a mere 13 years, and that most of our informants’ recollections hardly extend further than the 1960s. Our aim, however, is to trace the the articulation of the two medical traditions from the beginning of their coexistence and thereby offer a colonial and postcolonial anthropology as well as a political economy of medicality.

Fernand Braudel’s notion of the longue durée (1958) implied the ‘geographical time’ of slow environmental changes in a given region. The somewhat faster pace of change within and between human societies (anthropologically, usually the longest-term horizon) was to be analysed within the framework of ‘social time’, while people’s experiences took place in ‘individual time’. Braudel’s scheme may have some heuristic value for anthropology. We suggest an anthropological longue durée as the equivalent of what anthropologists habitually gloss with the synthetic notion of ‘culture’, which we prefer to think of as the particular
localized combination of cosmology – ideas and symbolic representations of the world and the place of humans in it – and sociality – ideas and practices related to the management of social relations. For Cambodia, this *longue durée* spans the Angkor period (ninth to the fifteenth centuries) to the present.

Khmer society represents a localized version of a cosmology common to the ‘Indianized’ states of Southeast Asia (Cœdès 1968), characterized by, among other things, the notion of a sacred mountain representing the centre of the world, territorial and ancestral guardian spirit cults, rituals to mark the annual agrarian cycle, the veneration of a semi-divine king, and a galactic polity centred in a royal city. Khmer sociality is characterized by a kinship system based on cognatic descent and a focus on the immediate family. While social relations are shaped by a pervasive interpersonal hierarchy (of age, gender, and socio-economic status), however, stable corporate groups beyond the family that might function as mechanisms of inclusion and exclusion are absent. Instead, social relations and social networks beyond the family are shaped mainly by patron–client relations. As in the historians’ environmental *longue durée*, cosmology and sociality are relatively slow to change, by no means static yet reflecting changes under shifting socio-political circumstances in ‘social time’.

We suggest that successive periods of anthropological ‘social time’ be defined by the political and economic structures that at any given period shape society in sociologically significant ways and install in people the durable dispositions that Pierre Bourdieu referred to as habitus (Bourdieu 1977). The relevant socio-political periods for this study are the French colonial era (1863–1953), followed by the first decade of independence; the economic decline and unrest from the mid-1960s, significantly precipitated by the American war in Indochina and leading to the republican period under Lon Nol and full-scale civil war (1970–1975); the Pol Pot communist regime of exceptional state terror (1975–1979); the continuation of communist rule during the Vietnamese occupation (1979–1989); and the liberal peace instigated by the United Nations (1991 to the present).

‘Individual time’, the lived worlds of individuals, is the level that the ethnographer may access most directly during fieldwork. Our informants’ accounts of their experiences and recollections at the personal, family, community, or national level, and our ethnographic observations of events and activities comprise the raw data of this study. Through anthropological interpretation these will be related to items at the other two levels, cosmology and sociality, and the political and economic structures as well as socio-political events that both formed and were formed by – both reproduced and transformed – the durable and transposable dispositions of habitus.
Introduction

For the colonial period we have attempted to access the lived worlds of individuals and groups through documents found in the National Archives of Cambodia (NA), which, remarkably, were largely untouched by the ravages of civil war and the Pol Pot regime in the 1970s. The colonial archival collection (Fonds de la Résidence Supérieur du Cambodge) contains a fair number of quotidian documents – decisions, decrees, memos, correspondence – as well as annual medical reports both from the protectorate as a whole and from the various provinces. Such material allowed us to get closer to the everyday workings of the medical services and form an impression of local administrative procedures and processes not necessarily reflected in the official reports submitted to the governors-general of Indochina or the Ministry of the Colonies in Paris. In this sense, our archival material is rather ‘ethnographic’ and we have approached it as social anthropologists.

A reliance on participant observation has often led the anthropologist to be seen as being partial to the group she is studying (vis-à-vis the nation–state, for example), because of her disciplinary obligation to represent the social and cultural perspectives of her host community. Empathy with informants does not necessarily imply, however, an anthropologist’s uncritical sympathy for the former’s causes, values, and motivations: we have viewed the authors of our archival material much as we would field informants, and the documents themselves as the equivalent of field notes, to be mined repeatedly for further details in the course of analysis (cf. Cohn 1987: 2).

The French doctors and administrators who struggled to make the colonial medical service work in Cambodia in the early decades of the twentieth century were themselves products of their cosmology, sociality, and habitus; they were bound up, naturally, with colonialism’s political and economic structures. Yet the picture that emerges from the pages of their memos and reports makes us wary of a priori assumptions that colonial medics were wilful agents of an imperial ideology, and that European medicine was primarily ‘a tool of empire’. For most French colonial physicians it was rather the other way round, they tended to see colonialism as a tool of overseas medical assistance and echoed Hubert Lyautey’s opinion (from the 1920s) that ‘the only excuse for colonialism was the physician’ (cited by Arnold 1988: 3). A survey of about 500 former colonial medical personnel showed that, in retrospect, more than 95 per cent were moderately to severely critical of colonialism in general and the colonial administrators in particular (Clapier-Valladon 1982: 203, 207). The doctors were primarily trying to give medical treatment and basic hygiene education according to the tenets of their profession. They were in a sense the original
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médecins sans frontières, who saw the cultural milieu in which they worked and the geopolitical and biopolitical ramifications of their efforts as secondary to their professional calling (cf. Lefebvre 1997: 117).

In Cambodia, therefore, indigenous medical practices were largely dismissed as irrelevant if not directly harmful by colonial doctors. In 1894, Adhémard Leclère stated that ‘Khmer medicine is not a science; it is a mixture of vague notions of the medicinal properties of certain plants and a lot of superstitions, mystical practices and ridiculous invocations’ (Leclère 1894: 715). Yet Leclère, administrator as well as keen scholar of Khmer history and culture, wrote a paper about Khmer medicine, while most of his compatriots (administrators and physicians) were both uninterested in and ignorant about Cambodian society (cf. Edwards 2007: 149). Of course, they could hardly have imagined that the whole colonial edifice would crumble by mid-century and that its ideological foundations would eventually be discredited. Their efforts must be understood without the benefit of such hindsight.

Our present-day Cambodian informants themselves often re-presented events in their lives in the form of autobiographical stories. Michael Jackson (2002) has provided an analytical framework for dealing with such stories. Jackson suggests that storytelling serves as a bridge between the private realm of experience and the public realm of politics, and that storytelling itself may therefore be a political act; the politics of storytelling consists in reconstituting events by actively reworking them, ‘both in dialogue with others and within one’s own imagination’ (Jackson 2002: 15). We found his perspective on the ‘politics of storytelling’ particularly apt for appraising the partially standardized stories offered by (ex-)Khmer Rouge medical personnel (Chapter 4) and spirit mediums (Chapter 5), for instance. Such narratives are to be read not simply as factual accounts but as structured efforts to create congruence between individual experience and contemporary conditions.

MEDICAL SYSTEMS

When we first visited Cambodia in 1995, we were struck by, among other things, the large number of conspicuous wats (Buddhist pagodas or temple-monasteries) throughout the country which were new, expanded, being renovated, or under construction. Another remarkable feature was the omnipresent pharmacy, found not only in the major cities but also in every district town and crossroads market in the parts of the country we visited. Judging from the products on display, virtually all these pharmacies offered a fairly impressive quantity and range of both
imported and domestically produced pharmaceuticals. This ready availability of sophisticated drugs, even in rural locations, was somewhat unexpected. At the time, Cambodia’s per capita gross national product was about US$130; such widespread access to modern pharmaceuticals was an unexpected feature of a country at that level of comparative poverty.

Our juxtaposition of *wats* and pharmacies here is made not only to illustrate our impressions. In certain important respects, as Arthur Kleinman argues, ‘medicine, like religion, ethnicity, and other key social institutions, is a medium through which the pluralities of social life are expressed and recreated’ (1995: 24). The parallel between religion and medicine may be drawn further. Medical systems, like religions, are relatively coherent systems of concepts, causal models and practices concerned with physical, mental and spiritual well-being and, ultimately, survival. Religions are conventionally classified into major, ‘world’ religions on the one hand, and local religions on the other. The former are thought of as ‘great traditions’, partly because they are based on ancient scripture and a tradition of written exegeses by theologians and philosophers, as well as a certain professionalization of their clergy.

Among the Asian medical systems, Ayurvedic, Unani, and Chinese medicine would represent the great medical traditions (Leslie 1976), comparable in many respects to the great, though much less ancient, European tradition of biomedicine. The notion of a medical system includes both theory and practice: theory as a more or less consistent body of medical cosmological ideas – a world view – and practice as an associated set of therapeutic techniques and technologies. Medical systems are by no means static, and changes within them occur to varying degrees and at a varying pace as a matter of course, precipitated, for instance, by globalization and indigenization. In biomedicine changes in technique and technology are virtually built into the system through the notion of continual scientific and technological progress, whereas changes in world view are considerably less perceptible and rather *longue durée*.

The biomedical world view

It may be illuminating to look for parallels between the great European traditions of religion and medicine: Christianity and biomedicine. Kleinman cites Paul Unschuld, historian of Chinese medicine, on the proposition that the monotheism of Christianity has had a determining effect on biomedicine. ‘The idea of a single god legitimates the idea of a single, underlying, universalizable truth’ (Kleinman 1995: 27). Biomedicine is unique among medical systems with respect to its ‘requirement that single causal chains must be used to specify
pathogenesis in a language of structural flaws and mechanisms as the rationale for therapeutic efficacy’ (ibid.: 29). The structural flaws and mechanisms to be discovered by biomedicine are a priori assumed to be almost entirely biological; other factors – social, psychological, socio-economic, moral, and spiritual – have traditionally and generally been ignored.

The very concept of a medical system is in itself a feature of European medical modernity. Vinh-Kim Nguyen and Karine Peschard have proposed distinguishing between the premodern, modern, and a-modern medical worlds. Medical premodernity, such as the indigenous Khmer ‘medical system’, is characterized by the absence of an institutional distinction between therapeutic and socio-political space, between illness and sorcery, healing and exorcism. Medical modernity implies ‘political spaces of health, where misfortune is managed through specialized therapeutic institutions’ (Nguyen and Peschard 2003: 448), defined and, to varying extents controlled by, the modern state, while in the a-modern condition, ‘the lines between political and therapeutic power are once again blurred’ (ibid.).

The application of the modern biomedical perspective to premodern systems for dealing with health and illness is problematic because the conceptual leap that transforms an indigenous ‘health cosmology’ into a ‘medical system’ implies a partly unwarranted medicalization of important aspects of people’s lives. The ‘medical system’ comprises tools and techniques for curing disease and countering poor health, while the ‘health cosmology’ is about the maintenance or restoration of the physical, social, and spiritual balance, which is the necessary precondition of diseaselessness; the two notions only partially overlap. A similar caution is warranted when dealing with the institutions of various systems. As we shall see, there is a vast difference between the (premodern) Angkorean arogyasala (halls of diseaselessness) and the (modern) munti pet (medical office) in Pol Pot’s Democratic Kampuchea although both have been glossed as ‘hospitals’. Both, moreover, are very different from hospitals in the contemporary sense. To treat them as historical variations of the same institution is to let ourselves be led astray by biomedical preconceptions.

Like Christianity, biomedicine has both missionizing and hegemonic tendencies. Biomedical healthcare was indeed frequently part and parcel of conversion to Christianity, and the one aspect of the mission often served to legitimize the other. The medicalization of non-pathological conditions among populations already subjected to a biomedical regime of healthcare may well be seen as a form of missionary activity. The professionalization of biomedical practitioners is one of the preconditions for biomedical hegemony. Eliot Freidson
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has observed that the medical profession promotes itself with reference to the expert authority of its practitioners:

[Bio]medicine’s knowledge about illness and its treatment is considered to be authoritative and definitive...[T]here are no representatives of occupations in direct competition with [bio]medicine who hold official policy-making positions related to health affairs. [Bio]medicine’s position today is akin to that of state religion yesterday – it has an officially approved monopoly of the right to define health and illness and to treat illness. (Cited by Leslie 1976: 5–6)

Freidson’s observation, made in 1970, related mainly to European governments, but it is equally true of Third World governments today, regardless of which non-biomedical great tradition forms part of the country’s cultural heritage. In Cambodia, the Ministry of Health still has the remnants of a department of ‘traditional medicine’, established in the 1980s, but its role is restricted to ‘research’, while medical policy-making is firmly in the hands of the ministry’s biomedically disposed civil servants.

Indigenization of biomedicine

The idea of the indigenization of biomedicine was suggested by Arthur Kleinman as the cultural counterpart of its globalization. In Kleinman’s conception, indigenization implies that identical therapeutic technologies are perceived and employed in different ways in different worlds (1995: 24). Indigenization is thus an aspect of the diffusion of biomedical therapeutic technologies, particularly their diffusion to non-Western societies. Indigenization and globalization should be seen as two sides of the same coin, and the focus on one or the other notion is basically a question of perspective. The perspective of globalization focuses on the policies, practices, and decisions by actors associated with the medical and economic power centre – whether this centre is spatially located in Western medical institutions and research laboratories or in international organizations and transnational companies. The perspective of indigenization implies a focus on the medical and economic periphery and attention to the national and local consequences of globalizing policies and practices. Indigenization is perhaps a particularly attractive perspective in anthropology because of the discipline’s customary preoccupation with local societies and cultural processes.

The adaptation and selective use of various biomedical technologies is not only a cross-cultural phenomenon. Kleinman himself (ibid.) has drawn our
attention to the plurality of biomedicine even within its core areas of origin in the West. Biomedicine is not monolithic within any society; its practices vary according to social and medical conditions, practitioners, and clientele. In that sense it may be said that biomedicine is ‘indigenized’ wherever and whenever it is practised. Biomedical practices themselves may be assumed to vary, for instance, depending on the workings of a particular national health system.

Indigenization is a process engaged in, consciously or unconsciously, by both providers and consumers of biomedical services. It has sociological, historical, cultural, as well as medical dimensions. It is useful to distinguish the two different aspects of indigenization that are implicit in Kleinman’s definition. One aspect is the diffusion of biomedicine, the process of application of various biomedical therapeutic technologies in different local contexts. The other aspect is local perceptions of such biomedical technologies, which are shaped by cultural ideas about health and illness, causation, diagnosis, and treatment. Such ideas are often at variance with those entertained by representatives of the biomedical culture of origin (see Chapter 8).

Khmer indigenous health cosmology

The Khmer were often reluctant to subject themselves to certain biomedical technologies offered or promoted by French doctors. In the colonial documents, such recalcitrance was commonly put down to ignorance and superstition, even if medical administrators occasionally referred to indigenous customs and traditions.

The French often cited the Khmer belief that disease is mostly caused by spirits or ancestors as evidence of their ignorance and superstitiousness. Such beliefs are perfectly logical in the Khmer world view, however, because spirits and ancestors are the moral guardians of Khmer society and they react to social or moral transgressions by inflicting sickness on humans (Ang 1986: 21–29). You get sick if you have done something you shouldn’t have done, or if something happens which shouldn’t have happened: sickness is caused by disruptions to the social, natural, or cosmological order. As long as things are in order – in the social as well as in the natural and spiritual world – one can be at ease. But disorder breeds dis-ease. Order is a question of the way things are properly arranged and of the way things should be properly done, namely the way they have always been done, ‘traditionally’. Thus, a corollary of order is predictability. Foreign customs and behaviour, or the customs and behaviour of foreigners, are by definition unpredictable and therefore potentially threatening to order and health. Order is
also associated with moderation and modesty; excessive behaviour and excessive consumption is disorderly.

Not all instances of disorder and ensuing sickness are caused by spiritual intervention, however. Minor disorders are created by people as an inevitable consequence of daily life, and the minor ailments or common diseases that they cause need not bother the spirits. Excessive work and stress cause disorder in the body, manifested by fatigue and headaches. Diarrhoea may be caused, among other things, by sudden changes in the weather, by eating raw vegetables, or other ‘normally wrong’ food, by drinking excessive amounts of water after toiling in the heat, by living in a disorderly domestic environment, or, in babies, by being fed ‘hot’ (and therefore ‘wrong’) breast milk. Malaria is caused by having spent too much time in the forest (prey), a place of wilderness and disorder. Such ordinary diseases are unsurprising hazards and can be dealt with by ordinary, non-spiritual measures provided by the village doctor, the local pharmacist/drug seller, or a herbalist. Other, less predictable diseases may require the intervention of a specialist who has the ability to communicate with spirits and invoke their assistance.

All sickness, whether precipitated by spirits or not, is related to human action, either the actions of the sick person, or persons in his/her social environment (or, in rarer cases, a sorcerer). Hence the sick person must actively participate in effectuating his/her cure. This is particularly important for less ordinary and unpredictable diseases that follow from mostly inadvertent actions. Such diseases may sometimes be diagnosed by a spirit medium, but most commonly they are dealt with by an indigenous healer. The common term for such healers is kru khmae, which means ‘Khmer (style) teacher’. The ‘teacher’ and the sick person jointly and actively take part in the treatment, which ideally leads to the mending of disrupted or disorderly social and spiritual relations and thereby to restored health. Central to the therapeutic process is the diagnostic dialogue, during which the patient learns how to get well, so to speak. This dialogue takes place in a spiritual mode, but its therapeutic import is social, psychological, and psychosomatic; it is a form of negotiation, in the sense that decisions about the diagnosis and the progression of the therapy must be based on a consensus between the kru, the patient, and his or her relatives – and the spirits.

The idea is that the client/patient enters into a student–teacher relationship with the practitioner through the consultation. The teaching element pertains also to the prior training of the kru himself by his individual teacher (kru kan). A sick person who consults a kru may occasionally enter into a learning process, a gradual initiation with the aim of becoming a practising kru himself, and his
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*kru* thus becomes his *kru kan*. A *kru* belongs to a spiritual lineage of a particular *kru thom* (big teacher), a shrine for whom he has erected in his house; healing practices of the *kru* are commonly carried out in cooperation with the *kru thom*, through burning incense and saying prayers in front of his shrine. The *kru thom* communicates with other inhabitants of the spiritual and ancestral world and may harness healing powers for the benefit of the *kru*. Communication with spiritual powers for purposes of keeping or regaining good health may also be brought about with the help of spirit mediums (*chol rup*), Buddhist monks, or Buddhist lay functionaries (*achaa*) who engage in ritual healing practices; their services include divination, invocation, exorcism, or blessing in order to increase the client’s well-being or avoid misfortune.

The indigenous healing process directed by a *kru* consists of three phases: finding the cause of the illness through negotiating and conducting a diagnostic dialogue (diagnosis); prescribing the proper herbal and spiritual treatment (cure); and feedback by socially expressing the conclusion of the process (acknowledgement). The first two elements are, of course, equally prominent in biomedical practice, even if the patient plays a less active role in the processes, and the social, moral, and spiritual dimensions are generally neglected. The social element of acknowledgement, on the other hand, is usually missing altogether from biomedical practice, which may be one reason why many Khmer patients feel markedly unfulfilled even after a successful biomedical cure. The indigenous conception of the healing process can be seen to follow the pattern of a classic rite of passage. The phase of separation is the diagnosis made by a *kru*, a spirit medium, or members of the sufferer’s family; the diagnosis entails that the sufferer is defined as ill and thus conceptually separated from the healthy members of his community. The liminal phase is the period of treatment itself, the period of ‘study’, preparation, and consumption of medical substances, and prayers and invocations of the spiritual agents. The phase of incorporation is the public acknowledgement that the therapy has been successfully completed and the sufferer, as well as his immediate family, has been reintegrated into the community of healthy people, in other words that the healing of the social person has been accomplished. The acknowledgement may range from a modest token of respect to the *kru* (and his *kru thom*), over an offering ceremony at the *wat*, to an elaborate sacrificial ritual with the participation of numerous spirit mediums (Trankell 2003).

Seen from this perspective, it is perfectly understandable that the sufferer has a sense of unfulfilment as long as the final phase of social reincorporation has not been performed, which can be likened to music that abruptly ends before the
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last bars have been played. Biomedical therapy does not only routinely ignore the
social acknowledgement component, it reverses the ‘natural’ course of events by
demanding payment (for medicine and for each consultation) before the healing
process is completed; according to the indigenous norm, payment should only
be made (voluntarily and as appropriate to the client’s means) as part of the
acknowledgement.

The contrasts between the above indigenous scenario and usual biomedical
practices are noteworthy. One of the qualities of a biomedical professional is that
he or she possesses knowledge and skills that the patient does not have. This
knowledge is in principle reductionist, since it is restricted to biological factors
of organic functions and malfunctions, and is a priori deemed to be beyond the
grasp of the patient. To protect the professionalism of biomedical practitioners,
their knowledge must be construed as esoteric. Put differently, the physician’s
professionalism rests upon his ability to cure diseases while simultaneously
protecting his specialized knowledge. The patient, in his turn, should be just
patient and comply with the physician’s recommendations. In contrast, the
indigenous healing process is one in which the teacher/healer and the student/
sufferer cooperate in the process of building up a multiplex and, in principle,
infinite body of knowledge of the physical, social, and cosmological aspects of
the latter’s health, and both parties’ contributions are equally important. An
indigenous healer’s reputation rests equally upon his specialized knowledge of
herbal medicine, his spiritual power gained from his own teacher, and his ability
to impart a body of healing knowledge to his client.

It follows that in the indigenous practice, the relationship between the healer
and the sick person is personal, and the mutual trust that evolves during the
therapy brings about a certain degree of warranted and inevitable intimacy. In
institutionalized biomedical therapy, however, treatment is depersonalized. The
individual physician is replaceable – any other doctor could, in principle, take
over the therapy if he or she has access to the patient’s case sheet, and the patient
is expected to reveal intimate bodily or biographical details to a professional who
may be a complete stranger.

The distinction between indigenous practitioners and practitioners of
biomedicine is commonly indicated by the Khmer words kru and pet, respectively
(for example, in Collins 1999: 12). In general terms this is accurate, insofar as
the agency of a kru stems from a moral obligation, and he offers social and ritual
solutions, while the pet is a professional who offers technical solutions. But those
two words do not in themselves denote a distinction between the indigenous
and the biomedical paradigms. Both are derived from Sanskrit (guru, ‘teacher’
and *bedya*, ‘medicine’ or ‘medical science’), and the meaning of the latter, by virtue of its etymology alone, cannot logically be restricted to biomedicine. The purported distinction is also blurred in practice since people refer to both their local village ‘doctor’ or pharmacy shopkeeper as *kru pet*. We will return to this discussion in Chapter 5.

**VARIETIES OF MEDICAL MODERNITY**

Most Cambodians have always oriented themselves along the parameters of the indigenous health cosmology, in which physical or mental illness is associated with social or moral transgression, and where health is only restored by the healer and sufferer jointly engaging in a process of mending the disrupted social and spiritual relationships. When the French introduced medical modernity, the Khmer interpreted it according to their indigenous health cosmology. Ignorance of this cosmology on the part of the French, and their implicit denial of its relevance, made any exchange between the two systems impossible, severely limiting the potential success of their efforts.

In Chapter 3, we mainly focus on the first three decades of the twentieth century, the formative years of the concerted French medical effort that began with the establishment of the colonial medical service in 1905. In our colonial ethnography we have found it as important to account for the strivings of the French medical doctors as to gloat over their failures. After all, *l’assistance médicale indigène*, and its later offshoot *le service d’hygiène*, were unusual colonial ventures in their ambition to provide medical care and a modicum of sanitation for the local population at large.

The lack of formal interaction between the two medical systems was to characterize successive medical modernities of the postcolonial ‘social time’ periods. Colonial medical modernity was transformed into a national modernity after independence. During the latter part of the colonial period and well into independence, increasing numbers of Cambodian students were sent to France to study medicine and pharmacology (as well as other disciplines). The indigenization of biomedicine after independence was largely manifested by seeking to accomplish at the national level what had earlier only been available in the colonial metropole. This contrasted with colonial indigenization – focused on biomedical technologies to meet local needs – and it meant that in independent Cambodia, public health was given lower priority compared to clinical and curative activities.
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The country’s economic decline from the early 1960s and the civil war during the Khmer Republic (1970–1975) entailed a marked deterioration of the medical services. Of the 40 existing hospitals in 1969, only 27 remained in operation by September 1970, and the number was down to 13 the following year (Desbarats 1995: 153). Medical facilities were dire for most people even in the urban areas controlled by the Khmer Republic. The republican army itself was badly led and poorly equipped, also in terms of its food supplies and medical services. The guerrillas, on the other hand, were better organized, even in medical terms, and often established field hospitals in the areas they controlled (Laura Summers, pers. comm.).

During the Khmer Rouge’s Democratic Kampuchea (DK) regime (1975–1979) medical care deteriorated further. The 1975 revolution, like other communist revolutions, was about class, but definitely not about classlessness. On top of the revolutionary hierarchy were the cadres and soldiers. They enjoyed most of the privileges, including adequate food and access to whatever biomedical competence and pharmaceuticals were available. The second class consisted of the rural population in the previously ‘liberated’ areas, classified as ‘old people’. At the bottom of the hierarchy was the urban population who had been evicted to the countryside when the revolutionary forces took control of Phnom Penh in April 1975 and who were classified as ‘new people’. A number of ‘new people’ were killed directly. Many others, including many physicians and pharmacists, died by being deprived of food, rest, and medical care.

The drastic deterioration of healthcare for the population at large under Democratic Kampuchea was not related to any departure from modernity. On the contrary, the DK regime was in many ways decidedly and self-consciously ‘modern’ (cf. Marston 2002). The medical dimension of modernity was manifested in state-managed hospitals and infirmaries, established ‘political spaces of health, with specialized therapeutic institutions’ (Nguyen and Peschard 2003: 8). Illness became bureaucratically defined as the inability to work. Whereas illness had formerly been very much a social concern and care of the sick person was primarily the prerogative of his or her family, a sick person was now transferred from his/her ordinary working and social environment to a designated ‘therapeutic’ space, a *munti pet* (‘medical office’, infirmary). This modernization of healthcare required the establishment of a number of infirmaries throughout the countryside, and therefore *wats* were frequently converted into *munti pet*. In so far as most general accounts have given us the idea that all biomedical facilities were destroyed and all healthcare abandoned under Democratic Kampuchea, our account in Chapter 4 is revisionist. It is certainly
true that the regime's deliberate neglect of proper medical care for the majority resulted in a large number of deaths. But it is also true that hospitals were still running and imported pharmaceuticals still available. This only exacerbates the seriousness of the regime's inhumanity, because these facilities were reserved for the exclusive benefit of the highest echelons of the new revolutionary society. The medical needs of the ordinary population were left to the 'care' of rudimentarily trained 'revolutionary medics' (after the model of the Chinese 'barefoot doctors'), frequently with disastrous results. The French had at least tried to promote basic notions of hygiene but the revolutionaries did not bother with such 'bourgeois' ideas; the scientific basis of their 'modern' medicine was eroded and their practice mostly reduced to trial and error. Through the voices of different informants, including doctors who worked in the DK system, we wish to restore some sense of agency to the Cambodian population and its doctors rather than seeing them merely as either perpetrators or victims of Pol Pot's murderous regime.

This latter picture was energetically promoted by the succeeding Vietnamese puppet regime of the People's Republic of Kampuchea (PRK) between 1979–1989. To the extent that this picture has won general acceptance and that the PRK medical regime has been successfully portrayed as a radical departure from that of Democratic Kampuchea, some revision is definitely warranted, and we have therefore included a brief account of the PRK medical regime in Chapter 4. The class hierarchy was adjusted to the new power situation: at the top were the Vietnamese – troops, and civilian political and technical advisors. Next were the Party cadres (including many former DK officials), while at the bottom were ‘the people’. This hierarchy was once again reflected in access to medical treatment. In every hospital and clinic there was a division of medical products and equipment, and doctors were forbidden by political commissars at the hospitals to use resources reserved for the cadres to treat ordinary people. Apart from this strict class-based distribution of privileges such as proper medical care, the two regimes had in common an ideological reliance on self-sufficiency, which medically speaking implied the promotion of traditional herbal medicine. This did not mean, however, that indigenous health cosmology was given official recognition, indeed it was ideologically impossible within the framework of socialist modernity. The integral social and spiritual dimensions of the indigenous health cosmology was purged and emphasis placed solely on the presumed physiological efficacy of herbal remedies. The emphasis was on the 'scientific' character of medicine, be it herbal or biomedical, and on treatment by more or less competent practitioners, which excluded the diagnostic dialogue and its intellectual or philosophical implications.
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In Chapter 5 we focus on the practices of indigenous healers who were excluded from French medicine and severely circumscribed during DK and PRK. Since the United Nations Transitional Authority in Cambodia (UNTAC) intervention (1991–1993) indigenous healers have increasingly succeeded in reinventing themselves, some making up for possibly lost ‘traditional’ knowledge through innovative practices. The sudden and massive influx of foreigners – more than 20,000 UNTAC personnel – brought with it bewildering cosmopolitan lifestyles and all sorts of consumer goods which contrasted sharply with the austere Vietnamese version of socialist modernity that had reigned for more than a decade. To many, it appeared that by being exposed to this influx, their world had become literally fantastic and re-enchanted. As one of our informants put it, ‘UNTAC released all the spirits’, and for the population at large the newfound freedom resulted in the revival of various kinds of ritual activities, including indigenous healing, the spiritual components of which had been repressed by both DK and Vietnamese socialist modernity. Various kinds of indigenous practitioners now figure prominently in the contemporary a-modern ‘mediscape’, where the lines between political and therapeutic power are certainly blurred.

The Ministry of Health is severely limited in terms of human and financial resources, and local and international bodies and non-governmental organizations (NGOs) often compete with the government over therapeutic control. And, it sometimes seems that all these parties often lose out to the pharmaceutical companies, whose commercial interests rarely coincide with those of either government or aid organizations. Apart from such ‘blurred lines’ – which stem from and reflect systemic global and national political-economic and medical inequalities – the a-modern Cambodian medical world is characterized by a syntheses of premodern and modern elements. Even among educated urbanites who may express disdain for ‘traditional’ medicine, a modern medical world view informed exclusively by the principles of biomedicine cannot be taken for granted. People consult indigenous healers not only to be cured of an illness but for a number of other reasons, such as life crises, family problems, or for psychological well-being. In other words, you go to an indigenous practitioner not only if you need to ‘see a doctor’ but also if you need to see a psychologist, a social worker, a lawyer, or a fortune-teller.

In Chapters 6 and 7 we take a longitudinal view of two different medicalized themes, childbirth and leprosy. Both phenomena have continually been of biological as well as social and symbolic concern, albeit in inverse ways. Though childbirth is a perfectly natural and non-pathological process, it is universally subject to ritualization, and in modern society it has been medicalized and
biopoliticized. Leprosy, conversely, is a clearly identifiable disease that may be medically diagnosed, treated, and even cured, but it has always been subject to symbolic interpretations and socio-political measures that have caused a great deal of suffering for those afflicted. Childbirth and leprosy were both a focus of colonial biopolitical interest in Cambodia and both were exceptional in that the French actively sought to engage with Khmer indigenous practices. For childbirth, the colonial efforts were directed towards midwifery training for young Khmer women, and for leprosy, an indigenous leprosarium was appropriated along with the pharmacological production of an indigenous herbal remedy. Of these measures, only the latter was modestly successful.

In Chapter 8 we focus on contemporary healthcare for ordinary people. Through ethnographic examples of pharmacists, drug-sellers, and rudimentarily educated village doctors, we try to convey an impression of rural people's options for dealing with everyday ailments, illnesses, and accidents. For most rural practitioners, tending to everyday medical needs is both a calling (or a result of their destiny) and a way to make a living. Fully qualified medical doctors and nurses may practise either at private clinics or in the generally less well-endowed public health system. There is general mistrust of government officials, including hospital staff, who are perceived not as public servants but, naturally and accurately, as people who have to make the most of the possibilities their position may offer.

In spite of the substantial development aid that has poured into the country since UNTAC, the current health situation is bleak: between 1990 to 2004, the infant mortality rate increased from 80 to 97 and the child mortality rate from 115 to 141 per 1,000 births. Almost 1 in 10 children does not survive his or her first birthday. The rate of infant mortality is twice as high for babies born into the poorest 40 per cent of households as for those born into the richest 20 per cent (Hong, Mishra and Michael 2007: 40). Only 32 per cent of all births are nowadays assisted by medically trained midwives (compared to 23 per cent in 1963), and the World Health Organization (WHO) gives the maternal mortality ratio as 540 per 100,000 live births (the highest in the region, compared, for example, to 110 for Thailand and 150 for Vietnam). Moderate or severe malnutrition is found in 5 per cent of all children.

According to the government's Demographic and Health Survey in 2000, the patterns of morbidity and mortality have remained virtually unchanged for years, and the general populace seems to be greatly affected by the same
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diseases including diarrhea, acute respiratory infections, dengue hemorrhagic fever, malaria, malnutrition, and other vaccine-preventable diseases’ (Kingdom of Cambodia 2001: 2). We may add that among infectious diseases, tuberculosis remains a serious problem, and that a number of ‘lifestyle’ diseases, most notably hypertension but also diabetes, gastric ulcers, and heart diseases, are increasing significantly but often go untreated. On a more positive note, the prevalence of HIV/AIDS has been reduced from 3 per cent in 1997 to 1.6 per cent in 2006. This is the result of a concerted effort by the government and international donors; more than one-third of donor funds have been allocated to HIV prevention and HIV/AIDS treatment and care alone (Michaud 2005: 11). This example shows what the combination of political will and sufficient funds can do for public health. But in Cambodia such a combination is the exception. In the contemporary medically a-modern world the proliferation of practitioners of all kinds, from indigenous healers, pharmacy shopkeepers, and village doctors to qualified medical doctors and nurses, implies that people get the medical care they feel they can afford. For most Cambodians, this is decidedly inadequate.
Chapter Two

Colonialism and Medicine in Indochina

During the colonial period, Cambodia formed part of a larger region known as French Indochina, which consisted of the colony of Cochinchina and the protectorates of Annam, Tonkin, Laos, and Cambodia. France’s colonial interests were first directed at Cochinchina, the name given to the fertile Mekong Delta, with Saigon as its main urban centre. Saigon was conquered in 1858. A couple of years earlier, King Ang Duong of Cambodia had made a plea for protection to the French to end his kingdom’s status as a vassal state of the Annam empire and at the same time counter Siamese pressure on the country’s western provinces. Eventually, the French seized the opportunity to secure Cambodia for strategic purposes and, through an agreement with the new king, Norodom, made it a protectorate in 1863 (for details, see Brocheux and Hémery 1995: 25–35; Forest 1980: 5–8; Tully 2002: 11–22). Compared to the relatively peaceful colonization of Cambodia, the subsequent conquest of Annam and Tonkin from the early 1880s onwards was a protracted and militarily demanding affair. The emperor of Annam had a standing army at his disposal, and even after its formal defeat in 1885, armed resistance against the French continued for decades.

The Colonizing Process

In another important respect, the French colonization of Cambodia (and Laos) differed from that of Annam. While in Annam ‘the French undermined the authority of the royal house’, in Cambodia they treated the ruler ‘in such a way that he managed to remain as the symbolic leader of the nation, [and the French were] instrumental in boosting the prestige of the royal family and the officials associated with the court’ (Osborne 1997: 70). The French also manipulated the king and made sure that he publicly supported or condoned their policies (Tully
Colonialism and Medicine in Indochina

2002: 101ff). In other words, the French created and upheld a Cambodian ‘theatre state’ as the symbolic exemplary centre of the realm, thereby both bolstering the self-esteem of the royalty and indigenous elite and helping to preserve the illusion among the populace that they were still ruled by their own king, while usurping real political power.

The notion of the theatre state was proposed by Clifford Geertz (1980) in his study of nineteenth-century Bali. Geertz suggested that in indigenous states in Southeast Asia the ceremonial splendour of royalty and court culture was primarily a ritual spectacle performed around a monarch devoid of real political power. Such power, Geertz claimed, ‘was not allocated from the top, it was cumulated from the bottom’ (1980: 63). As critics have pointed out, this rather implausible political scenario is contradicted by available empirical evidence, both from Bali (Schulte Nordholt 1993) and elsewhere in the region (Tambiah 1985). Neither does Geertz’s idea seem to fit the example of precolonial Cambodia (pace Au 2006: 8), unless we make the assumption that decisions such as the building of the monuments of Angkor, or waging war against Champa, emanated from the populace. The decision by King Ang Duong to seek French protection was precisely to halt the decline of his real political power vis-à-vis Annam and Siam rather than to safeguard his or his successors’ theatre performances. To some extent, the model of the theatre state came true, however, in Cambodia and elsewhere, as a consequence of European colonization. The Europeans gradually appropriated the prerogative of political domination and economic exploitation and left indigenous rulers and elite with little else to do than dress up for rituals and exercise their political talents by indulging in court intrigues or currying favour with the colonizers.

Alain Forest’s claim (Forest 1980) that the colonization of Cambodia went smoothly (sans heurts) is basically correct for the period covered by his work, that is, after 1897, when French appropriation of political power had been completed. But the process itself, of turning the indigenous state into a ‘theatre’, was far from smooth. In 1884 the French forced King Norodom to sign a treaty which would give them control of administrative, judicial, financial, and commercial matters, including taxes and customs revenues and the finances of the royal household. Indigenous provincial governors and district officials were to be placed under the supervision of French résidents, and land (formally the property of the king) was to be privatized (Tully 2002: 74). The treaty provoked fierce reactions among the local elite. Prince Sivotha, the king’s half-brother and arch-rival, instigated an insurrection in 1885 aimed against the French – and, by implication, against the king – for ceding royal and elite political power and economic privileges
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to the foreigners. Indigenous officials, anxious to maintain their prerogative of exploiting the peasants, rallied to the anti-French cause and mobilized large numbers of guerrillas among the peasantry, and soon a full-blown countrywide rebellion was underway (Osborne 1969: 207, 222; Tully 2002: 87–88). During the rebellion, the two hospitals in Phnom Penh – the infirmary of the military barracks and the ‘native’ hospital run by the religious sisters of la Providence de Portieux – had been overflowing with soldiers, wounded in battle or suffering from malaria and dysentery from campaigning in the jungles; the French were taken to the barracks while the sisters treated the tirailleurs annamites (Guillou 2001: 97). But the military casualties paled in comparison with the civilian ones: tens of thousands of ordinary Cambodians were killed, many more fled to Siamese territory (Battambang, Siem Reap), and large parts of the countryside were devastated, resulting in many more deaths from disease and starvation (Muller 2006: 210–211).

In 1887, the French established l’Union Indochinoise (Indochina) under the unified administrative authority of the Governor-General of Indochina. This was a completely colonial construction, the supposed unity of which was contradicted by the evidence of history, culture, society, geography, demography, and politics. Laos and Cambodia were ancient ‘Indianized’ states (Cœdès 1968) ruled by semi-divine kings with Theravada Buddhism as their official religion; these two states made up the ‘Indo’ part of Indochina. The ‘China’ part was the expansive Viet empire of Annam, which politically and culturally included both Tonkin and Cochinchina, and which from the mid-fifteenth century till the 1830s had gradually conquered and obliterated the Indianized Champa kingdoms on the Annam coast. The Viet territory, corresponding to present-day Vietnam, was ‘Sinicized’ through its status as a tributary to China, as well as in terms of the Confucian ideology that informed both its state and social organization (cf. Osborne 1997: 31–32).

Despite the fact that colonization had resulted in the administrative creation of three separate territories of what today constitutes Vietnam – Annam, Tonkin, and Cochinchina – the French in many contexts referred to all three as Annam, and to the population as Annamites. Demographically, Annam in this wider sense (i.e. present-day Vietnam) was absolutely dominant in relation to Cambodia and Laos. Table 2.1 (opposite) gives figures from 1913, when the first population statistics were made available.
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Table 2.1: Population and area of French Indochina, 1913

<table>
<thead>
<tr>
<th>Area (km²)</th>
<th>Population</th>
<th>Population density</th>
<th>French population</th>
<th>Percentage French</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cochinchina</td>
<td>3,165,000</td>
<td>60,000</td>
<td>53</td>
<td>7,357</td>
</tr>
<tr>
<td>Annam</td>
<td>5,000,000</td>
<td>140,000</td>
<td>36</td>
<td>1,676</td>
</tr>
<tr>
<td>Tonkin</td>
<td>6,000,000</td>
<td>116,000</td>
<td>51</td>
<td>5,338</td>
</tr>
<tr>
<td>‘Vietnam’ total</td>
<td>14,165,000</td>
<td>316,000</td>
<td>45</td>
<td>14,371</td>
</tr>
<tr>
<td>Cambodia</td>
<td>1,600,000</td>
<td>120,000</td>
<td>13</td>
<td>1,068</td>
</tr>
<tr>
<td>Laos</td>
<td>630,000</td>
<td>230,000</td>
<td>3</td>
<td>241</td>
</tr>
<tr>
<td>Cambodia + Laos total</td>
<td>2,230,000</td>
<td>350,000</td>
<td>6</td>
<td>1,309</td>
</tr>
<tr>
<td>Indochina total</td>
<td>16,395,000</td>
<td>666,000</td>
<td>25</td>
<td>15,680</td>
</tr>
</tbody>
</table>

Sources: Brocheux and Hémery (1995: 175, 248); Fourniau (1989: 121)

The French only made Indochina profitable through heavy personal taxation (head tax, corvée), the taxation of all agricultural produce (which also affected the French settlers, les colons), as well as government monopolies of the opium, alcohol, tobacco, and salt production and trade (Forest 1980: 198–224; Brocheux and Hémery 1995: 92–99). Rice and other agricultural produce were mainly exported, and in some areas of Cochinchina and Annam, tenants and peasants were kept in an almost continual state of near-famine.

COLONIALISM AND MEDICINE

Historians began addressing the medical dimensions of colonialism in the wake of academic critiques of European colonialism that gained momentum in the 1970s. Studies from the late 1980s onwards provided a timely antidote to the tales of earlier generations about the heroic colonial doctor who suffered all kinds of hardships in order to carry out his mission of giving medical treatment to needy colonial populations. One critique was that colonialism itself actively created ill health among the colonized. In East, Central and Southern Africa, as well as in India, the period between 1890 and 1930 was arguably the unhealthiest in history, according to David Arnold (1988: 4–6). For Malaya, Lenore Manderson was not so categorical, but noted that statistics showing improved health for the period were ‘sometimes illusory’ (1996: xv). Among the causes of the decline in public health were not only diseases (such as syphilis) transmitted directly by the Europeans themselves; colonial trade and transport created new epidemiological
links between Europe and the colonies, as well as between dispersed colonies, which were instrumental in the spread of diseases such as smallpox, measles, the plague and influenza, and facilitated the movement of disease vectors such as mosquitoes, fleas, and lice. Ecological changes brought about by the colonial economy could have had negative consequences for public health: irrigation schemes created favourable habitats for malaria-carrying mosquitoes, and labour migration between the highlands and lowlands, for instance, resulted in the spread of certain diseases (malaria, tuberculosis) to areas hitherto free of them (cf. Arnold 1988: 4–6).

Another kind of critique was that medicine in the colonies was a ‘tool of empire’ (Macleod and Lewis 1988). Initially, medicine as a tool of empire was used to keep the European colonizers alive and reasonably healthy so that they could carry out their job of managing the colonies. As structures of political domination and economic exploitation became more firmly entrenched, a native labour force of troops, militiamen, and indentured labourers was required. These natives had to be kept alive and sufficiently healthy as well, following a simple cost–benefit analysis. A third use of the medical tool of empire was in trying to win the hearts and minds of the general population, to demonstrate benevolent paternalism, ‘as a way of winning support from a newly subject population, of balancing out the coercive features of colonial rule, and of establishing a wider imperial hegemony than could be derived from conquest alone’ (Arnold 1988: 16; cf. Worboys 2001). This third application of the tool was in the British colonies conveniently left to Christian missionaries, given the ideological compatibility between the two hegemonic systems, biomedicine and Christianity. Manderson cites Frantz Fanon for the observation (in 1961) that ‘Western medicine was introduced into colonial societies as part of the introduction of Western cultural values’ (Manderson 1996: 14). This is a rhetorically attractive statement, ground-breaking at the time it was made. But today it is much less sensational. It could be argued that the accusation of more or less surreptitiously promoting Western cultural values could equally justly be levelled against most other aspects of colonial expansion, such as schooling and higher education, cash-cropping, industrialization and agro-business, wage labour, and the capitalist mode of production in general. Moreover, the ‘Western values’ associated with biomedicine do not necessarily conflict with indigenous ones; consider, for instance, that the Khmer standard formula for well-wishing most notably includes the wish for good health and long life. Manderson has suggested, still following Fanon but being somewhat carried away with the rhetoric, that ‘encounters with Western medicine […] were for colonised subjects always an encounter with the
Colonialism and Medicine in Indochina

colonising society; their acceptance of its services implied a complicity with the ideology and polity that enabled it’ (ibid.: 14). We can only partially agree with the first part of that statement. The second half does not necessarily follow from the first, logically or factually; in the case of colonial Cambodia, it is simply incorrect. Apart from the native labour force (troops, militiamen, clerks, and later, indentured plantation labourers) and prisoners – all those belonging to the ‘colonial enclaves’ (Arnold 1993) – who had little choice but to submit to French medical surveillance, the Khmer population in the countryside deliberately tried to minimize their encounters with the French. The occasional rumours that the French were dangerous foreign demons did not encourage unnecessary contact.

Secondly, the Khmer were very selective about which French medical services they would accept and under what conditions they would do so. Indeed, French doctors often complained that the Khmer only wanted medicines that had an immediate effect, that they did not let their women and children go to the clinic, and that they completely disregarded hygiene as a preventive measure.

The choice of which services to accept and which to reject was to a certain extent a question of individual or collective agency on the part of the Cambodians. For most ordinary people, the presence of their colonial masters was a fact of life they could do little to change, and their choices of therapy were less an ideological statement of complicity with or resistance against the colonial regime than the practical exercise of agency, of making decisions based on their perceptions of the relative advantages or disadvantages that the various services had to offer. For most people, access to what was perceived as efficient medical treatment would overrule possible ideological considerations. On the other hand, biomedical measures that went against the cultural grain would often be rejected, despite their efficacy. This, in our view, is very far from complicity with the tenets of biomedicine, let alone with imperial ideology or French colonial rule.

BIOPOLITICS: FROM MISSION CIVILISATRICE TO LA MISE EN VALEUR

French colonialism was commonly publicized as *une mission civilisatrice*, a self-imposed assignment to bring the colonial populations within the orbit of (French) civilization. This implied an attempted transformation of the populations of the colonies from a potential workforce of natives to governable colonial subjects. A central theme in Michel Foucault’s work is that of governmentality as a distinctive feature that emerged with the modernity of (European) states. ‘Maybe what is really important for our modernity […] is […] the “governmentalization” of the state’ (Foucault 1991[1978]: 103). Governmentality may be briefly rendered as the
effort to constitute governable subjects. This effort ensues neither automatically nor necessarily from administrative structures and institutions of statecraft, but is achieved through various techniques and practices aimed at regulating and controlling conduct. While rulers of indigenous Southeast Asian states (like their counterparts in premodern and early modern Europe) were generally content to leave people to their own devices once they had fulfilled their obligations to the state in terms of tax, corvée, and military service, for French colonial officials, governmentality was part and parcel of their rule. Measures of governmentality were aimed at the level of individual human bodies as well as at the level of populations. At the individual level it was a question of surveillance through various disciplinary techniques and institutions (hospitals, asylums, prisons, leprosariums…). But ‘discipline was never more important or more valorized than at the moment when it became important to manage a population’ (ibid.: 102). Biopolitics emerged in Foucault’s work as the field of simultaneous application of governmentality at the level of the individual as well as the entire population. Populations targeted for biopolitical measures may be defined in terms of race, national or regional affiliation, ethnicity, religion, gender, class, or occupation, or combinations of such variables.

The notion of *la mission civilisatrice* was promoted in the 1880s ‘as a rallying cry to motivate an ambivalent nation to acquire and invest in overseas possessions. A promise to reform, educate and improve the livelihoods of France’s new colonial populations, the civilizing mission embodied […] the specifically rational, secular ideas of the Enlightenment (Daughton 2006: 5)’. This civilizing promise entailed medical and educational programmes for the native populations at large (Monnais-Rousselot 1999; Bezançon 2002), which contrasted with the British colonial practices of mainly offering education to the local elites and medical services to the urban populations and the native colonial labour force. As for education, Governor-General Paul Beau in 1905 grandiosely declared, ‘Education is a prime right of every child and the government should grant it to the best of its ability, no matter the cost’ (quoted by Bezançon 2002: 76). But even construed as a moral obligation, colonization was also a biopolitical mission of incorporating the colonial populations into the social order in the metropole. Ann Stoler has argued that both racial and gender classifications were ordering mechanisms in the European bourgeois order, and that racial thinking was not subsequent to, but constitutive of that order (Stoler 2002: 144). This is an important point, but we would like to add that class was no less constitutive of the French bourgeois order, and we suggest that the goal of colonial biopolitics was to incorporate the native races, as races, into a fundamentally class-based
Colonialism and Medicine in Indochina

hierarchy of which they were to fill the lower rungs. This, Marie-Paule Ha has argued, was the guiding principle behind the curricula of colonial schooling: ‘Far from trying to transform the colonized into Frenchmen, the French colonial government’s prime pedagogic objective was […] to re-orient students back to traditional cultures and societies, which were reconfigured in terms that concurred with the imperative to maintain French hegemony’ (Ha 2003: 114).

Therefore, ‘the educational needs of the colonised Indochinese populations were […] perceived to be rudimentary, and largely of a practical rather than intellectual nature’ (Cooper 2001: 39). Indeed, too much education was not only unnecessary, but could be a threat to French hegemony. Thus, in 1919 a circular from the Indochina section of the Ministry for Colonies sounded a warning: ‘It is precisely those natives taught by our methods and with our ideas who are the most dangerous enemies of our authority and the partisans most committed to a home rule where we would no longer have a place’ (cited by Cooper 2001: 39).

The Enlightenment tenor of the civilizing mission was not uncontested. The ideological tensions within French society at the time, between the Catholic Church on the one hand and the Third Republic on the other, ‘led to heated […] disagreements over […] the form colonialism would take, and the very meaning of French civilization’ (Daughton 2006: 6–7). The colonization of Indochina (particularly Tonkin; Michaud 2007) was pioneered by Catholic missionaries, for whom civilizing the natives was synonymous with (and often restricted to) nominally converting them to Christianity. The perspective of the missionaries was shared by many within the military, who had been assisted by missionaries in their task of pacifying the natives (Michaud 2007: 74). Indeed, during the first decade of the Third Republic, opposition to republican ideas resulted in the army becoming increasingly Catholic and conservative (Rabinow 1989: 118), even anti-semitic, as the Dreyfus affair would reveal. The civil institutions of society, on the other hand, were dominated by republican values, and this pertained also to the colonial government in Indochina. Paradoxically, that government had to rely initially on missionaries to implement some of the ‘civilizing’ projects, since the missionaries had already established rapport with the natives and their activities did not incur any expenditure for the government (Daughton 2006: 6). Republican values were most fervently expounded by the Freemasons; in addition to Jean-Marie de Lanessan (see below), all governors-general of Indochina between 1897 and 1910 (Paul Doumer, Paul Beau, and Antony Klobukowsky) were Freemasons (ibid.: 85ff). Since the Republican Party had no organization in Indochina, the Freemasons claimed to be the true defenders of republican values: the struggle against reactionary ideas; the defence of secularism; and the
fight against clericalism (Dallos 2002: 37). They repeatedly demanded that only certified republicans be appointed to the colonial administration (ibid.: 40). By the first decade of the twentieth century (concurrent with the resolution in 1906 of the protracted Dreyfus affair) the participation of Catholic missionaries in the government’s civilizing mission was drawing to a close. The year 1905 saw the formal separation of the church from the state in France, and in Indochina the establishment of both the colonial medical service (l’assistance médicale indigène) and the Directorate of Public Education (Direction générale de l’instruction publique) (Bezançon 2002: 74–75).

The biopolitical role of medicine

Even more than education, medicine was a biopolitical instrument that simultaneously targeted individuals (bodies) and populations, through curative measures and preventive (public health) efforts, respectively. From the very beginning, French colonial medicine, in Indochina and elsewhere, was part and parcel of the military colonial conquest, and the emphasis was on curative (surgical) needs. French military medical officers had always been at the frontline of colonial expansion, to clean up when things got messy. ‘As soon as conquest was achieved, […] the mission of the military physicians was extended among the population’ (Michel 1985: 196), even with respect to preventive efforts. In Indochina in general, the military pioneered the establishment of mobile field hospitals, ambulances, in the 1880s, catering for Europeans (military and civilian personnel and colons) as well as native troops (tirailleurs annamites). The mobile hospitals were soon to become fixed establishments even though they were still known as ambulances (Martin 1985: 261). By French government decree, a military Corps de santé des colonies et des pays de protectorat was created in 1890 (Michel 1985: 186–187). In 1903 it was renamed le Corps de santé des troupes coloniales. For the colonial health services, ‘it was, of course, primarily a question of protecting the whites, whose numbers had been decimated by terrible epidemics, but the combat of these epidemics necessitated a much wider scope of action, geared towards the protection of the natives’ (ibid.: 188).

The protection of natives was a rational biopolitical goal. France’s main economic interest in Indochina was in rice production, and agriculture in general, both for taxation purposes and export potential. As labour rather than arable land was still the scarce resource, as many hands as possible were needed for agriculture and as a labour reserve for future plantation ventures (Brocheux and Hémery 1996: 245ff), so it was logical for the colonial medical service to target the entire native population. As a necessary labour force, the natives
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ought to be kept alive and in reasonably good health, so they needed protection from epidemics. Already in 1880, Dr Vantalon, pioneer of the colonial smallpox vaccination programmes, had made the overall aim quite clear.

The promotion of vaccination is not only an essentially philanthropic enterprise, it is first and foremost one of supreme political and social economy. Given that more than four fifths of the fertile alluvial plains of the Mekong are still uncultivated due to lack of manpower, and given that the European can never replace the Annamite as agriculturalist in a climate like this, it is abundantly evident that the future and the prosperity of the colony will depend on the increase of the native population. (cited in Brocheux and Hémery 1996: 251)

The marked biopolitical emphasis on the whole population as an element in the civilizing mission reflected the spirit of the social reforms that had taken place in France around the mid-nineteenth century, and which became official policy in the Third Republic. In his ethnography of nineteenth-century French social philosophy, Paul Rabinow (1989) has portrayed the French ethos of social modernity as one of ‘missionary and didactic pathos’. The men who represented and worked to realize this spirit of social reform were engineers, statisticians, administrators, socialist reformers, sociologists, colonialists, and military officers. They were ‘pragmatic technicians seeking to find scientific and practical solutions to public problems’ (Rabinow 1989: 16). ‘The understanding of social reality which yielded the pathos – its rejection of metaphysical solutions and the sense that society had no outside, but only margins – also produced a sense that there was no choice but to reform it’ (ibid.: 14).

Not only social science and statistics but eventually also biomedical science itself – a field in which France was becoming the leading nation – was enlisted for the republican biopolitical cause of preventive public health efforts. Since its foundation in 1888, the Institut Pasteur in Paris was oriented towards preventive medicine. The French realized early on the advantages of carrying out microbiological and other research on ‘tropical diseases’ closer to the ‘tropical’ environment and to the populations, European and native, that were to be its main beneficiaries. They even assigned some of their most eminent medical researchers to the task. Thus, to serve the needs of French Indochina an Institut Pasteur was established in Saigon in 1890, at the initiative of Louis Pasteur himself and with Albert Calmette as its founding director. To begin with, the institute specialized in the production of smallpox vaccine. In 1895, a second institute was set up in Nha Trang under the directorship of Alexandre Yersin. The previous year (during
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the pulmonary plague epidemic that devastated Hong Kong) Yersin had isolated
the microbe that caused the plague, and the institute at Nha Trang consequently
specialized in the production of vaccine against the plague (Bernard 1922: 11–15). Microbiological laboratories and research institutes were established
during the following years in Hanoi, Hue, Phnom Penh, and Vientiane, and
their activities were expanded to include, among other things, the production
of vaccines against cholera, tuberculosis, and rabies, as well as the prevention
and treatment of trachoma (Government General of Indochina 1931: 10–13).
Indochina was seen as the most promising of the French colonies, a showcase of
the success of the colonial order in all respects, and one that therefore deserved
to be helped along by the best French expertise, in the medical field by the most
eminent Pasteurians.³

In 1905, the responsibility for medical issues in Indochina was transferred
from the military to the colonial government, and the policy of medical assistance
for the natives (l’assistance médicale indigène) was laid down by a government
decree (NA B286). The colonial medical service was from then on managed by la Direction générale de la santé en Indochine. With the ‘demilitarization’ of
colonial medicine, the French government could fully incorporate the medical
service into its civilizing mission.

It was republican ideology that generally guided the colonial medical
policy-makers. In Indochina, the medical service was organized almost single-
handedly by Charles Clavel, then medical inspector of the French Colonial
Forces (Monnais-Rousselot 1999: 37). Clavel made it clear that the general
aims of the medical service in Indochina were ‘the battle against disease, the
physical improvement of the Annamite race, and, at the same time, the economic
development of the country’ (Clavel 1908: 2). Consequently, the new medical
service was explicitly aimed primarily at the native population, and its purpose
was threefold: treatment, prevention, and medical training. In his 1907 report
to the Governor-General, Clavel explained that although the medical service
would obviously provide necessary treatment to Europeans, its principal target
was to combat excessive mortality among the natives caused by ignorance and
antiquated ideas, through the propagation of hygiene, incessantly battling against
disease, and sanitation. Hence it was not enough to simply have a few hospitals
and consultation centres in the urban areas – what was needed was a continual
presence among the population, through talks, public lectures and tours of the
villages, in order to teach the natives how to protect themselves and fight against
diseases such as smallpox, leprosy, typhoid, plague, cholera, and malaria.
short, to teach them how a nation can preserve health and acquire strength (in Monnais-Rousselot 1999: 66–67).

The task ahead: La mise en valeur

After the First World War, the key concept for the colonial enterprise came to be la mise en valeur of the colonies, from 1919 onwards famously proclaimed by Albert Sarraut, then Governor-General of Indochina and soon to become Minister for Colonies (Sarraut 1923). This concept has been variously interpreted in postcolonial analyses. Nicola Cooper has suggested that la mise en valeur implied the moral and cultural improvement of the colonial subjects. She claims that the attention to the moral and cultural dimension was something uniquely French that ‘stemmed from the French belief in the universal value of its civilisation which in turn found its roots in the nation’s revolutionary legacy’ (2001: 29). We would suggest that a belief in the universal value of its civilization could equally well be ascribed to the British who on the strength of the legacy of Waterloo shouldered the ‘white man’s burden’ on the principle of victoire oblige. Frances Gouda and Julie Clancy-Smith (1998: ), on the other hand, have equated la mise en valeur simply with economic profitability. While this is certainly an expected outcome of la mise en valeur, it does not accurately cover the core meaning of the concept.

The direct translation of mise en valeur is simply ‘development’, particularly in the sense of infrastructural and economic development. In non-colonial and less politically and ideologically charged contexts, it is the term for land development and reclamation. The colonial use of the concept corresponds to the notion of development as more recently employed by both nation–states and international organizations, where it denotes improvements in infrastructure and technology as well as of economic and social institutions to promote, for example, rural development. In the colonial context it was implicitly understood, however, that la mise en valeur would be mainly for the benefit of the metropole, and the eventual moral and cultural improvement of the inhabitants of the colonized territories would only be secondary, contingent outcomes. In the early 1920s, the colonial social order seemed well established, with an almost perfect fit between race and class. It was at this historical conjuncture that Sarraut could afford to dispense with the self-congratulating rhetoric of la mission civilisatrice; in a Gallic speech at the École Coloniale in 1923 he declared:

Let us not pretend. Let us not try to deceive. Why mask the truth? Colonization, from the very start, has not been the work of civilization, a
The French and the Races of Indochina

So far, we have portrayed French colonial biopolitics as if the ‘natives’ formed a largely undifferentiated population. We have already noted the socio-cultural divide between the ‘Indo’ and the ‘China’ parts of Indochina, but even within these two divisions, the ethnic diversity required some finer distinctions, not least from the point of view of colonial administrators. The major ‘races’ (i.e. ethnic groups) of Indochina, all represented as residents within the indigenous Khmer kingdom, were the Annamites, Cambodians, Cham, Lao, and Chinese. The two former are now known as Vietnamese and Khmer; these terms will be
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used in the following, unless in direct quotes. Apart from these major races, the native races included the various aboriginal upland groups known collectively as moi (‘savages’, or montagnards to the French) in Vietnam, kha (‘slaves’) in Laos, and phnong (‘savages’) in Cambodia.

Among colonial policy-makers, the concept of la politique des races had gained some currency. To see this concept in its proper context, we need to bear in mind that the French discourse on biosocial evolution and physical improvement of various ‘races’ in the colonies was grounded in Lamarckian rather than Darwinist thinking (Rabinow 1989: 126–138, 146–151). If a politique des races was necessarily in some ways discriminatory, it did not imply an a priori hierarchical ranking of the various groups but rather advocated some amount of ethnic self-determination. The eventual ranking of the races, however, was to emerge ‘naturally’ according to ‘Lanessan’s law’, and to be manifested in social and mental accomplishments. ‘Also central to [the racial] doctrines was the concept of civilization as the unique attainment of superior racial groups, of nationhood as the supreme manifestation of human sociality, and of empire-building as an expression of superior national will and race spirit’ (Bayly 2000: 589).

Colonial ethnicity in Cambodia

A concomitant of this racial thinking was that the French as superior empire-builders were naturally entitled to order the natives according to race and class parameters. The adoption of special measures for particular ethnic groups was not completely a French innovation, however, and neither, of course, was the general ethnic classification. Although we have mentioned that rulers of the indigenous states did not generally attempt to regulate the conduct of ordinary people, this did not imply that they did not make political-administrative distinctions between different groups.

In Cambodia, only the Khmer were allowed to have paddy land, for instance. The Chinese in Cambodia had always been ambiguously regarded; on the one hand, as King Norodom declared in 1873, they were Asian but foreigners, asiatiques étrangers (Forest 1980: 468) and therefore not to be completely trusted, but on the other hand their activities in trade and commerce were vital for the national economy and made them a significant source of tax revenue. The French faced the same problem; they were reluctant to take colonial responsibility for groups other than proper ‘natives’ (indigènes) within the protectorate. So in 1891 it was decided to grant some amount of administrative autonomy (‘ethnic self-determination’) to officially recognized Chinese communities (congrégations)
and to decree that all Chinese should belong to one such community (Forest 1980: 470).

As for the Cham, a sizeable minority in certain provinces, no special provisions were made officially, although local colonial officials recognized them as rather exotic compared to other natives. As the resident doctor in Kampong Cham pointed out in 1924, ‘they are a people somewhat apart among the natives; they have their own customs and language and their preferred professions. They are Muslims. They also have their own doctors to whom they are very attached’ (NA 630). In the indigenous Khmer kingdom Chams had often been recruited as army officers, guards, and soldiers. Among ordinary Khmer they were often feared because of their reputation for possessing strong magic and practising sorcery.

If the ethnic/racial classification was uncontestedly employed by both colonizers and natives, there were subtle differences between the French and the natives with respect to its implications. To all, racial affiliation was determined by a combination of physical, mental, cultural, and linguistic characteristics, in a polythetic classification scheme. But while the French fixed their classification according to a bureaucratic essentialism, the Khmer to some extent recognized the constructivist nature of the racial scheme (Ovesen and Trankell 2004: 241–243). A Chinese, a Cham, or a phnong, for example, could ‘become Khmer’ (chol khmae, ‘enter Khmer’) by adopting the Khmer language and learning Khmer customs and thereby acquiring a Khmer habitus. For the Vietnamese, on the other hand, this was not a realistic option from the Khmer point of view.

The French in Cambodia were continuously faced with the socio-cultural differences between the Vietnamese and the Khmer, and the traditional animosity of the latter towards the former. This was partly because of the paradox built into the Indochinese Union, which necessitated a sort of double vision. From the general Indochinese (that is, French) perspective both Vietnamese and Khmer were natives (indigènes) while from a Cambodian (Khmer) perspective the Vietnamese were foreigners, indeed ‘enemy aliens’ whose scheming for territorial encroachment had originally made the Cambodian king acquiesce to the French protectorate. To illustrate with an anecdote, around 1880 a French Catholic priest, Father Lazard, had approached the Queen Mother to seek permission to establish a Vietnamese Catholic community on Cambodian soil. The Queen Mother had replied, ‘I do not want Annamites in my realm […] Put Cambodians on these lands and I shall be quite happy’ (Forest 1980: 435). The queen did not necessarily object to the possibility of having Christians in her realm, only Vietnamese were not welcome.
Colonialism and Medicine in Indochina

The French had early on adopted racial stereotypes about the Khmer and the Vietnamese which to a large extent guided their policies towards them. The Khmer were seen as docile, gentle, and friendly, but also lazy and therefore not dependable as wage labourers (Forest 1980: 442). The French orientalist ‘discovery’ of, and fascination with, the ruins of Angkor gave rise to the idea of the former glory and cultural sophistication of the Khmer that had now declined irretrievably (Edwards 2007). Contemporary Khmer were the degenerate descendants of the glorious Angkorean race who could nowadays no longer rule themselves but had to seek French protection. They provided an example of a race that according to Lanessan’s law should already have perished; as Penny Edwards puts it, for the French, ‘To be an authentic Khmer was to have vanished’ (ibid.: 152). The Vietnamese on the other hand had put up a fight against colonization, thereby earning a grudging respect from the French. They were troublesome and often aggressive, but once properly subjugated, the Vietnamese could be relied upon to behave as colonial subjects should, since they were dynamic, industrious, and therefore well suited to working for the colonials (Forest 1980: 442).

To the French, the Vietnamese constituted the prototypical Indochinese race. This was first of all because of their overwhelming numerical dominance. Compared to the Vietnamese who constituted more than 85 per cent of the population of the French Indochinese Union, both the Khmer and the Lao were minorities. Thus, when Clavel (1908) had seen the colonial medical service as a means for the physical improvement of the ‘Annamite’ race, he did not necessarily imply that the Khmer, the Lao, and the various smaller minorities should not also be physically improved, only that they were numerically so relatively insignificant that they need not be mentioned.

The combination of Vietnamese preponderance, the fact that the French efforts of la mise en valeur were primarily directed towards Vietnam while the territories of Cambodia and Laos were treated as colonial backwaters, and the French view of the Vietnamese as the prototypical native colonial subjects resulted in the French modelling their policies on the basis of their experiences of dealing with the Vietnamese. Although the French had created the Indochinese Union with a view to appropriating and unifying a region identified as ‘a great cultural meeting point for the once-great classical civilizations of the “Indic” and “Sino-Confucian” East’ (Bayly 2000: 591), it seems they had initially underestimated the sociological differences between these civilizations. The cultural and historical divide between the Indianized and the Sinicized societies of Indochina was reflected in decisive differences with respect to Khmer and Vietnamese sociality. The Vietnamese reckoned descent patrilineally and
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exhibited a tightly structured local organization based on Confucian hierarchical and patriarchal principles. Every local community, be it a commune, a rural village or a Vietnamese residential quarter in an urban environment, appeared as a well-administered, self-contained unit, represented outwardly (i.e. to the colonial authorities) by a chef des annamites. The administrative convenience that this kind of organization entailed was attractive for the French, so they attempted to extend it to Cambodia.

In precolonial Cambodia, local officials were the king’s appointed clients. After colonization, administration of each province (circonscription) was in the hands of a French governor (résident), answerable to the résident supérieur in Phnom Penh. With respect to indigenous officials of the districts (srok), the French seem to have preserved the office of mesrok. But in 1908, ‘the colonial regime attempted to establish territorial rural communities after the Vietnamese model, less difficult to control, they thought’ (Brocheux and Hémery 1995: 104). Such territorial communities were named khum, but despite the Khmer name, they did not correspond to an existing entity in Khmer social reality, as Jean Delvert (1961: 201) pointed out, and according to Brocheux and Hémery ‘the failure of the project of the Cambodian commune soon became evident’ (1995: 104).

Nevertheless, the French organized general elections for the office of mekhun (‘commune leader’) from 1909 onwards. Henri Locard (2002) argues for a more nuanced view of the commune ‘project’ and sees it as a genuine attempt to create a colonial democracy. But the principle of democratic elections through universal suffrage (according to French republican ideals) was not easily put into practice among the Khmer, and it seems that once elected, a mekhun was fairly secure in his position, unless French surveillance revealed blatant neglect of duties or criminal conduct (Locard 2002: 11–12). As we shall see in the next chapter, the refusal of mesrok and mekhun to cooperate with the officers of the medical service, for example, was not sufficient grounds for dismissal.

The main reason for the failure of administrative structures modelled on Vietnamese social realities (and/or French republican ideals) among the Khmer should be sought in the fundamentally different social organization and socio-cosmological ethos of the latter. Among the Khmer, local communities were loosely organized around a wat. Descent was reckoned cognatically and this precluded the emergence of consolidated, structurally defined corporate groups based on kinship. Neither was locality an operative principle for the formation of corporate groups; arable land had never been a scarce resource in Cambodia, and individual families or households had always felt free to settle and farm wherever they wished (cf. Thion 1993: 41–42; 226). Hierarchy was the major
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organizing principle, but in contrast to the Vietnamese case, it was not associated with patrilineal descent groups and patriarchy. Neither was hierarchy associated with caste-like groupings as in India. So basically, Khmer society was composed of individual families or households who created their own networks, vertically through patron–client relationships, and horizontally through more or less enduring relations of mutual cooperation between kinsmen or neighbours (cf. Ebihara 1968: 148–156, 181–186; Ovesen et al. 1996: 64–69).

French scholarly interest in Cambodia was mainly focused on history, art, and archaeology, but a few colonial officials around the turn of the century combined their administrative duties with amateur scholarship. Among the most notable of these, were Étienne Aymonier and Adhémard Leclère, both of whom contributed ethnographically and sociologically significant studies (see Brebion 1935: 15–16, 226–227). Such persons who showed more than a superficial interest in Khmer society and culture, intellectually or practically, and let their local knowledge influence their administrative practices were branded as khmérophiles by the Indochinese colonial establishment (Edwards 2007: 78–80). In addition to scholarly khmérophiles such as Leclère (who was mayor of Phnom Penh around the turn of the century), more practical khmérophiles included François Baudoin (résident supérieur of Cambodia 1914–1927), and Dr Bernard Menaut (who became Local Director of Health, directeur local de la santé, in the late 1920s); some of the efforts of these figures will be taken up in later chapters.

Most French colonial officials were hardly inspired in their daily work by scholarship (or affected by khméophilie), however, and they often showed an ‘extraordinary lack of knowledge about the actual lives and contemporary aspirations of Cambodians’ (Edwards 2007: 149). To add to the French problem of properly assessing and relating to indigenous society, the Khmer, when faced with demands from the authorities, tended to follow a strategy of avoidance (cf. Adas 1992). Khmer ‘distaste for becoming unnecessarily involved in unpleasant situations’, as May Ebihara once put it (1968: 186), is related to their concern not to lose face. In any confrontation, at least one party is likely to lose face, and loss of face is always unfortunate, regardless of who the loser is. So the best strategy was to retire with a smile, behaviour that the French mistook for docility. The Khmer strategy of withdrawal also entailed a wish to protect their private sphere from outside interference as well as an almost xenophobic attitude to foreign manners and customs. All this made the Khmer notoriously difficult to reach for the colonial administration.

The Vietnamese, on the other hand, were eager to interact with the French, eager to please and eager to quarrel, and, most notably, eager to take advantage of
the relationship. The policy of schooling, for example, worked quite well among the Vietnamese, particularly in Cochinchina where even girls attended village primary schools (Bezançon 2002: 92–97). One reason may be the structural compatibility between the indigenous mandarin system of education (even though it did not admit women) and the French school system; and the successful Romanization of the Vietnamese written language gave the Vietnamese an added advantage in learning French.

In Cambodia, secular village schools were doomed from the outset, and the French had to rely on a reformed version of the indigenous pagoda schools where young boys were taught by the monks. The reform of the pagoda schools was initiated in Kampong Cham in 1908 by François Baudoin (then résident of the province): monks were offered basic teacher training courses; Khmer would be the sole medium of instruction; and the main subject, apart from literacy and arithmetic, would be Khmer morality. Subsequent proposals to include French language in the curriculum were vigorously rejected by the monks, many of whom eventually lost interest in the project, which was abandoned in 1916 (Bezançon 2002: 81–82). Although the scheme seemed culturally appropriate, it put the Khmer at a disadvantage with respect to any higher education and employment opportunities. When the French needed to employ natives, these were almost invariably Vietnamese, not only for work within Vietnam, but also
in Cambodia and Laos. There was a substantial Vietnamese community in Phnom Penh, and most of the Vietnamese worked as domestic servants, clerks, and lower-level administrators, as well as workers, artisans, and coolies. Many had converted to Catholicism, and the Vietnamese quarter of Phnom Penh was also referred to as ville catholique. In addition, the French encouraged emigration of agricultural labourers and peasants from the very densely populated areas of central Annam and Tonkin into Cambodia and Laos. Between 1911 and 1921, the Vietnamese population in Cambodia as a whole had increased from just under 80,000 to over 140,000. In Phnom Penh, the Vietnamese population had increased during the period from 13,500 to almost 19,000 (Forest 1980: 446; see Table 2.2). ‘Of the 16 Indochinese bureaucrats working in the Town Hall of Phnom Penh in 1913, 14 were Annamese and the remaining 2 Cambodian. In the offices of the Commissariat at Battambang in 1915, 11 out of 21 bureaucrats were Annamese; in the résidence of Kandal, 8 of 14; 13 out of 19 at Kampong Chhnang-Pursat; 10 out of 16 at Takeo and so on’ (Goscha 1995: 24). Tellingly, Vietnamese rather than Khmer was the second language used at the native level of colonial administration (after French) (ibid.: 26).

Table 2.2: Population of Cambodia in 1911 and 1921

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>1911 Phnom Penh</th>
<th>1911 Whole country</th>
<th>1921 Phnom Penh</th>
<th>1921 Whole country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Khmer</td>
<td>29,559</td>
<td>1,360,188</td>
<td>30,810</td>
<td>1,978,300</td>
</tr>
<tr>
<td>% of total</td>
<td>47.3</td>
<td>80.7</td>
<td>41.1</td>
<td>82.3</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>13,508</td>
<td>79,050</td>
<td>18,990</td>
<td>140,220</td>
</tr>
<tr>
<td>% of total</td>
<td>21.6</td>
<td>4.7</td>
<td>25.3</td>
<td>5.8</td>
</tr>
<tr>
<td>Chinese</td>
<td>18,096</td>
<td>104,533</td>
<td>23,620</td>
<td>173,330</td>
</tr>
<tr>
<td>% of total</td>
<td>29.0</td>
<td>6.2</td>
<td>31.5</td>
<td>7.2</td>
</tr>
<tr>
<td>Cham</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>58,684</td>
</tr>
<tr>
<td>% of total</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>2.4</td>
</tr>
<tr>
<td>French</td>
<td>654</td>
<td>993</td>
<td>929</td>
<td>1,483</td>
</tr>
<tr>
<td>% of total</td>
<td>1.0</td>
<td>0.06</td>
<td>1.2</td>
<td>0.06</td>
</tr>
<tr>
<td>Total</td>
<td>62,500</td>
<td>1,684,000</td>
<td>75,000</td>
<td>2,403,000</td>
</tr>
</tbody>
</table>

Note: The table does not include Indians, Lao, or smaller minorities of aboriginal uplanders. Therefore the percentages do not add up to 100 per cent, and the total amounts to more than the sum of the categories listed.

Sources: Forest (1980: 95, 182, 446, 472); Baccot (1968: 343).
It was not only in terms of employment that the Vietnamese were favoured at the expense of the Khmer. Imperial French class society accommodated the native races in its hierarchy by juridical means. The major divide was between citizens and subjects. French citizens included Frenchmen – *colons* and colonial administrators and officers – and a tiny number of Vietnamese, presumably upper-class people who had been able to buy paddy land from the French in Cochinchina. Other natives were either French subjects or, because Cambodia was a protectorate, *protégés* (Forest 1980: 438). ‘For legal purposes “Annamite” citizens from Cochinchina residing or working in the Cambodian protectorate were allowed to register on an annual basis for the status of “French subject” giving them restricted rights of extraterritoriality and, as Khmer saw it, privilege’ (Corfield and Summers 2003: 186). Indeed, the privilege was tangible in that from 1882 the Vietnamese ‘French subjects’ were exempt from paying the head tax that was levied on the Khmer *protégés* (Forest 1980: 439–440; for details of the legal and fiscal status of the Vietnamese in Cambodia, see Khy Phanra 1974: 273–296). This was, of course, resented by King Norodom, who in 1891 managed to levy a head tax of 3.10 piastres on the Vietnamese as well as on the Khmer. The following year, the French persuaded him to lower the tax to the earlier rate of 2.50 piastres, which he did for the Khmer but not for the Vietnamese (Forest 1980: 440).

The eagerness of the Vietnamese to interact with their French colonial masters was certainly welcomed by the latter. In 1919, Albert Sarraut had launched his *mise en valeur* idea in front of an audience of mainly young intellectuals in Hanoi by co-opting the Indochinese population as partners in the development enterprise (Goscha 1995: 21). The response was enthusiastic, and during the 1920s and 1930s the Vietnamese gradually came to see themselves as synonymous with ‘the Indochinese’ at large and to substitute their racial identity as ‘Annamite’ with the geopolitical one of Indochinese. Thanks to the French, they felt that the whole of Indochina was basically theirs for the taking. ‘By the 1930s, literally thousands of Annamese were flowing with the French throughout all of western Indochina as workers, bureaucrats, fishermen and even *colons* in eastern Cambodia’ (Goscha 1995: 27).

It should be noted, however, that the relative privileges that the Vietnamese in Cambodia enjoyed due to the French policies did not necessarily make them wealthy. Vietnamese in the Cambodian countryside subsisted mainly as fisherfolk; as ‘foreigners’ (in the eyes of the Khmer) they were not allowed to own paddy land and grow rice. In addition, domestic servants, native bureaucrats and civil servants, artisans, and coolies in urban areas were never paid much for their
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toil, irrespective of their ethnicity. Yet many Vietnamese were forced to reside in the urban areas because these were the occupations open to them. The Khmer, on the other hand, regarded urban life as basically foreign and not in accordance with their ancestral customs, and many among the ‘urban’ Khmer population tended to settle at the outskirts of the cities, where they could at least have a vegetable garden and raise a few chickens and a pig to supplement their meagre earnings. This meant that also in the towns the Khmer were generally healthier and less malnourished than the Vietnamese, a fact that was noted, for example, in medical reports (NA 2466).

French colonial society in Cambodia

Indochina was publicized as the most promising of French colonies, and even before the goal of its mise en valeur was declared it had attracted a fair number of French immigrants. Most came directly from France, but a considerable number belonged to an established colonial circuit, members of which added Indochina to previous haunts in La Réunion and Pondicherry (de Gantès 2002: 16–19). Within Indochina the French immigrants were unevenly distributed. Cochinchina attracted by far the largest number, while very few opted for neighbouring Cambodia (see Table 2.1 above). Apart from official government postings, the French in Cambodia included colons, a few artisans and shopkeepers, and an assortment of business and petty industrial entrepreneurs. There were no more than 23 colons during the whole period 1887–1920 (Forest 1980: 258), and the number (and economic impact) of the industrial entrepreneurs was equally unimpressive. In 1908 the capital invested in French agricultural and industrial enterprises amounted to 5.5 million francs and they employed 30 Europeans and 3,500 natives; in comparison, neighbouring Cochinchina showed 56 million francs in French investment and the employment of 400 Europeans and 25,000 natives (ibid.: 265). Gregor Muller’s study (2006) of the early entrepreneurs who tried to make their fortune in Cambodia has shown that their dubious personal reputations were commonly matched by repeated economic and personal failure; quite a few of them were eventually offered ‘honourable employment’ in the colonial service in order to save the white race from further embarrassment (Muller 2006: 183–185).

Until the turn of the century it had been customary for French colonials to seek a female companion among the native population. Such relations of concubinage ranged from sheer sexual and domestic slavery to socially and emotionally stable unions (Muller 2006: 127–138). In Cambodia, as in other parts of Southeast Asia, concubinage was an indigenous institution that implied
the possibility for a man of relatively high social and economic status to acquire one or more ‘minor wives’ through a contractual relation with the girl’s family. Such relations, which were the norm among Khmer royalty and nobility, were commonly engaged in also by the French. To begin with, concubinage was actually encouraged for members of the colonial administration, which felt that such arrangements had several advantages: staff members were kept happy and became less inclined to leave their Cambodian postings; costs were reduced, as a European wife required additional expenses for travel, board, and lodging; and last, but not least, the relations provided the French with a way into native society and mediated communications for the benefit of colonizers and colonized alike (Muller 2006: 133). In the long run, however, concubinage turned out to be ‘not as economically tidy or politically neat as policy makers had hoped. It involved more than sexual exploitation and unpaid domestic work. It also involved children – many more than official statistics revealed’ (Stoler 2002: 68).

The emergence of children of racially mixed unions – métis – coupled with a changing moral climate in the metropole resulted in the eventual French condemnation of the practice of concubinage. In 1901 it was officially banned by Governor-General Paul Doumer (Muller 2006: 138). The offspring of relations of concubinage, the métis, could not easily be done away with, however; they were walking testimonies of an earlier but misguided colonial policy and of the ‘immoral’ lifestyle of previous generations of Frenchmen. Most métis (apart from those born into elite families) were destined to lives of poverty and social exclusion, and despised by the French and natives alike. The official position was that the métis children whose fathers did not register their birth with the colonial authorities were incorporated into their mothers’ native society. The existence of several orphanages for abandoned children – established and run, typically, by religious charities such as the sisters of la Providence – made this French illusion rather unconvincing.

Colonial ethnicities?
The extent to which ethnicities in Asia and Africa were actually created by European colonial administrations varies, as do the circumstances under which ethnic differences were invented, exaggerated, bureaucratized, politicized, or ignored. For Cambodia, Edwards has suggested that ‘In providing Cambodia with seemingly definitive categories, the colonial administration laid the groundwork for the ethnic nationalism [of the post-colonial era]’ (1996: 53–54). In the same vein Au Sokhieng has claimed that ‘the ethnic categories [were] constructed by
the French’ and that ‘the reification of these categories in administrative and bureaucratic structures, and the differential treatment of these various groups heightened Khmer dislike and resentment of the French medical establishment’ (Au 2005: 86). Although such perspectives are important, we should be aware of possible implications of post-colonialist teleology. The ethnic categories of Khmer and Vietnamese were not ‘provided’ or ‘constructed’ by the French, and the ‘reification’ and purported differential treatment (whether construed as discrimination or applied cultural relativism) stemmed from their repeated experiences of differences in mentality, sociality, and habitus between the Khmer and the Vietnamese rather than from bureaucratic classification. The very act of applying ethnic labels to sections of humanity is in itself a reification; it is not only ‘colonizers’ (and anthropologists) who are guilty of that. It did not take French classification for Khmer and Vietnamese to perceive differences between their respective ethnicities and to act accordingly (they had done so long before the French appeared on the scene). But in order to make their administration work, the French were obliged to take such differences into account, even if their ethnographic and sociological understanding of them left much to be desired. As we shall see in Chapter 6, for example, inter-ethnic animosity and French ethnographic ignorance were the ultimate reasons for the failure of the Cambodian midwifery school. There was nothing the French would have liked better than if ethnic difference and animosity (in the medical as well as in other fields) had not existed in their Indochinese Union.

On the whole, the postcolonialist dichotomy of ‘colonizers’ and ‘colonized’, in the sense first suggested by Frantz Fanon and implying a degree of cultural métissage on the part of the ‘colonized’, is rather unhelpful in the Cambodian case. While ethnic Vietnamese may qualify as ‘colonized’, the situation for the Khmer (with the exception of the urban elite) was different. They were certainly under French political rule, and they were severely exploited through taxes and corvée labour. But their particular habitus and sociality acted as a fairly efficient protection from attempts to colonize their bodies and minds, and the sociological ignorance of the French administrators about their society was a contributing factor.

However, the failure of the French to colonize the Khmer did not work in favour of the latter in the long run. We can now see that the whole idea of an Indochinese Union and, within it, the French preferential treatment of the Vietnamese in Cambodia, including educational and immigration policies, contributed both to the Vietnamese expansionist tendencies and to the traditional, precolonial Khmer animosity against the Vietnamese. After all, it
was the Khmer anxieties about Vietnamese (and Siamese) encroachment that had led the Cambodian king to seek French protection in the first place, and the great irony was that the Protectorate turned out to facilitate rather than to impede Vietnamese presence in Cambodia. It is also important to note (pace Edwards 2007), however, that France was not at the time engaged in consciously creating nations out of its overseas possessions; that is a figment of postcolonialist teleology. The French agenda was the consolidation of the French empire for the greater glory of France, and the means to that end was la mise en valeur, a contemporary version of what is today known as international development. In the next chapter we address the medical component of the French development efforts.

NOTES

1 Siam had annexed the provinces of Battambang and Siem Reap in the late eighteenth century; Siem Reap means ‘conquered by Siam’.

2 Such indigenous officials are often referred to as ‘mandarins’ in the literature. This is not appropriate in the Cambodian context, however. The (Confucian) mandarin system of administration, as practiced in China and Vietnam, was a meritocracy according to which administrators were recruited by competitive examination (Thion 1993: 22). By contrast, Cambodian local officials were collectively known as okhna, a title, with an associated endowment, bestowed by the king in accordance with the model of patron–client relations (Chandler 1992: 104–113). Among the okhna were the chaovaysrok, the ‘district governors’, who were supposedly elected by and among the notables of the district (Thion 1993: 25–26) and confirmed by the king. Under the French administration their title and function was formalized as mesrok, district leader.

3 The co-opting of the Pasteur Institutes for the colonial healthcare programmes, however, led to a certain rivalry between these institutes and the colonial government (see Au 2005, ch. 2).

4 The right to wet rice cultivation was granted to some Cham refugee groups in the seventeenth century by the Cambodian king (Mak Phoeun 1995: 397–398).

5 The particular fascination that the Cham held for the French has been analysed by Susan Bayly (2000).

6 The French used the word pagode for these Theravada Buddhist temple-monasteries, and this usage has been preserved in contemporary Cambodian English, in which ‘pagoda’ denotes a currently functioning wat.

7 Today’s version of la mission civilisatrice on the part of so-called donor countries centres on the promotion of democracy and human rights, and la mise en valeur consists in state budget support, administrative ‘capacity building’ and the economic opportunities of free markets.
CHAPTER THREE

French Medicine in Cambodia

This chapter is an ethnography of the French promotion of modern medicine in Cambodia and the varied indigenous responses to their efforts. The French saw their efforts as part of their civilizing mission, a moral obligation to improve the health of the local populations, and at the same time as a desirable precondition for *la mise en valeur*, as humanitarian assistance in the form of efficient medical treatment. Their agenda was also one of governmentality, requiring coercive prevention and surveillance; in that sense, colonial medicine was a biopolitical tool of empire. While the failure of French-promoted healthcare to reach large sections of the populace might be seen as due to local resistance (e.g. Au 2006), we will demonstrate that indigenous responses to biomedicine cannot be reduced to resistance. The main focus in this chapter is on the first two decades of the twentieth century, the formative period of French colonial medical policy. We take the three poles – humanitarian assistance, biopolitical tool of empire, and indigenous response – to delineate our ethnographic space.

*L’ASSISTANCE MÉDICALE INDIGÈNE*

Given the relatively peaceful colonization of Cambodia, the need for military surgeons was limited and at first, only Phnom Penh was equipped with a standard mobile field hospital, an *ambulance*. However, the 1885–1886 rebellion made heavy demands on the protectorate’s rudimentary medical facilities: the field hospital had the capacity to treat about 60 patients at a time, and suddenly there were more than 1,200 sick and wounded soldiers requiring emergency treatment (Guillou 2001: 97). After the rebellion, the military hospital in Phnom Penh was expanded and transformed into a mixed military and civilian one, *l’Hôpital mixte de Phnom Penh* (the Mixed Hospital; NA 96114). The French also set up about
40 postes médicaux in the countryside but initially only 4 of those were run by medical personnel and supplied with medicine and surgical equipment (Guillou 2001: 98). The rebellion had also necessitated the setting up of a local militia to ensure law and order in the countryside, as well as for a modest contingent of regular local troops, tirailleurs cambodgiens. The militia, la garde indigène, was officially created in 1893, but it was not until 1904 that recruitment began. The French had continual difficulties in recruiting young men for the militia.

The most important event in terms of the organization of medical services in the country was the establishment of l’assistance médicale indigène in 1905 throughout Indochina, as mentioned in Chapter 2. With the transfer of responsibility for medical care from the military to the civilian government, medical policy came to focus mainly on the native population. Medical personnel in the protectorate of Cambodia had hitherto been military officers but the medical service needed to recruit a fair number of new doctors. Most of the newly recruited doctors were civilians who came directly from France and lacked the colonial experience of the military doctors. Many of the military doctors stayed on, however, and worked on secondment for the medical service, as médecins militaires hors cadre. The recruitment of civilian doctors for colonial service was not easy; in 1907, three out of five French doctors in the protectorate were military, and in 1930 the latter still made up about 20 per cent of the medical practitioners (Guillou 2001: 104–106). A civilian recruit to the colonial medical service started out as probationer (stagiaire) and was then appointed médecin de 4ème classe. He could subsequently advance through the ranks to reach the level of médecin de 1ère classe (Clavel 1908: 22). Further advancement implied that one partially ceased to be a practising physician in order to assume administrative and executive tasks as médecin principal or médecin-chef (in Phnom Penh).

Even if Cambodia was administratively a part of Indochina, a fair degree of autonomy was in practice granted to the local administrations. In Cambodia, such partial autonomy was vested in the office of the résident supérieur. The protectorate was administratively divided into 13 circonscriptions, roughly corresponding to the present-day provinces plus Phnom Penh municipality. Each circonscription was headed by a résident who reported to the résident supérieur. For Phnom Penh municipality, the office was held by the résident-maire (mayor). Following the establishment of the medical service, medical matters were in the hands of the Local Director of Health. In practical terms, this meant that the successful running of the medical service depended largely on the diligence and commitment of the résident supérieur, the Local Director of Health, and the resident doctors in the provinces, as well as on the working and personal relations
between these officials. As we shall see, Gregor Muller’s observation (2006: 6) that ‘colonial rule in Cambodia was not a well-oiled monolithic campaign [but rather] a piecemeal affair composed of scattered and haphazard efforts, often initiated by individuals’ certainly holds true for the medical service.

The aim of the new medical service was officially formulated to include treatment, prevention, and medical training for the natives. In keeping with the rationalist tenor and republican ideals of the French civilizing mission, the medical service was to be strictly secular. Charles Clavel, who was Director-General of Health in Indochina and the main engineer of this new medical service, argued that it was improper to allow any confessional influence to be exerted on the sick and therefore members of missionary organizations should not be part of the official medical programme (Clavel 1908). The Roman Catholic Church had had a long, if not particularly glorious, history in Cambodia (Ponchaud 1990). Up until the establishment of the French protectorate, Catholic churches and mission stations frequently suffered devastation at the hands of bandits and local warlords. Unlike the Vietnamese, both Khmer Buddhists and Cham Muslims had proven difficult to convert to Christianity.

Half-a-dozen religious sisters of the order *la Providence de Portieux* had begun charitable and medical work in Cambodia in 1875. Ten years later they had been called to the hospital in Phnom Penh to assist in the surgical emergency that followed from the rebellion (ibid.: 93). By the first decade of the twentieth century, however, they were reduced to doing the laundry and dishes at the hospital; they also ran a crèche, an orphanage, and a hospice, mainly catering for the métis and Vietnamese Catholic converts. Speaking of the whole of Indochina in 1908, Clavel laconically observed, ‘The sisters are still here but their role should be considered to have come to an end […] With the personnel resources of the *infirmiers indigènes*, today the disappearance of the sisters will not entail any inconvenience for the service’ (Clavel 1908: 34–35). Two years later, the sisters were told to leave their medical work at the Mixed Hospital in Cambodia (Ponchaud 1990: 244). The ousting of the sisters was not only due to the anti-clerical stance of Clavel and his associates but also because their medical competence left much to be desired. Au Sokhieng (2005: 163–167) relates repeated accusations by French doctors about gross medical negligence on the part of the sisters and their continual refusal to seek professional assistance for their charges in the crèche. ‘For example, in 1919, the 309 deaths at the Providence crèche represented more than one third of the child mortality of the entire city of Phnom Penh’ (ibid.: 164).
In order to successfully implement its threefold programme of treatment, prevention, and training, the colonial government made concerted efforts to make biomedicine known and, it was hoped, popular among the natives. Known as *la réclame médicale*, the government’s promotional measures included the free dispensing of pharmaceuticals and medical treatment for all, a reliance on the acceptance of French medical technology by the royal court as an example to the general population, and the offer of medical education leading to a diploma as native doctor (*médecin indigène*) or native medical attendant (*infirmier indigène*).

The Mixed Hospital, in Phnom Penh’s European quarter, was the only fully equipped hospital in Cambodia in the early twentieth century, and it was the hub of the protectorate’s medical service throughout the colonial period. In 1908–1910 the medical staff of the Mixed Hospital comprised, apart from the director, two French doctors, two French medical attendants, a midwife, and a number of local (Khmer and Vietnamese) medical attendants. The administrative staff included a French administrator and a number of Vietnamese secretaries. In addition, four European sisters of *la Providence* (still) functioned as nurses and were in charge of cooking and laundering (NA 2486).

The hospital had 146 beds, 63 for Europeans and 83 for Asians. It served the colonially employed population, both European and native, as well as indigent natives, women, and children. During 1908, the hospital received 1,037 patients, of whom 307 were Europeans. Of the 730 Asian patients, 388 were Khmer, 272 Vietnamese, 50 Chinese, 10 *métis*, and a few Cham, Thai, Lao, and Indian; 344 of the native patients were colonially employed (civil and military) or prisoners; the rest were ‘ordinary people’, including women and children (NA 2486). Among the diseases treated, the most common were malaria, diarrhoea, dysentery, tuberculosis, venereal diseases (among military personnel), anaemia (among European civilians), and cholera and plague (among native civilians).

In 1908, a total of 78 patients (7.5 per cent of the total number) died at the hospital, 72 of whom were native civilians; the main causes of death among these were cachexia, cholera, and plague. The listing of cachexia as a major cause of death is curious; it was not listed as a cause for admittance to the hospital. Cachexia means a ‘chronic debility of body or mind’ (etymologically from a Greek compound signifying bad habits), so we may surmise that although it was not a sufficiently precise diagnostic term for admittance, it could be resorted to as an admissible cause of death among the natives, for want of a better explanation. It appears that ‘cachexia’ was often the result of repeated bouts of malaria (Ngo 1953: 4, 8, 9). Cachexia is equivalent to the Khmer experience of...
the partial loss of vitality, or rather the loss of some of the 19 vital spirits, the pralung, which animate the human body. The pralung are delicate and fragile. If frightened or threatened they can easily be scared away from the body, in which case they have to be summoned back, and secured to their bodily home by means of a ritual called hau pralung (Porée-Maspero 1951; Ang 1986: 25–29; 2004: 2). The condition of loss of pralung is experienced as apathy, loss of appetite and the like, and can be life-threatening. Medicine, whether indigenous or modern, is thought to have no effect on the condition. The important thing in this context is that the condition, whether diagnosed as cachexia or loss of pralung, is recognized as ‘real’, i.e. empirical, from both the indigenous and the biomedical perspectives; the high death rate of cachexia at the hospital confirms the indigenous diagnosis.

Apart from treating in-patients, the hospital ran a health clinic that was open to natives for consultations. Access to the clinic was through a special entrance, so that the natives could go there ‘without fear of meeting Europeans’, as the 1908 annual report solicitously put it (NA 2486). Both consultation and medicine were free of charge. The clientele consisted of employees (militiamen, students, policemen, and various officials) and indigents (about 40 per cent). Malaria was a common condition, but most patients had minor ailments, and students and officials in particular often came in order to get a few days off, according to the report. Conditions requiring minor surgery were also common; the report relishes the example of a 14-year-old boy who had been shot in the left buttock, from which a couple of lead bullets with a combined weight of 33 grams were extracted. Most of the outpatients were Vietnamese, a fair number were Chinese, while the Khmer were the most hesitant to go to the clinic. Table 3.1 shows the number of consultations during 1908. The figures for the percentage of the total population are probably a little too high, since some people may have come for consultation more than once.

Table 3.1: Number of consultations at the Mixed Hospital in Phnom Penh, 1908

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Consultations</th>
<th>Approximate % of city population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Khmer</td>
<td>212</td>
<td>0.8</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>716</td>
<td>7.2</td>
</tr>
<tr>
<td>Chinese</td>
<td>475</td>
<td>3.2</td>
</tr>
<tr>
<td>Indians, Cham, other</td>
<td>46</td>
<td>–</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,449</strong></td>
<td><strong>2.4</strong></td>
</tr>
</tbody>
</table>

*Source: NA 2486*
The Mixed Hospital was run by the protectorate government, but in Phnom Penh the municipality too actively promoted French medical treatment among the local population. During the years 1908–1911 the establishment, in quick succession, of four municipal clinics to complement the one at the Mixed Hospital turned out to be a spectacular success for la réclame médicale, at least in terms of client numbers. While the Mixed Hospital had attracted only about 2 per cent of the population of Phnom Penh in 1908, three years later, more than 20 per cent frequented the city’s medical facilities. It seems that frequenting the French clinics had suddenly become a feature of the urban lifestyle.

The first municipal clinic, opened in May 1908, was the Dispensaire Sisowath, named after the king. It was located in the Cambodian quarter of Phnom Penh in order to attract more Khmer patients; the chief medical assistant as well as two nurses were Khmer. Its greatest success was in dispensing medicine free of charge; the report noted the Khmer predilection for certain products, such as quinine, antipyrine (aspirin), potassium iodide, sodium bicarbonate, iodine, and...
skin lotions. Malaria was the main ailment for which people would seek medical help at the clinic, other frequent ones being wounds (such as cuts, bruises, and broken limbs), venereal and skin diseases, stomach and digestive problems, and respiratory tract infections. The report noted that the ailments for which the Khmer sought medical attention were generally not very serious (NA 2486). The second municipal clinic, Dispensaire Ang Duong (named after the previous king) was established in January 1909. Located in the Chinese quarter, it attracted mainly Chinese and Vietnamese patients; both chief medical assistant and nurses were Vietnamese (NA 1322).

The royal court was given its own clinic, l’Infirmerie du Palais, in May 1910. Situated in a corner of the palace grounds, it was established according to an agreement with the king, precipitated by the plague epidemic during 1907–1909 that had also affected the court and claimed lives among the royal family (see Au 2006: 52–55 for details). The palace infirmary catered mainly for members of the court and its numerous servants; it was staffed by a female indigenous nurse who was on call day and night. Serious cases were attended to by the doctor at Sisowath. Finally, the Lazaret Municipal was opened in May 1911. Situated next to the Chinese Hospital it was a small establishment with eight beds for the quarantine of troops and militiamen (NA 1322).

**Table 3.2: Number of patients at the municipal clinics in Phnom Penh, 1911**

<table>
<thead>
<tr>
<th></th>
<th>Sisowath</th>
<th>Ang Duong</th>
<th>Palais</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>2,505</td>
<td>4,318</td>
<td>931</td>
<td>7,754</td>
</tr>
<tr>
<td>Females</td>
<td>647</td>
<td>753</td>
<td>2,043</td>
<td>3,443</td>
</tr>
<tr>
<td>Children</td>
<td>768</td>
<td>1,323</td>
<td>19</td>
<td>2,110</td>
</tr>
<tr>
<td>Total</td>
<td>3,929</td>
<td>6,394</td>
<td>2,993</td>
<td>13,307</td>
</tr>
</tbody>
</table>

Source: NA 1322

Table 3.2 shows the number of persons who had frequented one of the clinics during 1911. However, many patients now came more than once a year, as Table 3.3 shows (33,000 consultations for about 13,000 clients). That table also shows the number of consultations according to ethnic group and reveals that, in large part thanks to the existence of the palace infirmary (frequented only by Khmer), the proportion of Khmer, as well as of women and children, had increased dramatically.
Table 3.3: Number of consultations at municipal clinics in Phnom Penh, 1911

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Khmer</td>
<td>18,070</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>8,078</td>
</tr>
<tr>
<td>Chinese</td>
<td>6,348</td>
</tr>
<tr>
<td>Indians, Cham, others</td>
<td>532</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33,028</strong></td>
</tr>
</tbody>
</table>

*Source: NA 1322*

In 1908, the most common reason to go to the clinic had been malaria; quinine, freely dispensed, seemed to work wonders and probably inspired locals to try other foreign medical remedies. In 1911, ‘various traumatic lesions’ (such as cuts, bruises, bullet wounds, and fractures) had become the most common reason for going to the clinic, followed by skin (and venereal) diseases, with malaria in third place (NA 1322). The 1911 report again admitted that few of the ailments were serious, so it seems that people were now going to the clinic for relatively minor conditions earlier left unattended.

The Chinese population of Phnom Penh also had the option of going to the Chinese Hospital. Following the plague that had broken out in 1907 in the Chinese quarter, the Chinese community (*congrégation*) had been allowed to establish its own hospital in the city. The 1908 annual medical report noted that 81 of the 82 plague patients admitted to the Chinese Hospital had died. The Chinese doctor from Canton ‘seemed to be familiar with the plague’ but ‘did not treat it according to our methods’ (NA 2486). On the whole, the colonial government distanced itself from the workings of the Chinese Hospital; it was formally monitored by the municipal doctor, but his task was defined only as ‘la surveillance morale’. The setting up of the hospital may be seen, alternatively, as a French gesture towards Chinese self-determination, or a way for the French to minimize the epidemic’s impact by letting the Chinese bury their own. A couple of years later, the author of another report felt obliged to emphasize that ‘the Chinese Hospital is completely outside all regular structures, it is owned by the Chinese community and directed by a Chinese doctor who is paid by the community. […] The only thing that interests us about its function […] is the isolation of patients with contagious diseases’ (NA 1322).

French doctors had regularly paid visits to the royal family since the early days of the colonial regime (NA 96114). Already in the mid-1880s, Dr Maurel,
Chief Naval Surgeon, had treated the Queen Mother in Udong. The royal court
was the exemplary centre of the Cambodian universe and the French were
sensitive to this and used it in order to introduce modern biomedical technology
into this premodern universe. The plague epidemic provided such an occasion
when it spread to the Khmer quarter, including the palace, in 1908. To begin
with, many Khmer reacted by fleeing the city. But when the king himself agreed
to be vaccinated following the death of one of his favourite sons, the panic
was stemmed and the population became more favourably disposed to French
vaccination (Forest 1980: 189; Au 2006: 52–55). As mentioned, this episode
also facilitated the establishment of the palace infirmary. Palace support was also
useful in the promotion of maternity care. In 1907, a private maternity clinic had
been established in the Cambodian quarter of Phnom Penh. It was directed by a
committee that included two Cambodian princesses, and although it was outside
the colonial medical service, it was financed by donations from Europeans and
natives and subsidized by both the King and the colonial authorities. We shall
return to the clinic in Chapter 6.

Nonetheless, the policy of enlisting the royal family’s participation in the
promotion of the colonial medical service was not without its drawbacks. As
part of this policy, two princes, grandchildren of the king, had been appointed as
native medical attendants by the Phnom Penh municipality. They had both left
their employment in 1910 to become temporary novices at a wat as part of their
general education, and another native medical assistant had been appointed in
replacement. The following year, the hospital administration was happy to find
that only one of the princes wanted to return at the end of his novitiate. But their
relief was short-lived, for this prince soon demanded double the salary, arguing
that he was now doing the work of two princes (!) and that higher authorities
(presumably the royal court) had accepted his demand; the municipality therefore
had to dismiss another native attendant (NA 1322).

Although most medical facilities were concentrated in Phnom Penh,
considerable efforts were made to reach the rural population. By 1908, the
medical service had been established in all circonscriptions, and the promotional
aspects of the service were unmistakable. The author of a report of an inspection
tour to the remote circonscription of Stung Treng in 1909 observed that sanitary
conditions seemed acceptable, that there had been only isolated cases of
cholera, and that smallpox seemed to have been at least temporarily eliminated.
Rheumatism, however, was frequent and available remedies, notably potassium
iodide, had become so popular that people from remote villages would travel to
the provincial centre to obtain it in large quantities for themselves, their families,
and neighbours. Although it was possible, the author commented, that such large amounts of medicines were not strictly needed by the people who asked for them, it should be recalled that since the government was still at the stage of *réclame médicale* and *vulgarisation sanitaire* (hygiene education), to refuse coveted drugs could adversely affect efforts to increase the number of consultations; hence certain pharmaceutical liberties were worth their share of the colonial provincial budget (NA 25738).

Promoting the medical services most notably included the free distribution of quinine and the provision of first-aid kits to commune and district chiefs (*mekhun*, *mesrok*). The distribution of the kits, *boîtes de secours*, was pioneered in 1905 by the then *résident* of Kampong Cham, François Baudoin. These boxes were to contain a minimum of six essential drugs (to treat cholera, diarrhoea, dysentery, malaria, boils, and eye infections) together with disinfectants, cotton, and bandages. With each box came a bilingual French-Khmer manual, *Guide pratique médical à l’usage des mésroks*, which contained short instructions for use of the medicaments and briefly detailed symptoms, treatment, and recommendations concerning the most common ailments (NA 1322). In 1908, it was decided to extend the provision of first-aid boxes to the whole of the protectorate; the Local Director of Health, Haueur, sent a circular to all doctors in the medical service, detailing the standardized contents of the boxes and urging them to see to it that local communities in every province were properly equipped with first-aid boxes (NA 2486).

The provision of quinine, the so-called state quinine, for malaria treatment was instituted in 1909 by decree of the Governor-General of Indochina (NA 7878); the decree stipulated that in declared malarial regions, quinine should be dispensed free of charge in specified doses. The *résident supérieur* of Cambodia sent a circular the following year detailing the distribution of quinine. Each province made provision in the annual budget for the purchase of quinine (between 1 and 8 kg depending on the size of the population and the frequency of malaria). Native troops, militiamen, and prison inmates were routinely given quinine as a prophylactic. Other than these groups, the general idea was that the *mesrok* were to be in charge of dispensing quinine to those who suffered bouts of malarial fever, in doses of 0.5 or 0.25 grams. The allocation of such a task to the *mesrok* was not always practicable, however, neither for the quinine nor for the first-aid boxes. In Stung Treng, for example, the resident doctor reported in 1913 that he felt obliged to take charge of the medicinal distribution himself because it was impossible to leave it to natives who were ignorant of the medicines’ proper use and furthermore distributed them ‘*absolument selon leur bon plaisir*’, that is,
used them as favours irrespective of need. This also meant that only two of Stung Treng’s four districts actually had any medical supplies at their postes médicaux, since the security situation was such that only in these two districts could a French official work without danger (NA 12505).

Training of colonial subjects
An early programme for recruiting native personnel for healthcare in the provinces was initiated by Dr Angier, médecin-chef in Phnom Penh in the 1890s. He asked each résident to send two or three promising Khmer youths to Phnom Penh to work at the Mixed Hospital for six months as apprentices. After having acquired some basic nursing and treatment skills, they were to return to their provinces to practice (Monnais-Rousselot 1999: 288). In 1905, in accordance with the new medical policy, a formal education programme for native medical personnel was established. The native medical attendants/nurses (infirmiers indigènes) were given two 6-month training courses at the Mixed Hospital. They were then offered employment in the various provinces, following the scheme established by Dr Angier. By 1910, there were a total of 142 such medical attendants in Cambodia, 17 of whom were women. The annual report for 1910 mentioned the difficulty of recruiting suitable medical attendants and explained that people with some education and intelligence would rather choose other employment, and those who were employed stayed on only until they could find a better job. The reasons were obvious: the salary was minimal; people were given fewer days off than other employees in the colonial administration (since they were needed permanently); and night duty was required every two or three days (NA 12617). In addition, the Khmer saw the work of a medical attendant as polluting. Therefore, the medical attendant education programme was only modestly successful in the long run. Alain Forest relates that in 1922, only 122 medical attendants, of whom only 4 were women, were active in Cambodia. It is all the more noteworthy, Forest says, that whereas all other forms of civil service employment open to natives in Cambodia were totally dominated by Vietnamese, the medical service had a Khmer majority. Already in 1904, of the 11 natives employed as medical attendants at the Mixed Hospital, 10 were Khmer and one was Vietnamese. The common colonial stereotype of Khmer as lazy was generally not subscribed to by the French doctors (Forest 1980: 188). We may add that the large proportion of Khmer among the medical attendants is probably related to the fact that the job was among the least desirable and thus manned by those at a low level in the colonial ethnic hierarchy.
Higher medical education had been offered since 1902 at the medical school in Hanoi, the training centre for native medical personnel throughout Indochina above the level of *infirmier*. Such people were known as native doctors (*médecins indigènes*). In 1907, inspector Clavel described the task of the medical service ‘to propagate notions of hygiene, incessantly fight against diseases, and lower the appalling mortality caused by ignorance and antiquated notions […] Such a task can only be carried out by the native doctor, guided by the European doctor’ (quoted in Monnais-Rousselot 2000: 38). Native doctors were authorized to treat only the native population; they were legally under the authority of the chief provincial administrator and professionally accountable to the nearest European doctor. They were obliged to offer their treatment, including vaccinations, free of charge. Their main task was to promote hygiene among the native population (ibid.: 37–38). The attraction of obtaining a diploma as *médecin indigène* lay probably in the possibility of leaving government service after a few years and setting up a private practice. This prospect no doubt appealed more to the Vietnamese than to the Khmer, since in the indigenous Khmer health cosmology being a healer/doctor was not a way to make a living but a vocational social responsibility, akin to being a Buddhist monk rather than a professional physician (see Chapter 5). Unsurprisingly, the great majority of native doctors were Vietnamese. Another factor was that the Khmer were less disposed to take advantage of the European tradition of (higher) education than the Vietnamese (and Chinese). They were also less formally qualified, since primary education was rudimentary (see Chapter 2). Thus in 1913, the Director of Education in Cambodia informed the *résident supérieur* of the possibility of recruiting two Cambodian students to the medical school in Hanoi. He was obviously aware of the official wish to promote education among the Khmer, for he added that if only he would be allowed to recruit Vietnamese or Chinese students his choice would be easier, since ‘the performances of Khmer students are almost invariably rated below those of the Vietnamese and the Chinese’ (NA 429). It was not until 1916 that the first Khmer native doctor received his diploma from the medical school, and in 1924 only 5 out of 64 students enrolled in the *médecin indigène* programme were Khmer (Guillou 2001: 117–118).

**PREVENTION AND SURVEILLANCE**

Considerable efforts to combat the three main epidemic diseases (smallpox, cholera, and the plague) were made early on through vaccination programmes. Smallpox inoculation was an important component of the colonial medical
programme, and one that well illustrates the tensions between the colonial goals of humanitarian assistance and governmentality; the indigenous responses were correspondingly mixed. The colonial medical authorities had started smallpox vaccinations throughout Cochinchina in 1867 (made compulsory in 1871), and in Tonkin in 1889; mobile vaccination teams, headed by French naval doctors, toured the villages. But in Cambodia such a programme was considerably more difficult to implement. Unlike the Chinese and Vietnamese, the Khmer in the beginning mostly refused French vaccinations, and the doctors received little support from the indigenous local authorities (mesrok). In Phnom Penh the clinic at the Mixed Hospital provided free vaccinations for all; after initial reluctance among the city’s population these sessions eventually became well attended. According to a 1902 French report, ‘the Cambodians happily take their children to the vaccination sessions which are free of charge and which provide them with occasions to chat endlessly. They have quickly appreciated the benefits of the vaccination which has eliminated the deadly epidemics of only a few years ago’ (cited by Ngo Hou 1953: 20). Of the 3,950 people inoculated in Phnom Penh in 1908 (about 6.5 per cent of the inhabitants), 1,464 were Khmer while ‘only’ 1,075 were Vietnamese; 951 were Chinese and 358 Cham/Malay (NA 2486).

In the countryside, the mobile vaccination programme only took off in earnest in 1896. Firstly, transportation was difficult: the doctors had to make use of a variety of means, from steamboats, canoes, sampans, and ox carts to elephants and horses. Some locations could only be reached during the wet season, others only in the dry season. Secondly, although the vaccine could be preserved for several months, it rapidly deteriorated in temperatures above 30°C, and had to be cooled in porous containers during the slow ox cart and elephant journeys (Ngo 1953: 19–20). Nevertheless, the mobile smallpox vaccination programme initially showed some encouraging results. The French doctor Nogué, who was in charge of the programme, reported having inoculated more than 21,000 people in 1897. The year 1899 was an exceptional one, with more than 114,000 inoculations, while numbers for 1901 and 1906 were around 40,000 and 35,000, respectively (Guillou 2001: 109–110).

The mobile vaccination programme was not a uniform success throughout the country, however, and in 1912 the résident supérieur (Ernest Outrey) issued a circular urging all résidents to establish an annual medical touring schedule to make sure that all localities in each province were adequately visited by doctors from the medical service, particularly through vaccination tours, and to submit the schedule to him for approval (NA 24014). In June the same year, the résident supérieur found occasion to reprimand the medical personnel of Battambang
Province for allegedly poor results in terms of the number of medical consultations, despite the fact that Battambang had two (French) doctors. ‘I have every reason to believe’, he wrote to the Local Director of Health, ‘that very shortly I shall be able to note a significant improvement of the situation that I hereby have the honour to bring to your attention’ (ibid.). But only a month later, smallpox vaccinations statistics from June 1911 to June 1912 from seven provinces reached the résident supérieur. It showed that the proportion of the population that had been vaccinated varied between 1.23 and 16.45 per cent. Battambang turned out to be next to last in the ranking, and this immediately occasioned another acerbic letter from Outrey, ordering the doctors in Battambang to shape up (ibid.). Whether or not the poor results from Battambang were caused by a lack of diligence on the part of the local doctors, as Outrey implied, there were probably other factors at work as well. We should note that Battambang Province (which included present-day Siem Reap Province) had been under Siamese suzerainty since the late eighteenth century and had only been ceded to France in 1907; it took another two years until the French deemed it safe for the Cambodian king to visit even the two provincial capitals (Chandler 1992: 150–151), so we may surmise that still in 1912 government control of remote areas of the countryside was tenuous at best. It would therefore have been in the political interest of the résident supérieur to strengthen the government’s role in Battambang and to make its presence felt locally through the efficiency of the medical service. However, smallpox vaccination campaigns were hardly the best way to win hearts and minds. The 1913 annual report from Battambang relates that the vaccination doctor (i.e. the native doctor Chieu, see below) had had problems convincing both indigenous officials and the local population in general; ‘whole populations are unwilling to accept this easy prevention of smallpox, and they bother even less about the hygienic prescriptions whose efficiency can never be as obvious as that of the vaccine’ (NA 24015).

Part of the reason for the indigenous reluctance to accept smallpox vaccinations lay in the different perceptions of the disease by the French and the locals, respectively. For the French, smallpox was one of the ‘terrible epidemics’ that decimated the population. In Cambodia, the disease was endemic; minor local epidemics broke out now and then, claimed some casualties but generally ran their course fairly quickly; those who caught the disease but survived acquired life-long immunity. Smallpox was thus a fact of life to which the population had adapted, also with respect to preventive measures. An indigenous form of inoculation, variolation (from the French word for smallpox, variole), was routinely performed among both the Khmer and, most notably, the Cham.
Among the Khmer, variolation was performed, usually by traditional midwives (*chhmob*), on virtually all children about the age of three; Khmer regarded a non-variolized child as not yet born, since they were not sure it would live. Smallpox was caused by a type of malevolent spirit called *bray*, spirits of women who had been childless or had died during childbirth and who were therefore a menace particularly for children and new mothers (Ang 1992: 108–109; see also Chapter 7). Among the Cham, variolation was performed by indigenous healers. In 1902, French doctor Martin reported, ‘I have twice seen Malay doctors make incisions on the arms with a rusty penknife and place on the wounds small balls of cotton imbied with smallpox virus. The payment was one piastre per child, half of which could be given in kind’ (quoted by Ngo 1953: 18). For both the Khmer and the Cham smallpox was seen as a children’s disease, in several respects similar to the way measles are seen in Western societies, and subject to a less panicky attitude than among the French. These differences of perception were also reflected in the attitudes towards vaccination and variolation, respectively.

The French strongly disapproved of indigenous variolation; it was prohibited by the colonial government in 1907. The ostensible medical reason for this was that variolation was more dangerous. The two procedures of inoculation appeared quite similar. According to Regnault (1902: 58) variolation of children had been practiced in China since the tenth century, from where it presumably spread into Tonkin and Annam and, eventually, Cambodia. The practice also reached Europe via the Middle East in the early eighteenth century, which was also the period when it was first reported from India (Appfel Marglin 1990: 106). The modern smallpox vaccination in Europe was pioneered around the turn of the nineteenth century. The difference between the two procedures was that vaccination used cowpox matter to induce temporary immunity against smallpox while variolation used human smallpox matter. This meant that a variolized person got an attenuated case of real smallpox, which might still prove fatal and moreover made him or her fully contagious with the risk of triggering a local epidemic. On the other hand, survivors of variolation, like ‘natural’ survivors of the disease, had life-long immunity, while vaccination had to be repeated at regular intervals. Furthermore, the perceived danger of variolation was possibly exaggerated. Frédérique Appfel Marglin (1990: 109–110) cites studies from India showing that the risk of death from variolation was between 1–3 per cent, and that in areas where variolation was regularly practised, there was little risk that it precipitated local epidemics; in such areas, moreover, epidemics killed only about 1 per cent of the population. We may doubt if conditions were equally favourable anywhere in Cambodia, but the general picture probably resonated.
with the experience of the Khmer and the Cham, and gave them reason to have faith in their traditional method. Against this background, French claims to the superiority of vaccination and their insistence on vaccinating even adults, as well as their urging of revaccination, made no sense and did not inspire confidence in their method. The French, on their part, tried to find explanations for the native resistance. Dr Angier (quoted by Guillou 2001: 110) suggested in 1901 that the potential loss of the modest income that traditional healers derived from variolation was a motive behind their resistance against the French taking over smallpox inoculation. Guillou (ibid.) further quotes Dr Nogué to the effect that for people to accept French vaccination would be seen as ‘a sort of Francification, to be avoided at all costs since it would imply the loss of their national character’.

This latter cultural dimension was probably important, particularly in the case of the Cham. While the Khmer gradually and partially came to accept vaccination (though only for their children), the Cham proved more adamant in their recalcitrance. As late as 1924, the French resident doctor in Kampong Cham, Fabry, reported his problems with the medical practices of the sizeable Cham population who, he noted, had their own doctors.

These practice variolation, that is for sure. Although the Malay have known for a long time that this has been forbidden by us, they will never inform against their own doctors, and even less surrender them to us. It would certainly be better from all points of view if no Malay would ever practice variolation in the future, but what could be efficient means, based on our experience, for accomplishing this? Should we once again repeat, more or less solemnly, that variolation is prohibited and send out copies of a circular to add to all the others and differ from those only by its date? (NA 630).

Fabry proposed instead to turn the Cham doctors into potential partners of the French by supplying them with proper French vaccine and authorizing them to use it under French supervision. There are no indications, however, that the authorities were inclined to follow this sound advice. On the other hand, according to Regnault (1902: 59), this was what happened spontaneously among the Chinese in Tonkin around the turn of the century when Chinese doctors started using French vaccine for their variolations. Apart from being even less dangerous, this had the added advantage, from the Chinese doctors’ point of view, that they got the vaccine for free but could still be paid by their clients, and that they could schedule vaccination sessions in advance without having
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to depend on the availability of someone infected with smallpox. Among both the Chinese and the Vietnamese in Tonkin, the vaccination of children quickly became popular, whether performed by Chinese or French vaccinators.

Work among the natives: A subaltern report

The following is our slightly abbreviated rendition of two monthly reports from the year 1913 to the médecin-chef at Battambang, submitted by the native doctor Chieu (NA 24015). Chieu who had the rank of médecin auxiliaire de 5ème classe had recently replaced one of the two French doctors in Battambang. The text illustrates the conditions under which the native (Vietnamese) medical personnel carried out their medical and vaccination tours in the countryside. But we should also remember that only the previous year the résident supérieur had reprimanded the French doctors in Battambang for their lack of diligence; no doubt Chieu as a recent native replacement was anxious to prove himself.

Dr Chieu had the honour to inform the médecin-chef that he and his team left Battambang for Pailin on 13 May to see the sick wife of a telegraphist. Upon arrival at Treng, about halfway to Pailin, he received a cable from the deputy commissioner ordering the team to return since the woman had died. Before leaving, they managed to inoculate 14 people at Treng and 2 at Snang on the way back. The reason for the small number of vaccinations was the great success of the vaccination campaign in these villages four months earlier.

For the second tour, Chieu again set out for Pailin on 21 May and two days later reached Chralieu where he inoculated 15 people. After another six hours’ travel he reached Pailin and inoculated 66 people. He stayed two days in Pailin to treat the telegraphist who was suffering from an abscess and resulting anaemia; Chieu changed the man’s bandages three times a day and left necessary medicaments. He also treated a Burmese man who had several fistulas in his right foot where he had been shot two years earlier. During the two days, the running of the sores had diminished and his foot looked better. But since he had not brought the necessary equipment to examine the bone, Chieu advised the man to go to the hospital (at Battambang) if he were not completely cured with the medicaments that he gave him. Whether he was eventually cured is hard to say, Chieu commented, since the natives always say yes to whatever recommendation we give, but hardly ever follow them once we turn our backs. Chieu left Pailin on 27 May and travelled north on foot, stopping for vaccinations at each village; over the next ten days he inoculated a total of 1,070 people in 8 villages. At Lovea, one of the villages, Chieu had
occasion to see a retired militiaman who had a cut on his wrist. The wound was now completely healed thanks to the treatment and medicaments Chieu had provided during his tour in April, but the man could still not move his thumb because he had refused to follow Chieu’s advice and go to the clinic to have the severed tendon stitched. Chieu also saw the district chief of Lovea who had jaundice and ran a fever every evening, due to a chronic ureter constriction, for which he had refused surgery at the hospital despite the doctor’s recommendation. His bladder appeared enlarged, but Chieu could do nothing but leave him 100 g of quinine for the fever. At Mongkul Borei he encountered a smallpox epidemic that had claimed a dozen deaths, but only two cases were still in progress. He inoculated people in the neighbouring houses and left bandages for the two sick children as well as quinine to fight the fever.

A third tour commenced on 11 June and took Chieu northwest to Tuk Chou (district) where he arrived three days later. At Phum Char, one hour on horseback from the district centre, he inoculated 14 people. The following day he held a vaccination session for the villages surrounding Tuk Chou, inoculating 70 people. The next day, after one-and-a-half hours on horseback, he was at Kralanh, inoculating 295 people, and after two hours’ additional travel arrived at Cham Lias Dai to inoculate another 73. In a village one kilometre from Cham Lias Dai he encountered a serious smallpox epidemic that had claimed 21 deaths, 16 had recovered and about 40 cases were still in progress. The epidemic had been caused by the illegal variolation performed by a Kuy medicaster for one piastre per head. Because of this, the population had refused to be inoculated by Chieu, as people were afraid he would give them the disease, like the medicaster. At the next village, four hours away, the epidemic had claimed 10 victims, 4 had recovered and 6 cases were still in progress; here too the people refused vaccinations. Returning to Kralanh, Chieu continued down to Ta Om where he inoculated 207 people. The next day, 19 June, he went to Ampil where the village chief refused to assemble his people on the pretext that most had already been variolized by the Malays. He reported 11 victims of the epidemic, 20 recovered and 8 cases in progress. Returning to Ta Om, he departed the next day for Bac Prea in a sampan. The following day he inoculated 103 people at Bac Prea and after fifteen hours of travel reached Battambang. In his report he emphasized that for smallpox prophylaxis it was not only necessary that the native authorities more willingly collaborated with the doctors, but also that they effectively prevented unauthorized variolation by locals; otherwise the vaccination tours would be useless, since people tended to believe that the doctors
used the same vaccine as the medicasters and therefore did not attend vaccination sessions.

Chieu signed his report on 1 July, and the very next day he started another tour, taking a sampan up to Bac Prea, from where he went with two canoes and four oarsmen up the Mongkulborei stream to Sramoch, visiting 8 villages en route over four days, inoculating a total of 212 people. On 7 July he continued on horseback towards Tuk Chou, visiting another 8 villages on the way and inoculating 786 people in the course of the seven-day trip. On 13 July he continued for two days by canoe down to Bac Prea and inoculated 104 people on the way. After a meal at Bac Prea, he started the twenty-hour journey back to Battambang.

The native doctors were likely to be frequently moved around between different postings within the protectorate for administrative convenience, and often at short notice. This applied equally to the French doctors, but promotion in the ranks (and salary scale) did not come as easily to the natives. In 1922 Dr Chieu had attained the rank of médecin auxiliaire de 4ème classe, that is, only one step up the ladder from his 93 position, while during the period he had had at least three different postings after Battambang: Stung Treng, Prey Veng, and Svay Rieng (NA 8847).

Surveillance and preventive hygiene

Certain categories of natives could not easily escape the attention of the colonial medical gaze, whether they wanted to or not. Native troops, militiamen, and prison inmates were evidently subject to medical surveillance. They constituted what David Arnold (1993: 61ff) has called ‘colonial enclaves’ where Western medicine occupied a position of special authority. As mentioned, the population of these ‘enclaves’ were supplied with state quinine as a prophylactic after 1909. In June the year before, the medical service had been extended to the Phnom Penh prison. This resulted in the immediate cleaning up of the whole establishment, including its infirmary. Most prisoners were not in good health at the time of their incarceration – as most ‘criminals’ were generally, almost by definition, poor. Apart from malaria and skin diseases, the report noted an excessive number of cases of diarrhoea and dysentery, which was blamed on poor diet (NA 2486). The report mentions that the average prison population was about 350 each month and that during the last seven months of 1908, 297 inmates had been treated at the prison infirmary. The report says nothing about the average length of the prison sentences; it would probably be counted in months (or even weeks).
rather than years. In any case, it is probable that a substantial proportion of the inmates received treatment at the infirmary.

The fear of epidemic outbreaks was ever-present among the colonials. Triggered by the plague epidemic in Phnom Penh in 1907, the medical service had instituted measures to deal swiftly and efficiently with newly discovered cases of contagious diseases. The measures consisted of medical surveillance, quarantine, and sanitation and led to widespread protests among the population of Phnom Penh (see Au 2006: 47–51). In the provinces, local authorities were ordered to report cases through the official hierarchy up to the résident of the circonscription, who ordered the resident doctor to take action and report the case, telegraphically, to the résident supérieur in Phnom Penh (NA 12617). The procedures consisted of isolating the sick person, vaccinating his/her family and keeping them under observation, burning the house and either burning or chemically disinfecting all clothes, linen, sleeping mats, and other belongings. To begin with, these draconic measures were zealously adhered to by the French and, naturally, resented by the natives; the risk of having your house burnt down, your belongings destroyed, and your family split up did not make the population favourably disposed to the medical authorities. Most people tried to keep a low profile when there was a contagious disease in the family; in the circonscription of Kampong Chhnang, for example, not a single case of epidemic disease was reported in 1910 (NA 12617). Eventually the French realized that a more cautious approach was needed. The 1911 report proposed that the confinement of people suspected to be infected could be efficiently undertaken only among the colonial enclaves of militiamen, troops, and prisoners ‘over whom the doctor has full authority and who cannot escape his surveillance’. But imposing this measure among the general population was not recommended, since ‘it would imply an inconvenience to the people who have only recently and partially become dependent on us’ (NA 12617). Instead it was decided that the municipal doctor in Phnom Penh was to report deaths twice a day; in this he was assisted by a European and a native policeman, ‘parlant tous les deux les langues du pays et montés à bicyclette’ (ibid.). Since 1908 the city had further had an epidemic disease search unit consisting of 11 native sanitary agents, equipped with special uniforms (though apparently not with bicycles). These agents reported suspected cases to the municipal doctor who made a house visit to determine necessary measures (NA 11611). In 1918 a mobile service d’hygiène was established as a separate unit within the medical service to improve the water supply and the sanitary conditions of marketplaces, among other things.
In contrast to troops and prisoners, the medical service was extended to registered prostitutes not with the aim of making French medicine popular among them, let alone out of any concern for their personal health and welfare, but in order to reduce the occurrence of syphilis and gonorrhoea among their customers (mainly native troops and Frenchmen). One assistant French doctor from the Mixed Hospital was charged with overseeing the health service of the city of Phnom Penh in general. Entitled médecin municipal, he served the personnel of the various municipal services and was in charge of the programme for les filles publiques. As in France, prostitution was not illegal in Indochina, as long as it was restricted to registered and licensed brothels, known as maisons de tolérance. The rules regulating Indochinese brothels were copied from those in France; they were first applied in Cochinchina in the 1870s. In Phnom Penh, which was the only place where licensed brothels existed in Cambodia, a medical service des filles publiques, and a set of regulations for prostitution were established in 1885, thanks to the efforts of Dr Maurel whose experience of the medical concomitants of prostitution was considerable (Muller 2006: 142–145). In 1901, Adhémard Leclère, then mayor of Phnom Penh, proposed an update of Dr Maurel’s rules (NA 12858). The rules were to apply to every woman ‘qui désire se livrer à la prostitution’ (as if it were a matter of career choice). In his preamble, Leclère noted that illegal prostitution was steadily increasing and stated that the administration tolerated the existence of les maisons de tolérance only because they were a means to keep prostitution within the purview of sanitary surveillance.

Among the measures detailed in Leclère’s proposal were the following:

- Personal details of the prostitutes would be registered, and continual surveillance would be carried out by the police; each prostitute would be issued with a carte sanitaire, to be shown to any police officer on demand.

- Unregistered women caught in illegal prostitution would be detained by the police until proper registration had been effectuated.

- A woman found guilty of having spread a venereal disease in the course of illegal prostitution would be arrested and sentenced to one month in prison, after which she should be properly registered.

- All maisons de tolérance must have a licence issued by the mayor of Phnom Penh. The licence must be renewed annually and may be revoked at any time following a breach of the rules. All girls admitted for work in a maison de tolérance must first submit to a medical examination.

- Illegal brothels would be shut down immediately upon discovery, and the owners sentenced to one or two months in prison plus a fine amounting to twice the cost of the annual tax.
A registered prostitute working on her own must not solicit customers on the street; breach of this rule would result in imprisonment between eight days and one month. The same applied to prostitutes working in brothels, in which case the owner of the brothel would be fined 25 piastres; in case of repetition of breach of this rule, the establishment would be closed down.

All prostitutes, whether employed at a brothel or working privately, must present themselves for medical examination once a week, at such time and place as the authorities decide; failure to do so would result in eight days in prison and a fine of 5 piastres.

Girls found to carry a venereal disease must immediately be sent to the prison infirmary where they would be detained and treated until their complete recovery.

The annual tax to be paid by the owners of the brothels would be:
- 25 piastres for Khmer and Vietnamese establishments;
- 50 piastres for Chinese and Japanese establishments.

The tax for the weekly medical check-up of the prostitutes would be half a piastre per visit.

Apparently, Leclère saw no reason to explain the ‘obvious’ idea that Chinese and Japanese establishments should pay twice as much as the Khmer and Vietnamese ones. The latter were run and ‘staffed’ by indigènes, colonial subjects, while the Chinese and Japanese were considered foreigners for whom the French assumed no social responsibility. The existence of Japanese brothels, and Japanese prostitutes, in Cambodia is perhaps unexpected. According to George Hicks, ‘in pre-war Japan, prostitution was state-organised, with the women licensed and subjected to medical inspections [like in French Indochina]. In the late nineteenth century and at the beginning of the twentieth, Japanese travelling prostitutes […] were to be found in many parts of Asia’ (Hicks 1995: 1). In Indochina, Saigon had long been the centre for trafficking of both Japanese and, primarily, of course, Vietnamese prostitutes. ‘A steady stream of young Vietnamese women traveled up the Mekong to work temporarily in the Cambodian capital’ (Muller 2006: 139), not least after concubinage had been banned for Frenchmen around the turn of the century.

The weekly medical check-ups for registered prostitutes in Phnom Penh, initially conducted at the prison infirmary, only added to their social stigmatization. Thus, it is understandable if many girls tried to avoid contact with the authorities altogether and decided to take their chances of not being caught by the police. The annual medical report from 1908 notes laconically that ‘les prostituées clandestines sont nombreuses’ (NA 2486). In 1908, health check-ups and treatment for prostitutes had been moved to a newly opened special clinic for
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les filles publiques at the Mixed Hospital. This facility was housed in a new wing, situated in a courtyard encircled by high walls topped with broken glass. The only entrance was through the courtyard of the main hospital. The frequency of the compulsory visits had been reduced to once every two weeks. The costs of the actual treatment were now covered by the colonial government, while the brothel owners were obliged to cover the cost of food for the patients. The change of venue from the prison to the hospital had necessitated the appointment of a native police officer to the hospital staff to ensure orderly conduct among the girls. The girls often behaved scandalously, were noisy, or destroyed the fixtures, for which they were duly fined (NA 1322). Of the 101 prostitutes admitted for treatment in 1908, 83 were Vietnamese, 9 Khmer, 8 Japanese, and 1 Chinese. The average period of hospitalization per patient was 51 days (NA 2486). In 1911, of the 246 prostitutes treated, 226 were Vietnamese, 8 Khmer, 8 Japanese, and 4 Chinese.

The reason for the preponderance of Vietnamese rather than Khmer prostitutes in Cambodia probably lies in a combination of several factors. In both Khmer and Vietnamese society, young women had a decidedly inferior social standing but Vietnamese social norms were much more strongly patriarchal; and the Vietnamese were better organized and had a much keener eye for business opportunities than the Khmer. Khmer morality could allow relations of concubinage for their daughters, but not indiscriminate commercial sex. Irrespective of the ethnicity of the prostitutes, the medical and biopolitical rationality of the surveillance favoured the economy of sexual slavery. Khmer prostitutes were most likely members of families of debt-slaves (Aymonier 1900: 98–100), while the Vietnamese girls seem to have been victims of organized trafficking. Since licensed brothels were allowed in France, arguments for their prohibition in Indochina were unlikely to get a hearing, and colonial officials not only acquiesced to the practice of sexual slavery but were occasionally complicit in trafficking, ostensibly by showing respect for local customs (Pomfret 2008: 198–211).

FRENCH MEDICINE IN INDIGENOUS SOCIETY AND COSMOLOGY

The colonial government in Cambodia was generally indifferent toward the various indigenous medical practices, which were not for the most part seen as a threat to governmental medical policy, and not subject to the regulations that applied to the biomedically trained native doctors. With three exceptions – variolation, as we have already mentioned, the activities of indigenous midwives
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(see Chapter 6), and leprosy (Chapter 7) – the French tended to neither interfere with, nor take inspiration from, indigenous healthcare practices. We recall that already in 1894 Adhémard Leclère had dismissed Khmer medicine as unscientific. Likewise Dr Angier, in 1902, talked about a mixture of quackery and superstitions (‘un mélange d’empirisme et de pratiques superstitieuses’; quoted in Monnais-Rousselot 1999: 356).

This offhand attitude by early scholars was not extended to indigenous Chinese and Vietnamese medical practices. These were treated not as ‘ethnography’ but as indigenous medical theory and practice, described in some detail, for instance, by the naval physician Jules Regnault (1902). Naturally, those practices were not eligible for incorporation into the system of scientific colonial medicine, but they were ‘a supplementary cultural stronghold which in the eyes of the colonizers represented a danger of potential anti-French propaganda’ (Bezançon 2002: 72).

In Vietnam, French medicine met with some resistance from indigenous medical practitioners who were anxious to preserve their traditional status (Clavel 1908: 38), and the French employed various means ‘pour se débarrasser des empiristes indigènes’ (ibid.: 39). Dr Clavel relates with approval a particularly cruel method adopted by a Dr Paucot in Haiduong (Tonkin). He had summoned some ‘empirics’ to conduct an examination, in the presence of local notables, of a woman under whose clothing he had placed a cushion. The practitioners immediately declared the woman to be pregnant and began to discuss the sex of the baby. Paucot then quickly produced the cushion and ‘the demonstration ended by a burst of laughter and the practitioners were hooted off the stage, they slunk away to their homes in disgrace and soon after left Haiduong altogether’ (ibid.: 39). Clavel noted that Dr Paucot spoke Vietnamese fluently and had profound experience of the natives (ibid.: 28–29). It is therefore all the more disgraceful that he abused his cultural knowledge to make the ‘empirics’ lose face so completely, since he should have known that in the first place it is unthinkable that male practitioners should conduct a physical examination of the lower part of the body of a female patient, and that, secondly, conditions related to pregnancy and childbirth are not even dealt with by such ‘empirics’ but by indigenous midwives (see Chapter 6).

Efforts like those of Dr Paucot were generally absent in the early decades of the colonial medical services in Cambodia where, following their debunking by Adhémard Leclère (1894), indigenous healers and medicine had largely been ignored by French doctors. By the 1920s, however, the official attitude to indigenous practices began to change; to begin with, the authorities tried to keep track of indigenous healers. The reasons for this are not entirely clear, but Au Sokhieng cites a 1921 letter to the résident supérieur from the Local
Director of Health. ‘We do not want to prevent the natives from resorting to healers, bonesetters, or others from day to day. We simply desire the ability to exercise a bit of surveillance over these individuals in order to prevent them from harming their peers’ (Au 2005: 100). This seems a reasonable concern; the same reasoning guided the measures for controlling the privately practising (traditional) midwives. As a result of the attempted surveillance, 20 Chinese doctors were registered in Phnom Penh in 1922; the number of Vietnamese practitioners was 33, of whom 7 were traditional midwives (NA 2108). In the countryside, ‘indigenous healer’ was a rather elusive category for the authorities to deal with. According to Au Sokhieng, the provinces of Kampong Cham and Pursat reported having none (2005: 100). Kampong Chhnang Province, on the other hand, listed no less than 63 indigenous practitioners, of whom 53 were Khmer, 7 Cham, 2 Vietnamese, and 1 Chinese (NA 2108).

In 1925, the government of Indochina commissioned an inventory of the native herbal pharmacopoeia, with Dr Menaut being responsible for reporting from Cambodia (Monnais-Rousselot 1999: 366–367). At that time, Dr Menaut was actively promoting an indigenous herbal remedy (krabao) for the treatment of leprosy (see Chapter 7). It was not until 1938, however, that the colonial authorities suggested the general mise en valeur of indigenous herbal medicine. ‘The tolerance of the traditional medicine is not only a moral obligation and a mandatory policy, it is also a material necessity’ (quoted in Monnais-Rousselot 1999: 367). But by then it was too late for this attitude to be transformed into colonial medical policy. The idea resurfaced, however, in a nationalist guise during the Pol Pot regime and its successor, the Vietnamese protectorate in the early 1980s (see Chapter 4).

Only occasionally do provincial medical reports provide a few glimpses into the indigenous medical world in which the healers operated. Such bits of information are usually given as curiosities, only obliquely related to the operation of the service. The 1913 report from Battambang, for example, provides an unusually detailed account of the case of a woman whose neighbour had attacked her by sorcery, magically inserting foreign objects (such as needles, nails, bits of charcoal) into her body. She was cured by an indigenous healer who managed to extract the objects. She then went to the provincial law court to demand that the neighbour signed a statement that he would refrain from further sorcery attacks; this was how the case came to the attention of the authorities. The author of the medical report, realizing that no French doctor could have accomplished an equally efficient cure, added that we should perhaps not be surprised by the slight number of clients that the medical service attracted (NA 24015).
Faced with such incomprehensible phenomena among the local population, French doctors occasionally displayed a rather gross ethnocentrism. This is not surprising given their specialized biomedical education and the manifest lack of ethnographic curiosity within the colonial establishment in general. In his 1913 report, the resident doctor at Kampong Chhnang, for example, described a number of instances of what he ‘diagnosed’ as mystical delusions (*le délire mystique*). This condition was particular to the Khmer, he claimed, whose religious beliefs are sometimes carried to the point of fanaticism. One instance illustrating the condition was that of a militia sergeant who was to undergo minor surgery at the provincial hospital; he suddenly ‘pretended’ to be possessed by an evil spirit because he had neglected to fulfil an earlier vow to have his child treated by an indigenous healer. He was allowed to go home and perform an expiatory ceremony, after which he returned to the hospital and calmly submitted to the planned surgery. Another instance was the murder by a man, *fanatique du même genre*, of an indigenous midwife who was suspected of having started a minor smallpox epidemic by performing variolation on newborn children. A third instance was a young militia recruit who had repeatedly tried to desert his post because he had been told that the French were malevolent demons. He was detained at the prison infirmary where he showed signs of mental illness: chanting, whistling, and muttering incoherently. The doctor was unable to communicate with him – he was literally scared out of his mind. Eventually it was decided that he was incurable and he was sent home. The doctor marvelled that as soon as he was back in his village, he showed no further signs of mental disturbance (NA 12505). We may be less surprised. The symptoms were obviously a reaction to his capture by the terrifying foreign demons, from whom he had now escaped.

*Responses to colonial indigenization*

The French were totally convinced that their biomedical technologies were vastly superior to those that were employed in indigenous medicine. This may have been true in a number of instances, but we should also bear in mind that before the advent of sulphonamide antibiotics and penicillin, in the 1930s and 1940s, respectively, the ability of biomedicine to actually cure diseases was quite limited. At the time the colonial medical service was established, biomedicine’s potential to properly cure was virtually limited to fairly uncomplicated surgery. Direct prevention was possible through vaccination against smallpox, cholera, plague, and rabies; of these only smallpox vaccination was reliably efficient. Apart from these areas, the measures were directed at relief and overall prevention. The most common and most important relief remedies were quinine against malarial fever
and arsenic and mercury against syphilis and yaws. Prevention was accomplished through sterilization, disinfection, the isolation of people with contagious diseases, and promotion of general hygiene.

Of these various technologies, the relief remedies were the most widely accepted. They were dispensed in the form of pills, powders, and lotions and thus resembled the indigenous herbal remedies in terms of their physical form, so there were no cultural obstacles to using them instead of, or concurrent with, herbal concoctions. Moreover, they were generally superior to the indigenous remedies in terms of efficacy and, not unimportantly, they were dispensed free of charge by the colonial government. Curiously, the administration of medicines (as well as vaccinations other than smallpox) in the form of injections did not meet with major culturally based objections either. Although a foreign procedure, and therefore initially greeted with scepticism, injections eventually got the reputation as being the most efficient way of taking medicine, and today both hypodermic injections and drip-feeds are the most trusted measures among all sectors of Cambodia’s population (cf. Cunningham 1970).

On the other hand, surgery was almost universally rejected, except in very minor cases, or as a last, life-saving resort. The Khmer’s ‘distrust of the operating knife’, as a French colonial doctor put it (NA 2486), is more deep-rooted than mere distrust in surgical technology. To the Khmer, a person’s bodily, mental, and moral states are interlinked and expressive of his or her general virtue and karmic status. Lindsay French, in her analysis of Cambodian amputees (French 1994), has made the connections clear. A bodily defect signals mental and/or moral defects. A person’s physical and mental habitus is a reflection of the person’s karma, which in its turn is determined by the person’s (or being’s) accomplishments in previous existences. But just as your present karmic state is influenced by deeds in previous existences, there is scope for individual agency to gain merit in order to achieve some improvement of your karma for the benefit of your future existence. For ordinary people, among the most common ways to make merit, apart from trying to lead a virtuous life in general, is to give alms to monks and make donations to the wat. Conversely, one may also be anxious not to impair one’s karma. Because of the connection between karma, virtue, morality, and bodily wholeness, any act that will result in the body becoming incomplete or disfigured should be avoided. Surgical procedures such as stitching a wound or removing a foreign object (such as a bullet) from the body are acceptable since they aim at the restoration of the wholeness of the body, but the removal of integral parts of the body by the surgeon’s knife – or pulling out a tooth, for that matter – is tantamount to impairing the social, moral, and cosmological standing of the person.
Hygiene education, *vulgarisation sanitaire*, was another area in which the French did not succeed, simply because it made no sense. To the Khmer cleanliness was more or less synonymous with orderliness, to put things in their proper place and to appear tidy; to do so people did not need fussy outlandish ideas. Educating the general population about hygiene, however, was a major responsibility of the native doctors, mostly in connection with smallpox vaccinations. After each vaccination session the doctor would gather the people and teach them ‘some very simple notions, adapted to the simplistic mentality of the natives, cleared of all superfluous details, condensed in few words’ (NA 12617). Such ‘culturally sensitive’ hygiene education was also extended to the schools, since ‘impregnating the minds of the children with what they have to know in this area is surely the most useful way to popularize hygiene’ (ibid.). The efforts of hygiene education proved mostly in vain, however, and the annual medical reports were largely unanimous on this point. For Takeo in 1913, for example, the poor results were ascribed to ‘the unfavourable climate, seasonal inundations, the scarcity of drinking water, and not least the apathy and indifference of the population which stifle all prophylactic efforts’ (NA 12505). And in Stung Treng the same year the realization of sanitary goals generally faced ‘the lack of financial resources and the total unresponsiveness on the part of the natives’ (ibid.).

While passive non-compliance was an option with respect to the observance of rules of hygiene, other preventive measures taken by the French called for concerted action. One such measure was the mandatory autopsy performed on the body of any individual suspected to have died from a contagious disease. In April 1924, the Cham community on the Chrui Changvar Peninsula outside Phnom Penh filed a petition to the *résident superieur*, and another to the indigenous counterpart, the Council of Ministers, asking to be exempt from the autopsies (NA1347; see also Au 2006: 72–74). The Cham petitioners pointed out that according to their religion, Islam, a corpse should be ritually mummified, and that the violation of the body that autopsy implied was an affront to their religious practices, which the colonial government had otherwise respected. They argued that autopsies on Khmer, Vietnamese, and Chinese corpses should suffice for the medical battle against the microbes that cause epidemics. They called attention to the fact that the Cham community had always loyally abided by the orders of the colonial authorities, without showing the least resistance, for ‘we consider [the authorities] as our parents who never cease to protect their children’. But when a Cham person dies, the letter went on, only fellow Muslims are allowed to touch the corpse, and it is particularly serious if the private parts of a female corpse are exposed to the medical gaze of a non-Muslim doctor. If these rules are
not respected, it is a great calamity for all the Cham, since it prevents them from being considered good Muslims (NA 1347).

The arguments used in the petition are significant. The Cham demonstrated that they had mastered the discourse of the colonial administration and, in a spirit of cultural relativism, signalled their respect for the European biomedical worldview which they themselves did not share; and they made a plea for a similar respect on the part of the colonials in a matter which was every bit as important to the Cham as the battle against microbes was to the colonial medical service. What they did, in effect, was to turn the medical gaze back on a colonial practice. The Council of Ministers referred the case to the résident supérieur, Baudoin. His answer (formulated by the Local Director of Health, Vallet, on the suggestion of the municipal doctor, Bouvaist) was that the Cham, like everybody else, must follow the rules of the authorities; that the procedure was to remove a small piece of the liver for medical analysis, for which the word autopsy was an exaggeration; and that the Cham had to accept the practice which Europeans, Chinese, Vietnamese, Khmer, and Indians in Phnom Penh had agreed to without difficulty, since it was the only way to ascertain plague infection. Faced with such an inflexible attitude, we may assume that the Cham did their best to keep their dead out of reach of the French authorities.

Resistance?
The notion of (peasant) resistance has enjoyed considerable intellectual popularity among anthropologists and historians since James Scott (1986) originally proposed that various manifestations of non-compliance with state regulations among Southeast Asian indigenous populations could be viewed as acts of resistance. The reluctance among the Khmer to seek French medical treatment could be an obvious case for interpretation along the lines of ‘peasant resistance’, as Au Sokhieng (2006: 79–84) has suggested. But some ethnographic caution is in order to avoid an over-simplistic picture. First, for the concept of resistance to be meaningful, it must be a question of acts consciously committed as a manifestation of opposition to a specific phenomenon that is the object of resistance; this was made explicit in Scott’s original formulation (Scott 1986: 22–31). Even if, for instance, the young Khmer militiaman’s efforts to escape the French authorities who scared him speechless could be construed as resistance, such an interpretation tends to obscure the complex relationships involved. From the young man’s perspective, he was not putting up any resistance, he was trying to save himself and his sanity by fleeing from his tormentors. It would be even more of a mistake to make a general claim that the Khmer resisted French
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medicine, even if very few of them chose to turn to it, or had the opportunity to submit to it. Thus, Au Sokhieng is far too categorical when she claims that 'the Khmer population misunderstood and deeply distrusted French medicine. Naturally, they wanted nothing to do with it' (2006: 81).

The general picture that emerges from the French medical reports is that the Khmer were selective in their use of the medical services on offer, and they did not necessarily perceive the colonial medical service as a monolithic entity. They certainly rejected, or even resisted, measures that made no sense or represented a violation of their customs or property. Among these were most notably the measures for the prevention of contagious diseases: quarantine, burning of property and belongings, and chemical disinfection. The choice of not reporting contagious diseases was made not primarily to resist the authorities but to avoid damage to property and social relations. The young militiaman in Takeo was certainly not the only one to regard the French as malevolent demons, and their preventive measures clearly confirmed this belief.

On the other hand, the Khmer chose what made sense to them and proved efficacious. What they did need was relief from fever and pain and medicine for coughs, diarrhoea, and skin diseases. As we have seen, the use of quinine against malarial fever was a success and the state quinine programme paved the way for Khmer confidence in French medical products, as shown in the 1909 report from Stung Treng cited above. Even smallpox vaccination was relatively quickly accepted – but for children only – particularly in areas where variolation was less common. Thus in 1908, the resident doctor in Kampong Thom noted 'with satisfaction that even if the Khmer to begin with were apprehensive, their timidity disappeared already with a second visit. The sick come spontaneously to ask for medical care. It is not even necessary to insist very strongly to persuade them to have their children vaccinated' (NA 2486).

To the extent that conscious resistance occurred, it tended to come from the mesrok and mekhum rather than from common people. We have already cited the Dr Chieu's complaint about the lack of cooperation from these local authorities, and a similar observation was made in the 1908 report from Kampot: ‘The Cambodians come willingly to ask for medicine […] Unfortunately the native authorities do not at all support the doctor […] at times they do not even announce to the people the days when the doctor will visit for vaccinations. Quinine is delivered to them, but often they do not bother to distribute it. What to do about such apathy?’ (NA 2486).

Resistance, rather than apathy, is perhaps the proper word here. But it was not necessarily resistance against French medicine as such, of which the indigenous
leaders probably knew as little as the common people. More likely their passive resistance was inspired by fear of losing their traditional privileges of power and influence over the locals, including that of dispensing French medicine at their own discretion. The positions of *mesrok* and *mekhum* were economically attractive, since holders of these offices were entitled to keep between 3–5 per cent of the taxes they collected for the government (Forest 1980: 124). But this meant that these indigenous officials were regarded by the common people more as agents of an exploitative government than as trusted representatives of the local communities, so in order to rally support for their re-election, the medical supplies from the *bôites de sécours* as well as the state quinine could be useful as gifts for persuading the more important members of the local communities – who were not necessarily the most medically needy.\(^8\)

Even occasional written complaints to the French about medical matters were not necessarily instances of medical resistance. Au Sokhieng relates the case of a complaint against Dr Fabry, resident doctor at Kampong Cham, which she describes as a group petition written by the inhabitants of the province in 1927. Fabry and his wife had apparently offended some of the locals in various ways, but since our interpretation of the complaint differs somewhat from that of Au Sokhieng, we shall discuss it in some detail. On the basis of the letter, Au Sokhieng concludes that ‘Fabry, it seems, was not simply a bad doctor, but also an abusive human being’ (Au 2006: 75). Fabry may well have lacked intercultural communication skills, but the conclusion that he was a bad doctor can hardly be substantiated from such a letter alone. Dr Fabry had begun his service in Cambodia in 1922 as probationer at the Mixed Hospital in Phnom Penh (NA 887). In February 1924 he took up appointment as resident doctor in Kampong Cham, a province that had been regarded as a model of medical development in the country ever since the efforts of Baudoin and Menaut (Monnais-Rousselot 1999: 210).

His first annual report (in 1924) comes across as the work of a conscientious physician with a keen eye for social aspects and a socio-medically informed critical distance, not to say almost subversive attitude, to conventional policy. As such it is an example of what Paul Rabinow referred to as ‘missionary and didactic pathos’: ‘The understanding of social reality which yielded the pathos […] also produced a sense that there was no choice but to reform it’ (Rabinow 1989: 14). We have already related Fabry’s sensible proposal to forge cooperation with indigenous Cham practitioners for vaccination/variolation. Among the other issues he took up was a warning about alcoholism, ‘a sensitive problem to discuss in a country where the state derives a large part of its revenue from this
cause of moral decay’ (NA 630). Fabry was equally critical of certain aspects of the medical service itself. He suggested that it was questionable, for instance, to see the annual number of consultations as a measure of the progress made by l’assistance médicale. A local epidemic may considerably inflate the consultation figures for a given year, without indicating anything about the efficiency of the service. He even questioned the justification for one of the central tenets of the service, the free provision of state quinine. The state quinine programme, he said, had well served its original purpose – to demonstrate to the natives the efficacy of French medicine. But things had changed and we should not think in the same way as fifteen years before, hence the distribution of free quinine should be abolished. By now everybody, even in the remotest village, was aware of the potency of quinine, and virtually everybody could afford the 10 cents necessary to buy 10 quinine pills to cure a bout of fever. Therefore Dr Fabry, with the consent of the résident, had instituted the government sale of quinine to counteract the inflated prices asked by the ‘dishonest’ Chinese shopkeepers who were wont to raise the price by up to 1,000 per cent during the malarial season (August–November), since the amount of state quinine available to the provincial authorities was in any case vastly insufficient to cover the needs of the whole population. Fabry instead proposed concerted anti-malarial efforts during the season, including public information and promoting the use of mosquito nets (NA 630).

There is no evidence that the French regarded Fabry as a bad doctor, despite his unorthodox views. But it is obvious from the letter that he did not get along very well with certain members of the local population. Whether or not as a result of the complaint, Fabry was transferred from Kampong Cham to Svay Rieng in May 1930; he then held the rank of médecin de 1ère classe, and in December of that year he was appointed practising physician (médecin traitant) with the same rank at the Mixed Hospital in Phnom Penh (NA 1675; NA 2466). As for the letter itself, it mainly accuses Fabry of corruption, of only seeking to enrich himself and neglecting his medical duties (NA 14582). Among the allegations were that he only treated people who were able to pay for treatment and medication, and did so in his own house, while indigent patients in the hospital were left to the care of the indigenous medical attendants, and that he demanded payment for issuing medical certificates, which were made to conform to the wishes of interested parties. The four specific cases detailed in the letter concerned fights (including one killing) among the local population, and the letter alleged that in each case the party who could afford it had paid Fabry for
a certificate (or an autopsy report) that either exaggerated his own injuries or belittled those of his opponent.

There are some curious circumstances about the letter. To begin with, it carries no signature(s), neither in the translation nor in the Khmer original. Secondly, the letter claims fairly detailed knowledge both of the contents of Dr Fabry’s certificates and of the physical conditions of those they concerned. The letter also alleged that Fabry had received payment from his private patients for medicine that he had taken from the government stocks; on this issue, the letter added, ‘If you deem my allegation unfounded, it may be corroborated by private inquiry, since M. Fabry has no proof of purchase of the medicine’ (NA 14582; emphasis added). The author had also sought to pre-empt Dr Fabry’s likely refutation of the accusations by intimating that he was cunning and lied to his superiors. These circumstances seem to indicate that rather than being a group petition by the local population in general, it was written by a person with inside knowledge of the medical procedures and routines, quite possibly one of the infirmiers indigènes, who for some reason bore a grudge against the doctor. In his 1924 annual report Dr Fabry had mentioned that the native medical attendants tasked with overseeing the provincial leprosarium and the quarry where some of the lepers worked had quite a cushy job and were liable to abuse their charges, and he had therefore instituted a rotation scheme for these assignments (NA 630; see also Chapter 7). It is possible that these or similar measures to have the indigenous attendants shape up had provoked the ire of the letter-writer.

We do not, of course, deny the possibility that some of the allegations were true. Already in his first annual report Dr Fabry had expressed some exasperation about Khmer medical attitudes. ‘Those of our medical products that work rapidly enjoy great popularity among the natives’, he noted; ‘all they want from us is medicine that takes effect immediately. On the other hand, all cases that demand delicate, attentive, careful and prolonged treatment are closed to us’ (NA 630). After three years, he may well have become demoralized by a feeling that his talents were being wasted. But he may not be the only one who was a clever liar, and the veracity of the letter’s allegations cannot automatically be taken for granted. Whether to interpret the letter, as Au Sokhieng suggests, as an instance of peasant resistance among a colonized population or, as we suggest, as an attempt at vengeance by a disgruntled employee, is a matter of preference in the absence of conclusive evidence."
Outreach

Despite the good intentions of the medical service, the physical presence of French doctors was not impressive. In 1910 there were 13 French doctors on duty in the provinces, of whom 6 were military doctors on secondment to the medical service (NA 12617). When the military doctors eventually retired, the medical service had often been unable to appoint replacements, and in 1923 still only 7 of the provinces had a resident French doctor (Guillou 2001: 102).

A consistent worry among the French doctors throughout the colonial period was the inability of the medical service to reach the rural population. While the Vietnamese and the Chinese tended to frequent the French clinics in reasonably satisfactory numbers, the Khmer (as well as the Cham, where they were present) proved extremely reluctant to consult the French medical establishments. In 1908 at the Takeo clinic, for example, the resident doctor noted that ‘it must be mentioned that we reckon above all Chinese and Annamites among the clients’ (NA 2486). Furthermore, very few women were among the clients. Of the 3,012 clients noted at Takeo in 1908, only 212 (7 per cent) were women and virtually all these women were Vietnamese. The number of children was 311 (10 per cent). Five years later, the situation was much the same, as table 3.6 illustrates.

### Table 3.4: Number of consultations at the clinic in Takeo Province, 1913

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Population</th>
<th>Per cent</th>
<th>Consultations</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Khmer</td>
<td>193,339</td>
<td>88.7</td>
<td>6,845</td>
<td>3.5</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>14,072</td>
<td>6.4</td>
<td>4,745</td>
<td>33.7</td>
</tr>
<tr>
<td>Chinese</td>
<td>9,773</td>
<td>4.5</td>
<td>1,990</td>
<td>20.4</td>
</tr>
<tr>
<td>Cham</td>
<td>826</td>
<td>0.4</td>
<td>90</td>
<td>10.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>218,010</strong></td>
<td><strong>100</strong></td>
<td><strong>13,670</strong></td>
<td><strong>6.2</strong></td>
</tr>
</tbody>
</table>

Source: NA 12505

Not only was the number of Khmer clients very low, but a disproportionately large number of them were either militiamen or prison inmates who could not escape medical surveillance. In Takeo in 1913, of the total of 13,670 consultations, 9,124 were ordinary people (who came voluntarily) while 1,377 were militiamen and 3,169 were prisoners. Members of these ‘colonial enclaves’ thus accounted for one-third of all medical consultations, further reducing the proportion of ordinary people (to 4.2 per cent). We do not know the total number or the ethnicity of either militiamen or prisoners in Takeo, but considering that the militia in 1913 consisted of only about 1,500 men in the whole country (Forest
1980: 137), we may infer that the Takeo militiamen were quite frequent clients of the medical service. The resident doctor tried to make the best of the situation. In the 1910 report he noted that he took the utmost care in the treatment of the prisoners. They came from all over the province and would return home after their release from prison, so they could therefore serve the useful function of contributing to la réclame médicale (NA 12618).

Such optimism was not shared by the resident doctor in Battambang. In his 1913 report he complained that only 1.3 per cent of the ordinary population had ever visited the clinic, and moreover that a fair number of these were Vietnamese and Chinese in a province where the majority were Khmer. Part of the reason for this dismal state of affairs, he argued, was that the province had both a militia contingent and a unit of tirailleurs cambodgiens who required daily medical attention. The army camp was outside the town and the doctor had to spend two hours travelling every morning, precious time that he could otherwise have been spent on consultations in town. Furthermore, the doctor noted, nine out of ten cases among the militia and troops either involved sores that would gain them temporary leave from their duties, or damage to their bodies caused by venereal diseases as a result of their unsavoury habits (‘leur malpropreté’; NA 24015). As for tours of the countryside, these had to be left to his assistant, the native doctor Chieu. As indicated by Chieu’s report, in addition to vaccinations, he would also occasionally treat acute cases, but such treatment virtually never induced the patients to travel to the clinic in town themselves, however much he so recommended.

The inability of the French colonial medical service to reach substantial parts of the indigenous rural population was not unique to Cambodia. However, the common observation that the French mainly focused their economic and administrative development of Indochina on Vietnam, while Cambodia was treated with ‘benign neglect’ (Desbarats 1995: 29), does not hold true for the medical service, where the amount spent on Cambodia corresponded roughly to the relative size of its population within Indochina. Between 1910 and 1925, expenditure for Cambodia varied between 6 and 13 per cent of the total for Indochina (Guillou 2001: 94), with the population of Cambodia constituting about 10 per cent. Neither was there any difference in the share that health expenditure had of the total colonial budgets. For Vietnam, David Craig cites the figure of 4 per cent for the colonial period in general (incidentally the same figure as the share of health expenditure in the Vietnamese state budget for 1990! Craig 2002: 53; 224, n. 55), while for Cambodia the figure varied between 3 to 5 per cent in 1910–1925 (Guillou 2001: 94). Moreover, despite the presumed
greater readiness of the Vietnamese than the Khmer to take advantage of the French medical services, the account for Vietnam itself was equally dismal in terms of outreach. According to Craig, the medical service in Vietnam had little impact beyond urban elites, and ‘practical access to Western medicine would have been available to [...] around 3 percent of the population in 1937’ (Craig 2002: 52). By contrast, a significantly greater percentage had practical access in Cambodia, even in the rural areas, although not many took advantage of it. During the years 1908–1913, i.e. the period following the establishment of the indigenous medical service, the number of hospitals in Cambodia grew from 2 to 14, while Annam and Tonkin saw a modest growth from 11 to 14 and 23 to 24, respectively, and Cochinchina showed a steady figure of 22 (Monnais-Rousselot 1999: 115).

To sum up, the ability of the medical service to reach the local population in Cambodia varied greatly with residence, occupation, ethnicity, and gender. The inhabitants of Phnom Penh were fairly well provided with medical facilities, and taking good advantage of them had early become part of the sophisticated urban lifestyle. Among the rural population, however, a disproportionate percentage of the clients were from the colonial enclaves of militiamen, prisoners, and native civil servants. Among the native civilians, the Vietnamese (and to some extent the Chinese) were strongly over-represented in relation to the Khmer. Among all native civilians who encountered the indigenous medical service, moreover, only about 10 per cent were women, and most of these were Vietnamese. As for children, usually their only contact with the service was for smallpox vaccination. In other words, rural Khmer women and children, who made up about 60 per cent of the total population of the country, had virtually no contact with the French medical service.

‘FRENCH’ MEDICINE AFTER INDEPENDENCE

By the end of the Second World War, the French had begun to ‘indigenize’ the medical institutions. The Mixed Hospital was still the main facility and had undergone several expansions and renovations. In 1945 its name was changed to Preah Ket Mealea Hospital, named after the legendary hero Ket Mealea (Ketu Mala in Pali), son of the god Indra and mythological founder of the city of Angkor. In 1946 a medical school, l’École des officiers de santé was established in Phnom Penh; it offered a three-year training programme, with the possibility for further studies in France.
After Sihanouk successfully negotiated the country’s independence in 1953, he embarked on an ambitious modernization programme, made possible by substantial foreign aid; initially, the United States was the primary donor, but contributions were made also by France, the Soviet Union, and Japan. In 1955 Sihanouk formally abdicated in order to lead ‘his’ country as prime minister. From 1955 to 1969, the number of hospitals and district clinics rose from 16 to 69, and the number of commune dispensaries from 103 to 587 (Guillou 2001: 150). At independence l’École des officiers de santé became the Royal School of Medicine (l’École royale de médecine) and the number of students more than doubled, from an initial intake of about 50 to more than 100 (Royaume du Cambodge 1964: 19). The school was still under French scientific supervision, and of the 218 health officers trained between 1946 and 1961, 30 went on to do a doctorate in France (ibid.). Academic medical independence was achieved in 1962 when the Royal School became the Faculty of Medicine with a teaching staff of 52, half of them French and half Cambodian (ibid.: 20).

Figure 3.2. Hospital inauguration, late 1950s. Courtesy of the National Archives of Cambodia
Sihanouk’s national modernity implied that the Cambodian state should take over the role that had earlier been played by the French colonial government. Modelling himself on the semi-divine Angkorean kings (*devaraja*), Sihanouk took it upon himself to symbolically ‘create’ hospitals, health centres, and other modern institutions for the benefit of his subjects. The invocation of Angkorean grandeur was explicit: the title page of the government’s showcase publication on the health sector in the early 1960s carries the following epigraph, ‘He suffers the diseases of his subjects more than his own, for it is the sufferance of the people that is the woe of kings and not their own fate’ (Royaume du Cambodge 1964). This was the text of the ‘hospital edict’ of the twelfth-century king Jayavarman VII (see Chapter 5) that Sihanouk found fitting to recall. It should be noted, however, that in terms of medical services those subjects who could benefit from the modernization belonged mainly to the urban and semi-urban minority of the population. What reached the rural majority were, at best, rumours of the prince’s benevolence. Phnom Penh was still the place where most things happened on the medical front. In 1955 a special hospital for monks, *l’Hôpital des bonzes*, was opened under Sihanouk’s patronage; interestingly, French doctor Pierre Huard (1963: 678) refers to *l’Hôpital des bonzes* as an ‘American foundation’, presumably because it was financed by US foreign aid. Despite the royal government’s ambition to focus primarily on preventive medicine, in practice the curative efforts were dominant. In 1959 the French opened *l’Hôpital Calmette* in Phnom Penh, a state-of-the-art research hospital. The French could not bring themselves to let such an advanced institution be run by Cambodians; in the interest of ‘medical quality’, they insisted on French management (Guillou 2001: 156–157). Unsurprisingly, the Cambodian doctors at Calmette Hospital were not treated as equals by their French colleagues, who, we may guess, saw them more as *médecins indigènes* than as *confrères*. Neither was their status enhanced by the fact that most of the patients strongly preferred to be treated by ‘proper’ French doctors rather than by their own compatriots (ibid.). This did not contribute to Cambodian national self-esteem, and significantly, the Calmette Hospital is not even mentioned in the government’s health sector publication (Royaume du Cambodge 1964).

The following year, the Soviet Union made its medical presence felt in Phnom Penh. Cambodia was politically non-aligned, and relations between Sihanouk and the United States had become progressively less cordial. The magnificent Khmer–Soviet Friendship Hospital (*l’Hôpital de l’amitié Khméro–Soviétique*, commonly known as the Russian Hospital) was opened in August 1960. In contrast to the Calmette, the Russian Hospital was proudly and prominently
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portrayed in contemporary government publications. With 500 beds and the latest medical equipment, and with a medical staff of both Soviet and Cambodian doctors, it aimed at full coverage of both medicine and surgery. After the first year of operation, the Russian Hospital launched an annual publication, *Revue Médico-Chirurgicale*, in which the staff published scientific articles based on the latest medical findings and related to the cases they had treated during the year. Each issue ran to 200 or more pages and contained more than 50 articles, mostly co-authored by Russian and Cambodian doctors. The annual publication of the *Revue* marked the emergent professionalization among Cambodian medical doctors. Another indication of this professionalization was the founding of the Royal Society of Medicine in 1962. The society held regular meetings and its scholarly proceedings were reported in the periodical *Bulletin de la Société royale de médecine du Cambodge*.

In 1963, the domestic production of pharmaceuticals started. The *Pharmacie d’approvision khmère* in Phnom Penh produced a range of basic pharmaceuticals to compete with the expensive imported French products. At the same time, French pharmaceutical companies prominently advertised their products in the *Bulletin de la Société royale*. Whether or not Cambodian doctors were influenced by the French advertisements, most people preferred the imported French products and distrusted the cheaper domestic alternatives, just as they preferred hospital treatment by French doctors rather than by their own compatriots. After all, 'French' medicine was presumably best practised by the French.

With the professionalization of medical practitioners (doctors and pharmacists) came also commercialization. Given the customary Cambodian expectation that obtaining a diploma was a guarantee for a salaried position in the civil service (Martin 1994: 14), students who returned with a foreign education would often feel entitled to the most lucrative jobs. So, in Cambodia after independence, although medical treatment was officially free of charge, physicians and pharmacists in both hospitals and private practice would normally demand payment for their services or add to the price of medical products. Due to the increasingly strained financial conditions of the state from the mid-1960s, free medical services were no longer readily available. This also meant that from now on, distance to the medical facility was no longer the sole determinant of adequate healthcare; class had become an important factor as well. Cambodian-educated doctors were notionally state employees, but they were allowed to use hospital facilities for private practice outside ordinary working hours (Guillou 2001: 173). An increasing number of doctors opened their own private practices, although strictly speaking this was against the law. Most private practitioners also
agreed to make home visits, something that was much appreciated by those who could afford it. The Khmer had (have) always been reluctant to seek treatment in public hospitals or clinics, as care for the sick is an aspect of life strongly associated with the intimate sphere of the family.

The economic decline and civil war during the Khmer Republic (1970–1975) also entailed decreasing imports of pharmaceuticals. What little was available was very expensive (Brun 1998: 23), and only those who could afford an inflated bill would receive treatment. Under Lon Nol, corruption was widespread and alleged corruption of doctors was particularly resented by the population, because their greed caused direct suffering. Patients in public hospitals and private clinics would receive treatment only if they could pay both the doctor's fee and the price – set by the doctors or pharmacists – of their prescribed medicine, and poor people were often left to die, virtually on the doorsteps of the hospitals.

NOTES

1 Au Sokhieng’s unpublished PhD thesis (2005) importantly complements our account in this chapter. It is an historian’s analysis of the French medical interventions over most of the colonial period. A version of one of the chapters has been published (Au 2006); when commenting on material from that chapter, we refer to the published version.

2 A published version of Anne Guillou’s 2001 thesis is forthcoming (Guillou, in press).

3 Baudoin was later to become résident supérieur of Cambodia, from 1914–1927. Among his subsequent initiatives in medical matters were the establishment, in 1918, of a mobile hygiene service in cooperation with then Local Director of Health Menaut (Monnais-Rousselot 1999: 96, 98, 100); the production of krabao oil for the treatment of leprosy, also with Menaut (see Chapter 7); and the creation, in 1926, of a Cambodian midwifery school (see Chapter 6).

4 It is worth noting, in comparison, that in France smallpox vaccination for the armed forces was made compulsory in 1876, and for schoolchildren only in 1887 (Bynum 2006: 194).

5 ‘Le droit de pratiquer des vaccinations est exclusivement réservé aux médecins européens ou indigènes et aux sages-femmes diplômés, La variolisation est interdite’ (NA 7878).

6 The Kuy are an indigenous ethnic minority in northwest Cambodia and adjacent parts of Thailand.

7 Au Sokhieng here seems to have been carried away by her anti-colonial rhetoric. In an unpublished chapter of her thesis she provides a much more nuanced and sensible account: ‘The Cambodian population […] did not reflexively [sic!] refuse French medicine. While some Khmers refused French medicine because their needs were met by traditional practitioners, others made choices based on their own experiences
or experiences of their peers [...] Many of these choices had little to do with a conscious desire to maintain Khmer traditions or thwart colonial power’ (2005: 77).

8 The offices of mekhum and, particularly, mesrok entailed considerable status and prestige, and even if they were invented by the French, they were perceived by the Khmer population in terms of patronage (rather than republican democratic values). The widow of a former mesrok whom we talked to recalled her unhappiness about her husband’s several concubines; ambitious members of his constituency offered their daughters to him as a way of becoming his clients (see story of Chap Yan, Chapter 4).

9 Irrespective of interpretative perspective, Au Sokhieng’s account contains a couple of factual inaccuracies. She claims that Fabry was removed from his post in 1932 as a result of the petition that the Kampong Cham inhabitants filed in 1931, and that only the French translation of the petition is on record (Au 2006: 75). The correct date of the letter, however, was 1927 and the handwritten Khmer original is appended to the translation (NA 14582); her speculations about various scandals triggering rotations of Fabry and other medical personnel are thus not supported by the chronological facts. Finally, although there was sometimes an ethnic dimension to the local violence related in the letter, it does not support the claim that Fabry was guilty of ‘favourable treatment of rich Vietnamese over poor Khmer’ (ibid.).

10 ‘Il souffre des maladies de ses sujets plus que des siennes car c’est la douleur publique qui fait la douleur des rois et non leur propre destin’. This is most likely Coëdes’ translation of the Sanskrit inscription. Thompson (2004: 97) has offered quite a different one.

11 The various causes of the country’s economic decline have been accounted for by Chandler (1992: 200–202).
Chapter Four

The Khmer Rouge Medical Regime and Socialist Health

In this chapter we provide an ethnographic account of the medical situation during Democratic Kampuchea, which has commonly been portrayed as the wholesale destruction of the country’s healthcare system. Through the ethnography we want to nuance this picture – not in order to defend a medical (and political) regime that we regard as disastrous, but to give voice also to some categories of people whose testimonies have hitherto been less prominent and thereby leave room for reflections on the individual agency of various actors in their varied circumstances.

Pol Pot Time

The Cambodian regime officially called Democratic Kampuchea (DK), and popularly known as the Khmer Rouge or, in Cambodia, as Pol Pot time (samay Pol Pot), lasted from 17 April 1975 to 7 January 1979. The DK assumption of power nationwide followed five years of civil war between the revolutionary guerrillas and the government of the Khmer Republic under general Lon Nol. During the civil war, the guerrillas increasingly gained control of areas in the countryside, until they were able to invade Phnom Penh on 17 April 1975 and declare victory. From the outset, the Khmer Rouge had been heavily supported, militarily and in terms of practical and ideological training, by the National Front for the Liberation of South Viet Nam (NFL, known derogatorily as ‘Viet Cong’). But thanks to the American bombing of the countryside between 1969 and 1973, Sihanouk’s appeals to the people to join the resistance against Lon Nol, and the guerrillas’ massive recruitment of children from poor families,
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the Cambodian revolutionaries in 1973 felt strong enough to break with their Vietnamese comrades, whom they felt pursued a different agenda from their own and who eventually came to be depicted, in the time-honoured Khmer tradition, as their most dangerous enemies.

As soon as revolutionary victory was proclaimed, Phnom Penh and all provincial cities were emptied of their inhabitants who were ordered to leave for the countryside. The urban population was classed as ‘new people’ (or ‘17 April people’, referring to the date of the Khmer Rouge assumption of power). The population of the already ‘liberated’ areas of the countryside, on the other hand, was referred to as ‘old people’ or ‘base people’ because they formed the base of the revolutionary society. The ‘new people’ were treated as potential enemies and often put to work as agricultural slaves. People classified as ‘intellectuals’ (panh nha chum), such as medical doctors for example, were particularly harshly treated.¹

The distinction between ‘base’ and ‘new’ people was spontaneous and not part of the policy of the Party, but it had some basis in social reality. Most middle-class townspeople had no experience and very little understanding of the living conditions of the rural population, and vice-versa; they belonged to two different worlds that were brought into dramatic contact when Phnom Penh was taken by the rural revolutionaries and the city people were deported to the countryside.² Secrecy had always been characteristic of the revolutionary movement and even after the victory, the leaders of the revolution were unknown to the people. Reference was made only to the Angkar, the ‘organization’ (rather than to the Communist Party of Kampuchea, CPK) and its upper echelon, Angkar loeu, (the Central Committee) whose will was made known to the population by the higher cadres (khamaphibal). The power of the Angkar was absolute, and the cadres were organized along military lines. The rank and file cadres were organized into ‘soldier groups’ (kong youthea) consisting of 3 persons (male as well as female). Three such groups (i.e. 96 people) formed a vireak under the command of a prothean vireak. Although the groups of low-level cadres were referred to as soldiers, their tasks were not necessarily only military in nature. They were stationed permanently in a given area and could be assigned to a variety of duties, such as working in the paddy fields or in the construction of roads and irrigation canals, or, as we shall see, in hospitals. Larger infrastructural projects required the slave labour of ‘new people’ who were directed by the soldier groups. In the countryside, a process of forced collectivization had already been under way in the ‘liberated’ areas before 1975. Villagers were organized into groups (krom) of about 12 families, a number of which (generally about 30) formed a collective (sahakor). Much of the rice crop produced by the collectives
was stored (and mostly wasted), some to be exported to China. The people were subjected to very severe food rationing, and most suffered from malnutrition. From 1977 the Angkar instituted communal eating for the sahakor and arranged marriages for the young. Members of the sahakor were often divided into labour teams formed according to age and gender, so members of a family did not share the same kind of work and often worked in different places. Some labour teams consisting of young people were designated ‘mobile teams’ (kong chalat); they could be deployed for clearing land, digging canals, and the like. In this way, people were continually reminded that the traditional family cohesion was to be broken down and substituted by the governing role of the Angkar to which loyalty was mandatory. Some ‘base people’ regarded by the cadres as especially trustworthy, were appointed sangkumakech; their task was to oversee the distribution of foodstuffs and medicine in the sahakor, and they were exempt from the hard agricultural work.

Already from about 1976, the regime had begun to self-destruct. The leadership’s increasing paranoia gave rise to frequent internal purges. In these purges, the Angkar followed the practice of traditional Cambodian rulers, of eradicating the offending elements to the root – arresting and (usually) killing not only the persons suspected to be traitors, but also their whole ‘line’ (khsae), i.e. the network each individual forms part of through family, friendship, or patron–client ties. Democratic Kampuchea’s rhetorical aggression against Vietnam continued, and on the pretext of retaliation for alleged border violations by DK troops, Vietnamese army units invaded Cambodia in early January 1979. The Vietnamese Volunteer Army, as the invasion forces were called, met with surprisingly little resistance. The DK forces quickly withdrew to the northwestern provinces, where they eventually concentrated in a number of enclaves along the Thai border (such as Pailin, Malai, and Anlong Veng) that to all intents and purposes continued as Democratic Kampuchea until 1996. These enclaves were materially supported by the Thai military, in exchange for timber and gemstones extracted from the areas under DK control, and were armed by China. The Vietnamese turned the rest of the country into a protectorate, supported by some 150,000 troops and a large number of political and technical advisers, and Cambodia was in practical terms under Vietnamese occupation until 1989. During the early 1980s, the perceived oppression of the Vietnamese protectorate drove thousands of Cambodians into exile via refugee camps along the Thai border.
The medical reputation of the Khmer Rouge

It is commonly believed that modern biomedical services were completely abolished under Pol Pot, and that, with few exceptions, hospitals were abandoned. The infamous evacuation of patients from Phnom Penh hospitals on 17 April has often been taken as an illustration of the extreme cruelty of the Khmer Rouge takeover. Though cruelty was certainly part of it, we should also remember that the soldiers who were sent into the capital to evacuate the hospitals were mostly young, uneducated men from the countryside who might never have seen the city before or seen a real hospital from the inside, and who seemed totally unprepared for what they would find.

David Chandler, prominent historian of Cambodia, states that Khmer Rouge practices included ‘a rejection of Western-style medicine’ (1993: 259), and that ‘tens of thousands of Cambodians died of malnutrition and of inadequate healthcare owing to the regime’s refusal to import medicine’ (ibid.: 249). This is not entirely accurate, however. It is certainly true that a large number of people died from inadequate medical care (see Appendix). But in fact major hospitals, both in Phnom Penh (the Russian and Calmette hospitals) and in the provinces, were used by the Pol Pot regime, and biomedical pharmaceuticals were imported in substantial quantities, mainly from or via China. In September 1975 Pol Pot had told the Central Committee that to develop public health, the regime should use traditional medicine as well as buy modern medicines in exchange for rice and rubber (Short 2004: 305). The fact that female family members of some of the highest leaders of the regime (Ieng Sary, Ta Mok, Thiounn Thioeun) were given important posts in the medical sector also attests to the importance that the regime placed on medical matters. The crucial point is that proper hospitals and imported pharmaceuticals were not for everyone. As Chandler has noted, hierarchy was by no means abolished by the revolution, ‘but high positions were held by different categories of people than before and were no longer expressed in terms of money, possessions, or prerevolutionary titles. Instead, those with power and status […] had access to [the] commodities that most of the population lacked: food, weapons and information’ (Chandler 1993: 241). We need only add medicine to the list of commodities to get the proper picture. Imported pharmaceuticals were stored in warehouses in Phnom Penh and Sihanoukville, from where they were distributed to the major hospitals. These hospitals were reserved primarily for the highest Khmer Rouge leadership (Angkar lœu) but also for the treatment of complicated cases among revolutionary cadres and occasionally among trusted ‘base people’. Domestic pharmaceuticals, the production of which had begun during the 1960s, were now of increasingly inferior
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quality because of the lack of qualified pharmacists, but they were produced nevertheless, in Phnom Penh as well as in some provinces. They were dispensed to revolutionary cadres and other trusted individuals. According to Leng Vouch Eng (1982: 203) only ‘base’ people had the right to use modern drugs. As before, the remedies available to the great majority were herbal medicines – but which had now been ‘modernized’, that is, manufactured as tablets, colloquially known as ‘rabbit droppings’ since that was what they looked like.

Why then has the impression of the DK totally abolishing biomedical healthcare persisted? There are a number of interconnected reasons for this, we believe. One is that the testimonies we have about the medical situation during DK have almost exclusively come from surviving ‘new people’, most of them in exile. They were the most articulate and they were the ones who had the opportunity to tell their stories to foreign journalists and researchers, and eventually to publish their autobiographies – and they were the ones who received absolutely dismal medical treatment. While we do not question the veracity of their narratives, or the sincerity of their recollections, we have to recognize that their testimonies represent one of several kinds of experience of the Pol Pot regime.

The picture of absolute medical misery under Pol Pot has been most forcefully conveyed by surviving medical doctors – also for good reasons. Not only were they ‘new people’ but they had been educated in the French medical tradition, which had instilled in many of them both a strong esprit de corps (fellow medical doctors were referred to as confrères) and a pride in their profession and its ethics. So they could only despise a regime which had murdered many of their colleagues, and which through ignorance and arrogance had scorned the competence of most of those who survived, and allowed malpractice and neglect of basic hygiene to cause the death of a large number of people. An example of such survival stories by medical doctors is that of Dr Ly Po, retired professor of medicine but still an active member of the scientific council at the Medical Faculty of Phnom Penh University.

Ly Po was born in 1930, his parents were farmers in Kampot Province. To make a living, he joined the army and eventually attended l’École des officiers de santé as a military student from 1950 to 1954. After graduation he remained in the army as a medical officer; in 1963 he was awarded a scholarship to study in Paris, where he specialized in tropical and preventive medicine. He returned to Cambodia in 1968 and worked as an army doctor, first in Siem Reap and later in Kampot. In early 1975 Kampot was surrounded by the Khmer Rouge and he was evacuated by
helicopter to Phnom Penh. At the Khmer Rouge takeover in April, he was sent to Battambang, to do hard labour. While there he was identified as a doctor but he was not killed because being a farmer’s son, he had proved to be a skilful and diligent agricultural worker. After a while he was imprisoned in Battambang town; the prison had about 700 inmates, all ‘intellectuals’. Fellow prisoners were often taken away for interrogation and disappeared. Only about 40 survived the Pol Pot regime, and most left the country afterwards. In prison he worked as a builder, demolishing abandoned houses in the neighbourhood and using the materials to build prison barracks. After three months in prison he was sent to do compulsory work in the countryside in Battambang. The food was insufficient, people lived on sweet potato leaves, banana stalks, and whatever else they could find.

Only twice did he practise his medical skills: the first time was when an 8-year-old boy had fallen from a tree, breaking his wrist and cutting his upper lip badly. The mother, knowing he was a doctor, asked for his help. He said he could help but she had to have permission from the cadres before he could do anything. Permission was granted, and Ly Po easily set the wrist; to stitch up the lip was more difficult, since he had no surgical material, only a sewing needle and some thread. He boiled the needle and soaked the thread in alcohol and went to work. After the Vietnamese invasion he had attended the boy’s wedding and was pleased to see that the scar was barely visible. The second time, it was a question of a head wound that had become infected after treatment by the local revolutionary medic. Again he was permitted to treat the person and succeeded in cleaning and dressing the wound.

Ly Po attributes the fact that he survived DK – being a known doctor as well as a former officer in Lon Nol’s army – to the way he conducted himself in front of the Khmer Rouge cadres. Since everybody was suspected of being a real or potential enemy, he decided that the best survival strategy was to be honest about his own position and at the same time show that he was dependable and willing unquestioningly to obey their commands. The DK people were ignorant, poor, and incapable of empathy, he said. Such people were also vain and extremely sensitive to explicit or implicit criticism. He gained their respect by showing respect to them and by proving his ability and stamina in agricultural work.

It is understandable that Ly Po in retrospect asserts his moral and intellectual superiority over his oppressors, and it is common that people claim to have survived Pol Pot because of their personal qualities. One should treat such claims with some caution and beware of drawing the inverse conclusion, i.e. that people
were killed because of their ‘bad behaviour’ towards the Khmer Rouge cadres. Rather than focusing on personal qualities and behaviour, however, we would place the emphasis on habitus and agency in the management of social relations. There can be little doubt that Ly Po’s habitus as a Khmer farmer’s son, and his capacity for personal agency (which he had previously deployed in his choice of career, among other things) stood him in good stead in his relations with the cadres. In addition, not all DK cadres were equally cruel, some were actually quite humane.

When assessing the alleged DK total destruction of existing medical equipment and infrastructure, we should note also that it was not as if the revolutionaries were taking over a well-functioning medical system in the first place. The civil war had led to a rapid deterioration of the health facilities (Vickery 1984: 75–78) and almost half of the country’s hospitals had been closed down between 1969 and 1971 (Desbarats 1995: 153). The remaining hospitals were overcrowded and unsanitary, and there was a desperate lack of medicine, as pharmaceutical imports had almost come to a halt for economic reasons (Brun 1998). Because of the deteriorating political, economic, and medical conditions during the Khmer Republic, about 200 of the approximately 450 trained physicians had left the country; of those who remained, many were regarded as corrupt. In the countryside, there was very little left of Sihanouk’s ambitious public health programme, and the revolutionary regime felt the need to establish numerous infirmaries in rural areas, often using wats for this purpose. So in order to make sense of two apparently contradictory kinds of accusations levelled against the regime – that they ‘destroyed all hospitals’ and that they ‘desacralized the wats’ (by turning some of them into ‘hospitals’) – a more dispassionate, historically and ethnographically grounded approach is necessary.

As for the way DK managed the shattered remains of the medical system, we should bear in mind that virtually none of the evacuees from the cities – medical staff or patients – had a chance to observe and assess what was going on in the urban centres. When surviving medical personnel returned to the cities after the Vietnamese invasion several years later, they found the hospitals abandoned and much equipment missing or destroyed. Their testimonies, however, cannot be taken as primary evidence of what happened in their absence. During DK a different set of people populated the cities, namely the revolutionary cadres; there was no overlap between the two sets. The medical cadres came in after the cities had been emptied of their previous inhabitants, and they had left by the time the latter returned. In between the departure of the DK cadres and the return of the civilian population, the Vietnamese invasion forces took the
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opportunity to pillage the cities of tools, machinery, and industrial goods (Heder 1980: 31), quite possibly including medical equipment.

**DK MEDICAL POLICY AND PRACTICE**

The DK regime’s approach to healthcare, and to most other government tasks, was thoroughly bureaucratic. Sickness among the population was to be taken care of by appointed medical personnel (*pet*). Medical education or training was rudimentary; for most appointed medical staff (*pet padevat*, revolutionary medics) in the countryside, a nursing training course of a few weeks was deemed sufficient; learning by experience, revolutionary zeal and love for the Angkar would take care of the rest. Sickness was defined as a person’s inability to carry on his or her allotted tasks, and a person who was unable to work had to be transferred to confinement in the therapeutic space of the ‘hospital’. Because of the scarcity of hospitals or clinics in the countryside, the Angkar appropriated suitable buildings to serve as infirmaries (*munti pet*; *munti* may be translated as ‘office’ but has the general meaning of a place where official functions are carried out). As already mentioned, the buildings were often *wats*, which were now available for such ‘useful’ purposes, as all forms of religious worship had been banned.

At the *munti pet*, patients were offered the treatment that the Angkar made available, and if they died, it was of no great consequence as it proved their lack of gratitude for the concern that the Angkar had shown. To dispense loving care was not part of the training of the *pet padevat*. On the contrary, to be sick and thus claim inability to work for the revolution was suspicious and should not be repaid by kindness. Since most illness was related to general malnutrition, and since food was not always more plentiful at the ‘hospitals’ than outside, the efficacy of the ‘treatment’ lay mostly in the temporary rest from hard physical labour that a visit to the hospital offered. Medication was almost invariably in the form of herbal pills, the ‘rabbit droppings’. They were produced in great quantities from herbs used in indigenous Khmer medicine, but whereas the traditional way of administering herbal remedies was to boil the herbs and drink the decoction, which might have had some effect, the pills, produced to resemble modern pharmaceuticals, tended to pass through the digestive system without releasing their active ingredients into the bloodstream. In this sense, the bureaucratization and ‘modernization’ of DK healthcare represented a deterioration, even for those people who had previously had access only to traditional healers. Furthermore, in the pre-revolutionary society, the
sick were preferably treated in their homes, surrounded by compassionate family members; the treatment by traditional healers (kru khmae) was not restricted to herbal remedies either, but most importantly included a spiritual component which provided additional psychological comfort (see Chapter 5). In DK, the spiritual component of healthcare was cut off; those kru who were permitted or conscripted to practice were not allowed to use mantras and offerings. The family’s role in healthcare was abolished. Relatives were not allowed to visit the sick at the munti pet; they were generally not informed of the death of a patient, let alone allowed to reclaim the body for a funeral.

The hierarchy characteristic of the DK regime also applied to the medical sector. Local munti pet had rudimentary resources in terms of medicine and educated personnel. At the district level, facilities were slightly better, domestically produced pharmaceuticals were sometimes available. Provincial hospitals usually had a few fully trained doctors, mostly Chinese advisers, while a couple of larger hospitals in Phnom Penh were reserved for the higher ranks of the DK political and military leadership – the Russian Hospital for adults and the Calmette Hospital for their children.

Hospital conditions
If taken ill, ordinary people, ‘base’ as well as ‘new’, started as patients at some local munti pet (where many ended up dying). Some ‘new people’ were, however, successfully treated.

Our colleague and friend Heng Kimvan was a high school student in Kampong Cham in 1975. After the DK takeover, education became wholly political and soon the students were transformed into a mobile team (kong chalat), with Kimvan one of its youngest and smallest members. The group was deployed at various locations along the Mekong River, basically fending for themselves; they often had to sleep in their hammocks in the forest; Kimvan was continually exhausted. One morning, he did not get up; whether he was asleep or unconscious he does not know. A couple of his friends took him in his hammock, suspended on a pole between two bicycles, to the local munti pet some kilometres away. There he was given injections, and as the pet padevat apparently needed practice, he was kept there for a week as a guinea pig, given numerous vitamin B injections and intravenous drips of coconut juice. He eventually returned to his group, significantly restored, but with rather sore arms. At the end of the Pol Pot regime, he was one of the about 60 survivors from the original group of 120–150 schoolboys.
Sometimes ‘base people’ would be referred to district or even provincial hospitals. The following case gives an example of the conditions that were available to ‘base people’ in the countryside, even if they were not active supporters of the regime.

**Nou Yen** is a farmer’s wife, now in her mid-sixties, living in a village in Thmor Kol District, Battambang Province. The Khmer Rouge sent the family to work in Kadol, a village, some 20 kilometres away. The atmosphere was one of fear and misery. Sometimes ‘17 April people’ were brought to the place. Obviously not used to the rural surroundings, they walked in a peculiar way; some were fat. The locals were scared and embarrassed to look at these people who were often killed. Those in charge of village affairs were mostly young female cadres whom everyone was afraid of. Yen’s 8-year-old son contracted dengue fever and died. She herself was also taken ill, suffering convulsions. She was taken to Wat Kadol, which the Khmer Rouge had turned into a *munti pet*. There were 30–50 patients at the Wat Kadol. They did not get enough food, only thin rice porridge. Apart from ‘rabbit droppings’, they were treated with what was rumoured to be burnt and crushed human bone mixed with coconut milk. Yen did not dare to refuse to drink it. But otherwise she tried to keep up her natural good spirits and she recalls a practical joke of once making one of her friends eat real rabbit droppings by telling her it was medicine. Her cousin was a *kru khmae* who was *sangkumakech* and in charge of the *munti pet*. Treatment was administered by young female *pet padevat* who were ignorant and uncaring. She stayed for seven days at Wat Kadol, with her 7-year-old daughter, and was then transferred to the Bavel District *munti pet*, while her daughter was left behind with the father. In Bavel, conditions were somewhat better, the staff were more attentive, the porridge thicker, and serum injections available. She was tentatively diagnosed with tetanus, which merited transfer to the Battambang provincial hospital. At Battambang there were Chinese medical doctors, real ones with stethoscopes, who treated her very well. They spoke only Chinese and interviewed patients through an interpreter; they prescribed Chinese pills and a great number of serum injections; they also prescribed soup, because when she ate rice, she would have convulsions. She was at the hospital for more than one-and-a-half months, after which she was well enough to leave.
Kae Sambath is Nou Yen’s cousin and lives in the same village. He is 72 years old and has been a *kru* since he was 28. He had been a monk from the age of 15 and had studied traditional healing at the *wat*. In 1975 he was transferred from his native village to join a ‘group’ (*kong*) of 27 families in Bang Baeng, about 20 kilometres away. The following year he was appointed *sangkumakech kong* and was later made chief *sangkumakech pet* at Wat Kadol. In that capacity he produced traditional medicine, DK-style: he boiled the herbs in a large pan and reduced the liquid to one litre. He mixed this with starch made from potatoes, lotus, or banana and shaped the pills using empty cartridges as moulds. The Khmer Rouge did not permit him to pay respects to his spiritual teacher and he could not have a shrine, but he made his own incense, claiming it was powder for medicine, and burned incense and prayed to his teacher secretly in his room at night. In 1979 he returned to the village and was village chief from 1979–1984. He still practices as a *kru*; his speciality is treatment of snakebites and he claims that nobody will die of snakebite if they come to him. Even so, he does not have many clients nowadays.

The story related below by Pech Sareth is from the perspective of a DK cadre. Sareth had been chief of the hospital of District 105 (the DK designation for Tramkok District, Takeo Province). After 1979 he had become a police officer but was now retired and lived in his native village in Takeo. He was apparently well-liked and trusted by the people in the area. Presently a CPP supporter, the party had nominated him as its candidate for commune chief for the 2002 commune elections.

In the early 1950s, when he was a schoolboy of about sixteen, Pech Sareth had become attracted to the ideas of socialism from his reading of a newspaper called *Pracheachon* (The People) and other reading material given to him by the editor of the paper, Nop Bophann. This reading convinced him of his love of socialism. He followed Khmer Rouge political education from 1970, going to classes in political and military theory two or three times per month. He was the eldest of nine siblings, three of whom were later killed as soldiers in the DK army. His parents were farmers in Takeo. During the ‘period of struggle’ [the civil war 1970–1975] he was a construction worker, building bridges and roads. In 1974 the chief of District 105 ordered him to oversee the delivery of medicine and medical equipment to Wat Cham Pa. The district sent four illiterate young men to assist him, they carried a letter that said they were to be medical staff under his command. After guarding the equipment
at the *wat* for two days, he asked the district chief what he was supposed to do with it. He was told that since there was no hospital in Tramkok District, they had taken over the *wat* for this purpose, and that he was to organize the district hospital and be its director. To begin with, when patients came he sent them to the Zone [provincial] hospital because he knew very little about medicine. Two or three patients were sent to him per day, many suffered from malaria. After a while he asked the District to summon the indigenous healers in the area so he could discuss medicine with them, and he appointed one of them to work with him. At that time there was no Western medicine available; he himself knew a little about antibiotics only.

One day Ta Mok sent him a truck with Western medicine from Phnom Penh; there were many kinds of medicine. He himself was sent for some very basic medical education at the Zone hospital. After two or three months, he transferred his district hospital to better facilities at Wat Tropeang Kul. At a political meeting, he was told by his leaders that Cambodia was now a revolutionary country and therefore independent and not having to rely on help from other countries; the Cambodian people did not have to beg or ask favours anymore, and therefore had to produce their own medicines. At the Zone hospital he learnt to produce distilled water used for dissolving medicine for injections. He was also taught some medical theory. The teacher was Dr Sey who had worked at the Preah Ket Mealea Hospital before 1975 and had joined the revolution together with Hu Nim. After the course he received a distillation apparatus, which he had been taught to use. He had no raw materials for producing medicine but the hospital had some money that he spent on buying materials from Vietnam: vitamins B1 and B12, and some calcium. He had the right to do this in accordance with the party’s policy of independence and self-sufficiency. He also received some medicine from an old revolutionary friend of his who was in charge of a rubber plantation in Kampong Cham, where they had a good supply of medicine. It was important to have old friends in the revolution, he said; if you had established bonds of trust and friendship with people in your party group early on, you need not be afraid, but could rely on them to do you favours.

The hospital had a staff of 96 people, of whom 16 were male. Twenty-five were engaged in producing medicine. The staff was organized in groups, 30 for treatment, 10 for laundry, 10 for cooking, the rest for home visits. Every week the tasks were rotated. The staff were taught by him, he relayed the knowledge he had acquired at the Zone hospital to those of his staff, about 20, who were susceptible to teaching; the illiterate were taught how to do injections and were given menial tasks. Those who
were literate, mostly young women who had completed secondary school, got whatever technical training he could provide and were appointed group heads. He had established four medical groups: malaria, maternity, general diseases, and cleaning equipment.

Sareth received the patients himself. He had decided on this practice since he had so few trained staff and had to supervise everything and allot the patients to their proper place according to the nature of their disease, be it malaria, diarrhoea, or dysentery. From late 1977, he received 10–15 patients per day; many patients died. He also sent serious cases to the Zone hospital. The Zone hospital, however, was no better than his, its chief was a younger sister of Ta Mok who had no education or medical experience; but they had more medicine than he had.

The number of diarrhoea cases increased dramatically during the last years of the regime. They discussed this at party meetings. Sareth argued that it was because people did not get enough to eat. But he was told that he should not blame the situation on the sahakor. He said he was not blaming anybody but insisted that insufficient food was the main cause of the problem. He managed to persuade the chief of District 105, who was his friend, and was permitted to collect rice, livestock, and vegetables from the sahakor in the district. After this he could feed his patients properly, and the diarrhoea diminished significantly. He was never afraid of the Angkar. While other people were afraid to do anything without order or permission from the Angkar, he did what he needed to do in his job.

When the Vietnamese troops approached, there was a lot of confusion and he decided that the best way to protect his patients was to send them home. One patient, a large woman with diarrhoea, could not (or was afraid to) speak, and he did not know what to do with her; he left her, on her bed, at the roadside with some food and hoped she would be taken care of.

After our meeting with Pech Sareth we went into Takeo town to see Dr Keo Thong Sin. We met him at his house, a villa in town which also housed his private clinic. It turned out that Dr Sin’s account provided a sort of counter-narrative to that of Pech Sareth.

**Keo Thong Sin** was born around 1940 and is now retired médecin-chef of Takeo Province. His father had been a contractor in Kampong Chhnang. In the early 1960s he had married the daughter of the then Minister of Justice, in whose house he had lived during his medical studies at the École royale de médecine in Phnom Penh 1960–1965.
During the Lon Nol regime Keo Thong Sin started out as military doctor in Koh Kong, where there was not much military activity. He was moved to the Department of Hematology at the military hospital (Preah Ket Mealea) in Phnom Penh and passed his final exams for the doctorate in 1974. In 1975 he was deported to Takeo to work in the rice fields in the countryside. During that time he did no medical work, the regime used only young and uneducated people and relied mostly on herbal medicine. Malnutrition gave him beriberi, and an acquaintance managed to have him hospitalized; he spent one year (1978) in the Tramkok district hospital in Takeo.

The treatment at the hospital was rudimentary but reasonable under the circumstances. The main thing was that the patients had enough to eat. There were on average a hundred patients at the hospital. The largely uneducated staff could only successfully treat the least complicated diseases, their universal remedy was injections of serum made at the hospital. Many died, mainly of water in the lungs. They had no remedies for this or for other complicated diseases. Every morning two or three dead patients were taken away on stretchers to be buried (without ceremony or notification of relatives). If people were cured, it was thanks to adequate nutrition rather than medical treatment.

Late in 1978 they could hear the gunfire of approaching Vietnamese troops, but made no comments. After the invasion, the Vietnamese asked people to return to their native villages, but even though he had lived in Phnom Penh, the authorities told him to stay on in Takeo and organize the medical services there, since he was the only doctor in the province. In 1979–1980 he worked at the Takeo hospital, with Vietnamese assistance. They had made a politically appointed bureaucrat chief of the hospital, rather than a doctor. The staff received no salary, all lived on the hospital premises and shared their cooking and housekeeping. The provision of medicines to the hospital was from Phnom Penh and it was channelled through the Department of Commerce (rather than the Ministry of Health), coming from the stores left by Pol Pot. In late 1979 the Ministry of Health, under Vietnamese guidance, held a reunion in Phnom Penh of all surviving medical doctors – about 40 altogether. They planned for the future of the country’s medical system, along socialist lines dictated by the Vietnamese. Sin was appointed director of the Takeo provincial medical services but was placed under Vietnamese guidance, since he had no previous experience of directorship and administration. The provinces had a fair amount of autonomy regarding health issues.

During the 1980s, Takeo received assistance from Czechoslovakia in the form of a mobile military hospital, consisting of 20 trucks and Czech
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staff. Keo Thong Sin was sent to Prague for one year for a refresher medical course. The Czechs departed after four years but left their equipment behind. At that time, the emphasis was on hygiene, but also on treatment by ‘traditional’ methods such as herbal medicine and acupuncture, because of the Vietnamese influence. This was not something that had been regarded favourably by the Cambodian-educated doctors.

Pech Sareth and Keo Thong Sin did not seem to be aware of each other’s existence and whereabouts; their paths had crossed in another world, and even now they live in separate worlds. Pech Sareth lives as a farmer, but made a political comeback as the CPP candidate in the commune elections. Keo Thong Sin, in his semi-retirement, is materially quite comfortable in his suburban villa, with his private car and an income from his private clinic. One may only speculate about how they would relate to one another should they ever meet and be conscious of each other’s pasts: would Keo Thong Sin acknowledge, for instance, that Pech Sareth had actually saved his life? In any case, the juxtaposition of their stories is interesting in several ways. As mentioned, the patients at DK hospitals were not necessarily given sufficient food. While Sareth’s less than surprising hunch was that adequate nutrition was decisive for patient health in general and for reducing diarrhoea cases in particular, his observation was confirmed by Keo Thong Sin’s medical opinion, and his own experience, that adequate food was decisive for reducing patient mortality.

Secondly, both stories reveal, contrary to common assumption, that biomedical pharmaceuticals were indeed both available and appreciated under DK – not in sufficient quantities to serve the needs of the population in general, to be sure, but they were part of the regime’s medical consciousness even at the district level. Pech Sareth could even arrange for individual imports from Vietnam, and the regime apparently had considerable stocks in warehouses in the capital.

Thirdly, the stories convey a clear impression that both men were justifiably proud of their respective achievements; they were satisfied that they did as well as could be expected from anybody under the circumstances and neither of them felt that they had anything to be ashamed of. Keo Thong Sin was a professional, and his professional criticism was directed not only against the unprofessional conduct of the Khmer Rouge, but also against the practices followed by subsequent overlords, the Vietnamese. Pech Sareth equally did his best to act ‘professionally’ – and with a great deal of empathy – despite his lack of formal training for the tasks he was given.
Few district munti pet were managed as conscientiously as that in Tramkok. But given the importance the regime placed on its medical system, hospital staff were usually well provided for and given more privileges than other ordinary cadres, as the following case illustrates.

**Chap Yan** was born in Kampot Province around 1930. At the age of six she came to live with her aunt in the Royal Palace in Phnom Penh, the aunt’s husband being a palace guard. She was brought up in the classic Khmer tradition for girls, learning cooking and weaving, among other things. At the age of 18 she was married to a district chief (*mesrok*) from Kampong Cham, who had spotted her during his official visits to the palace. After a few years, the couple had to leave Kampot to escape reprisals by the Khmer Issarak for the husband’s collaboration with the colonial administration. They found a hiding place in Memot, a remote district of Kampong Cham, close to the Vietnamese border, and lived there as agricultural and plantation workers for more than 20 years. In 1974 they sought to return to Kampot, but were dissuaded (the old Issarak ghost was invoked) and settled in Phnom Penh where they built a roadside house north of Wat Tuol Tampoung.

They had eight children, all boys, the five eldest were government soldiers, the husband worked as a cyclo driver. At the Khmer Rouge capture of Phnom Penh, she, her husband and the five eldest sons were first sent to work in Takeo. The three youngest children were sent elsewhere and disappeared. From Takeo they were put on a truck to Pursat, dropped at the roadside and made to walk for five days into the forest, to Kbal Moch District. Being former Lon Nol soldiers, the five sons were killed. The husband worked on cattle raising some distance away from her, but they were able to keep up some contact. Yan herself was appointed cook for the district munti pet in Kbal Moch, since the chief *pet padevat* of that hospital (a pretty young woman) had learned of her background and skills and apparently found it appropriate that her staff could eat royally. The staff consisted of 25 persons, and they ate very well indeed: six chickens a day and a pig per week, lots of rice and vegetables. Yan herself also lived well, being allowed the chicken entrails that the ‘doctors’ did not want. The 150 or so patients, on the other hand, were served thin rice gruel and a few vegetables. Yan was allowed to use 60 cans of rice per day for the patients (which equals about 200 grams per person), but she often managed to add some extra rice, at considerable risk to herself.
Cambodians and Their Doctors

Training revolutionary medics

Already before 1975, the revolutionary movement had instituted medical education in the liberated areas. A notebook kept by the student Ngin Chann Tha may illustrate the educational style. 8 On the cover it says:

SECONDARY MEDICAL TRAINING COURSE
Mr Ngin Chann Tha, Hospital 153, Division 3, Eastern Region 2, 1975, 2nd Year

The following are excerpts from Tha’s lecture notes on symptoms of lung diseases:

Respiratory Tract

1. Phlegm: The amount of phlegm is related to swellings in the lung or its capillaries. In case the capillaries of the lung are swollen, lung tuberculosis is evolving and the dense lung produces much phlegm. We have to take note of the amount of phlegm every day in order to examine the development of the lung condition.

2. Colour of phlegm: Examining the colour of the phlegm is necessary to diagnose the disease.

3. White or pale phlegm: Swollen lung capillaries and lung tuberculosis.

4. Blue phlegm indicates lung tuberculosis.

5. Blue-yellow phlegm indicates swollen lung capillaries.

6. Violet phlegm indicates swollen lung capillaries.

7. Red and violet phlegm indicates swollen lung capillaries.

8. Smell of phlegm: Normal phlegm does not have a bad smell. In case the patient’s phlegm smells bad he has a lung disease.

9. Taste of phlegm: Most patients produce salty phlegm which means they have swollen lung capillaries.

10. Texture of phlegm: There are several kinds of phlegm, as follows:

   a. The phlegm is clear and sticky and its colour is white. Liquid phlegm has a lot of albumin. Sometimes the phlegm is violet because of a small number of cells. In the case of a swollen lung the patient produces a lot of phlegm and has difficulties in breathing.

   b. Phlegm with pus: Dense or thin phlegm indicates a lung disease and the pus enters the lung capillaries.

   c. Phlegm with blood indicates tuberculosis. On the other hand, phlegm with pus can also indicate diphtheria. After removing some phlegm we send it to the laboratory. Sometimes we examine it many times so that we can find symptoms of disease.
The level of diagnostic detail is quite surprising for a second-year course of general medicine for revolutionary doctors in the countryside, and one wonders how useful, or indeed medically accurate, the diagnostic criteria would be for the practical treatment of patients with respiratory tract infections, particularly when there might not be any nearby laboratory to which samples could be sent for further analysis. We do not know how the medical training at Hospital 153 was organized, but we may speculate that the teacher of this course may have been Chinese, since phlegm occupies a prominent place in Chinese medicine, where its pathological occurrence is related to interruptions of qi (the flow of cosmic energy in the body) (Hsu 1999: 220–222; Scheid 2002: 151–157).

After the DK takeover, the ideology of self-sufficiency and revolutionary omnipotence was promoted. Political ‘seminars’ taught that there was no need for doctors who had spent seven years on their education, when the DK could train its own people sufficiently in seven days. Pol Pot has been quoted saying that ‘if our ancestors could build Angkor, we can do anything’; but he seemed to have forgotten that the Angkorean kings did not start their building projects by killing off all the architects. Very few among the DK leadership (with the probable exception of Thiounn Thioeun, see below) presumably had any realistic perception of what it took to manage a national healthcare system. Most young persons appointed as medical personnel were given only rudimentary training to become pet padevat. The lack of competent medical teachers meant that the ‘students’ had to rely on revolutionary zeal and an exaggerated faith in (the magic of) the bureaucratic modernity of the designated therapeutic spaces that the Angkar had created. Going through the motions of giving injections and handing out pills like ‘real doctors’ was supposed to produce ‘real’ results.

The ‘programme’ for the training of pet padevat – inspired by the Chinese model of ‘barefoot doctors’ – seems to have been flexible, however, and often somewhat more elaborate than the proverbial one-week course. The following two cases are probably representative of those who received more than the barest minimum of training.

En Neam lives in a village in Takeo Province. She was a 16-year-old high school student in Takeo when she joined the revolutionary movement in 1970. She did so not out of political conviction, but because all her friends had joined; Takeo was among the early ‘liberated’ areas. To begin with she, like many other girls, was given the task of bringing food to the guerrillas in the battle zones, and in the evenings she attended political seminars. In 1973, when the Americans were bombing the area, she volunteered to become a soldier but this was refused because she could read and write,
and eventually, in 1974, she was brought to Kampong Speu to become a pet padévat. The Khmer Rouge hospital (munti pet) was in the forest. She was taught acupuncture by a Chinese doctor, and a Khmer doctor taught her to give injections by practising on cushions and banana stems, before she continued practising on patients. In the evenings the trainees attended medical seminars on diagnosing illnesses such as tuberculosis and malaria. The medicines available were santamycine (an antibiotic), vitamin C, and herbal medicine.

In 1976 she was sent for five months of further training to Phnom Penh where she was placed at the city’s major hospital, the Russian Hospital, renamed by DK as the ‘17 April Hospital’. This had become the elite hospital where treatment was reserved for the DK leadership; the staff included Thiounn Thioeun. At the hospital the highest-ranking leaders were placed in private rooms with attached bathrooms and personal servants, had choice food and were treated with imported medicine. Lower-ranking leaders did not have these privileges and were mostly treated with domestically produced pharmaceuticals. Admittance to and discharge from the hospital was according to letters from the Angkar. Patients were often reluctant to leave the hospital as the stay gave them a reprieve from their daily toil.

Back in Kampong Speu she continued her work at the munti pet until 1978 when the regional leader was arrested as a suspected traitor to the Angkar, and as a member of his khsae she was sentenced to hard labour. She and other ‘convicts’ were moved about in the province, and she was constantly afraid of making some mistake that would give her guards an excuse to kill her. When the Vietnamese troops arrived, the Khmer Rouge retreated, using the convicts as human shields, but in the confusion she managed to escape and surrendered to the Vietnamese who told her to go back to her native village, where she has lived by farming ever since.

Nhiek Sovanny lives in a fairly remote village in Takeo Province. She was born in the village in 1963. As a child she worked in the rice fields, and she was chosen by the revolutionaries because she was the quickest worker in a group who harvested rice together, so she was sent to Phnom Penh to become a pet padévat. She went to Phnom Penh in March 1977 and was placed at the hospital Pet Po Meuy (‘Hospital P1’, formerly the Calmette Hospital). The director of the hospital was a daughter of Ieng Thirith (and Ieng Sary). The hospital was for children between the ages of 3 to about 17. They were not children of ordinary people but of important leaders from all over the country. The children were referred to the hospital by district leaders and brought to the hospital by their relatives who left them there.
When admitted to the hospital, the child was diagnosed by a reception committee of seven people, and assigned to the relevant department and put in one of two kinds of rooms, for ‘serious’ or ‘not serious’ cases. She stressed that she knew nothing about the atrocities and deprivations that the population suffered under the regime, she only worked at the hospital and knew nothing about the situation outside.

Her work in the hospital was in the department of contagious diseases. The chief of the department was an elderly woman called Roeun who instructed her in the work. The work consisted of giving injections, distributing the right dosage of medicine and assisting in operations. Sovanny worked full-time and had to study theoretical medicine for one or two hours in the evening. The hospital was supervised by a Chinese doctor by the name of Yung. He was a medical expert and taught the heads of the various departments. There were usually between ten and thirty patients in her department suffering from tuberculosis, measles, chicken pox, and jaundice. Each had a bed with a mattress and a mosquito net. The medicines used in her department were mostly santamycine and vitamin C, but also penicillin and ‘strepto’. All medicine, syringes and medical instruments came from China. There was no Khmer medicine at the hospital. It was a special hospital, only for children of important people. When a child was cured, a letter of release was written and the relatives were contacted by telephone to come and pick up the child.

Sovanny lived in a house opposite the hospital. She did not move about in the city, she was afraid to get lost as she was very young, and besides she was not allowed to go out by herself for fear she would run away. Sometimes, on a Saturday or a Sunday, all the medical staff would be taken to a theatre at the Olympic Stadium or to see Chinese or North Korean propaganda movies at the Chenla Cinema near Deum Kor market. One of the movies, she recalls with a smile, was about waves on the ocean, which kept rolling on and on, unstoppable like the revolution. Once, everybody was taken by cars to Pochentong airport to welcome an official Chinese delegation.

On 7 January 1979, the staff was evacuated. This was organized by Ta Peun, son-in-law of Ieng Thirith. Staff members were taken by train through Pursat and Battambang to Sisophon, and from there they proceeded to Pailin. Sovanny stayed three months in Pailin. Then she managed to escape, thanks to a man from Kampot who helped her and seven other young people go south with him. She eventually reached her home village in Takeo, where she has been living and working ever since.
The kind of education offered in the Medical Training Courses at the 17 April Hospital was significantly more advanced than that given to the average (mostly female) pet padevat.

**Leng Virak** was born in 1954 in Takeo Province. He completed sixth grade in school. In 1970 the school was closed down because of the civil war, so he stayed at home for two years. He was conscripted to the guerrilla from 1972–1975. In October 1975 he was assigned to attend medical training courses in Phnom Penh. He attended a summary course in anatomy and general pathology. There were about 200 students, divided into two classes. After classes the students practised treating patients. The course was led by Dr Thiounn Thioeun. Other teachers included medical doctors In Sokan and Men Tol. The teachers were doctors who had worked under Sihanouk and Lon Nol, apart from the Chinese teachers who had come from China. Health education under DK was similar to that in the previous regimes. French textbooks were used, translated into Khmer by the teacher; the students wrote down what was said by
the teacher. Pictures and posters were also used as teaching aids. There were also Chinese teachers, who used Chinese reference books and taught in Chinese, translated into Khmer by interpreters. The hospital used medicine and equipment left by the previous regime, as well as Chinese medicine supplied by the Chinese teachers.

Virak was happy when his commander assigned him for medical training, because when he was a soldier he never knew when he would be killed, and he did not want to return to the military base, so he paid a great deal of attention during the course. When he had finished the training, he was supposed to return to the base, but he stayed and continued the medical training until 1979. His commander’s idea had been to give him some training so that he could attend to wounded soldiers, but after the initial course no one was sent to take him back, so he kept attending classes for three years and practised on patients.

For the increasingly paranoid DK regime, all kinds of specialist knowledge were dangerous and potentially subversive, and even medics trained by the regime itself risked eventual elimination during the internal purges. A colleague of Virak who had also stayed with the DK forces after 1979, related that more than 10 doctors, several of whom had been his teachers, were killed in 1977, even though the Chinese medical teachers had appealed to the cadres not to kill their Cambodian colleagues. Some months later, all the medical students who were enrolled in the First Medical Training Course at the ‘17 April Hospital’ in Phnom Penh were also arrested and killed immediately after having completed the course. These students were well educated and had a great deal of experience because they had worked as medics for the Khmer Rouge since the early 1970s. ‘I do not know why so many medical doctors were killed’, our informant said. ‘I worked and lived in that regime, but it is painful for me to talk about it. At the time I was not afraid of being killed because I did something good so I could not die. In 1979 I saved many people’s lives and I was in serious trouble many times, but I survived. Perhaps we can say that war needs brave men and peace needs intellectuals’.

Production and distribution of pharmaceuticals

Pharmaceuticals, both biomedical and based on indigenous medical substances, were produced in Phnom Penh and some provinces. In Kampong Cham, the local leadership had uncharacteristically conscripted no less than six medically trained ‘new people’ to work for the local service. One of them, Dr Ly Den, has published an account of his experiences (Ly 1982a). Ly Den was put in charge of
pharmaceutical production. A factory was set up in the former Chinese school in the town and a couple of hundred people were employed as workers. Part of the production was ‘traditional’ medicine, the composition of the ingredients for which was overseen by a local herbalist (kru). Biomedical products included injectable vitamins, glucose serum, physiological serum, cardio-tonics, and aspirin and sulphadimidine pills. The raw materials were supplied from Phnom Penh. Given the rudimentary technology used in the factory, however, its output fell short of what was needed in the area (Ly 1982a: 197–198).

A former cadre who had stayed with the Khmer Rouge until 1998, and whom we met in Pailin, described how pharmaceuticals were produced and distributed in Phnom Penh.

Figure 4.2. DK pharmaceutical laboratory in 1978. This was the laboratory in which Ly Den was conscripted to work. Photo: Hedvig Ekerwald
Sok Kep Phalla was born in 1956 in Takeo Province. She joined the revolution in 1970, after the coup, when her village was liberated by the guerrillas. In 1975, at the age of 18, she was sent to Phnom Penh to serve as a courier (nearasa) for the Angkar, and until 1979 she worked for the Ministry of Health. She was team leader at K2, the Ministry of Health’s central medical warehouse on Kampuchea Krom Boulevard. The warehouse was divided into four sections: for imported pharmaceuticals, imported dental materials, chemicals and medical raw materials for distribution to local factories, and one that received the final medical products for distribution to the countryside. Her unit was also in charge of quality control. She herself had no education in chemistry, she learnt by practising under Mrs Chan Thorn, who later left for France.

The chemicals and raw materials were distributed to the four pharmaceutical factories in Phnom Penh, referred to as P1, P3, P4, and P6. P1 was a factory for traditional medicine, it was next to P4. P4 was located near the railway station, the present location of Cambodia Pharmaceutical Enterprise. P3, P4, and P6 produced penicillin, serum, setropharine (for diarrhoea), and vitamins B1, B6, and B12. P3 was located towards Pochentong; it also produced dental equipment. P6 was located on Chrui Changvar, across the Japanese bridge; there is now a petrol station at the site.

All the factories were managed by Chinese experts. The Chinese also oversaw the production of traditional medicine. The herbs were chopped and pounded into powder in a machine and mixed with starch and compressed into tablets. Only the Chinese knew this method of making traditional medicine. In addition, traditional preparations for injections were made from herbs. The traditional medicine was distributed to people in the provinces.

K2 had a staff of about 400, divided into teams of 10 each, but Phalla’s team had 15 members. It was also in charge of receiving imported raw materials for medicine and distributing medicine and medical equipment to various destinations within the country, as well as for keeping the warehouse records. Another team was responsible for transport. Supplies would come in by train from Kampong Som (Sihanoukville, the country’s only deep-water port), to where they had been shipped from China; some drugs were from Australia. Her team had to unload the supplies from the trains and take them to the warehouse; organize the transport of raw materials to the factories; receive the final products from the factories; and finally, organize distribution to all zones, regions, and districts.

The regional hospitals submitted their requests for medicine to the General Department, Social Affairs, which was run by Ieng Thirith. As
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director of Social Affairs, she was responsible for medicine production and distribution. She would decide on distribution to the regions and order production at the factories according to demand, and also suggest further imports from China. Delivery from China took two to three months.

When deliveries came in to K2, they would work all night. Even the cooks were very busy, to ensure they had enough to eat. Phalla worked closely with Ieng Thirith who was her immediate superior. Ieng Thirith took good care of her people. They worked hard, but she made sure they had three meals a day, and she protected them. No one in Social Affairs was killed, said Phalla; even when family members of the staff were arrested and executed, the staff member herself was spared, on Ieng Thirith’s orders. So her staff were happy, they worked hard and the atmosphere was cheerful.5

Central Medical Warehouse medical deliveries to Districts 203, 303 and 405, 22 August 1976

<table>
<thead>
<tr>
<th>District 203</th>
<th>District 303</th>
<th>District 405</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raw penicillin 6.5 kg</td>
<td>Aminomephane 2 bottles</td>
<td>Raw penicillin 6.5 kg</td>
</tr>
<tr>
<td>Tetracycline 30 tins</td>
<td>Streptophan 6 bottles</td>
<td>Raw strept 13 kg</td>
</tr>
<tr>
<td>Streptomycine 13 kg</td>
<td>Paraquine 32 packets</td>
<td>Tetracycline 20 tins</td>
</tr>
<tr>
<td>Raw quinine 3 kg</td>
<td>Glyco 160 packets</td>
<td></td>
</tr>
<tr>
<td>Aminomephane 3 bottles</td>
<td>B12 160 packets</td>
<td></td>
</tr>
<tr>
<td>Streptophan 7 bottles</td>
<td>Deltazolone 476 packets</td>
<td></td>
</tr>
<tr>
<td>Paraquine 48 packets</td>
<td>Becozine 3 packets</td>
<td></td>
</tr>
<tr>
<td>Glyco 240 packets</td>
<td>Tifomycine 1 packet</td>
<td></td>
</tr>
<tr>
<td>B12 239 packets</td>
<td>Chloramphenicol 80 packets</td>
<td></td>
</tr>
<tr>
<td>Deltazolone 714 packets</td>
<td>Chloroquin 16 packets</td>
<td></td>
</tr>
<tr>
<td>Becozine 5 packets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tifomycine 1 packet</td>
<td></td>
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</tr>
<tr>
<td>Chlorotetracline 28 bottles</td>
<td>Amethyste 40 packets</td>
<td></td>
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<tr>
<td>Chloroquin 24 packets</td>
<td>Nitro 50% 38 packets</td>
<td></td>
</tr>
<tr>
<td>Chloramphenicol 120 packets</td>
<td>Nitro 5% 36 packets</td>
<td></td>
</tr>
<tr>
<td>B1 297 packets</td>
<td>Raw serum 3 kg</td>
<td></td>
</tr>
<tr>
<td>Amethyste 60 packets</td>
<td>Raw vitamin C 1.5 kg</td>
<td></td>
</tr>
<tr>
<td>Nitro 50% 54 packets</td>
<td>Penicillin 100 bottles</td>
<td></td>
</tr>
</tbody>
</table>
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The warehouse apparently reported daily to the Ministry of Commerce. The deliveries made on 22 August 1976, and signed by Comrade Roeng on behalf of the warehouse committee are detailed on opposite page (NA B03).

Interestingly, the country of origin for all these products is given as Thailand. So, contrary to our informant’s impression, not all imported medicine came from China. In a Ministry of Commerce list of imported goods during 1976 (NA B07: 32) we find recorded imports of medical supplies from Thailand via Poipet by train and truck about once a week. The supplies consisted mainly of raw penicillin, raw quinine, raw serum, and raw vitamin B and C, each item in quantities of about 100 kg per delivery (see also Kiernan 1996: 139–145 for details of DK’s trade with Thailand).

After the right-wing military coup in Thailand in October 1976, trade relations with Cambodia dwindled and DK had to seek other sources of medical (and other industrial) supplies. For that purpose, DK established a trading company, the Ren Fung Company in Hong Kong (Ponchaud 1978: 84; cf. Kiernan 1996: 145). This made it possible for DK to engage indirectly with the West (Martin 1994: 192), despite the regime’s official denunciation of the ‘reactionary imperialists’. Thus, during the last quarter of 1976 the company purchased US$1 million worth of industrial goods, including pharmaceutical products; for the first quarter of 1977, the purchases amounted to US$3.5 million.

To give a concrete example, medical supplies to the total value of US$6,300 were part of a cargo that arrived from Hong Kong on the freighter Hay Kwang on 7 December 1976. Most of the products had Germany as their country of origin, but a few items came from Britain, Switzerland, and Japan (NA B07: 27). The same week the company had purchased further medical supplies on the Hong Kong market to the amount of US$3,300 (ibid.).

At the same time, China remained a supplier, not only of (raw materials for) biomedical pharmaceuticals but also of Chinese herbal pharmaceuticals (‘Chinese traditional medicine’). A DK Ministry of Commerce contract with ‘Chinese Comrades’ in April 1977, for example, specified the purchase of 16 different products, listing the Chinese brand names and descriptions in Khmer of their use: medicine for colds, coughs and headaches, for diarrhoea, for dysentery and vomiting, for rheumatism, for eyes, and for lung disorders (NA B02: 10).

So much for ‘the regime’s refusal to import medicine’. As for DK ‘medical’ exports, these consisted of indigenous remedies, mainly krabao (Hypnocarpus anthelmintica, for leprosy; see Chapter 7) and krob sleng (Strychnos nux vomica, for malaria and dysentery; see Chapter 5), but also frangipani flowers and cardamom seeds. An important group of products were animal items with
purported aphrodisiac or generally invigorating properties, such as dried geckos, snake skins, deer antlers, tiger bones, and pangolin scales (NA B06: 25; NA B07: 33; NA B07: 35). These items were exported on a fairly large scale, according to Ben Kiernan amounting to ‘an unprecedented plunder of Cambodia’s ecology’ (Kiernan 1996: 137–138).

**DEMONCRAITIC KAMPUCHEA AFTER 1979**

With the Vietnamese invasion in January 1979, it seems that Phnom Penh was evacuated as suddenly and swiftly as in April 1975. DK followers, from Phnom Penh and elsewhere, who eventually regrouped in enclaves along the Thai border were mainly officers, soldiers, and party cadres, and the DK medical personnel had to (re)adapt to guerrilla conditions. Sok Kep Phalla, inspector at the medical warehouse, continues her story:

On 7 January 1979 the staff of K2 were all told to go to the railway station immediately, and to take only their clothes along. They were very afraid of attacks from the air, so they hurried to the station and were put on board a train to Battambang. At 11 P.M. the train arrived at Kampong Chhnang, and it was only then that they heard of the Vietnamese invasion of Phnom Penh. When Phalla heard this, she regretted that she had not taken some drugs and the gold [from the warehouse, used for dental fillings] with her. The train journey to Battambang took three days. Some other staff from the warehouse went to Battambang by car. All staff met up in Battambang. When Battambang was attacked by air strikes, they went on to Bantey Meanchey by truck. In Bantey Meanchey Phalla was put to work with a materiel transportation unit and worked with the soldiers transporting equipment along the border. One day Ieng Thirith visited the unit and saw her, and told her to come to work for her. Thirith took her to a camp on the Thai side of the border, and she worked there as logistics officer. She did medical pre-nurse training in 1980–1981. On the border, she met Mr Chhean who was a specialist in children’s diseases and she attended his two-year training course. When Chhean left for France, she started training as a midwife under Ieng Vichada (daughter of Ieng Sary and Thirith) in 1987 and practising at the hospital; Vichada had just returned from a midwifery course in China. More than a hundred medical students were trained at the DK central hospital on the border in Chanbury. She was assigned to work at the Kam Reang Hospital on the border. In 1997 she went to Pailin and was employed at the Municipal Health Department.
Leng Virak’s story continues in much the same way:

After 1979, when the fighting began, Virak was sent by train from Phnom Penh to Battambang as medical staff in order to look after the patients who were being evacuated. Many wounded patients were sent on the train. When they reached Battambang, they sent the patients to the Battambang hospital called P1. After a few days, when the Vietnamese troops were advancing, those patients who could walk were evacuated to safer places along the border; the rest were left at the hospital. Virak never knew what the Vietnamese did with those patients. He worked as a medical attendant in the forest while following DK medical training courses. The DK medical school in the forests of Battambang Province, along the Thai border, was moved from place to place because of fighting. They had many difficulties; many people who had not been sick in Battambang and Phnom Penh fell ill in the forest. Many people died in the border region because there was a shortage of medicine. The stocks they had brought from Phnom Penh were soon depleted. In early 1981 they received some medical supplies from the Thai authorities, because high-ranking DK officials had negotiated with them. The majority of patients along the
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border had malaria, which could be treated as long as they had quinine tablets, tetracycline, and injectable quinine.

Virak worked along the border from 1979 to 1997. DK’s central hospital was located in Kam Reang District, Battambang Province, very close to the border. More than a hundred medical staff worked there, it was the biggest Khmer Rouge hospital. It had more than two hundred beds and received many patients. Sometimes there were not enough beds for the patients, and in the dry season some patients stayed under the trees around the hospital. Most of the patients had been wounded in battle or were suffering from malaria. They had organized an operating room and performed surgery almost every day. Medical doctors were in charge of anaesthetics; they had attended the training courses with Virak, but he himself had never specialized in that field. In 1997 he moved from the central hospital in Kam Reang to Pailin and was appointed Director of the Technical Office of the Pailin Municipal Health Department.

Both Sok Kep Phalla and Leng Virak related that Battambang town was their first base after the flight from Phnom Penh, if only for some days. It seems that the Khmer Rouge forces had not envisaged the immediate capture of Battambang by the Vietnamese. Indeed, neither had the Vietnamese. The original plan had been to occupy only Phnom Penh and the provinces east of the Mekong, with a view to their eventual permanent incorporation into Vietnam, but the scant Khmer Rouge resistance to the advancing Vietnamese troops triggered the decision to keep moving and take the rest of the country while they were at it. The reason for the comparatively late arrival in Battambang was that the tanks ran out of fuel on the way north and had to wait a week in Kampong Thom for refuelling (Chanda 1986: 343–347).

In early January 2003, on a return trip to Pailin, we talked to Yar Eang. He had been recommended to us by a resident medical doctor of the new generation, as a particularly honest person who could be relied upon to tell us only the truth. Yar Eang was a surgeon at the Pailin Municipal Health Department, and we met him at the hospital conference room.

Yar Eang was born in Svay Rieng Province in 1954; his father was a high school teacher and his mother was also a teacher. Both were active in the revolutionary movement; his father had become division commander of the guerrilla forces in Kampong Cham in 1971; he saw his father there for the last time in 1972 – he was killed in action three months later. In 1970 Eang had gone to live with his grandmother in Kandal Province where
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he went to high school. Encouraged by one of his teachers, he had joined a demonstration against the Lon Nol regime in 1970; people marched from Kandal to Phnom Penh chanting ‘Long live Sihanouk, those who do not join will be killed!’ He followed the sayings and the example of his teacher, and in 1971 he joined the guerrillas in the forests in Kampong Cham Province. He was first put to work in a communications team; but soon he passed the entrance examination for medical studies and studied in the forest medical school in Kampong Cham. At that time the guerrillas and the Vietnamese troops were cooperating against Lon Nol, and he was taught by Vietnamese medical doctors in 1971–1973. He had a good Vietnamese teacher; they used interpreters in the beginning, but gradually each side learnt some of the other’s language, and they communicated in a mixture of languages. In 1973 relations with the Vietnamese were broken off, but he continued his medical studies in the Eastern Zone (Kampong Cham) during 1973–1975, now having Thiounn Thioeun as his teacher. Thioeun translated technical medical terms into Khmer. In 1975 he followed Thioeun to Phnom Penh to work in the 17 April Hospital. The hospital was the biggest in the country, it received patients from all provinces, mostly from mobile team members, but there were also factory and railway workers. The patients were referred from commune, district, or provincial hospitals. Even a few ‘new people’ were admitted, if they had relatives working at the hospital. As a doctor, he made no distinction between his patients, he always treated every patient who was brought to him – after 1979, this included both Vietnamese and Hun Sen soldiers. He rarely left the hospital, but before 1977 he occasionally accompanied foreign visitors, from China, Laos, Vietnam and Cuba; once, he went to the countryside with a group of visitors, and he understood how hungry the villagers were from the way they received the food that was served, stuffing themselves until some became ill.

The purges in 1978 were a bad time, the Renakse and Heng Samrin were starting to invade/infiltrate the country, and the DK forces killed many people. In January 1979 he had to leave Phnom Penh and went to Kampong Speu. Eang had wanted to return to Phnom Penh [that is, to defect] but he was intercepted by Ta Mok and ordered to work as a surgeon in Kampong Speu, treating wounded soldiers in a remote area near the provincial border to Pursat and Koh Kong. After treatment, the surviving patients were sent to Battambang, which had not yet been invaded by the Vietnamese troops. He had to perform surgery in a Chinese military truck that had been converted into an ambulance. One day Ta Mok requisitioned the truck and gave him his own in exchange, because the ambulance truck had a 12mm machine gun mounted on the roof. Ta Mok’s bodyguards
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were to swap the contents of the two trucks, but misunderstood or messed up, so when he got into Ta Mok’s truck he found 15 cases of gold and dollars inside. After the Vietnamese invasion of Battambang, the DK medical services transferred staff and patients to Malai. Eang also went to Malai and used three cases of Ta Mok’s treasure to establish the hospital there. The rest of the treasure was given to somebody named Dal who was to take it to Ta Mok. But Dal stepped on a mine and was killed…

Eang worked at the hospital in Malai until 1985; this was the main DK hospital at the time, and Thiounn Thioeun also worked there; they received patients from Koh Kong and from military divisions along the border. The hospital received supplies from the International Red Cross. At that time, Eang planned to escape to Thailand, where he had had contact with an old friend from Lon Nol times, but he was prevented by DK’s highest leader in Malai, Sok Pheap who ‘persuaded’ him to stay with the DK. In 1985, Malai was taken by Hun Sen’s forces, and Eang and other staff escaped across the border, taking with them 15 patients, carried in hammocks. He worked in several border camps and in Sao Dai in Chanbury Province, Thailand where Ieng Sary stayed until 1993. He married there in December 1987; Ieng Sary organized the wedding. He went back to Malai when it was retaken by DK forces, and in 1993–1994 he was at the DK central hospital at Kam Reang.

In 1994 he went to Pailin, where he has been living since. In 1999 he made a trip back to his native village in Svay Rieng and found his elder sister; she now lives with him in his house in Pailin. In 1985 he had interrogated a captured Vietnamese soldier who knew about his old teacher from the early 1970s (he recognized him from a photo that Eang had); the soldier said that the teacher was still alive and told Eang his whereabouts. In November 2002 Eang had a chance to go to Vietnam and he tried to look up his old teacher, but it appeared that he had died the month before.

In order to clarify some points in Dr Eang’s story, we paid a visit to his house the next day, since he was not at his office. He was not at his house either, but we found his sister, Yar Noeun, sitting outside the house with her husband and surrounded by half-a-dozen children aged between 6 and 13. She was indeed an elder sister, 16 years older than Eang. And while Eang looked what he was, a civil servant of early middle age, Noeun looked just as much what she was, an old and poor peasant woman. She was first surprised and a little embarrassed that we wanted to talk with her, since, as she said, she knew nothing. But when we explained that we only wanted her to talk about her own experiences, she
accepted; her husband was present during the conversation and confirmed her information.

Yar Noeun is now 62 years old and lives in Eang’s house with her husband. Before 1975 the family lived in Svay Rieng. Her father was an achaa in the village and her mother helped him with his work at the wat; she was a very pious woman, would never kill a chicken or even fish. Her father died in their native village in 1968. During Lon Nol time they had very little food because the Vietnamese troops looted the area; they often had to move from place to place within the district to avoid the depredations of the Vietnamese soldiers.

In 1970, the guerrillas recruited children from poor families, and her younger brother Eang and one of her own sons, aged 12, were both sent to Kampong Cham. Her son returned the following year, he had managed to escape while being moved to the western provinces. Some of the children escaped, she explained; some drowned in the river while others made it across and were sent to the western provinces. Her son never said anything about his time with the guerrillas, but she understood that it must have been terrible. Eang did not return. Two of her younger siblings had died aged five and eight, and in 1975 she and her husband decided to move to Pursat with her widowed mother. The family arrived in Pursat on 8 April and stayed there nine days after which they were forced by the Khmer Rouge to leave the city; they were ordered about by child-soldiers carrying guns. On their way back some friends invited them to settle in Krakor where they could have a house, but her mother objected, she wanted to return to their village in Svay Rieng, so they went back.

Once [after 1979] Noeun heard that her brother was in Phnom Penh and she went there to search for him, but didn’t find him; she feared he had died and held commemoration rites for him. But in 1999 he had finally come to find her in Svay Rieng, and he proposed that she should come and live with him in Pailin. She decided to accept his offer in 2001 because there was a drought in Svay Rieng and they had no water for irrigation. She had left without any belongings because she did not have any. She came with her husband and eight grandchildren and nieces. Her two brothers and one sister still live in Svay Rieng. Eang has more than 10 hectares of paddy land, he feeds them all and takes care of the children’s schooling. Noeun and her husband have started clearing some land of their own and will grow maize. She is very happy to be with her younger brother and grateful to him for the help he provides.
The discrepancies between the two versions of doctor Eang’s family background and his recruitment into the guerrilla were quite remarkable. It is unlikely that any other outsider would ever be interested in the life of Yar Noeun, and the probability that she and her husband should have rehearsed their version for our benefit is nil. So this leaves the question of why Eang, who was vouched for by his acquaintances as a particularly honest and trustworthy person, should have felt obliged to rewrite the history of his early life. What difference did it make to him, and what difference would he perceive it made to us, whether his parents were devout Buddhists who put their energy in the service of the village wat, or active revolutionaries? Or whether his father died peacefully in the village in 1968, or was killed in action as a guerrilla commander in another province four years later?

Michael Jackson’s reflections on storytelling are important here. The politics of storytelling consists in reconstituting events by actively reworking them, ‘both in dialogue with others and within one’s own imagination’ (Jackson 2002: 15). Eang was brought up in a pious Buddhist family, according to his sister. But he was exposed to the world and ideas of the revolutionary movement of the Khmer Rouge at the age of 6, and for the next 25 years he lived exclusively in that world; his habitus was formed by the dictates of the Angkar. It is significant, perhaps, that his sister recounted his abduction by the guerrillas in terms of ‘crossing the river’. On the empirical level this reflects the factual movement of the revolutionary forces from the Eastern Zone, where they were most effectively organized (Kiernan 1985: 315), to the provinces west of the Mekong. But ‘crossing the river’ is also a metaphor, for giving birth (see Chapter 6) as well as for passing away, and after crossing the river there is no return. Eang on his part exhibits a capacity for self-reflection, and he probably realizes that his early involvement with the revolution was what gave him his future in terms of education, social position, and personal identity, in contrast to what may have been the case had he remained with his poor peasant family. Such reflections may have played a part already when he and his nephew were abducted. It is not unlikely that he helped his 12-year-old nephew to escape while he himself made the conscious choice of ‘crossing the river’ and staying on. As pure speculation we may guess at some sort of a childhood trauma following his father’s death in 1968, since he went to live with his grandmother in another province for a while; in Noeun’s story, the mother comes across as quite a determined lady – a role often favoured by older Khmer women – and her demise was not commented upon by Noeun; it is possible that she was more respected than loved, and it appears that Noeun saw herself more like a mother than a sister for Eang.

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François Ponchaud has argued that despite the seemingly radical and extreme policies and actions of the Angkar, which entailed onsloughts on most of the core institutions of Cambodian society, it was at the same time a revolution that decidedly ‘bore the stamp of Khmer culture’ (Ponchaud 1989: 152). The authority of the parents was abolished only to be assumed by the Angkar; young people in Eang’s circumstances were told that the Angkar was their father and mother. Among the Khmer cultural traits discernible in Eang’s case is the conception of a personal destiny, associated with the Buddhist notion of karma. Eang’s two attempts to defect from DK after the Vietnamese invasion – his plan to return to ‘liberated’ Phnom Penh in 1979 which was thwarted by Ta Mok, and his idea of fleeing to Thailand at a later stage – both appear rather half-hearted, but we believe that rather than taking them as signs of indecision or cowardice, they should be read as an exercise of personal agency, which in his case also includes his conscious acknowledgement of the force of his destiny (to remain with the movement) which had been forged from the moment he had joined the movement. If the revolution had given Eang the life he had been living, he, in his turn, was obliged to give himself to the revolution, in accordance with the Buddhist ethos that François Bizot has described as ‘the gift of oneself’, le don de soi-même (1981). Eang’s revolutionary agency was paradoxically – but we believe not uncommonly – shaped by the Buddhist values to which he was exposed in early childhood. A further Khmer cultural trait exhibited in Eang’s story is life-long respect for, and indebtedness to, one’s teacher (kru). For Eang this pertained first to his high-school teacher, whom he claimed to have followed to become a guerrilla in the forest; and secondly to his Vietnamese teacher, whom he somewhat improbably claims to have tried to locate almost 30 years later.

Before going back to Pailin in early January 2003, we had spent some time in Battambang. At the provincial health department there we had by chance met Mr Seng Ron who was director of the Municipal Health Department in Pailin, and we made an appointment with him for the following day in Pailin. We came to the Pailin hospital for our meeting at 8 A.M. on 7 January; that date is the anniversary of the Vietnamese invasion of Cambodia in 1979, and it was a public holiday. But no public celebrations were held in Pailin whose population is predominantly ex-Khmer Rouge, who saw no reason to celebrate their defeat. It turned out that Mr Ron had also brought his wife, since they were both free, on the assumption that we might want to talk to her as well. We did indeed; her name was Ieng Vichada and she was director of the technical branch of the Pailin Municipal Health Department. But more importantly, she was the daughter of Ieng Thirith and Ieng Sary. As mentioned, Thirith had been DK
Minister of Social Affairs; her sister was Khieu Ponnary, Pol Pot’s first wife. Ieng Sary had been DK Minister of Foreign Affairs. Vichada was thus born into the very highest ranks of the Angkar. During our meeting she did most of the talking but was seconded by her husband.

**Ieng Vichada** was born in 1961. In 1973–1975 she was a *nearasa* for the Angkar. She then lived in Kampong Tralach District, Kampong Chhnang Province, her place of birth. In 1975 she was posted to Phnom Penh and worked for the National Drug Factory. From 1976 she was member of a team of six young people and three Chinese experts who toured the country to make an inventory of traditional medicinal herbs and plants and brought samples to Phnom Penh. They travelled on elephant and on foot in Kampong Cham, Kampong Thom, Koh Kong, Kampot, Pursat, Battambang, Siem Reap, and Kratie. The team consulted local *kru khmae* wherever they went.

In the factory she worked in the raw materials section. In the laboratory they extracted the poison (strychnine) from *krob sleng*. Medicines were produced in another section. The factory had a Chinese machine for pounding the raw materials and compressing them into tablets. On 6 January 1979 her team had returned from Bokor in Kampot Province. The next morning she heard gunfire at Wat Phnom and walked away from the city towards Kampong Som on Road no. 4. At Pochentong she found a car that took her first to Kampong Chhnang and then on to Battambang Province and the Cardamom Mountains. Her team had split up, and three of her six team members were killed on the road.

In 1980 she was sent for medical studies in China, and studied in Shanghai until 1986 when she returned as a qualified midwife and specialist in gynaecology and obstetrics. She married Seng Ron in 1988.

On her return she worked at the DK central hospital in Kam Reang District, Battambang Province. This was the main DK hospital for treatment and training and headquarters for the DK medical administration. The hospital treated both war injuries and general civilian diseases. Training courses ran for one month each and were mostly held during the rainy season because there was less fighting then.

During DK, life was good and simple, she stated. Roads and the railway were in much better condition then, all roads to the provinces were paved and travel was much easier and faster than now. We were happy if we had enough food, and we did not need money, she recalls. Nowadays everybody wants to become rich, so even we have to get money to provide for our family. Vichada runs a private clinic for women, and Ron owns large tracts of farmland.
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While the politics of Yar Eang’s storytelling consisted in the adjustment of the autobiography of his childhood and youth to fit his self-perception as it was shaped by the authority of the Angkar, Vichada conflated her own experience with revolutionary politics by mythologizing. Disregarding the fact, for example, that it was the French who had constructed roads and railways throughout the country, she leaps over history and time, dreaming up the beauty of primary forests, untouched by the French or by the war, where she herself travels on elephants like the great people of the Angkorean civilization, surrounded by sages, traditional healers, and teachers of the revolution, i.e. the invited Chinese experts. As a virgin daughter of the revolution, of impeccably pure cultural, genealogical, and ideological background, she herself is never touched by the horrors of her own time. Just as the French penetrated the deep forest to reveal the ancient treasures of the Angkor temples and thereby ‘discovered’ the legacy of the ancient past, she discovered treasures in the forest, medical plants for her herbarium. These were treasures that not only attested to the ancient Khmer wisdom, but which would be put to use for the benefit of the revolutionary nation and its people, as the Chinese sages had kindly provided the necessary technology.

The DK policy of promoting and relying on Khmer traditional medicine was no doubt inspired partly by Maoist China, where traditional Chinese medicine had been officially promoted since the 1950s. Among the reasons for this, Volker Scheid mentions the wish to utilize all possible resources for healthcare in a country where everything was in short supply; the wish to avoid excessive and costly dependence on imported technology and drugs; and a sense of national pride that China’s old culture would be able to make a unique contribution to world medicine (Scheid 2002: 70–71). This latter dimension, the precious Khmer cultural legacy, was clearly expressed in Vichada’s story. And we should not forget that the ideology of the Pol Pot regime was a mixture of extreme communism and extreme Khmer ethnic nationalism.

SOCIALIST HEALTH IN THE VIETNAMESE PROTECTORATE

Officially, the Vietnamese protectorate was headed by the Solidarity Front for the Salvation of the Nation of Kampuchea (Renakse samaki samkru cheat kampuchea), which had been established in Vietnam in late 1978 for the purpose of overthrowing the Pol Pot regime. Among its figureheads were recent defectors from DK, including Heng Samrin and Hun Sen, who quickly proclaimed the People’s Republic of Kampuchea (PRK), with Heng Samrin as head of state and
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Hun Sen as foreign minister. Immediately after the invasion in January 1979, the PRK administration under Vietnamese direction started rehabilitation of the infrastructure, but they also made serious efforts at political damage limitation. These efforts included the setting up of the People’s Revolutionary Tribunal in August 1979 at which Pol Pot and Ieng Sary were tried and sentenced to death in absentia for genocide (DeNike et al. 2000), and the construction of the Tuol Sleng Museum of Genocidal Crimes that opened in mid-1980 (Chandler 1999). The message that these measures were meant to convey was that there was nothing wrong with the Socialist Revolution, but it had been abused and betrayed by a small clique of genocidal maniacs, notably Pol Pot and Ieng Sary. The concentration of responsibility for the DK atrocities to a few leading figures also allowed the government to take a lenient attitude towards those numerous Khmer Rouge cadres and collaborators who did not follow the leadership and armed forces to the Thai border. Such people were important to the new regime as they represented a political and administrative experience that the government needed. Remaining former DK officials were offered amnesty on condition that they declared their loyalty to the People’s Revolutionary Party and the PRK government (Gottesman 2003: 66–78). So in practical terms the PRK administration consisted to a large extent of former DK personnel (Lucioli 1988: 85; Shawcross 1984: 257).

Public health

After the devastations of the medical infrastructure and severe reduction of health personnel through the civil war and the DK regime during the 1970s, the PRK government and its Vietnamese advisers faced a formidable task of rehabilitating the public health system. Restoration of the medical infrastructure was supposedly high on the list of government priorities. The Calmette Hospital was renamed the Revolutionary Hospital, but it was still an elite institution, now reserved for the treatment of high-ranking party cadres and their Vietnamese advisers (Lucioli 1988: 256). The medical faculty at the university in Phnom Penh reopened in December 1979.

In terms of both medical treatment and medical education, the government put a premium on quantity. Surviving medical personnel were enrolled in refresher and/or crash courses in the provinces, and new students were admitted in significant numbers to an abbreviated education scheme (cours accélérés). In 1981 a government report could boast of the existence of 1,225 ‘health bases’ and a total of 11,231 medical staff (Slocomb 2003: 173). Prevention of communicable diseases was a priority, and in this respect the PRK, perhaps unwittingly,
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followed the example of the French by organizing mobile vaccination teams ‘to go down to the base and inoculate the people in areas where there were disease outbreaks. The report for 1981 claimed, “We have treated 1,849,478 people”’ (ibid.). Such figures should naturally be taken with a grain of salt. Esmeralda Luciolli mentions that the government in 1986 reported that over the past year 432,400 persons had received medical treatment in Siem Reap Province – out of an estimated total population of 500,000! (Luciolli 1988: 257).

Like DK, the PRK government also encouraged the development of indigenous herbal medicine as part of its nationalist/socialist ideology of self-sufficiency. People who had served as herbalists in DK were conscripted and put to work at provincial and district hospitals and clinics, all of which were to have a medicinal garden attached to them. Also as in DK, even the most rudimentary medical education had an important component of political education. According to a government decision, all higher education ‘should reflect a scientific manner of thinking based on Marxist-Leninist philosophy, and it should link with behavior appropriate to the party’ (cited by Clayton 2000: 136). The physician Esmeralda Luciolli, who worked in Cambodia for the French Red Cross for 15 months in 1984–1986, was one of the rare foreign medics who could (and was willing to) report on the conditions inside the country. Her book is a passionate denunciation of a regime that she found extremely authoritarian and oppressive, both medically and in general. Luciolli commented on the disproportionate amount of time that had to be spent on political education. She quoted a newly examined medical student commenting, ‘I thought I would become doctor of medicine, but it turns out that I have also become doctor of politics’ (Luciolli 1988: 250). After passing their exams, the medical personnel (like other government officials) had to continuously attend political courses which took precious time away from their medical work, and the most promising doctors were often given increasing political responsibilities and ended up with little or no time for medical practice, and conversely politically reliable ‘revolutionary medics’ were given medical duties quite beyond their professional competence (ibid.: 251–255).

The few surviving doctors from before Pol Pot time were not necessarily trusted or appreciated. In his story related above, Dr Keo Thong Sin expressed mild criticism at the Vietnamese way of running the Takeo hospital at which he served. Others were less diplomatic. Pharmacist Ly Den, also referred to above, had been conscripted by the Khmer Rouge to produce pharmaceuticals in Kampong Cham. After the Vietnamese invasion he was appointed director-general of the pharmaceutical department at the Ministry of Health. In July 1979 he had complained that one of the ministry officials had stolen medicine
from the department and sold it on the black market. But this man was the Party’s political commissar at the department as well as a former Khmer Rouge cadre, so Ly Den, as the whistle blower, was arrested instead of the thief and charged with opposition to the regime; he spent nine months in jail (Ly 1982b: 249–253).

In practice there were two standards of medical treatment in the PRK, one for the cadres and one for the people; this reflected the general transformation of the Khmer Rouge class society; but where the DK hierarchy had consisted of cadres, ‘old people’ and ‘new people’, the new order was made up of Vietnamese, cadres, and ‘the people’. In Phnom Penh the Calmette Hospital was reserved exclusively for Vietnamese and cadres. Luciolli reported that in most hospitals there were even two pharmacies. The one for the people was generally either empty or stocked with inferior and often expired pharmaceuticals, courtesy of fraternal East European countries, while the one for the cadres was stocked with the best and most efficacious products. The irony was not lost on Luciolli’s Khmer colleagues, one of whom commented, ‘Socialist medicine for the people, capitalist medicine for the cadres’ (Luciolli 1998: 257). The division of medicine for the cadres and for the people was vigorously upheld. In one case a young man was brought to a provincial hospital, comatose with malarial fever. Luciolli recommended immediate intravenous quinine, but the injectable quinine was for cadres only and the doctor dared not use it on a man of the people. Luciolli managed to finally persuade the member of the revolutionary committee responsible for health issues to authorize the use of a few ampoules, but as soon as she had left the hospital, the treatment was suspended (ibid.: 126). Another case was when Luciolli herself needed an electrocardiograph for diagnosis; the one available was out of order but there was another one in the section for cadres. It proved impossible for Luciolli to either have that machine on a short loan or to send her patient to the cadre section to have the electrocardiogram done (ibid.: 256).

**Foreign aid**

One important difference between the DK medical regime and that of the PRK was that the latter received a substantial amount of foreign aid. The PRK Ministry of Health, like other ministries, was effectively directed by Vietnamese advisers; the same applied to all provincial hospitals, and physicians from Cuba, the German Democratic Republic, Hungary, Poland, and the Soviet Union were sent to Cambodia to assist their Vietnamese colleagues. In 1981, ‘a total of 956 tonnes of medical equipment had been received from fraternal socialist countries and from humanitarian aid organizations’ (Slocomb 2003: 173). However, the
The downside of such fraternal and humanitarian gestures was that the donors often used them as a way to get rid of their domestic surplus. As a current medical inspector at the Ministry of Health recalled, the supplies came in ‘boxes’ and because of the urgent need and the lack of qualified personnel, the boxes were sent directly to the provinces without being inventoried or subjected to quality control. Luciolli reported that in 1985, some products donated by the German Democratic Republic and the Soviet Union were not only long expired but in varying stages of decomposition (Luciolli 1988: 257).

The PRK government had permitted a limited number of humanitarian aid organizations to work in the country, notably the International Red Cross and United Nations’s Children’s Fund, as well as Oxfam and a few other NGOs (Shawcross 1984). The presence of Oxfam dated from 1979, and since it was the first NGO in place when the emergency was declared, Oxfam was anxious to maintain its continued presence. Despite their explicitly non-governmental ideology and rhetoric, Oxfam and other NGOs had little choice but to comply totally with the PRK government’s regulations and policies; non-compliance would result in immediate expulsion from the country. In order to safeguard the organization’s presence in the country, Oxfam representatives were even prepared officially to condone the regime’s political imprisonments and other human rights violations (Luciolli 1988: 299). The collusion of Oxfam and the PRK government helped to sustain the impression that the international isolation of Cambodia (that is, the UN General Assembly’s refusal to grant diplomatic recognition to the PRK and the absence of assistance from most Western bilateral aid organizations) amounted to ‘punishing the poor’ (Mysliwiec 1988). This view might have had more credibility if ‘punishing the poor’ had not been just what the PRK government itself was doing – medically, by reserving adequate treatment for the political elite and by sending thousands of poor people to slave labour in the K5 scheme without medical facilities (see below).

It seems that the attempts at rehabilitating the public health system were concentrated mainly in the emergency period. In his country assessment Grant Curtis noted, ‘The outreach of medical services in Cambodia is a remarkable achievement […] The quality of health services, however, is poor and utilization of services is generally low. Personnel […] at the commune level particularly have received inadequate training, may lack practical experience, and receive almost no supervision or support’ (Curtis 1989: 153). With allegedly 1,225 ‘health bases’ and 11,231 medical personnel in 1981, the corresponding figures from 1989, of 1,616 ‘bases’ and about 10,000 personnel (ibid.: 153–154), are not overly impressive.
Unhealthy defence

In spite of the medical rehabilitation success story of the early 1980s promoted by official rhetoric with corroborating statistics, and the ongoing relentless political ‘education’ of medical personnel, even the government had to admit that there were problems. In 1985, a report to the Party’s Central Committee admitted that ‘the perspective on the goals of socialist health is not yet very deep or strong, the organization of the health network is not yet firm, the ranks of the cadres are still lacking in quantity and quality’ (quoted in Slocomb 2003: 174). At the same time, other government policies increased public health hazards.

This was notably the case for the kor pram (K5) scheme. Kor pram is the Khmer pronunciation of ‘K5’²⁰, which was a large-scale plan to defend the nation’s western borders (see Luciolli 1988: 105–135; Slocomb 2003: 229–251; Gottesman 2003: 231–237). The aim was to contain the remaining Khmer Rouge forces and other Cambodian resistance and refugee groups along the Thai border and prevent them from infiltrating the rest of the country. This was to be accomplished by constructing a barrage and a two-kilometre-wide deforested minefield strip inside Cambodia and parallel with the Thai border, from the Lao border to the sea, a distance of about 800 km. The construction work for the scheme was carried out between 1984 and 1988 by conscripted labour from all over the country, referred to as ‘volunteers’. The K5 scheme was meant to relieve the large contingents of Vietnamese troops that had hitherto been deployed against the DK and other opposition forces along the border. The ‘volunteers’ were recruited according to quotas for each commune, district, and province in the country and had to serve for three to six months. The possibility for village and commune chiefs of conscripting people for the kor pram often provided an opportunity for these authorities of getting rid of people regarded as troublemakers in the community (Luco 2002: 82, 88). Other people whose behaviour or dispositions did not conform to the socialist ideal were also at risk. Poor people were hardest hit by kor pram service because they could not afford to bribe the officials or to pay somebody else to take their place (Slocomb 2003: 241). Estimates of the total number of conscripts for the kor pram vary from 380,000 (Slocomb 2003: 236) to at least one million (Luciolli 1988: 123).

Conditions for the conscripts equalled the worst that Pol Pot had had to offer; there were no sleeping quarters, and supplies of food, medicine, blankets, and mosquito nets were erratic but always insufficient (Luciolli 1988: 113–115). ‘It was said that when you left for K5 you left in a truck but you returned in a burial urn’ (Luco 2002: 90). Our Cham informants told us that they often held buffalo sacrifices for the young men who had been conscripted, to send off their souls in
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the anticipation that their bodies would not be returned. Malaria was by far the greatest hazard, but there was no quinine, no hospitals, and only a few doctors in the K5 area. Tree-felling accidents and landmines left from the civil war or planted by Khmer Rouge forces maimed large numbers of workers (Slocomb 2003: 238–239). The government was aware of the situation but did almost nothing to improve it. The Ministry of Health estimated the rate of malaria among the K5 workers at 80 per cent; Hun Sen told the Council of Ministers in 1985, ‘It’s true that there is a lot of malaria, but it is easy to cure’ (quoted by Gottesman 2003: 235); however, neither he nor any other minister did anything to provide medicine for the workers. The negative health effects of the kor pram scheme were soon being felt throughout the country. Surviving conscripts brought back malaria to villages in the plains that had previously been free of the disease. Luciolli (1988: 123) reported that in 1985 in Kandal Province, for example, of 12,000 returned workers there were 9,000 cases of malarial infection and 700 deaths. She calculated that the kor pram scheme had resulted in a total of 50,000 deaths from malaria between 1984 and 1986.

In short, as in DK, the PRK tried to realize the Party’s political ambitions at the expense of the health and lives of a great number of the country’s inhabitants. ‘Socialist health’ in PRK was a modernist bureaucratic rather than a social concern, and emphasis was on perfunctory treatment rather than on care. And ‘socialist health’ was characterized by a rigid class division between the cadres and the people. A comparison between the DK and the PRK regimes commonly made by Luciolli’s informants was summed up as ‘We have changed the driver, but the vehicle is the same and it goes in the same direction’ (Luciolli 1998: 103).

Emergence of an informal medical sector

Although there was officially no private healthcare sector during the PRK, a fair amount of donated boxes as well as pharmaceuticals stored in abandoned DK warehouses found their way to the private market, being sold, for gold and jewellery21 by Vietnamese and Khmer army or civilian personnel; the racket that Ly Den exposed in 1979 was by no means a singular instance. Rice and pharmaceuticals were the most precious commodities in the first years after the Vietnamese invasion, and together with gold, they entered into a sort of triangular trade, carried out mainly by Chinese and Sino-Khmer traders. Many of the pharmacies that exist today were founded on this kind of trade conducted in the marketplaces from boxes or vegetable baskets in the early 1980s.
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From the mid-1980s onwards, illegally imported pharmaceuticals, mainly from Thailand, entered the open market. Another source of pharmaceutical supplies to the open market during the late 1980s was private donations from Cambodians in exile; given the difficulty of bank transfers and the risk of sending cash through the postal system, many expatriates chose pharmaceuticals as a form of remittance to relatives within the country (Curtis 1989: 151). Curtis estimated that 60 per cent of the pharmaceuticals available in the country in 1989 were ‘private’ in the sense that they derived from sources other than domestic production and officially controlled imports (ibid.). Since the economic liberalization in 1989, the private medical sector has expanded dramatically, as we shall see in Chapter 8.

NOTES

1 The Khmer label panh nha chun signifies people who make a living through their school education, such as teachers, engineers, or medical doctors. The gloss ‘intellectuals’ does not therefore imply the sense in which that word is currently used. Another category of ‘new people’ treated with equal harshness and suspicion was that of merchants and petty traders (largely, ethnic Chinese); they were known as neay thun, glossed as ‘capitalists’.

2 Some of the autobiographies of surviving ‘new’ people convey the culture clash from a children’s perspective: ‘Here, instead of concrete city buildings, people live in huts made out of straw that squat on four stilts […] Life on the farm is boring and dull’ (Loung Ung 2000: 38, 41). When another young girl was leaving Phnom Penh on the back of her father’s scooter, they stopped on the way. ‘Children swarm around us out of nowhere, hovering the way flies cluster around raw flesh […] This herd of half-dressed and naked children […] are unlike anything I have ever seen. […] The youngest ones approach with noses encrusted with soot and snot […] I am repulsed, recoiling from these children, some even my own age, as they continue to chase us’ (Chanrithy Him 2000: 73–74). As for indigenous medicine, the medical mainstay of rural people since time immemorial, it was new to Bunheang Ung, for example. The remedies ‘included the use of certain leaves, roots and bark, which were said to be part of the ancient folk pharmacopoeia of the Khmer people’ (Stuart-Fox and Bunheang Ung 1985: 68; emphasis added).

3 Speaking about the period from 1975 to 1978, Laura McGrew, for example, claims that ‘the entire healthcare system was destroyed: equipment, supplies, buildings, and personnel’ (1990: 77). A more defensive stance towards DK medical policy and practice is taken by Michael Vickery (1984: 165–171).

4 Thanks to Anne Guillou for making this point.

5 Ta Mok, known as ‘the butcher from Takeo’, was DK military commander of the ‘Southwestern Zone, i.e. Takeo, Kampot, and part of Kampong Speu and Kandal provinces. He was a native of Tramkok District, which is why it became a model district under DK, in medical as well as in other respects.

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6 Hu Nim was appointed DK Minister of Information in 1976. But as an intellectual he soon became suspect and was tortured and killed in early 1977 (Corfield and Summers 2003: 157–158).

7 This seems a very large number of staff for a district hospital, but the most likely explanation is that three *kong youthea* were assigned to run the hospital since a unit of three such groups, a *vireak*, was the smallest that was placed under the command of a trusted cadre, in this case Pech Sareth.

8 Copy of the notebook courtesy of the Documentation Center of Cambodia, DC-Cam.

9 Thioeun was one of the four Thiounn brothers, all left-wing intellectuals of Khmer elite family background. Trained in France, he was chief surgeon at the Russian Hospital in the 1960s, author and co-author of more than 40 scientific articles in the *Revue Médico-Chirurgicale*. He joined the revolutionary movement in 1970 and became DK minister of health. He stayed with the DK in the enclaves along the Thai border after 1979, being in charge of the organization of medical matters. He put himself at the disposal of the Cambodian government in 1998 (Corfield and Summers 2003: 422–423).

10 In Sokan had been a colleague of Thioeun at the Russian Hospital in the 1960s. He too had been a frequent contributor of articles for the *Revue Médico-Chirurgicale*; his field was internal medicine, specializing in tuberculosis. According to Anne Guillou (pers. comm.), he supposedly died at the Thai border sometime after 1979.

11 The *nearasa*, recruited among young people, often girls, of undoubted revolutionary zeal, were also spies and informers for the *Angkar*. They travelled on bicycles or horseback to the districts and collectives to relay the leadership’s decisions, such as the removal (killing) of people. For this reason, they were much feared by the population. When a *nearasa* visited a place, it was expected that bad things would happen.

12 The predilection of socialist regimes for denoting various state institutions by a letter and a number can be confusing in the Cambodian case since the Khmer alphabet has no less than 33 consonants. The p in *pet* (as in P1 for the Calmette Hospital) is consonant number 22, while the p in the Khmer rendition of the French *pharma* is consonant number 23.

13 Cambodia Pharmaceutical Enterprise (CPE) had been a state pharmaceutical company, established 1963 as ‘Pharmacie d’approvision khmère’ (see also Chapter 8).

14 ‘P6’ was probably the former Institut Pasteur.

15 This narrative illustrates, once again, the importance of patronage through the *khsae*. But it also says something about a political regime in which even its active supporters feel gratitude for not being innocently arrested, tortured, and killed.

16 Henri Locard (1996: 21) has suggested that this slogan was used by those who opposed the revolutionaries in order to denounce their violent methods of recruitment. This case shows that it was also used within the movement itself, *pour encourager les autres*.
17 Ta Mok had apparently begun hoarding treasure at an early stage. In his autobiographical account of his capture by the Khmer Rouge in 1971, François Bizot relates that when he was about to be released by the guerrilla, he was to be given back his personal belongings, but his wristwatch was missing. His sentry, Duch, told him that Ta Mok had taken it and was prepared to have him killed just in order to keep it. Duch, however, managed to retrieve the watch, and when at their final meeting one man asked if Bizot had now gotten back all his belongings, Duch commented, ‘Oui, mais le Camarade Mok est très fâché…maintenant il n’a plus de montre!’ (Bizot 2000: 223). The propensity for hoarding treasure was not a unique trait of Ta Mok’s character but seems to have been inscribed in the habitus of the DK leadership. Much of the rice harvest was taken away for storage (where it was often wasted) while the people went hungry, and pharmaceuticals were stored in considerable quantities while the people went without medical treatment.

18 Current Prime Minister Hun Sen was also 16 years old when he was assigned to agitprop work for the revolutionary movement in 1968 (Corfield and Summers 2003: 59); the lessons he learnt and taught have stood him in good stead ever since.

19 Soizick Crochet has provided a thorough and detailed account of the medical situation during PRK (Crochet 2008: 378–389).

20 The k in K5 is the first consonant in the Khmer alphabet; it refers to the initial syllable of kar karpier which means defence (Slocomb 2003: 229). The k in K2, the medical warehouse (khleang) mentioned above, is the fourth consonant (cf. note 12).

21 Money had been abolished in DK, and gold was the main medium of exchange, even for some time after money was officially reintroduced in 1981. Still today, gold remains the preferred medium of payment and standard of value for major economic transactions.
Chapter Five

Indigenous Practitioners: Healers, Spirit Mediums and Magic Monks

As related in some detail in Chapter 1, indigenous Khmer health cosmology is characterized by the conviction that illness as well as actual or potential misfortune is not primarily a question of the individual’s physical or biological condition but of his/her integral position in the wider natural, social, and spiritual life-world. In the indigenous Khmer medical universe, the focus is on healing the social person (rather than ‘only’ curing the physical body), and this implies a personalized relationship between the physically, socially and morally suffering person and his/her individual ‘therapist’ (teacher, kru).

AN ABSENT ‘GREAT TRADITION’

Some Cambodian scholars are fond of noting that the country had a functioning system of public hospitals already during the reign of King Jayavarman VII (1181–1219). It was the responsibility of the semi-divine kings of Angkor to ensure the prosperity of the state and the welfare, including the health, of their subjects (cf. Thompson 2004: 93–98). Jayavarman VII ordered the construction of no less than 102 ‘halls of diseaselessness’ (aroayasala) throughout his realm (Ang 1992: 102–103; Mabbett and Chandler 1996: 206). These ‘hospitals’ were for the treatment of ‘the four castes’, i.e. they were not reserved for the higher social strata. They were all constructed from the same architectural plan and staffed by an identical number of people, according to various stone inscriptions:

There were two doctors, each assisted by a man and two women, two store-keepers with the job of giving out medicine, two cooks having the
responsibility of the fuel and water as well as for cleaning the temple, two servitors to prepare the offerings for the Buddha, fourteen hospital attendants, six women to heat the water and grind the medicines, and two women to pound the rice. The total number of workers who were housed [at each hospital] was thirty-two. (Cœdès 1963: 103)

The king supplied (ordered the peasants to produce and surrender) medicinal substances to the hospitals three times a year. The medicines were of 36 different kinds, mainly spices and condiments, including honey, sesame, pepper, cumin, nutmeg, camphor, coriander, cardamom, ginger, cinnamon, and jujube. As Menaut noted, most substances seemed destined for increasing the appetite and invigorating the patients and thereby assist nature to run its healing course (Menaut 1930: 10). Whatever its efficacy, we clearly have a medical system that could well have the hallmarks of a potential medical great tradition of Asia, on a par, for example, with the related Ayurvedic tradition of India. Indeed, most of the abovementioned medicines figured in ancient Ayurvedic texts, where their specific healing properties were related to both their taste and their humoral qualities (Mulholland 1979: 104–109).

Nevertheless, despite evidence in ancient Khmer medical texts of a considerable systematization of medical knowledge (Chhem 2001; Chhem and Antelme 2004), an institutionalized Khmer medical system with associated doctrine-based practices, comparable to the Ayurvedic school in India, did not survive into the modern age in Cambodia. One reason, of course, was the gradual decline and eventual conquest of the Angkor empire by the Siamese. French scholars tend to blame this primarily on the fact that during the thirteenth century, the combination of, or oscillation between, Brahmanism and Mahayana Buddhism as the state religions was gradually replaced by Theravada Buddhism, ‘une religion énervante et inénergique’ (Menaut 1930: 11, citing Adhémard Leclère; cf. Cœdès 1963: 106–107, citing Louis Finot).

In any case, the Chinese diplomat Chou Ta-Kuan who visited Angkor in 1296–1297 was not overly impressed with the state of medical care in the capital. His chapter on ‘sickness and leprosy’ is so brief that it may be quoted in full.

The people of Cambodia often cure themselves of many illnesses by plunging into water and washing the head again and again. Nevertheless, the traveller meets many lepers along the way. Even when these unfortunates sleep and eat among their fellow-countrymen, no protest is made. By some it is said that leprosy is the outcome of climatic conditions. Even one of the sovereigns fell victim to the disease, and so the people do not look on
it as a disgrace. It is my humble opinion that as a rule the illness results if one takes a bath immediately after sexual intercourse – a practice which, I am told, is very prevalent here. Nine out of ten cases of dysentery end fatally. As in our country, drugs can be bought in the market; of these, with their strange names, I have no knowledge. There are also sorcerers who practice their arts on the Cambodians. How utterly absurd! (Chou Ta-Kuan 1993 [1297]: 35)

The decline and fall of Angkor did not in itself necessarily destroy the whole medical tradition. Firstly, as Charles Higham has noted, ‘it is important to stress that [the Siamese conquest of Angkor] did not signal the end of the kingdom of Cambodia’ (Higham 2001: 162). The state and its traditions were maintained as the Khmer capital was moved south of the Great Lake (Tonle Sap), first to Lovek and later to Udong. Secondly, the Siamese appropriated rather than destroyed most of the medical knowledge they had gained from Angkor and preserved it as Thai rather than Khmer (Mulholland 1979: ).

We would suggest that French colonialism also played a role in preventing the rise of a Cambodian great medical tradition. A comparison with Ayurveda and the British colonization of India may be instructive. That colonization was a long and gradual process, to begin with, in the early eighteenth century, directed by the commercial interests of individual merchants and companies (eventually under the umbrella of the East India Company) and only later did it become a government affair. The early colonists, being ‘far from home and the assistance of their own physicians […] sometimes turned for help to India’s [Muslim and Hindu doctors], and their readiness to seek Indian assistance was encouraged by a belief that local doctors would be more familiar with the diseases of the climate and with the locally occurring medicines’ (Arnold 1993: 11). Even as European doctors increasingly established biomedical practices in India during the eighteenth and early nineteenth centuries, the relations between European and Indian (Ayurvedic) practitioners were characterized by a ‘relatively open and informal dialogue’ (Pati and Harrison 2001: 10). Until the 1830s the Native Medical Institution that trained native doctors favoured a pluralistic approach (ibid.: 7) and allowed its students to take inspiration from Ayurveda. This also meant that the Ayurvedic and biomedical schools had had a fairly extended period of adaptation to each other’s ways of doing things in terms of the professionalization of practitioners and institutionalization of practices. When British colonial medicine eventually adopted an exclusively biomedical stance, their Ayurvedic indigenous colleagues were well prepared to posit an alternative
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on organizationally equal terms. By the early twentieth century efforts towards ‘restoring Ayurveda to a fully scientific basis’ emerged. Ayurveda ‘also benefited from a simultaneous revival of indigenous cultures that was closely associated with political nationalism’ (ibid.: 11).

In contrast, none of these conditions obtained for Cambodia. French colonization was almost instantaneous and the medical needs of the French colonizers were met by a biomedical corps of *troupes coloniales* whose rationalist enterprise had generally no use for indigenous herbal knowledge and absolutely no use for the associated ‘superstitious’ practices. There was to be no dialogue with indigenous practitioners. Adhémard Leclère’s early study of Khmer indigenous medicine, true to the French rationalist world view, was published in two instalments: one on ‘medicine among the Cambodians’ (Leclère 1894) and the other on ‘sorcery among the Cambodians’ (Leclère 1895). The medicinal and spiritual aspects that were integral parts of the Khmer health cosmology were thus kept separate according to the (French) biomedical logic.

After independence, the course of history continued to work against the invention of a Cambodian great medical tradition comparable to that of India’s Ayurvedic one. Sihanouk’s modernization programme during the 1950s aimed primarily at indigenizing French modernity, and Sihanouk himself, as a semi-divine monarch, carried out his responsibilities for the health and welfare of his subjects by advancing modern biomedical health services. During Pol Pot time, the spiritual dimension of indigenous healing was vigorously suppressed. We do not know the extent to which existing palm-leaf manuscripts containing indigenous medical knowledge were destroyed under Pol Pot, but the tradition of transmitting spiritual healing knowledge from a *kru* to his apprentices was seriously interrupted. A possible revival of this tradition was not exactly encouraged during the succeeding decade-long Vietnamese occupation. Maurice Eisenbruch, who began his fieldwork among *kru khmae* around 1990, mentions that many *kru* were still afraid to openly use *mon akum* (from the Sanskrit *mant*, ‘mantra’, and *agama*, ‘holy text’); they ‘claim to know only how to administer traditional herbal medicines similar to Western medicine. By professing to take this position they do not challenge socialist and Western politics that favour modernisation of the people at the expense of their “primitive” Khmer rituals’ (Eisenbruch 1992: 284). The persistence of the Indian Ayurvedic tradition probably owes more to its philosophical respectability than to its medical efficacy, and such philosophical respectability was denied the Cambodian tradition, mainly thanks to the successive policies of the French, Sihanouk, Pol Pot, and the Vietnamese. In the post-UNTAC medical a-modernity, the remnants of an
indigenous medical great tradition have fragmented to some extent into locally reinvented traditions.

**KRU: THEMES AND VARIATIONS**

Nowadays the words *kru* and *pet* refer to indigenous and biomedical practitioners, respectively, although both derive from Sanskrit terms. This raises the question of how to deal with the frequently used compound *kru pet*, both historically and contemporarily. The ‘doctors’ in Jayavarman VII’s ‘hospitals’ were undoubtedly *kru pet*, as they were scholarly practitioners of the medicine that existed at the time; and today’s *kru pet* include both proper biomedical doctors and less educated biomedical practitioners (such as ‘village doctors’ and pharmaceutical vendors). Au Sokhieng has observed that today the term *kru pet* is used only about a ‘western-trained doctor’, and infers that therefore ‘the definition of *pet* is linked to a type of institution’ (Au 2005: 27). This leads her to the counter-factual claim that ‘when the French arrived on the scene in the nineteenth century, the country had no *pet*’ (ibid.: 27–28) – because there were no hospitals. However, until well into the colonial period, it was the level of learning, rather than the institutional setting or the specific medical tradition (indigenous or biomedical), that defined the *kru pet*. In his article on indigenous Khmer medicine, Adhémard Leclère (1894) distinguished three kinds of indigenous practitioners:

- The *kru pet* had acquired his knowledge through study of palm-leaf manuscripts (santas) and being taught by his peers; he studied continually, and had some anatomical knowledge. His knowledge was not restricted to medical matters, he was also an *achaa, a savant theologien*, and was appreciated and revered by the people for his honesty and morality. The *kru pet* were not numerous, they were found at the royal palace in Phnom Penh, at the queen-mother’s residence at Udong, and in certain provincial towns frequented by merchants and court officials.

- The *kru thnam* were ordinary herbalists, numerous in all parts of the country. Their knowledge was restricted to certain herbal recipes, they had little or no diagnostic abilities, and they did not seek to improve their competence through medico-religious studies.

- The *thmup*, finally, were plain sorcerers, ignorant healers with no professional decency who would often sell medicines that they knew were ineffective. Nevertheless they were said to know medical secrets that enabled them to cure diseases that the *kru pet* or *kru thnam* could not cure (Leclère 1894: 716).
But even the tradition of learning and philosophical and theological sophistication of the indigenous *kru pet* was eventually discredited by the French. ‘Unfortunately, the *kru pet* is no less superstitious than his less educated countrymen. He believes in demons and in spirits who cause diseases and who must be driven out of the body of the sick by means of incantations and practices that have nothing to do with medicine’ (ibid.). The few remaining *kru pet* stood little chance of defending their medical status as their clients among the urban and upper classes became convinced by the French *réclame médicale* that proper medical learning was achieved by reading a French textbook rather than a palm-leaf manuscript. So today, a *kru pet* is by convention (though not by definition) a biomedical practitioner, irrespective of his or her level of education or institutional setting. Indigenous counterparts, no matter their level of training, are collectively referred to as *kru khmae*, indicating the indigenous rather than foreign medical tradition.

Following Leclère’s early account, a number of French ethnomedical and ethnopharmacological studies have addressed the indigenous Khmer medical universe and the healing practices of *kru khmae* (Menaut 1930; Huard 1963; Piat 1965; Martin 1983). Cambodian scholars have portrayed the indigenous Khmer medical universe as a unified system of spiritual and nosological beliefs and diagnostic and curative practices, providing descriptions of a synthesized ‘great tradition manquée’, as it were (Ang 1992; Chhem 2001; Chhem and Antelme 2004). The most important anthropological work on Khmer indigenous healers has been carried out by Maurice Eisenbruch. Based on encounters with a large number of healers, Eisenbruch has provided detailed accounts of the Khmer medico-religious symbolism and the ritual practices of the *kru*, particularly with respect to the ritual healing of mental illness (Eisenbruch 1992; Lemoine and Eisenbruch 1997).  

Within the general category of *kru khmae*, practitioners may be classified according to the main methods they use, and/or to the kind of affliction they specialize in treating, or the services they provide. The classification is tentative and partially overlapping since individual healers may perform multiple roles (see also Martin 1983: 140–143).

- **Kru thnam**, or **kru phsom thnam** (‘combine medicine’) are the traditional herbalists; their skill is in the proper way of combining the various roots and herbs; the mixture is boiled and the decoction is given to the patient to drink.
- **Kru bakbeg** (‘broken’), also known as **kru to chhang** (‘connect bone’) are bone-setters who use herbal concoctions in (bamboo) bandages to reduce swelling and heal broken limbs.
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- **Kru teay** are diviners/fortune-tellers; they are often *achaa*. Some do only astrological divination, revealing auspicious and inauspicious days for certain activities with the use of charts; some have recourse to a spirit, some also mix herbal medicines, some use *mon akum* (mantras), and some blow/spit (*sdoh phlom*).

- **Kru sneh** (‘charm’) provide ‘love medicine’ and promote good luck in the form of charms and the like; they are quite popular.

- **Kru son thith** (‘stay with’) have permanent access to one or more spirits, with whose help they divine the cause of the illness. These people usually began practising after they themselves had experienced serious and protracted illness. Occasionally, they combine divination with herbal remedies.

- **Kru thmup** are sorcerers who are said to inflict illness, on the demand of a client, on someone named by the client. They may magically insert a piece of nail or a bit of buffalo skin into the stomach of the victim, or use spells or curses to cause afflictions from evil (*am peu*).

*Kru thmup* is an elusive category. Sorcery afflictions are common and sorcery is widely feared in Khmer society. But almost nobody will admit to being actively engaged in sorcery, so it is virtually impossible to find a practising *kru thmup*. Those who are recognized as *kru thmup* are usually dead, having been accused of sorcery and therefore killed by others in the community. A person suffering from *am peu* will have to consult another *kru* (*teay, son thith*), a spirit medium or a monk for exorcism, which is the only way to cure *am peu*.

Apart from the *kru*, sensu strictu, the universe of indigenous healing comprises a few additional categories:

- **Chol rup** (‘enter body’), sometimes *kru chol rup* or *kru boramey*, are spirit mediums, mostly female, who are possessed by their spirits who make the diagnosis or direct the exorcism. The mediums frequently recommend the use of material objects, such as amulets for protection and to ward off bad spirits.

- Buddhist monks may engage in healing, commonly by performing exorcisms. In many cases, it is a question of a ‘preventive exorcism’ to avert misfortune and give spiritual protection at certain stages of life when a person is particularly vulnerable.

- **Chhmob boran** are indigenous midwives who work under the guidance of a personal spirit and perform the necessary nursing and ritual assistance for mother and child during and after delivery. We shall consider the *chhmob* in more detail in Chapter 6.

Common to indigenous healing is the centrality of spiritually derived healing power. Such power may be harnessed by the practitioner through study and
apprenticeship (*kru*), religious learning and devotion (monks), or by direct intervention by spirits (*chol rup*). Healing power is deployed through the symbolic communication between healer and patient, in the course of which the healer enters the social sphere of suffering in which the patient has been isolated in her affliction and incorporates it into his sphere of spiritual power (Lemoine and Eisenbruch 1997: 99–100). The communicative aspect pertains not only to the individual healer and the patient, for the communication takes place in a semi-public context where family members, fellow patients, and even curious or concerned outsiders may participate. Healing the social person is necessarily a social process in which moral norms and religious values may be rehearsed and reaffirmed for the benefit of both the sufferer and the audience.

In contrast to the public nature of the healing practices, the acquisition of the ritual and practical knowledge of the *kru* is surrounded by some secrecy. A *kru* is taught by one or several immediate masters (*kru kan*) who initiate him into the spiritual lineage (*khsae*) of a particular *kru thom* (‘big teacher’). The *kru* is bound by a code (*tranom*) of ascetic rules, akin to the Buddhist precepts; these are injunctions specific to the individual, but they are variations of common themes such as to go barefoot, always sleep in one’s own house, and abstain from eating certain foods, such as buffalo or beef and certain fruits or vegetables. Observing such ascetic rules is necessary for the *kru* to preserve his healing powers. Each *kru* compiles his own manual (*kampi*), which contains the rules of the *tranom*, the recipes and mantras he has been taught, as well as his own remedies and ritual procedures. This manual is a jealously guarded secret; to share it with others would be to wrong the teacher (*kos kru*) and damage the healing power of the *kru* and his *khsae*.

In the following we will present some individual cases of indigenous practitioners in order to demonstrate the variations among them and open up for a perspective that takes into account specific historical, social, and personal circumstances as well as the deployment of individual agency of particular practitioners.

**Sok Cheat** is a typical *kru khmae* who combines herbalism and bone-setting techniques with spiritual healing and divination. He lives in a village in Battambang Province. He is 46 years old and has been a *kru* since the age of 17; his teacher, Aim Neang, also lived in the village; he died in 1984 at the age of 87. Cheat has four (former) students who all live in America; one of them sells traditional Khmer medicine. One of Cheat’s specialities is making and selling protective charms to be worn on a string around the waist; he teaches people to recite magic formulae for making
the charms effective. He is also a bone-setter and treats abscesses with herbal medicine. Medicine for abscesses is a mixture of three ingredients, viz., yeast (mee), burnt crushed mussel or snail shells (kambau), and honey. The mixture is applied to the spot with a pad of cotton and bandaged. When the mixture dries, it is moistened with alcohol. It is kept moist for one day, after which the patient is better. To set broken bones he makes a mixture of five ingredients: sticky rice; a herb (slab changvar; Plantago major); jujube leaves (trouy putrea; Zizyphus jujuba); a grass (smao cheng kras; Eleusine indica); and yellow ginger (panlei; Zingiber zerumbet). The mixture is wrapped in bamboo around the broken limb; young people will be cured in a week, older persons take a bit longer. This mixture is also kept moist with alcohol. He also cures stomach infections and typhoid fever; for the former he prepares leaves of slek tradet (Vitis pentagona)
boiled with palm sugar and water, to be drunk once a day for seven days. For typhoid, he uses pounded leaves of water spinach (trakuon; Ipomoea aquatica) in coconut juice, also to be taken for seven days. Cheat is very meticulous about paying respects to and communicating with his kru thom. When we asked permission to take his photograph, he asked us to wait, entered his house and addressed the shrine, informing his teacher that he was about to explain his practice and have his picture taken. Both he and his teacher were happy to oblige and we were invited to photograph the shrine as well. Before Cheat begins treatment, the client has to provide the token of respect to the teacher, the preah pis nokar, which consists of one areca nut, five betel leaves, five cigarettes, five incense sticks, five candles, five units of currency (500 or 5,000 riel, or 5 baht) and five yellow flowers, to be placed at the shrine. Treatment consists not only of the application of the herbal mixtures but, most importantly, of the accompanying mantra (mon akum). Cheat refers to the mantra as sot balai (’Pali prayer’); it consists of the repetition of the words ek, merk, smang; these words have to be repeated a specific number of times according to the day of the week.

The relative emphasis on the spiritual and the herbal–medical aspects, respectively, in indigenous practice varies between practitioners. Some, particularly itinerant indigenous drug sellers in the markets, concentrate on the medical substances. Their stock typically includes not only vegetal matter (dried herbs, seeds, roots, bark, and wood shavings), but also parts of various wild animals (boar’s tusks, bits of fur, snake skin, dried lizards and geckoes, turtle shells) that we would recognize as purely magical substances. The magical efficacy of these substances may be interpreted according to Mary Douglas’s classic analysis (1966) of the ritually powerful properties of certain marginal or anomalous species. But it is also a question of appropriating the dangerous forces of the wilderness (prey) to combat disease and enhance vigour, and parts of the most ferocious – but also most ecologically threatened – animal species (bears, tigers, pythons) are much in demand.

Seng Huon produces indigenous herbal medicine and sells both his products and the unprocessed ingredients from his permanent shop in the main market in a provincial town. He owns a second shop, which is run by his wife, in another main market in town. Huon presents himself as a kru khmae, but he does not keep a shrine for any teacher and on the whole he does not acknowledge any spiritual dimension of his art. Huon is now in his late sixties. His father was a native medical doctor employed at
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the hospital in Takhmau (south of Phnom Penh) who also took an active interest in traditional medicine, and as a boy Huon was sent out to collect medicinal herbs and was taught about their properties by his father. In the late 1950s, Huon himself was trained as a medical attendant for three years at the Preah Ket Mealea Hospital in Phnom Penh, where he continued to work until 1975. He managed to pass himself off as a traditional healer to the Khmer Rouge and he was sent to a sabakor in the forest to produce herbal medicine and teach herbalism to Khmer Rouge cadres.

When he got back from the forest in 1979, he was going to leave the country, but the Vietnamese got hold of him and put him to work at the provincial hospital in Kampong Chhnang as medical inspector and specialist in herbal medicine. During the Vietnamese period the authorities set great store by the medical potential of indigenous herbalism, and he became an important figure. But as modern pharmaceuticals became increasingly available in the early 1990s, official interest in herbalism declined and both his fame and his salary dwindled, and eventually he quit government service and set up his shop. He is quite bitter about his fate and feels he has been let down, even betrayed, by the government.

Among his products, various wine tonics (sra thnam) are popular; the best used to contain tiger bones or pythons, but nowadays such ingredients are expensive and hard to find. The tonics are bottled and have Seng Huon’s photo on the label; they are mainly taken against rheumatic ailments, and numerous customers stop by his shop for a fortifying tonic, at 200 riel for a small glass. Another popular remedy is a tonic for post-partum mothers. The post-partum period is subject to great ritual attention in Cambodia, so there is a niche for traditional practitioners to cater for the needs particularly of poor people. Among the raw ingredients, the anti-malarial remedy known as krob sleng (‘poisonous seed’, of Strychnos nux vomica) sells well; it is a seed the size of a coin, the active ingredient of which is strychnine, so it has to be administered with care. To begin a cure, the patient takes one-eighth of a seed for the first couple of days, and gradually increases the dose to one-fourth and to one-half. Krob sleng is resorted to by the poorest customers (typically Vietnamese fisherfolk) who cannot afford anything else.

Even if Seng Huon is perceived, by himself as well as by others, as a kru khmae, he differs markedly from the majority of his colleagues, and he may perhaps be described as a neo-traditionalist. The spiritual component is completely absent from his practice. He survived DK because his secular herbal knowledge was deemed useful, and he became important during PRK as a state-promoted
'traditional' herbalist whose outlook tallied with the nationalist ideology of the Vietnamese-backed government regarding beliefs in the future of a domestic medical production from indigenous herbs. He differs from typical kru khmae in that he never conducted a healing practice from his house, but practised in 'modern' institutional settings, first in the Khmer Rouge collective, then in the PRK district hospital. He is now a member of a traditional healers' association that seeks to reinvigorate herbal medicine.

Our next case is Keo Sarin. He is a kru phsom thnam, one of the best known experts in herbal medicine in the country. He lives in a village along a national highway. Next to his living quarters is the shop cum clinic and storeroom for his healer's practice; it contains large quantities of indigenous medicines, roots and dried herbs in plastic bags, and herbal decoctions in bottles. All products are neatly stored on shelves and each item has a label with Keo Sarin's portrait on it. In a corner of the large room is a large nine-level spirit shrine. The shrine reflects the status of his main teachers, kru thom. Above the entrance to his shop is a signboard announcing the Khmer Angkor Traditional Healers' Association, of which he is the founder and chairman. The full name of the association is 'Association des Guérisseurs Khmers d’Angkor pour la Recherche des Médicaments Traditionelles en Vue de Développement' (Samakum Srav Chrev Orsoth Boran Khmer Angkor Apivath). This name proclaims that we are dealing with the genuine Khmer article, a tradition that goes back to the roots of all things Khmer, the great civilization of Angkor; it also proclaims that the knowledge and practice of traditional medicine is not only a thing of the past, but has equally great potential for contributing to the nation's contemporary and future development.

When we first looked for Keo Sarin he was not at his house. Instead we met one of his clients, a man who was temporarily living with his household and doing menial tasks in return for being treated and taught by Keo Sarin to (hopefully) cure his paralysed left arm. We also met Sarin’s young wife who directed us to his herbal ‘farm’ where he was working. It was a plantation about 8 km west off the main road where Keo Sarin grows medicinal plants on a fairly large scale. Although managed solely by Sarin, the plantation is officially owned by the Traditional Healers’ Association, allegedly because the provincial government has limitations on the amount of land that may be owned by individuals, and Keo Sarin also has rice land of his own.
Keo Sarin is a charismatic man who exudes strength, health, and cheerfulness. He has been a kru khmae all his life. His great grandfather was the legendary Khmer patriot Okhna Kralahom Kong. Both his grandfather and father were kru and used herbal medicine, as well as magic, which is why they lived to a ripe old age. Keo Sarin himself is 70 years old, very strong, fit, and healthy and takes herbal medicine every day. He has eight children by his former wife. They all sell traditional medicine. His current young wife has already borne him three children and is pregnant with the fourth. He was taught by his grandfather and his father, and started practising himself at the age of 16. He was further taught by other knowledgeable kru at Phnom Sampov and Prey Chhley in Battambang, at Phnom Kulen in Siem Reap, and at Phnom Sonthok in Kampong Thom. He also studied at a wat in Battambang, where he was ordained as a monk. He left the monkhood in 1952 to join the Khmer Issarak movement. In the late 1950s he was the secretary to Dap Chhuon, former Issarak commander at Phnom Kulen and then governor of Siem Reap. Chhuon wanted secession for Siem Reap and in 1959 plotted to kill Sihanouk [see also Corfield and Summers 2003: 96–97]. Keo Sarin claimed to be the one who informed the government in Phnom Penh about the plot, which led to the capture and assassination of Chhuon at Phnom Kulen. After that Sarin went to Kampong Chhnang and practised as a kru.

During Pol Pot time he was sent to Phnom Penh and put to work in the National Drug Factory. There were then a large number of kru khmae in the country; Pol Pot rounded up many of them to learn from them, but afterwards many were killed and/or sent to S-21. If the kru failed to meet with Pol Pot’s demands, especially in various experiments that were performed, they were sent to S-21. Only four survived, himself and three others. Sarin himself survived because he successfully managed to cure a seriously ill malaria patient with injections. If the patient had died, Sarin too would have been killed. At the National Drug Factory he was director cum controller of production. He directed the collection and sorting of herbs, including those brought back by the travelling teams (see Chapter 4). He stresses that he did not work voluntarily for Pol Pot; it was slave labour.

After 1979 Sarin was recruited by the Heng Samrin government because they needed his expertise. He was placed in the department for traditional medicine and was not involved with modern medicine at all. At the ministry there was no production of traditional medicine – during Pol Pot time they at least had a Chinese machine for pill production – so he only did research and collected samples of herbs from the provinces. From
1980–1988 the government showed some interest in traditional medicine, but since then modern pharmaceuticals have increasingly taken over, and the ministry’s interest in traditional remedies has dwindled. He claims that the state lost interest because traditional medicine is not profitable for the government. He has urged his kru khmae colleagues to quit the government and set up private businesses, because the government has ignored the traditional sector. This was why he established the association. He retired from the Ministry of Health in 1988 and set up his place in the village hoping for NGO support for the further promotion of traditional medicine; but after the coup in 1997, many foreigners left the country, and thus far he has been unsuccessful in obtaining the necessary funding. He claims that traditional medicine is still very popular outside Phnom Penh and that 80 per cent of the population use it. It is only in the capital that modern pharmaceuticals have replaced traditional remedies.

There are clear parallels between Keo Sarin’s practice and that of the leprosy expert, kru Pen, in the early twentieth century, as related by Dr Menaut (see Chapter 7). Like kru Pen, Keo Sarin is a natural farmer and involves his clients in the running of his household and offers treatment in return. In this way he incorporates the afflicted person into his sphere of spiritual power. But Keo Sarin has adapted successfully to modernity by applying (the colonially introduced idea of) plantation monoculture to the growing of medicinal plants, instead of relying on the customary collection of wild species in the forest. A herbalist’s popular reputation is to some extent based on the extent of his herbal knowledge and his practice of combining a large number of herbal ingredients. Keo Sarin claimed to know how to use more than 3,000 species of plants and promised to show us his book of herbal lore. On a subsequent visit, he produced the book, which turned out not to be a palm-leaf manuscript, as we had naively imagined, but photocopies of parts of a French-educated Cambodian botanist’s inventory of Cambodian flora. One might have the suspicion that possessing the ‘book’ is seen as the equivalent of possessing the knowledge that it contains – just as possessing the name of a medical product in a pharmacy is almost equivalent to having the product itself.

Despite his gentle and cheerful appearance, Keo Sarin is also steeped in the more sinister world of Khmer magic and cruelty. The Khmer Issarak were as brutal towards their perceived (‘Francophile’) enemies as the Khmer Rouge were towards theirs (Vickery 1984: 5–8). Eventually, however, the Issarak lost its influence as an anti-colonial resistance movement and thus its national political importance, and it degenerated into terrorist groups led by local warlords and a
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disgruntled prince (cf. Kiernan 1985: 50–61). But many of its former supporters (such as Dap Chhuon, governor of Siem Reap) became fiercely Khmer nationalist and anti-communist and promoted a world view that rested on a blend of Buddhism/Brahmanism, magic, and the glorification of the Angkor era and achievements.

Indigenous Khmer healing depends to a large extent on the spiritual powers that the individual healer may harness, whether the immediate healing agents are herbs or spirits, or both. A successful healer is one who has built up his spiritual powers in the course of his earlier career. One source of spiritual prowess is related to the cosmic geography of the land of the Khmers. In the geo-cosmography of the Cambodian state, cosmologically significant, ‘sacred’ places notably include mountains and montane forests, which are seen as local representations of Mount Meru, the centre of the world in Theravada Buddhist (as well as Hindu) cosmology. Thus, it is no coincidence that Keo Sarin received instruction and guidance from teachers residing in such cosmologically powerful places: Mount Kulen, Mount Sampov, Mount Sonthok, and the Chhley forest. Such places, while physically located at the margins of the state, assume a position of cosmic centrality for the nation, and the healer appropriates the cosmic forces of these places for his healing purposes, making him not only a kru, but, indeed, a kru khmae. It is also no coincidence that Keo Sarin has chosen to locate his business along a national highway, in the hope of being able to tap into the (financial) powers of the spirit of development for the promotion of his enterprise to combine the Angkorean Khmer healing ‘tradition’ with the magic of development.

A further variation on the kru khmae theme is provided by kru Chhoy, a kru sneh who is doing a brisk business at his house in a rural village in Kampong Chhnang Province, where one feels far from the highway, hospitals, and clinics. Kru Chhoy makes no concessions to biomedical modernity. He is a friendly and cheerful person with considerable social skills that win him the confidence of his clients. His practice is conducted on the verandah of his house in a semi-public setting, and both his wife and waiting clients participate in the consultations by offering or being asked their opinions about the various cases brought before him. The same courtesy was applied to the couple of visiting anthropologists, and we did not feel out of place when observing the proceedings, occasionally being asked our opinion, and talking to Chhoy between his consultations. Chhoy made it clear to his clients that a promise is a promise. If clients have promised to pay him for his services, they need to come up with at least some kind of
small payment, in order for him to do the lia ban non (‘pay offering’) ceremony, otherwise he will be in trouble with his kru thom. The shrine to his teacher is a modest one and kept inside his house. Chhoy himself has made the promise to his teacher that when engaged in his practice he is not permitted to stay on in other people’s houses or to eat with them, because this would bring them bad luck. He has to return to his own house and to eat in his own place, even if he is seeing clients outside his home area, or occasionally performing a ceremony in the house of a client. As already mentioned, observing such rules of asceticism, including food taboos, is common among most kru, but the particulars vary from one kru to the next. It is significant, however, that rules of asceticism do not pertain to sexuality; on the contrary, sexual vigour is an indication of a kru’s healing power.

Kru Chhoy had originally wanted to become a sorcerer (kru thmup) in order to take revenge on the people who had allegedly killed his parents by putting a spell on them. He never entered the monkhood. He went to Thailand for two years to study with a kru khmae in Samraong along the border. It turned out that his teacher refused to teach him sorcery but instead persuaded him to let go of the past and to accept his and his parents’ fate. Instead he should use his knowledge and power to support people and to heal them. He learnt how to combine his ‘lessons’, how to mix medicine, and how to use mantras (mon akum) to accompany the medicines to make them more effective. Since then he has studied with a number of other teachers named Ku’song, Roem, Sap, and Korn.

He has been married three times. His first wife died before Pol Pot time. Their two children died of illness during DK. His second wife died after the Vietnamese invasion and left him with five children. He has four children by his third wife, and rumours have it that he also recently had a baby with his ‘minor wife’ in the village. His clients come from all over the country, and even Khmer from Australia and United States come to consult him. He showed us some pictures of himself with his clients in Australia. He had also received permission from the authorities to travel to the United States, but when he learnt that he had to stay on for five years in order to bring his family members over, he gave up the idea.

Chhoy told us that he had just had a client, a woman who was indebted to a moneylender and who had asked for his assistance to make the moneylender show her mercy. He had supplied her with a charm in order to make the moneylender show her kindness like her more and show her kindness.
While we were talking, the next client arrived: a woman in her thirties, accompanied by her brother. The woman was a regular customer and she and the kru were joking with each other during the consultation, even though her problems were serious. The woman owns a small business, and another person had approached her with a suggestion to invest some money in her business in order for them to share the profits. She was ambivalent. Did this person really have the money, or would she be better off not accepting the suggestion? Kru Chhoy burnt his incense sticks and carefully observed the way the ashes moved and curled. Finally, he said that he estimated that there was a 50 per cent chance that the person would come up with the investment. As for the remaining 50 per cent, he suggested that he should perform some magic, to be on the safe side. If she agreed he would request 2 kg of longans from her. She put a small amount of money on his incense tray, thereby agreeing to his offer. He brought out a bottle of oil with which he massaged her forehead, chanting a mantra. He also blew (sdok phlom) his breath over the client. She joked with him and said that if the agreement with the new partner did not work out, he would not get any longans from her. ‘Oh dear’, he joked back, ‘And I who love longans’.

The woman’s brother, who had also come to consult the kru, was having a difficult time. He had divorced his wife some time ago because he had found life with his in-laws hard, the mother-in-law in particular was not fond of him. Now he missed his wife and his little daughter whom he was not permitted to see. Now everyone is surprised. Did he try to see his child? Why not? The child belonged to him and it was his duty to keep in touch with the child! No, he was very sorry, but he was afraid of his mother-in-law. She was strong and he was sure she hated him. But nevertheless he would like to try again, if he could just learn how to handle his wife’s family. He would like to reunite with his wife, maybe she would agree. The problem was still the mother-in-law, she needed to be persuaded and won over to his side. He was sure that if the mother-in-law would permit her daughter to come back to him, his wife would accept. The mother-in-law had come between him and his wife, and he could not solve the problem by himself. Would the kru help him? The kru proposed a ritual purification with water (sraw tuc), and to put a charm on him. The young man hesitated. He would like to have the charm, but he did not believe that the purification by water was needed.

Kru Chhoy said the charm would not work on its own; he needed to ‘combine the lessons’ and explained how he would start by removing the bad luck from the man’s head, and continue to work it down his body, from the head down to the stomach, until it could be released from
underneath his feet. That was why the water was needed. The young man agreed but seemed shy. He was offered a krama and went inside to change. In the meantime Chhoy’s wife placed the buckets of water next to the stairs. The kru blessed the water with Pali mantras and incense before sprinkling it over the head of the young man; his temples were gently massaged while the wife’s name was repeated and more water was scooped over the body, along with mantras and the gentle blowing of the kru’s breath down the body of the client. The kru also repeated the following words three times:

Oh, lok srei [name of the wife mentioned], please accept lok bong [name of client mentioned], Oh lok srei, if you accept, I am the witness of all this, and I am the witness of his wish to do good.

As the water ceremony was finished and the client had changed back into his clothes, he received the charm. The kru explained to him how it works; the young man should pass the compound of his in-laws seemingly by chance, and the power of the charm would penetrate the fence and spread around the house and affect his in-laws so that they would take pity on him. The kru said he knew that the man’s wife still loved him, but her mother had to be persuaded, so he should approach her place and release the charm there. Everyone on the verandah agreed that this was the best way and that he should do this immediately, without hesitation, when his wish was still strong and the charm still fresh.

Next in line was a young couple with a 9-month-old baby girl. The baby was sick, her tongue was swollen, hanging out of her mouth, and covered with blisters. Oh! said the kru, this is pus – pus pong kyong (heat, the poisonous heat of snail’s eggs). For this the child needed herbal medicine. A basket full of bark and roots of different varieties was provided for the family. The father of the child was instructed to do the grinding and set to work. The mother rested with the baby on the verandah and joined in the conversation as other clients arrived. The preparation of the medicine took about an hour; the powder was mixed into a bottle of drinking water that the clients had brought with them; the kru blew on the bottle and put the cap on. The medicine was to be taken back home and boiled for the mother and child to consume together. With the medicine followed a number of food-taboos. ‘Do not eat chicken, duck, pork or beef. Do not eat seafood, and do not accept for food any creature lacking blood’. Only freshly cooked fish, rice, and fruit was recommended for the mother and child to eat. We were worried that the child perhaps still needed to see a doctor.
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While the medicine was being ground, the kru took on the next client, a troubled young man with a problem very similar to the previous one. He was deeply in love with a young girl, and now she was four months pregnant. The girl’s family was angry with him, a fact that everyone on the verandah could readily understand. The young man would like to marry the girl and keep the child. The problem, once again, was the girl’s mother who did not want her daughter to marry the young man and had decided to persuade her to have an abortion by telling her that she could not get married if she was pregnant, and that she must get rid of the baby before any negotiations about marriage could take place. The young man appealed to the kru for help to save the child and marry the girl, and the kru proceeded with a water ceremony and a charm, as in the previous case.

The last client of the day was a car dealer from Phnom Penh, who had travelled all the way from the city to obtain a charm from the kru, since he was about to sell a Toyota pick-up. The kru had previously helped him sell other cars successfully, so he was a regular customer; he put a 10,000 riel note on the tray. The kru listened to the man while adjusting the incense sticks. He came to the decision that he was a hundred per cent sure the client would be able to sell the car the next day. The customer produced an amulet, a little piece of soft lead sheet wrapped in paper. The kru smeared some balm on the amulet, recited a mantra and blew on it, and told the client to hide it well in the car, but make sure to remove it before handing over the car to the new owner. Then the car received its treatment; the kru took some incense and water to it and sprinkled the bonnet, reciting mantras; on the inside, the steering wheel and windshield got a mantra, a sprinkling and blowing. Our driver, who had parked his car next to that of the client, also wanted a blessing, and our car was sprinkled and had a mantra said over it for free. As we took our leave, all parties were happy with the afternoon’s work.

Despite the fact that kru Chhoy is very much a representative of the premodern Khmer medical universe, he makes some concession to modernity in that he expresses the possible outcome of his healing efforts in terms of chance and risk rather than trust in the spiritual powers (cf. Giddens 1990). He used magic to cover the ‘50 per cent’ risk that a client’s associate would not invest in the business, and he felt ‘a hundred per cent sure’ that another client would sell his car.
While *kru* are almost always male, the majority of spirit mediums (*chol rup*) are female. The *kru* practice by choice and of their own free will on the basis of the spiritual and medical teaching they have received and the spiritual power they have been able to harness. Their competence is vested in their personal abilities and experiences. The mediums, on the other hand, are perceived merely as vehicles for forces outside their own persons. A medium does not as a person harness the powers of her spirit (*boramey*), on the contrary, the spirit appropriates her body for its own purposes. Most mediums we have met claim to have become mediums not of their own free will, but reluctantly and against their own wishes; their *boramey* became attracted by their bodily persons. These differences between male *kru* and female *chol rup* reflect the ideal Cambodian gender system, as detailed in the moral codes for men and women, *chbap pros* and *chbap srei*, which were given literary shape in the early nineteenth century in the form of long poems (Pou 1988; Jacobsen 2008: 119–122). According to the *chbap*, women should be modest, acquiescent, and self-effacing and let men make decisions on their behalf. The gender ideology encoded in the *chbap srei* reflects the values and ideals of a small urban middle-class elite in the old society. But as Annuska Derks has argued in her account of gender in Cambodia (2008, ch. 3), this does not mean that the moral code is just a relic of an old-fashioned bourgeois culture. The texts also have contemporary relevance ‘in an effort to restate a social order which is thought to be either lost due to years of war and destruction or at stake in the face of foreign influences’ (ibid.: 47). Indeed, Derks in her study of young migrant women in Phnom Penh found that a considerable number of her informants were quite familiar with parts of the *chbap srei* and consciously tried to observe its tenets.

So while the mediums’ lack of personal initiative in relation to the spirits and their alleged passive acquiescence may be seen to conform to the cultural ideal of female behaviour, this does not mean that spirit mediums are devoid of practical agency. Indeed, from the ‘politics of storytelling’ perspective (Jackson 2002) the semi-standardized ‘conversion’ narratives of the initial possession serve the double purpose of reaffirming Khmer gender ideology and granting the medium a privileged position in the gendered system. The fact of having been ‘chosen’ as a vehicle for a *boramey* allows the medium to claim a special status. She can make it known that her life is never going to be easy and that her spirit is likely to make continual and heavy demands on her. At the same time, this gives her a scope for personal agency that most ordinary women do not have. Since her life is directed by her *boramey* she can act without regard for her own fortunes and misfortunes,
and she can refer to her *boramey* in various interactions and negotiations both during crises and in daily social life. In the following we shall give a few examples of the ways in which mediums may deploy personal agency within the bounds of culturally acceptable gender behaviour. Our first example, a ‘classic’ one, is that of the fairly well-known medium of Yei Tep in Kampong Chhnang town.

The spirit name, Yei Tep (‘divine grandmother’), is the name of a female *neak ta*. The *neak ta* are ancestral guardian spirits of a certain territory. Most *neak ta* are male; they are usually individually named and their legendary history is known locally (see Forest 1992 for examples). A couple of female *neak ta*, however, are known only by their generic names, such as Yei Tep and Ye Khmau. Shrines devoted to the figure of Yei Tep have been reported from *wats* all over the country (Ang 1986: 219–220). In Siem Reap there is a statue of Yei Tep which is the object of an elaborate cult (Hang 2004: 116–118). Yei Tep in Kampong Chhnang was the alleged founder of Wat Yei Tep, which bears her name. Yei Tep the medium is a woman in her late thirties, friendly and rather plump, with a strong personal presence. She lives with her husband in a modest house in a back alley behind the *wat*. When we visited she was about to perform a ceremony for a client who had an appointment in about 15 minutes, and we were invited to attend.

**Yei Tep** was possessed by the spirit the first time when she was still single. She stressed the importance of the fact that she was still a virgin when she became the medium of Yei Tep. This was in 1982 and it happened when she was present at a ritual to be performed for her young cousin who had been taken seriously ill. The relatives had collected their resources and called upon a medium to perform for the cousin. As Yei Tep herself approached the ritual space, she fell ill, fainted, and became *sanlop* (unconscious), and ‘did not know her body’; she could not eat for seven days and seven nights. Her family and relatives were poor people, but they pooled what money they had to invite a medium to come to cure her. The medium was called Pali, and her spirit was called Lok Ta Son. Lok Ta Son revealed that the young woman was possessed by Yei Tep, and that the *neak ta* had requested her services and had come to stay with her as her *boramey*. The spirit had found her attractive and liked her personality and character. She felt heartbroken by the request of the spirit to remain with her, and she resisted the demands made on her to live like a medium of the spirit with all the restraints upon her life that it would entail. In order to escape her destiny, she ran away from her family and went to Phnom Penh to do business.
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She had a hard time in Phnom Penh; whatever she tried to do turned out to be a failure. Her small business went bankrupt and she became ill again. Finally, she decided that she had to accept her fate and returned to her family. She said it was difficult at that time to be a medium because of the Vietnamese presence, they did not take kindly to mediums or their followers. She was conscripted for the dreaded kor pram scheme (see Chapter 4), and was sent to the forest in a mountainous area of Pursat Province. Her group was accompanied by Vietnamese soldiers and foresters and since her boramey was strong and supported her, she gained their respect. She could divine and help the Vietnamese with their own anxieties and family worries, and this helped them to relax a little, so she was fairly well treated. In 1988 she met her husband, who was also a medium and they were married, not as ordinary couples by a wedding, but by their spirits, and by performing a ceremony for their spirits only.

As the medium of the legendary founder, the neak ta, of the town and the wat, it is her duty and privilege to lead the Khmer New Year procession of provincial officials to the various shrines of the local neak ta. Apart from that she runs her practice in her house. Her husband assists her. She receives many clients and treats a wide variety of conditions. Some suffer from illness because they have been afflicted by sorcery; they have mostly sought medical treatment by a doctor or at the hospital first, but without being cured, since a pet cannot cure such conditions. She treats these patients with ‘medicine’, mainly betel and areca and limestone which they chew, so that the foreign objects are expelled naturally when emptying the bowels. Some clients need her to cast a spell on others, typically men whose girlfriends have left them and who want to prevent the girl from marrying someone else. She also treats ordinary diseases, by ritual purification. But most clients are treated by her boramey, that is with a spirit possession ritual. Some of them come to her because they suffer from problems in their marriage. Some suffer from bad luck, others need good luck, for example in order to improve their career, succeed in university exams, or obtain authorities’ signatures on various documents. People often consult her before travelling, because travelling is wearying, and you need to make sure of your standing with the spiritual world before the start of the trip, and sometimes to divine a suitable day for travelling.

In the front room of the house is an elaborate shrine. It has five levels and contains about a dozen Buddha statues of varying sizes, six golden representations of the nine heavens, a couple of silver bowls, various photographs, and assorted bric-a-brac. On the lower level of the shrine there are three small Shiva statues.
Beneath the shrine is a place for Yei Tep to sit, enclosed by a low railing. To perform the ceremony, Yei Tep and her husband had prepared a ritual space for the client in front of the shrine. It was marked by four tops of banana trunks with small candleholders attached, to represent the guardian spirits of the four cardinal points; they are called the *bon tus* (four directions). The banana trunks are condensed symbols: they are the *opakut*, which means that during the ceremony they are a representation of the bad luck that the client needs to get rid of. At the same time they are cut in a way that leaves three young leaves at the top, representing virginity. Towards the end of the ritual the stems will be chopped up to chase out the bad luck, and thrown away. But, said the husband, if the stem still shows sign of life after this, it is an indication that the bad luck remains with the client. In the middle of the ritual space was a piece of white cloth, on which uncooked rice was arranged in an anthropomorphic shape. This was the bad spirit or the bad luck that had to be removed from the client during the ceremony. It was to be deposited on a *bae*, a small square tray of banana stems and leaves that was placed behind the client (cf. Ang 1986: 90–92). In this *bae* was another anthropomorphic picture, made of sand, representing the earth-being. Clippings from the client’s fingernails and toenails, hair, and a piece of cloth belonging to the client – representations of her bad acts – will be added to the *bae* at the final phase of the ceremony. The *bae* with all these items is then removed and thrown away.

As demarcations of the ritual space, apart from the *bon tus* in the corners, the following items are placed in two pairs on each side of the space:

- *sla dharm*, a banana stem with three incense sticks, for the *preah puttoa*, the *preah sat*, and the *preah sang* (the Buddha, the Dhamma, and the Sangha).
- *pay si preah pram*, an ornament of banana leaves, with five incense sticks for all the five Buddhas, including the Buddha Maitreya.
- *sla dharm tun*, a coconut with nine incense sticks, four for the four *meak* (*maga*, the paths to enlightenment); four as reminders of the four *phala* (merits, the results), and one as a reminder of Nirvana.
- *sla jam*, another coconut, for the Buddha, the top of which has been cut to display the white flesh inside, the edge left from the cutting is used for five incense sticks, being representations of all the Buddhas (cf. Ang 1986: 86–89).

The client, a young woman in her early twenties, arrived, and to begin the ceremony, Yei Tep prepared her tray of offerings necessary to invoke her *boramey*. It was a round brass tray and the offerings consisted, as always, of five pieces of
the following five items: incense sticks, small candles, cigarettes, areca nuts, and betel leaves. Yei Tep went behind a screen to change into the proper attire: a white blouse and wide white trousers, the traditional sarong called sampat cong, tied up in male ‘royal’ fashion. Her hair was rearranged and tied to resemble a small chedi on top of her head. The client went into the bathroom to change into shorts and a loose shirt (in anticipation of the aspersion at the end of the ceremony). In the meantime the husband lit candles and incense, presented the incense to the shrine and placed sticks on the various objects around the ritual space. Yei Tep took her place in front of the shrine, prayed and put on a diagonal yellow scarf, signifying royalty. The husband had put on a white scarf and started the music from the CD-player. The music is important as a means of communication to guide the boramey through the ceremony. The husband closed the windows and doors and lit the four small candles on each of the four banana tops. After praying for a while, Yei Tep took a couple of deep breaths and suddenly called out loudly and lifted the tray of offerings towards the shrine; the spirit had arrived, and she now spoke in the spirit’s voice. The client entered the ritual space and seated herself on the anthropomorphic rice shape and offered a prayer. The husband sat in front of the shrine, to the side. Yei Tep chewed betel and areca, and she and her husband took turns talking to the spirit.

Yei Tep then moved out of the sitting enclosure in front of the shrine and placed herself facing her client at the end of the ritual space; she talked in the voice of the spirit, addressing first us, then her client, ‘In honour of you, barang, and in honour of you, lok srei, we are pleased to welcome you all!’ She took a lit candle and held it above the water bucket so that melted wax could drop into the water while praying to the Buddha. The husband made a sima (ritual boundary) by draping a white cotton thread around the four banana tops that constituted the corners of the ritual space and threaded it across the client who in this way became tied to the ritual space in a virtual web. He also made another sima around the ritual space on the floor. Yei Tep lit a couple of candles which she held over the bucket of water in front of her; she and her husband chanted for a while, Yei Tep facing the client, her husband facing the shrine. Yei Tep stirred the water in the bucket with a wisp while holding the lit candle over it. She started sprinkling water on the client, both she and her husband chanting continually. This went on for about ten minutes. Then Yei Tep changed into the voice of the spirit, speaking very fast, and sprinkling water. After a few minutes she went back to chanting mode, her husband joining, and after another few minutes back to spirit mode, solo. Eventually Yei Tep stopped sprinkling, performed the vai, and the husband removed the thread that had bound the client. The client was
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given a pair of scissors to cut her fingernails, toenails, a bit of her hair, and a bit of her shirt, and put the cuttings in the bae. During the snipping, Yei Tep kept sprinkling water and chanting. The husband fetched a large plastic basin and Yei Tep, talking in fast spirit mode, took the four banana tops, held them over the client and then handed them to her husband who quickly cut them into pieces over the basin. The client wrapped the anthropomorphic rice shape in the cloth, Yei Tep put the candle that she had held over the water bucket on top of the package and her husband put it in the bae. After some more sprinkling Yei Tep took a piece of red thread and tied it around the client’s right wrist, and continued the sprinkling for a while, all the time speaking in spirit mode. Finally, Yei Tep performed the vai and rolled back the thread on the floor. The client went to sit on the back verandah where the husband performed the aspersion by pouring buckets of water over her. Yei Tep had turned back to face the shrine and take leave of her boramey. The client dried and dressed herself, the husband removed the bae and the basin to the front verandah and swept the floor.

Yei Tep offered Ing-Britt the blessing of her boramey and gave her a small handkerchief printed with a divination diagram. She did the same for the client when she returned after dressing. The whole procedure took about 45 minutes. The client explained that she had asked for the ceremony because she was about to travel. She had signed up to go to Korea where she would attend a course for fashion designers, and she planned to return to her country to set up her own shop. The training in Korea was free of charge, but she would have to work in the garment factory that offered the course. Inwardly, we shared her apprehension about the whole enterprise but could only wish her good luck.

We referred to Yei Tep as a ‘classic’ example of a medium, primarily because she was first possessed already in the early 1980s when spirit possession was disapproved of by the socialist regime. But it should also be noted that the ceremonies she performs are unusually elaborate in terms of ritual paraphernalia compared to those performed by more recently established mediums. Since the mid-1990s the number of practising spirit mediums seems to have increased dramatically. Many mediums have recourse to several spirits, of whom one is usually the main one, the first to possess the medium. This spirit is often referred to as the boramey (Sanskrit parami, a word that denotes the ten states of perfection of the Buddha, and by implication the sacred power that emanates from the Buddha or Buddhist divinities; Eisenbruch 1992: 290; Bertrand 2004: 151, 168). Occasionally a medium may have more than one boramey (in which
case the first will be the *boramey thom*, the ‘big spirit’) and most often the *boramey* will have an entourage (*khsae*) of lesser spirits as assistants. The contemporary proliferation of mediums (and, indeed, of spirits) and their inventiveness as ritual *bricoleurs* makes the phenomenon of possession difficult to classify according to criteria usually employed by scholars of religion. Maurice Eisenbruch has already pointed to the blurred boundaries between supposedly Brahmanist and Buddhist healing practices (of *kru* and monks, respectively; Eisenbruch 1992: 291, 310). And the distinction between a *kru* who pays respect to his *kru thom* and one who gets possessed by his spirit (*kru son thith*) may not always be easy to draw. In his account of spirit possession Didier Bertrand has noted similar ‘ecumenical’ tendencies among mediums (Bertrand 2004). Nevertheless, Bertrand is keen to stress the relation of mediumship to Buddhism and refers to the mediums as *kru boramey* rather than the more vernacular *chol rup*. At the same time he excludes mediums of *neak ta* from the category of (Buddhist) *kru boramey* (ibid.: 158–159), but the case of Yei Tep blurred this distinction, as a *neak ta* was the founder of a Buddhist *wat*.

The terminological ‘upgrading’ of *chol rup* to *kru boramey* may also be related to a seeming softening of gender distinctions, as male mediumship is

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*Figure 5.2. Male spirit medium at his shrine. The vase in front contains a large number of burnt incense sticks.*

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becoming increasingly common. Bertrand notes that among those who qualify for his category *kru boramey*, ‘as many men as women are professionally involved in healing’ (ibid.: 159). This does not necessarily mean that the culturally feminine character of mediumship has changed, however. It rather indicates that mediumship is a transgendered phenomenon. In the case of Yei Tep and her husband, a male medium practised as spiritually subordinate to a female one, and generally it is common for male mediums to have a female *boramey*. Bertrand’s formulation about the mediums being ‘professionally involved in healing’ is significant. It is also our impression that mediumship has to some extent changed from being a purely social/spiritual obligation to a more conscious career choice. The following cases may illustrate some of the above points.

**Hok Saray** is a male spirit medium in his mid-forties. He lives in a village not far from Kampong Cham town. He is of a Sino-Khmer family from Svay Rieng, his father raised pigs but eventually became a Khmer Rouge soldier and his mother worked as a cook for the troops, so the family survived the Pol Pot regime. After Pol Pot, Saray went to live with an uncle at Koh Kong to work as a boatman, but after six months he fell ill. His uncle took him to a healer who diagnosed problems with the ancestors. But even after making offerings, his illness worsened. An old lady came to see him and prayed to Yei Khmau and he was possessed by the spirit of Yei Khmau, who demanded that he give her betel and areca. His friends chided him for being possessed by a woman and becoming like a woman. That made him unhappy and he destroyed the shrine he had made for Yei Khmau. But as soon as he had done so, his body convulsed and nobody could do anything. The old lady came back and asked him to apologize to Yei Khmau which he did. This was in 1993 and he has been her medium ever since. In 1998 he moved to Kampong Cham and lived with a female friend who became his *snang* (spiritual partner, disciple; the word also means royal concubine). Among his clients are several rich people from both Phnom Penh and Kampong Som, an *okhma* among others, they consult Yei Khmau with problems such as land conflicts, marriage problems, sorcery, and creditors who want their money back. Because of their generosity he was able to buy a house of his own on the village main street in 2002, and a couple of years later he had it renovated with solid wooden floorboards and even glass windows.

Yei Khmau, who has taken such good care of Saray, is a very well-known figure in the Cambodian popular pantheon. Her name means ‘black grandmother’ and she has been seen as a Cambodian version of the Hindu goddess Kali (Ang 1987:}
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20; Bertrand 2004: 153), but she is a figure of popular worship also among Vietnamese and Cham in the Mekong Delta (Taylor 2002). In Cambodia she figures as a neak ta, with a specific local history, or rather several specific histories (Forest 1992: 146–150). She is thought particularly to protect travellers; on the main road between Phnom Penh and Kampong Som there is a place where numerous shrines for Yei Khmau are set up, and both buses and private cars will make a stop to allow passengers to place offerings of bananas to Yei Khmau. While visiting Saray we expressed our wish to talk to Yei Khmau and ask her advice, as protector of travellers, since we would be travelling back to Sweden a few days later and had had reports of violent storms over Scandinavia. Saray obliged, lit a bunch of incense sticks and turned to the altar, chanting a brief invocation; a shudder signalled that Yei Khmau had taken possession of his body, his voice became squeaky, and he immediately started preparing betel and areca which he put in his mouth in copious quantities during the possession.

Yei Khmau said that she is 600 years old. She has an entourage of three spirit child servants named kumar pich, kumar kil, and kumar kos (diamond child, elusive child, and disobedient child). In her life she was a royal dancer at Lovek (the Khmer royal capital after the fall of Angkor) and the wife of a five-star general in the royal army, named Ta Nakry. At that time she was known as Chum Tiev Khmau (‘very important black lady’). Nakry went to battle with the Siamese at Koh Kong and after a while she started to miss her husband so she went out on elephant with an army detail to find him. When she arrived at Koh Kong, close to her husband’s quarters, she was told that he was now living with a Thai girl. She became very upset and decided to head home, but on the journey back her boat capsized and she drowned. – As for our travel plans, she said we should not worry.

In the same area in the vicinity of Kampong Cham town we got to know several other mediums. At one house we were unsure at first whether we had come to the right place. The whole compound looked more like a rubbish dump than a courtyard. It turned out that the family, obviously poor, was in the recycling business and collected scrap metal, plastic bottles, and beverage cans. But the mother of the medium was sitting at the foot of the stairs peeling tamarind and she confirmed that her daughter would start receiving clients in half an hour. We decided to wait and were offered a couple of chairs that had not quite reached the recycling stage. The daughter, Kang Chhea, was an ordinary looking village girl in her late teens, she said that her boramey was a Chinese princess but did not elaborate on the circumstances of the initial possession.
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A couple of clients had already arrived and by two o’clock we all went up into the house. Kang Chhea sat in front of her shrine and made herself ready by putting on a white shirt and tying a white cloth, turban-like, around her head. The mother managed the proceedings throughout, including the seating arrangements of the clients as more arrived and receiving their donations of incense and money. Chhea lit incense, offered a prayer and shuddered as her spirit took possession. She then turned to the audience with an ecstatic expression on her face and spoke in a high childlike voice. As each client stated his/her reason for the consultation, the spirit started by reading the palm of the client. Then the conversation between spirit and client went on, the comments of the spirit were often amusing and members of the audience occasionally joined in, the atmosphere was one of almost hilarity. The spirit seemed quite flirtatious, particularly with male clients, but also capricious. When a male client, for example, asked advice about whether to emigrate, the spirit first said, ‘A stupid man like you, how can you believe that anyone would give you work’, but soon after she said, ‘Yes, this sounds a good idea, I think you should sell your assets and leave on Thursday’. After about two hours when all the six or seven clients who had come that day had had their consultation, the medium turned to the shrine and bade her spirit good-bye.

The relative popularity of this medium among ordinary people from the town and surrounding areas is no doubt due to the rather extraordinary behavioural license of her spirit. By human standards such behaviour in a young Khmer woman, moreover in the presence of her mother, would be unthinkable. We may recall that in the chbap srei, the mother admonishes her daughter,

Do not be rude or vulgar or petty,
do not fail to devote yourself to all members of your family.

[...]

If you must speak or converse, think of your reputation as a woman:
Do not make frivolous remarks,
do not prattle and smirk like a little girl.
In the presence of young men, do not insinuate yourself

(Pou 1988: 413).8

Although it is doubtful if Kang Chhea’s family would be familiar with the actual text of the chbap srei, it seems that the spirit’s transgressive behaviour was by the book. The palm reading (which we have not seen with other mediums) was surely an added attraction, since the intimacy of physical contact (particularly between opposite sexes) is not normally extended to strangers. On the whole, both
the medium and the clients entered into a titillating make-believe world where social and behavioural norms could be inverted, while the mother contentedly collected the cash. We calculated that the spirit medium practice would bring a couple of dollars a day, a significant amount for a poor rural household.

Not far away in a neighbouring village lives another medium, Pen Maly, who in many respects presents a contrast to Kang Chhea.

Pen Maly is 52 years old and lives with her husband in a house on the outskirts of the village. This family is very poor, but the house is in good repair and well kept, the courtyard is meticulously swept and there are flower pots along the staircase; a half-tame tokay gecko lives in a corner of the verandah, it belongs to Maly’s boramey. The house is off the village road and is approached by a path through the paddies. Water is supplied by a horse cart, and the water seller complains about the difficult access and has threatened to claim damages if the horse stumbles and hurts itself. We detected a certain rivalry between the two mediums, and Maly confided that the Chinese princess has withdrawn from Kang Chhea and that she is now possessed only by the spirit of a very minor Vietnamese servant of the princess. Maly herself, on the other hand, is a genuine medium in the proper Buddhist/Brahmanic tradition. Her boramey thom is the spirit of a deceased hermit monk, Lok Ta Phouang, who was affiliated to a nearby wat and whose photograph she keeps at her shrine. The spirit of Lok Ta Phouang first came to her in 2000. He wanted to help her because she was poor but pious and he instructed her about how to build the shrine and about dietary restrictions; she was to eat only vegetarian food and only in the morning. Lok Ta Phouang eventually brought along his spiritual entourage as her minor boramey; these include Lok Yei Sak Sar (white-haired grandmother); Lok Yei Seh Meas (golden horse grandmother); Lok Ta Maetrap Chey Rithisen (victorious legendary general); Lok Ta Preah Muni Eisei Sak Sar (white-haired hermit monk); Lok Ta Kantan Lea (matted hair); Lok Ta Udong Seh Sar (white horse from Udong); Lok Ta Kumar Vayreap (child named Vayreap); Lok Ta Kralek Chhey (fiery stare); Lok Ta Kumar (3-year-old child); and Mreing Kungyeal (small house spirit, possibly the tokay gecko).

The assortment of characteristics of these auxiliary spirits is fairly typical for the variety of spiritual forces one may harness. The appellations lok ta and lok yei signify male and female ancestors, respectively. The character Kantan Lea, the one with matted hair, deserves a comment. The spontaneous growth of matted hair (sak kantan) is a sign that the person, male or female, is endowed
with a special spiritual disposition; the *kantan* is attractive to the spirits who are therefore likely to possess the person and make him or her a medium. John Marston (2004: 172), for example, reported the *kantan* for a very reputable medium outside Phnom Penh. The tuft of matted hair is in itself powerful and may be carried as an amulet or placed on somebody’s personal shrine (Ang 1987: 5–6).

Despite her impressive spiritual credentials, Pen Maly does not have many clients. The peripheral location of her house reflects the socially marginal position of the family. Other villagers have refused to lend them rice for fear that they would be unable to pay back the loan, and the husband complains bitterly that he has been living in the village his whole life but has always been scorned by his fellow villagers. Their daughter had had to drop out of school after second grade to take a construction job in town, but she had been cheated of part of her salary. Two sons also work at construction, as does the husband occasionally.

The day of our first visit, Maly was expecting a client who had been to see her a few days before. This client did not turn up until two days later, she was feeling unwell, presumably because of her hopeless economic predicament. Her husband and son had gone to seek work in Thailand to support the family, but as an illegal migrant worker the husband had been put in jail, so they no longer had his contribution to the family finances. Since the woman could not manage their small plot of land on her own, she had mortgaged it and had been obliged to take a very bad deal: she was given a loan of 60,000 riel (US$15) with the land as security, and double that amount was to be paid back within 12 months, otherwise the land would be lost. The time was nearly up, and the family’s desperate economic situation had made the woman sick with worry. As far as Pen Maly is concerned, clients like this will hardly make her rich, even if her *boramey* was perhaps inspired by the success of Hok Saray who is well known in the area. But not even spirits with the best possible Buddhist credentials are necessarily sufficiently powerful to break the vicious circle of rural poverty.

**MONKS AS HEALERS**

The role of monks as healers varies from preaching the *dhamma* and interpreting its moral admonitions, over the performance of more or less elaborate blessing or purification ceremonies, including aspersion with water, to more vigorous counter-sorcery measures that involve not only the teachings of the Buddha but also require the active participation of spiritual forces (*boramey*) harnessed from outside the sphere of orthodox Buddhism. Even the more theologically correct
monks who wish to restrict their practice to Buddhist teachings will often give in to popular demand for more spectacular symbolic action and offer ceremonies that resemble those performed by mediums. Didier Bertrand has commented on the somewhat paradoxical phenomenon of the blurred boundaries between the ritual performances by monks and mediums. Apart from seeking help with sickness and misfortune, people consult a medium to achieve worldly success, in love affairs, school exams, business ventures, or work. This ‘may seem contradictory to the Buddhist ideal of morality, asceticism, and inner spiritual development. But in Cambodia, where sacred words are used both to exorcise and to teach morality, the desire for material success and well-being is believed to be complementary to the Buddhist path’ (Bertrand 2004: 168). Indeed our observations indicate that catering for such desires may be accepted as integral to the ‘Buddhist path’. In certain wats, not least those favoured by the Cambodian People’s Party (CPP), a veritable blessing industry has emerged. Hundreds of young people, mainly women, come on weekends to get a blessing, for themselves as well as for selected personal possessions, notably cosmetics and mobile telephones, that represent extensions of the self. They light a few incense sticks and place their possessions on a tray with the proper amount of money (2,000–5,000 riel). When the floor is filled with people, a senior monk gives a brief sermon after which he blesses the possessions of each supplicant (his assistant retrieves the tray and the money). People then proceed to the courtyard where a couple of younger monks energetically spray the group with water while chanting mantras. The ceremony may be performed for about 40 people at a time and while one group get their ablutions, the next is already filling the floor at the monk’s feet.

The degree to which a monk is prepared and/or allowed to perform obvious magic and less orthodox practices depends on the personal inclination of the monk and, not least, on the permissiveness of the abbot of the wat who will have to weigh the liberties taken with orthodox Buddhism against the desire to attract devotees – and their donations – to the wat. The following example is of a monk whose practices include a moderate amount of magic.

Ong Soth is a healing monk who lives in a small house (kuti) on the grounds of a wat at the outskirts of Kampong Chhnang town. He receives clients at his house most mornings and, for major ceremonies, by appointment. He was born in 1930 in Kampong Chhnang Province. As a novice at the age of 6 he was taught by a kru khmae, whom he helped to collect herbs. At the age of 8 he was ordained as a monk and at 25 he was married and worked as a kru khmae. He was well known for his ability to assist at difficult births. Ong Soth’s teacher did not want him to work
with childbirth, but he felt he had to, because there were neither doctors nor midwives in the area. During DK he became a lay person, and worked on boats transporting rice. He managed to transfer some of his medical/magical knowledge to a man named Phon, who is now an itinerant trader of traditional medicine; he comes to pay his respects to his teacher at the wat about twice a month. After Pol Pot time, Ong Soth was reordained at Wat Yei Tep and he stayed there for ten years. These were difficult times because of the Vietnamese regime. The Vietnamese strictly controlled the wats, their experts demanded detailed reports from the monks; every time he delivered a sermon he had to report how many attended, men and women, including their identity, and how much money, food, and other items he had received; he had to give half of whatever the wat received to the Vietnamese. The regime had also prohibited a number of popular Buddhist festivals.9

After the Vietnamese experts had left, the Krasung Thammaka Sasana (Ministry of Cults and Religions), which controls the sangha, took over. The ministry officials come for an inspection two to three times per month, which is usually bad news, because they too demand a share of the money and food the monks have collected. When asked what they want it for, they sometimes say it is for the construction of new wat buildings, sometimes for their personal needs. In the mid-1990s Ong Soth moved to Pailin, which was controlled by the Khmer Rouge. They did not allow monks to preach without written texts, they had to read the texts only, not add comments or thoughts of their own. After one year he left Pailin because the climate was cold, there was no fresh food – only canned food and fermented soybeans – and HIV/AIDS was rampant even among the monks. But he still goes to Pailin occasionally, when someone needs his healing services. Ong Soth has a son in Pailin, a former Khmer Rouge soldier who had stepped on a landmine and had his leg amputated and who makes a living driving a taxi.

Ong Soth is quite famous for his healing and magic. The basic, most usual treatment – for improving good luck and avoiding misfortune – consists of a recitation of Buddhist Pali texts and mantras accompanied with blowing his breath over the person or an object belonging to the person, and followed by a purifying bath on the staircase, accompanied by blessings. The monk stirs the water in the bucket with three lit incense sticks and uses them to sprinkle water on the back of the client; he then uses a tin bowl to bathe the client and finally empties the rest of the bucket over him or her, all the while chanting Pali invocations. In case evil forces have to be exorcised, he ends by pouring water from a clay pot over the
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client and smashes the pot on the ground below the stairs. After the bath, when the client is dried and dressed, the monk writes a magic formula on the forehead of the client, while chanting, and ends by blowing, *sdok phlom*, on it.

For more serious conditions, Ong Soth can provide a more elaborate ceremony. One typical such condition is that of *chhnam kot*, the state of vulnerability and consequent risk of bad luck or accidents that occurs when a person reaches the inauspicious age of 20, and the following even decades. To counter this state, the ceremony *kat kos* (‘cut bad’), also called *bangcheas kos* (‘throw away bad’) may be performed. One instance of this that we witnessed was performed for a young woman of 20, who arrived with her grandmother at 9 A.M.

Soth had arranged two rows of golden *pay si* on his *krae* (dais), five in each row. He had also placed a brass bowl of water with a wisp (stick with soft feathers tied to it), a china plate, and a china bowl beside him. The client had brought 2 kg of uncooked rice and a piece of white cloth. The monk started by placing the white cloth on the floor in front of his *krae* (the usual place for clients), counted out handfuls of rice on it and

**Figure 5.3.** Monk performing an exorcism ceremony. The young woman is dressed for the purifying bath.
shaped the rice into an anthropomorphic shape, after which he folded the cloth around the rice into a package. The number of handfuls of rice is computed the following way: 20 (for the age of the client) + 9 + the number of the lunar year + the number of the lunar month + the date (of the month). He then poured some rice into the china bowl and stuck a small candle and a 1,000 riel note into the rice; some rice also went onto the china plate. He fastened a candle on the rim of the brass bowl. He counted rounds of white thread by rolling it around the fingers of his hand, one roll counted in the same way as the handfuls of rice, another smaller roll of 21 rounds (20 for the age and 1 for the gender); the latter he placed in the china bowl of rice.

The monk was assisted by three young boys, kmeng wat (‘pagoda boys’), aged between eight and thirteen. The boys brought two bae, rectangular trays made from banana stems and containing various bits of dried noodles and other stuff, and adorned with white paper ‘flags’; one tray was placed on the krae, the other on the floor behind the place of the client. The boys also placed two clay pots with water just beneath the krae and two large buckets of water on either side of the tray on the floor. The client had changed into ‘bathing costume’ and took her place on the floor. The monk produced a roll of cotton white thread for the sima, which the boys helped him fasten; from the brass bowl, the thread was draped in a rectangle from the krae and including the clay pots, the buckets, and the bae; this marked the ritual space for the occasion. The boys and the grandmother (and the anthropologists) sat on the floor outside the ritual space. The boys placed the lit incense sticks on all the paraphernalia.

The proceedings began with the monk, the boys, and the grandmother chanting in unison; a little later the monk led the chant and the boys repeated. After the chanting, the monk wrote magic formulas on the rice on the plate while the boys prayed. The monk gave the bigger roll of white thread to the client and asked her to put it behind her right ear. He stirred the water in the brass bowl with the wisp, chanting, and after a while sprinkled water on the client. For about ten minutes he alternated between sprinkling the client and throwing small handfuls of rice from the china plate on to the two bae, chanting continually. When he stopped, one of the boys removed the sima thread, took the two buckets of water to the top of the staircase, and put the bae from the krae on top of that on the floor. The boys and the grandmother prayed, and the monk smoked a home-made cigarette. He told the client to turn around and push the bae toward the side door with her feet. One of the boys took the cloth package.
of rice, swung it over the head of the client and threw it away. The monk threw the rest of the rice from the plate onto the bae, which were then removed by the boy. The client went to sit on the top of the staircase, and the monk performed the usual aspersion of her. After emptying both buckets, he ended with pouring the contents of one of the clay pots over her, then threw the pot to the ground with a loud exclamation and told the client to descend the stairs and get out immediately. The client went to dry herself and dress beneath the house, after which she returned to her place beneath the krae. The monk had put the contents of the china bowl in a plastic bag for her to take home; he told her what to do with it: the rice was to be cooked and eaten the same evening; the money was to be kept for one year; the roll of thread was to be placed under her pillow for her to sleep on; the small candle to be lit on her bed above her head; and she was to recite a mantra over and over again until she had fallen asleep. The monk wrote a magic formula on her forehead and blew on it. The grandmother also had a formula written and blown on, and they both took leave. The whole procedure took about 45 minutes.

It is striking that the ceremony performed by the venerable Ong Soth, in terms of paraphernalia and procedure, is very similar to that performed by the spirit medium Yei Tep, related above. The main difference is that Ong Soth is not possessed by any spirit but relies on the Buddhist spirituality derived from his status as an ordained monk. The two cases provide an illustration of the blurred boundaries between ritual performances by mediums and monks.

SORCERY

Most people in Cambodia are familiar with sorcery, and sorcerers (thmup) are supposedly common in the countryside. They act either on their own behalf, out of greed, envy, or simple wickedness, or they may be indigenous practitioners (kru thmup) who attack a person at the request of a client who wants to harm somebody. In either case, their practices are kept secret and known only by hearsay, so it is virtually impossible to meet a live sorcerer. More or less vague sorcery accusations are common, but they are ultimately substantiated only when the suspected sorcerer is killed by his purported victims or other members of a local community. Newspaper reports of people being killed as sorcerers are not uncommon. The ‘knowledge’ of the operations of various sorcerers is remarkably uniform, not to say stereotypical, considering (or perhaps because of) the absence of observational accounts (see Ang 1986: 247–262 for the general picture).
Sorcery is a form of violence. The condition of being afflicted with sorcery is known as *am peu*. The symptoms of *am peu* are multiple and varied, including pain in various parts of the body, swellings, constipation, dizziness, and insomnia, as well as autism or temporary loss of speech or sight. Modern medicine is per definition incapable of curing *am peu*, it can only be treated by counter-sorcery measures by indigenous healers, spirit mediums, or Buddhist monks. To engage in counter-sorcery, however, one may come dangerously close to becoming a sorcerer oneself and thereby committing violence. Once the spiritual force of sorcery has been unleashed, it is not easy to neutralize, but an efficient counter-sorcery measure is to redirect the force back against the sorcerer. To be able to do so requires considerable spiritual strength and carries the danger of the counter-sorcerer him/herself being hit by the sorcery. The treatment of *am peu* may thus in some sense be seen as a combat between two sorcerers whose battlefield is the person of the victim. These agents thus engage in a form of symbolic violence in order to counteract the violence committed against the sorcery victim. Sorcery not only brings bodily pain but often entails both economic and social suffering as well. The victim is not only stigmatized, but sorcery also commonly blocks the victim’s contact with his or her ancestors and disrupts family relations; a harmonious relationship with one’s ancestors is essential for a person’s well-being and sense of social fulfilment.

The venerable *Im Saroeun* is a Buddhist monk at a countryside *wat* in Kandal Province; he is referred to as Lok Khmau, the Black Monk, because of his dark skin. He specializes in the treatment of sorcery victims. He has had a couple of shelters built on the pagoda grounds for clients to stay during their treatment. Treatment is supposed to last for a week or two, but in many cases, considerably longer time is needed. At any given time, there will be at least half-a-dozen clients staying in the shelters, often with close relatives staying as well, to cook for the sorcery victims and keep them company. Lok Khmau represents a particular trend in sorcery treatment by Buddhist monks in that he relies not only on the spiritual powers of his own Buddhist learning, but also on the powers of a number of *boramey*, including two spirits of deceased hermit monks (*eisei*), that of the former abbot of the *wat* (whose ashes are kept at his shrine), as well as a host of auxiliary spirits. In contrast to regular spirit mediums, Saroeun does not treat his clients while possessed by his *boramey*; interaction with his *boramey* occurs in the privacy of his room, as ‘dreams’ during the night. Saroeun’s parents, who live in the nearby village, play an active role in the management of his practice and the promotion of his reputation.
as a powerful healer. His mother, for example, was eager to add details of his immaculate conception by a stroke of lightning (while his father sat beside her looking non-committal), and of his previous, transgendered incarnations as a princess and an important lady.

One of Saroeun's clients is a middle-aged woman, **Yei Koan**. She has been with the monk for more than two years and she is convinced that if she leaves she will die from the sorcery that afflicts her. Her affliction started 13 years ago, shortly after the birth of her youngest daughter. Her husband had just left her for a Vietnamese girl. The suspected sorcerer who does her harm is a neighbour in her village who desires the small plot of land she owns. The physical symptoms come and go, they include temporary blindness, swellings of various parts of the body, constipation, loss of appetite, pain in the bones, and insomnia. She cannot return to her village lest the symptoms will recur dramatically. She mentions in passing that a doctor has tentatively diagnosed bone cancer but she perceives this as irrelevant, since biomedical treatment by definition cannot cure sorcery. The sorcerer has blocked the ties to her maternal ancestors and has weakened the ties to her children who have not visited her for a long time. Her only chance to live is to remain under the monk’s protection; she is desperate to stay alive, because if she dies, the *am peu* will be transmitted to her children.

Yei Koan’s condition is represented as a struggle between the powers of the sorcerer that derive from Shiva (*eisau*) and those of the monk that derive from the Buddhist hermit monks (*eisei*); her person is the battleground for this spiritual struggle. The monk could have the strength to turn the powers of the sorcerer against himself and kill him, but that would require him to give up his monkhood in order to actively engage in harmful magic; this he cannot do, so the situation is a stalemate with Yei Koan permanently caught in the middle. But although her prospects for being healed do not appear promising, her (temporary) survival depends on her keeping her refuge with the monk where she can remain within his sphere of spiritual healing power.

The importance of indigenous healers in Cambodian society should not be underestimated. Even if their remedies and procedures may be inferior to those of biomedicine for curing somatic illness, they provide significant psychological comfort that may indirectly assist a cure. And for mental health problems, the ritual healing they provide is possibly as adequate as what western psychiatry has to offer (which in Cambodia is next to nothing). Moreover, the fact that people
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seek indigenous practitioners for a number of not strictly medical conditions may well have illness-preventing functions and thereby fall within the purview of public health measures. Finally, the Khmer ecumenic attitude to healthcare – the predilection for combining not only several medicaments but also biomedical and indigenous treatment (see further Chapter 8) – implies that indigenous healers serve as a complementary, albeit officially muted, factor in the healthcare of the Cambodian people.

NOTES

1 There are no indications, however, that subsequent kings of Angkor continued Jayavarman VII’s ‘public health’ policy.

2 The important field of ethnopsychiatry, specifically the role of indigenous healers in treating mental suffering in the wake of Khmer Rouge atrocities, largely falls outside the scope of this study (see, for example, van de Put and Eisenbruch 2002; Bertrand 2005; Eisenbruch 2007).

3 The botanical names of the various remedies are from the study by Douk Phana (1966).

4 The precautions surrounding the use of krob sleng are well known among the rural population, and poisoning seems uncommon (though possible cases would hardly be reported). But a few cases of strychnine poisoning from krob sleng among Cambodian immigrants in the United States have been reported (Katz et al. 1996; Libenson and Yang 2001). The danger seems to lie in a combination of an exaggerated confidence in Cambodian ‘traditional herbal medicine’ among immigrants and their loss, through exile, of the concrete knowledge of the administering of various ingredients.

5 Kralahom was the title of the Minister of the Navy, one of the five most important ministers in the pre-colonial state (Osborne 1969: 7). Okhna Kralahom Kong was one of the leaders of Si Votha’s rebellion against the French in 1885–1886. He afterwards made his peace with king Norodom, but was later betrayed by another member of the royal entourage. The French tortured and killed him on board a naval vessel on the Tonle Sap outside Phnom Penh, after which they dumped his body in the river (Suon Om and Meyer 1969).

6 Among the Cham, spirit mediums are predominantly female, but their spirits are mostly male (Trankell 2003). In Burmese spirit possession, the transgednered nature of mediumship is also apparent (Brac de La Perrière 1989).

7 A clue to why Ye Khmau specifically requires bananas is found in the story related by Alain Forest (1992: 147). The belief in her ability to prevent traffic accidents is common also among the Vietnamese population in the Mekong Delta (Taylor 2002: 89).

8 This is a part of the chbap srei that a prostitute in Phnom Penh recited for Annuska Derks (2008: 44). But as Derks’ informant also recited, the mother’s admonitions began with a proviso: ‘Oh my daughter, my dearest, it is very difficult, my child, to follow the chbap srei’.
9 For an overview of the re-establishment of Buddhism during the Vietnamese occupation, see Keyes (1994: 59–65).

10 The ‘fact’ that biomedicine is in principle ineffective against sorcery does not, however, prevent some people from seeking complementary biomedical treatment for conditions suspected of being caused by sorcery. To regain health, people are generally prepared to try any potential cure that is available and affordable (see also Chapter 8).
Chapter Six

Midwives and the Medicalization of Motherhood

While ‘reproductive health’ is a relatively recent term for a cluster of medical specializations, the idea of childbirth and female fertility as a legitimate domain of medical science is a feature of European modernity linked to the biopolitics of the state. The ‘medicalization’ of pregnancy and childbirth began in the seventeenth and eighteenth centuries with the incorporation of these states of the female life cycle into scientific medical discourse (Oakley 1984). Pregnancy and childbirth were gradually redefined as medical phenomena and became subject to the exercise of the biopower of the (male) medical establishment, acting as an instrument of the state. Thus medical science, with its claims to both superior knowledge and the capacity to improve the human condition, became a powerful agent in the struggle to control female sexuality and reproductive capacity.

In this chapter we address the medicalization of maternity in Cambodia from the colonial period onwards. The French efforts to create a corps of young, biomedically educated Khmer midwives was a dismal failure, as the French seemed never to realize that for the Khmer, childbirth was not medicalized and midwifery could not be a profession but was associated with a spiritual calling, social maturity, and experience of giving birth. Such qualifications were wholly incompatible with the French scheme.

This incompatibility has been only gradually and partially bridged in the postcolonial era. At the time of writing, less than a third of all births are assisted by medically trained midwives, which has severe consequences for the rate of both infant and maternal mortality.
Following France’s defeat in the Franco-Prussian War (1870–1871), French authorities had become extremely concerned about the health of the country’s youth, primarily its army recruits; in Britain the same concerns were brought about by the Boer War (1899–1902). In both countries, long-term measures were taken to ensure healthier babies and educate mothers in nutrition and proper infant care: motherhood became a national, biopolitical issue rather than just a family concern. If this led to a certain glorification of motherhood, it also placed a fair share of individual and collective responsibility on mothers. Thus, even if the British defeat in the Boer War could be partly ascribed to the physical shortcomings of the soldiers (rather than the military shortcomings of their officers), ‘the underlying cause of Britain’s impending failure to be great and free was thus unequivocally identified as maternal ignorance and inadequate devotion to duty’ (Oakley 1984: 35; emphasis in the original).

The medicalization of childbirth as an aspect of colonial governmentality followed a different trajectory in Cambodia, compared, for example, to the nearby British colony of Malaya. In Malaya, the British colonial government at the turn of the century had adopted a ‘long-term strategy to reproduce the labour force locally, hence placing […] reproductive practice[s] under imperial gaze’, and ‘maternal and child health programmes were from the outset a government rather than a mission concern’ (Manderson 1998: 35–36). In Cambodia, the early situation was rather the opposite: The military physicians showed little concern for maternity, childbirth, and childcare, and even after the establishment of l’assistance médicale in 1905, these issues were initially left to charitable organizations.

Colonial maternity policies in Cambodia

Despite the colonial government’s initial inattentiveness to maternity and childbirth, around the turn of the century, the question of including midwives in the medical service had been briefly on the agenda. It was proposed that a French midwife be attached to the maternity ward of the Mixed Hospital, possibly as a consequence of the increasing number of wives accompanying colonial personnel. The hospital’s chief doctor advised against such an appointment, however, for medical and economic reasons. In a letter to the résident supérieur (20 July 1903), he recommended instead the appointment of one more medical doctor (médecin aide-major de 1ère classe), arguing that such a doctor could well be in charge of the maternity ward while being on call in cases of serious illness.
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among government employees in the protectorate’s interior. He also rejected the claim that the natives would more likely frequent the maternity if a midwife was present; he referred to the experience from Saigon, where the locals would consult a doctor rather than a midwife, even in uncomplicated cases (NA 741).

His recommendations appear to have been followed, and for the next 16 years, maternity and child health issues were handled mainly by charitable organizations. In 1907 the sisters of la Providence were joined in this work by a non-religious organization, the philanthropic Société de protection de la natalité indigène au Cambodge. This society established a private maternity clinic in the Cambodian quarter of Phnom Penh, to cater mainly for the Khmer population. The maternity was financed by donations from both Europeans and Cambodian notables and subsidized by the Cambodian king and the colonial authorities (NA 1322). Laurence Monnais-Rousselot has described the Société as founded partly on ‘the altruism of the Cambodian royal family’ (1999: 179) – although such ‘altruism’ was part of the king’s traditional symbolic responsibility for the welfare of his subjects. She has also pointed out that the Société’s varied financial sources, which included la Banque d’Indochine, indicated that biopolitically, issues related to maternity represented ‘a possible confluence of interests that did not and could not manifest itself in other fields’ (ibid.). Thus the metropolitan French commitment to increasing the birthrate was semi-officially promoted in Cambodia through the Société, more than a decade before maternity and childbirth became incorporated into official colonial public health policy.

The establishment elite’s concern with childbirth was shared by practising colonial physicians, who recognized infant mortality as an acute problem. The infant mortality rate in Indochina at the turn of the century was close to a staggering 40 per cent (Monnais-Rousselot 1999: 180), which may be compared to 25 per cent in Malaya (Manderson 1998: 36), and 15 per cent in France in the same period. By far the most frequent cause was neonatal tetanus, the proximate cause of which was poor hygiene during the cutting of the umbilical cord by indigenous midwives. These indigenous practitioners played both spiritual and practical roles: while their invocations of protective spirits and arranging of the ritual space for the delivery were psychologically important for the well-being of the mother, the common practice of cutting the umbilical cord with a sliver of bamboo, shred of glass, or a sharp-edged stone was a serious health hazard to the baby. Different strategies for reducing infant mortality were adopted in different parts of Indochina. In general, efforts were made to persuade pregnant women to give birth at a maternity clinic rather than at home. In Cochinchina (Saigon and Cholon), and to some extent in Tonkin (Hanoi), indigenous (Vietnamese)
midwives were targeted. In 1904 the municipal physician in Saigon had organized campaigns among indigenous midwives. These women were given a package containing thread for tying off the umbilical cord, sterile bandages, and a pair of curved scissors. They were taught how to employ these and to observe rules of hygiene at the delivery. Two weeks after a delivery, a physician would visit the newborn and if there were no symptoms of tetanus, the midwife would get a reward of one piastre (Monnais-Rousselot 1999: 181). The results were spectacular (if the physician’s own statistics are to be trusted); in 1905–1906, infant mortality during the first month dropped from 23 to 9 per cent, and during the first year from 38 to 27 per cent.

However, the same strategy was not followed in Cambodia (pace Frieson 2000) until after independence. Instead, the practice inaugurated by Dr Angier in the 1890s was continued (Monnais-Rousselot 1999: 288). The résident of each circonscription was asked every year to send two or three young Cambodian women for a six-month training course at the Mixed Hospital in Phnom Penh, where they were taught the basics of hygiene, diagnostics, bandaging, and medication, after which they were sent back to their province to act as medical assistants or delivery nurses. We have no statistics to evaluate this scheme, but the ambition of reaching out to the provinces contrasted with the practice in Cochinchina (and Tonkin), which targeted only the urban and semi-urban areas of Saigon/Cholon (and Hanoi).

We may only speculate as to why the successful Saigon strategy was not adopted in Cambodia. Monnais-Rousselot seems to imply that it was out of reverence for the efforts of Dr Angier who had gained a reputation as an inventive pedagogue (Monnais-Rousselot 1999: 288). But we should also keep in mind that the French recognized indigenous Vietnamese and Chinese medical practices as closer to ‘real’ medicine. By contrast, Khmer indigenous medical practices were generally dismissed as unscientific and superstitious by the colonial establishment (e.g. Leclère 1894). So even if the practices of indigenous Vietnamese midwives (ba mu) were in many respects similar to those of their Khmer counterparts (chhmob), French physicians were extremely reluctant to grant the latter any medical legitimacy whatsoever. Most importantly, the French medical service had considerable problems in actually identifying and locating Khmer indigenous midwives, let alone persuading them to become involved with the colonial authorities.
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MATERNITY IN PHNOM PENH

The Société’s private maternity was established in November 1907 to cater mainly for the Cambodian elite. It was directed by a committee that included two Cambodian princesses (who by virtue of their status were supposed to promote the maternity among the Khmer population) and staffed by one doctor-cum-administrator, a secretary and two undiplomaed midwives, one Khmer and one Vietnamese. In 1908, 115 women gave birth there, of whom 97 were Khmer, 17 Vietnamese, and one Chinese métis. On leaving the maternity, each mother would be given a set of clothes for herself and her baby and the sum of one piastre (NA 86). Three years later, the proportion of Vietnamese clients had grown; of the 218 clients in 1911, 145 were Vietnamese and 73 Khmer. The increase in Vietnamese clients, the annual medical report says, may be explained by the fact that most Vietnamese in Phnom Penh originated from Cochinchina where they were accustomed to European maternities (NA 1322).

In 1917, the director of the private maternity and president of the Société was a Frenchwoman, Mme Doucet, the wife of a military physician of les troupes coloniales. The medical staff consisted of a French doctor and a couple of native (Vietnamese) midwives. Native midwives, like native doctors, were initially trained either in Hanoi or in Cholon. The fact that the native midwives working in Phnom Penh were thus ethnically Vietnamese rather than Khmer did not make the maternity attractive for potential Khmer clients. Moreover, the maternity suffered from a continual shortage of native (even Vietnamese) midwives, and those who were employed were not always satisfactory. Thus, in early 1917, two recently appointed midwives caused a minor crisis (NA 1089). They were young Tonkinese, trained in Hanoi, and got along badly with both the Cochinchinese midwives and the menial staff. After one of the older midwives resigned, the two Tonkinese were dismissed, leaving the maternity three midwives short.

Personnel problems at the private maternity coincided with a renewed official concern, in the aftermath of the First World War, for birthrates and by implication, for motherhood and midwifery (cf. Edwards 2002: 121). First of all, the presence of a substantial number of colonial wives implied the immediate need for proper midwives to serve the European community, and the private maternity only catered for native women. Europeans’ needs had so far been met by the maternity ward of the Mixed Hospital, which had, at least since 1908, employed one delivery nurse (NA 2486). In time, the medical authorities accepted to oversee maternal care for both Europeans and natives. In 1919, the private maternity in Phnom Penh was incorporated into the colonial medical service. It was merged with the maternity ward of the Mixed Hospital, which
now had a French midwife on the staff and was frequented mainly by European women. Under the name *Maternité E. Roume* the combined maternity became administratively and physically a part of the hospital. With the government takeover of the private maternity, the *Société* had been made redundant and formally dissolved (NA 2466).

The government had also inherited the problem of recruiting suitable midwives, however. In 1920, another (Vietnamese) native midwife at the maternity was investigated for alleged serious negligence in the line of duty; it appeared that her misconduct was not overly grave, but since her manners had made her disliked by all the native staff, it was decided that she should be transferred. This left Roume with only one French and one native midwife, and the situation had become untenable. Khmer women refused the aid of both European and Vietnamese midwives, and besides the French midwife was herself due for maternity leave. Between September 1920 and April 1921 the Local Director of Health sent three letters and one telegram to the Governor-General of Indochina stressing, in increasingly urgent terms, the need for additional indigenous midwives for the maternity. Finally, the *résident supérieur* himself (Baudoin) repeated the plea (on 23 June 1921), only to get the terse reply that the Governor-General had no native midwives available at the moment and that several other maternities were also short of midwives (NA 1089).

The shortage of midwives in 1920 was underlined in June of that year when a new wing was added to the Roume Maternity; this new *pavillon des indigènes* was specially meant for natives (NA 34445), in this case meaning women in comfortable circumstances (*femmes indigènes de condition aisée*). Announcing the new wing, *résident supérieur* Baudoin proudly advertised its facilities: for the sum of one piastre per day each parturient woman would have a room with a private bathroom; she was allowed to have one or two relatives staying with her (at one piastre per head); the food was of the ‘first category’, but even European food was available, at the additional price of 1.25 piastres. The delivery would be done according to the wishes of the parturient woman with the assistance of either a French or a native midwife. The *médecin-chef* would be permanently on call in case of difficulties. Realizing the deeply ingrained custom of all Khmer women, irrespective of class, of giving birth at home, Baudoin ended his sales-talk by pointing out that most Frenchwomen, even those in the most comfortable circumstances, preferred to give birth at a hospital for its superior hygiene and medical safety. As prospective clients, the distinguished natives (*les notables indigènes*) were invited to visit the new wing on any day except Sunday between 10–11 A.M. or 4–5 P.M.
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Irrespective of the pavillon des indigenes' chances for success among the Khmer elite, the medical service's 1922 annual report lamented that it still proved almost impossible to persuade ordinary Khmer women to give birth at the hospital. To address this, the local health authorities recruited two princesses, granddaughters of King Sisowath, to serve as honorary midwives at the Roume Maternity, ‘in order to demonstrate that this is an honourable profession, even if it is regarded by the people as degrading’ (NA 8847). From having started with a conscious appeal to socially ambitious wives of the local elite, native government officials, and other members of the Khmer middle class, it seems that the Roume Maternity eventually adopted a more democratic stance; the user fee of one piastre per day was abolished.

Furthermore, there seems to have been a realization that a charitable organization such as the now defunct Société de protection de la natalité indigène had served an important purpose, and might well continue to do so, even after maternity issues had come under l’assistance médicale. The Local Director of Health in December 1924 suggested to the résident supérieur that a charitable committee be created in order to increase the number of native women giving birth at the maternity (NA 1093). Entitled Œuvre de protection maternelle et infantile au Cambodge, the committee should be run by French ladies, with Mme Vallet (the Director’s wife) as temporary chairperson, awaiting the return to the colony of Mme Baudoin (the résident’s wife). This committee should raise funds (‘soit par collectes, soit par fêtes de charité, soit par fêtes sportives payantes’) destined to help mothers and mothers-to-be in Cambodia, and particularly in Phnom Penh, and to follow-up on the conditions of those mothers (and their babies) who had either given birth at or at some stage consulted the maternity.

The Roume Maternity began to register an increase in clients soon after. In his report for 1926 (NA 76), Dr Hervier, médecin-chef of the maternity, noted that the total number of births by native mothers (including stillbirths and abortions) was 547, compared with 472 for the previous year. Thirty cases were complicated ones, and several of those clients had come from outside the city, something which showed that the natives were becoming aware that it was possible at the maternity to save the lives of women in a serious condition. Among the reasons for the success, Hervier cited the role of the French ladies who visited the maternity and gave out financial aid to the new mothers; the fact that giving birth at the maternity was free of charge; and that the authorities had discontinued registration of the clients. In other words, if the natives could not be persuaded to give birth at the maternity through rational arguments showing that it was for their and their babies’ own good, a culturally more appropriate
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way of making them comply was to bribe them and relieve them of culpability by not revealing their identities.

In subsequent years, the number of clients at the pavillon des indigènes was to fluctuate; it decreased to 507 in 1927, but rose to 527 in 1928, 620 in 1929, and 681 in 1930. The number of Europeans giving birth (at the pavillon des dames) presumably more directly reflects their demographic profile; it rose from 19 in 1924 to 49 in 1930 (NA 2466). Since the Roume Maternity no longer had to officially record such details, we have no statistics concerning the ethnicity of the native clients. The notables indigènes whom the colonial government had in mind as prospective clients were primarily from the Khmer elite, but the trend observed already in 1908–1911 of a decreasing number of Khmer and an increasing number of Vietnamese clients seems to have persisted.

The annual medical report from 1930–1931, translated and paraphrased below, discussed this issue in some detail and with a fair amount of anthropological sensitivity.

First, it was noted that no Malays (Cham) ever came to the maternity, even though they were fairly numerous in and around Phnom Penh. The Chinese had largely stopped coming because they were obliged to pay for the service, and indigent Chinese women were only admitted if the leader of their community (congrégation) would certify in writing that the costs would be covered by the community. As for the Khmer, it was emphasized that there was a room especially and exclusively reserved for them, with both a midwife and a nurse ‘uniquement cambodgien’. Those who are aware of the racial antipathy between Khmer and Vietnamese will appreciate the necessity to avoid mixing the races in a common room and as far as possible avoid contact between clients and staff of either ethnicity.

Despite these precautions, Khmer women shun hospitalization at the maternity. Only unfortunate women who have been abandoned by the child’s father and/or denounced by their family, or have been surprised by the onset of labour while travelling, may approach the ominous buildings of the maternity with great trepidation. Among the possible explanations for this reluctance on the part of Khmer women are modesty and timidity, but above all the Khmer respect for their ancient customs. These include all the precautions to be taken during pregnancy, delivery, and its aftermath, knowledge of which are vested in the mother of the family and the neighbourhood matron who overwhelm the young mother with advice and recommendations. How could such a young female be expected confidently to deliver herself into the hands of strangers who
employ incomprehensible methods and follow procedures in complete contradiction to the wisdom of the ancestors?

Vietnamese women were the most numerous clients; they were more *évoluées* than the Khmer, having associated with European civilization for a long time and therefore more amenable to our practices. But they were also more likely to have problems in connection with childbirth, because they lived in deplorable hygienic conditions, they were malnourished, had poor housing, and generally their physical constitution was frail, with small bones and poor musculature. For these reasons, we ought to see Vietnamese in even greater numbers, but some of the factors that prevent the Khmer from coming to us may equally dissuade the Vietnamese, such as their adherence to the custom of having a fire under the childbed, which could definitely not be accommodated at the maternity (NA 2466).

The financial incentive offered for childbirth at the Roume Maternity, initially between one and three piastres plus a set of baby garments, handed out at the discretion of the French ladies, appears to have eventually become a standardized allocation of one piastre per woman giving birth (as it was in 1908 when the maternity was private and run by the *Société*), and its character had changed, in public perception, from a charity to something more like compensation for giving birth at the hospital. Hence, the Local Director of Health in 1937 decided that the allocation would be discontinued (NA 31889).

The *Cambodian midwifery school*

To improve the continual midwife shortage and the frequently unsatisfactory performance of the Vietnamese midwives, an *École pratique des sages-femmes indigènes* was initiated in Phnom Penh in 1924 by the Local Director of Health in Cambodia, Vallet. In his letter dated 11 July 1924 (NA 1148) to the *résident supérieur* in Cambodia, Vallet noted that all of the eight practising native midwives in Phnom Penh were Vietnamese. He pointed out the negative consequences of both the small number of midwives as well as their ethnicity, and that the school should aim to recruit ethnic Khmer students: ‘*les cambodgiennes préfèrent des sages-femmes de leur race*’ and were likely to seek assistance from uneducated neighbourhood matrons rather than Vietnamese midwives. As a result, eye and skin infections, tetanus, and gastro-enteritis were frequent. The *résident supérieur*, Baudoin, passed on the suggestion for the school (pretending it was his own idea) to the Governor-General of Indochina in a letter dated 25 July 1924. The latter in his reply (20 August) approved of the suggestion but noted that, at least for the time being, there might not be all that many eligible Khmer women
and that therefore the school should also be open to women of other ethnic origins (meaning Vietnamese), admittance to the course being for young women ‘d’origine cambodgienne de préférence’ (NA 1148).

In order to get the school off to an auspicious start, Baudoin sent out a circular to all résidents in the provinces, calling on them to recruit suitable candidates: young native women between 17 and 23 years of age, preferably Khmer, ‘de bonne moralité et pourvues’ and, if possible, possessing a certificate of primary education (NA 1146). In spite of this effort, the Governor-General’s misgivings came true. Of the eight applicants who were admitted in December 1924, four were Vietnamese and four Khmer.

The failure to recruit a larger number of Khmer women reflects the intersection of ethnicity and class. The applicants were typically daughters of the urban middle class, their fathers being civil servants, schoolteachers, or businessmen. As a consequence of French policy, most native civil servants were Vietnamese. As for businessmen, traditional Khmer culture did not value commerce as a suitable endeavour, and most businessmen were Chinese or Vietnamese. The tiny Khmer middle class consisted typically of schoolteachers and the like, members of the Cambodian intelligentsia, who were likely to be culturally quite conservative and not in favour of public education for women. In traditional Khmer society, formal education was reserved exclusively for males, the primary educational institution being the Buddhist wat. Female education was a private family affair, the formal component of which was a three to twelve month period of seclusion following the girl’s first menstruation. During this seclusion (chol mlup, ‘entering the shade’), the girl was instructed about proper female behaviour and responsibilities, the relations between the sexes, and taught female skills such as embroidery, cooking, and housekeeping. The seclusion prepared young women to be housewives and mothers. The female virtues imparted to young women were codified in the chbab srei (the ‘code for women’; Pou 1988: 405–456), which young women were obliged to be able to recite more or less exhaustively. In this conservative cultural milieu, institutionalized public education for young, unmarried women was decidedly a foreign idea, likely to be met with severe reservations (cf. Frieson 2000). Moreover, the ritual pollution that adhered to midwifery in indigenous society was something middle-class parents would certainly wish to avoid for their daughters.

Application to the midwifery school was a cumbersome procedure and certainly did not favour the lower classes. The applicant had to supply several documents, ideally all of the following: a birth certificate, issued by the notary’s office and signed by three witnesses (cost: 24 cents); certificate of primary
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education (often difficult to obtain and therefore not absolutely mandatory, if the applicant could demonstrate knowledge of French); affidavit of no criminal record issued by the office of the Court in the applicant’s area of residence (cost: 58 cents); medical certificate of physical aptitude, with a photo; and a ‘certificat de bonnes vie et mœurs’ issued by local authorities or, for Vietnamese applicants, commonly a local community leader (chef des annamites) and attested by three witnesses (cost: 12 cents) (NA 1154). The documents were to be submitted with the application itself, handwritten (or occasionally typed) in the correct French style of formal correspondence. Composing such a letter probably required the assistance of older male relatives, family friends, or professional scribes.

Admission itself was no less exacting. Applications were forwarded, normally with a positive recommendation by the Local Director of Health, to the réident supérieur, who made out and personally signed a decree of admission consisting of three clauses, detailing the name of the person admitted; the monthly allowance (10 piastres if a certificate of primary education had been submitted, otherwise 5 piastres); and an order that the Local Director of Health implement the decree.

The school offered a two-year training course. The first year curriculum comprised courses in anatomy and physiology; general knowledge of pregnancy and delivery; hospital practice; and French language. The second year comprised practical delivery; the pathology of pregnancy and post-partum; women’s hygiene during pregnancy and labour; hygiene of newborns and vaccinations; hospital practice; and French language.

There are indications that the French language was likely to present the greatest obstacle to the young women’s successful education (NA 76). After the first year of the course, the students sat for an examination. Most of those who did not pass were allowed to remain in the first year, while those who had ‘fait preuve d’inaptitude complète’ could not continue but might nevertheless obtain a licence (though not a diploma) as midwives, which meant they could not be employed as midwives by the government but might be allowed to open a private practice. Presumably, even if their command of the French language and/or their clinical skills left much to be desired, they were evidently regarded as more qualified than the average neighbourhood matron. Of the eight students admitted for the first year, two left soon after starting, three passed the examination (NA 2237), two were given the opportunity to remain in the first year course, and one was sent away with a licence.

Those who managed to complete the whole course and received a diploma were enrolled in the ranks of truly governable subjects. A decree from the governor-general of Indochina in Hanoi (April 1925; NA 1146) ordered that they were to
form an exclusive category of colonial subjects, namely *sages-femmes auxiliaires de l’assistance médicale au Cambodge*. This category was divided into eight classes, namely *sage-femme auxiliaire principale*, first to second class, and *sage-femme auxiliaire titulaire*, first to sixth class. Their annual salary varied between 360 piastres for *titulaire* sixth class to 996 piastres for *principale* first class. The decree also gave details of the number of years one had to serve in one class before seeking promotion to a higher class and listed the six kinds of sanctions, in order of increasing severity, that could ensue in the case of misdemeanour: oral reprimand; transfer; reprimand noted in one’s file (with consequences for future promotion); demotion; dismissal; and dismissal with cancellation of diploma.

The regulations for Cambodian *sages-femmes auxiliaires* may seem excessive in relation to their actual number. Of the total of nine diplomaed midwives who had begun their studies at the *École pratique* in Phnom Penh in 1926 or earlier (NA 76), six were still in government service by the end of 1932 (NA 10575), one working at the Roume Maternity in Phnom Penh, the others in the provinces. In his 1926 annual report on the Roume Maternity (NA 76), Hervier ended by observing that while the native midwifery school was now functioning according to plan, it was desirable to apply stricter admission criteria, particularly with regard to the command of French, and, for Vietnamese students, knowledge of Khmer. Undoubtedly, the colonial authorities in Cambodia – the *résident supérieur*, the mayor of Phnom Penh, the Local Director of Health, and the *médecin-chef* of the Roume Maternity – all wished for both the maternity and the native midwifery school to be state-of-the-art institutions, superior to all others in Indochina, and that midwives and delivery nurses in Cambodia should meet high professional standards.

In 1926, the Governor-General had decreed that nurses holding a diploma from the native midwifery school in Cholon, and who were employed by the colonial government in Cambodia, could acquire the status of *sages-femmes auxiliaires de l’assistance médicale au Cambodge*, subject to approval of the Local Director of Health. Three such nurses, employed in the provinces of Kampong Chhnang, Takeo, and Svay Rieng, were eligible, and in March 1926 they were called to Phnom Penh to sit for an oral and written examination for two full days before a committee of French doctors and midwives. All three failed (NA 3009), a result that no doubt boosted the self-esteem of Baudoin and his colleagues, confirming that their local educational facility was superior to anything Cochinchina had to offer.

Still, not only were there too few Khmer applicants for the midwifery course, but it was not uncommon for students, both Khmer and Vietnamese, to be asked
by their families to leave the course. One of the earliest recruits, Vietnamese
Nguyen Thi Manh, who had applied on 15 November 1924 and had been
admitted a week later, withdrew her application on the day of her admission.
The reason she gave was that her presence was required at her widowed mother’s
shop (‘Magasin Franco-Khmer’ in Phnom Penh) where she had to take care of
the business after an employee had resigned and gone back to Cochinchina (NA
27018).

The case of young Marie Louise from Kep in Kampot Province is another
example (NA 27018). Her letter of application², in a very neat hand, reads as
follows:

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Phnom Penh, le 6 December 1924

A Monsieur le Médecin Chef
à l’Hôpital mixte à Phnom Penh

Monsieur le Médecin Chef,

Je soussignée, Marie Louise (Canavy), âgée de 17
ans, fille de Canavy (Léon) demeurant à Kep (Kampot),
Aie l’honneur de venir très respectueusement solliciter de
votre haute bienveillance de bien vouloir m’inscrire sur la liste
parmi les élèves des Sages-Femmes, dont l’établissement est
nouvellement crée à Phnom Penh.

Espérant que vous voudriez bien accueillir favorable-
ment ma demande, veuillez agréer Monsieur le Médecin
Chef, avec mes sentiments respectueux, l’assurance de ma parfaite
et profonde gratitude avec lesquels j’ai l’honneur d’être

Votre très humble et très obeissante servante.
Marie Louise (Canavy)
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The Local Director of Health noted on the letter, ‘Knows how to read and write
French; I propose her as first-year student at the school’ and forwarded it to the
résidence. The résident supérieur admitted her on 29 December, with a monthly
allowance of five piastres. However, a month after her admission, the director
received her letter of resignation³ – this time in a different and rather more
immature handwriting, possibly even her own:
We can only speculate about the kind of discussions and deliberations in Marie Louise’s family that led to her resignation. Marie Louise was a métisse, daughter of a French colon, Léon Canavy. It is possible that papa Léon had wanted a useful education for his daughter but had later realized that a career as a midwife was socially inappropriate for a young woman in Khmer society.

In another case two years later (NA 11288), the young Juliette Pakiry sent in her letter of resignation soon after admission; in the letter she explicitly stated, ‘I can no longer continue my studies because I have personal family problems. My father demands that I stay at home’. Juliette was also a métisse, daughter of a French soldier and a Vietnamese mother. Since Juliette could produce a certificate of primary education, she had been granted a monthly allowance of 10 piastres. The Local Director of Health was apparently not happy about losing this promising student, and he accepted her resignation with the stipulation that she returned the allowance already received, and that she would never in the future be admitted to the ranks of the medical service.

The modest allowance of 10 piastres per month was apparently not decisive for the economy of the Pakiry family, but for poorer Vietnamese it could have been important. A case in point is that of young miss Nguyen Thi Dung, whose father was a native civil servant (secretary at Customs and Excise). Dung had finished high school (l’École Norodom des jeunes filles) and had continued with her higher education, obtaining a Certificat d’études primaires franco-indigènes. She applied to the midwifery school, stating that she could not continue her
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Previous studies because her parents had many children and could not afford the fees (NA 1154).

Despite considerable efforts by the authorities to make the midwifery school a success, the number of graduates was far too small to satisfy the demand for native midwives in the capital, let alone the protectorate as a whole. The Roume Maternity employed a total of eight native midwives, and in 1933, six of whom were Vietnamese (one a graduate of the Phnom Penh school) while two were Khmer, graduates of the Phnom Penh school (NA 5079). By 1939 there were also ten authorized privately practising midwives in the country, seven in Phnom Penh, two in Battambang, and one in Kampot. All were Vietnamese and only one was a graduate of the Phnom Penh school; the others had their diplomas from Cochinchina or Tonkin (NA 606).

Thus, in terms of the stated goals of offering a fully adequate midwifery education to satisfy the demand for professional midwives in the protectorate, the school can only be described as a failure. The cultural obstacles to recruiting a sufficient number of suitable ethnic Khmer students proved insurmountable, and among those few who were recruited, several terminated their studies during their first year and could therefore not even be granted a licence. The École pratique des sages-femmes indigènes in Phnom Penh was closed down in 1932.

**Midwives in private practice**

Alongside the Roume Maternity, private maternities in Phnom Penh and in the major provincial towns were beginning to appear during the mid-1920s. These were a far cry from the official establishment of Roume. They were all set up by Vietnamese native midwives (whose diplomas were from Cochinchina or Tonkin). In contrast to Khmer women, most Vietnamese saw midwifery as a career possibility. This was apparent already in some of the applications for acceptance to the midwifery school. Thus, 18-year-old Nguyen Thi Lieng, who had applied to the school in 1926, had stated that ‘I wish to follow the maternity course in order to make a living and provide for my old parents in the future’ (NA 1148).

The private maternities were individual enterprises, located in the midwife’s own house and run with the help of her children or other household members. Private midwives had to obtain permission to practice from the Local Director of Health, the résident supérieur, and the mayor’s office, following an inspection of the premises; the authorization had to be renewed annually or every second year. Many applications were approved (NA 832), but occasionally authorization was refused, on the grounds that the premises were unsuitable or the applicant’s
qualifications insufficient. Thus, in one case it was stated that ‘[the applicant], although holder of a diploma as native midwife issued by the local health directorate of Cochinchina, has only very vague notions of obstetrics’ (NA 1101), and the application was turned down.

The following case (NA 1103) is a more detailed example. Nguyen Thi Yen had had authorization, duly renewed annually, to run her private maternity since 1926, but in 1930 she wanted to retire, following the death of a relative, and she proposed to the authorities that her colleague Nguyen Thi Soi take over her practice. At the same time, Ms Soi herself, who held a midwifery diploma from Cholon, submitted her application to replace Ms Yen as authorized private midwife. In his review of the application the médecin-chef of the Mixed Hospital stated that Ms Soi appeared to have some idea of obstetrics, that she would be capable of performing a sufficiently hygienic delivery under normal circumstances, and that she would in any case be less dangerous than the native matrons practising in the town. Ms Soi received her authorization. A few months later, Ms Soi wanted to transfer her maternity to new premises opposite Bac Tuk market. The new premises were inspected by the médecin-chef du service d’hygiène, and permission was granted for the year 1931 on the condition that the maternity should have no more than six beds (with only one parturient woman per bed) and that the work space should be properly equipped in accordance with the rules of hygiene (whitewashed walls, etc.). By late 1931, it was time for renewal of Ms Soi’s authorization. After an interview the médecin-chef concluded that she (still) had sufficient knowledge of obstetrics to allow her to run a private maternity. The médecin chargé du service d’hygiène who inspected the premises, however, was far from impressed. His verdict of ‘this so-called maternity’ was distinctly unfavourable. The whole place was dirty, there was no water except for a bucket in the kitchen which was directly adjacent to the toilet. A parturient mother with her baby was lying on one of the beds, under which a charcoal fire was burning; although this is known to be a Vietnamese custom, the inspector was dismayed to find it allowed by an ostensibly diplomaed midwife (NA 1103). It appears that Ms Soi reacted adequately to the inspector’s devastating critique; in a letter stating that she had ‘followed your eminent orders’, she asked for a new inspection with a view to renewed authorization. This time the very same inspector was full of praise: the maternity had been moved to the upper floor of the building, a light and airy room with sufficient space between the six beds, the toilets were no longer adjacent to the kitchen, and on the whole all previous objectionable conditions had been rectified. Ms Soi’s authorization was renewed.
The strict government control of private maternity clinics was triggered by an unfortunate incident. In 1925, a Vietnamese woman, Nguyen Thi Xuan, had been admitted to the Roume Maternity with an acute uterine infection which led to her death. It turned out that she had given birth ten days earlier at a private maternity run by a Vietnamese woman, Ly Thi Nho, wife of a Vietnamese secretary at the Phnom Penh city administration. The case was reported by the médecin-chef of the Roume Maternity (Hervier) to the Local Director of Health (Vallet) and to the résident supérieur (Baudoin) who ordered the mayor’s office to immediately close down the private maternity, as it turned out that the unfortunate practitioner had no authorization from the city administration, and furthermore that her diploma, issued at Cholon, was not as a midwife but only as a delivery nurse (infirmière accoucheuse), which did not qualify her for private practice in Cambodia (NA 094). The case led to a more rigorous control not only of private maternities, but also of those women practising midwifery in the homes of clients – the ‘neighbourhood matrons’.

The authorities found three such (Vietnamese) practitioners who all lacked authorization, two of whom, moreover, had no diploma whatsoever. One of these was Nguyen Thi Luu, aged 57. On 3 July 1925 Ms Luu wrote to the Local Director of Health, stating that she had practised the art of delivery in Phnom Penh for 30 years, and although she did not have a diploma, she had never had any occupational mishaps. Now she was approaching old age, and if the administration discontinued her practice, she would be deprived of her means of livelihood. She argued that although the Roume Maternity was free of charge for all, not everybody could benefit from that facility; some of Ms Luu’s clients already had children whom they could not leave unattended, others lived in lodgings from which they might be evicted if they left for the maternity. In reviewing the case, the administration had a note from the Phnom Penh police chief, stating that Ms Luu was a well-known figure in the city who had assisted at deliveries for many years, particularly among the working classes; she was known as a brave woman, always ready to be of service and devoted to helping the poor; she was herself very poor. Perhaps with a view to popular opinion, the résident supérieur eventually decided to let the old lady continue her practice (NA 1096).

Although occasioned by the accidental death of a client, the crackdown on unauthorized midwifery was possibly also fuelled by the hopes of a supply of well-trained candidates from the Phnom Penh school, as expressed, for example, in Dr Hervier’s 1926 report (NA 76). But it was not a question, as Kate Frieson (2000) claims, of the private clinics being ‘scorned’ from 1925 onwards; on the
contrary, the annual medical report for 1930–1931, for example, mentions that the four recognized private maternity clinics in Phnom Penh were found to be generally well run (NA 2466). In practice, the authorities were rather lenient – as mentioned, even students who had failed their finals could be granted a licence for private midwifery practice. Between 1938 and 1940, eight authorizations were granted to private maternities run by natives, in Phnom Penh, Kampot, and Battambang (NA 832); six of the eight clinics were run by Vietnamese midwives. The renewal included a standard phrase that hygiene standards at the maternity were satisfactory and that the practitioner had accomplished numerous deliveries without any mishaps.

A new application was from a French-Cambodian midwife who had graduated from Strasbourg, and whose proposed private maternity in Phnom Penh would cater only for native clients. The chief of the hygiene service who inspected the premises found everything in order and declared the establishment not only highly satisfactory but even luxurious. Another was from a Vietnamese midwife, Pham Thi Kim, who wanted to open a private maternity in Kampot. Ms Kim was a graduate of the Phnom Penh midwifery school; she had been admitted in 1924 when the school first opened, had done well at the exams (NA 1148) and had been among the three very first students who completed the course in two years and graduated in 1926 (NA 2237). We do not know if she had practised as a midwife in the meantime, but in 1940, at the age of 36, she was apparently ready to cash in on her education and start a private practice. Her application was also approved.

**KHMER INDIGENOUS MIDLIVES**

In Khmer society childbirth is associated with the privacy of the home. The process of bringing a newborn baby into the world of humans, and of restoring the body of the new mother after pregnancy and childbirth is simultaneously physical, social, and spiritual, but not primarily ‘medical’ (cf. Ang 1995: 155–156). For a Khmer woman, the most important rite of passage is giving birth for the first time. Known as ‘crossing the river’ (*chlan tonle*; cf. Ang 1982: 89–90), the first childbirth is what definitively marks the passage to the status as a proper adult woman. But in contrast to the elaborate public rituals associated with the wedding, for example, giving birth is a strictly private affair. At the birth itself, no males or children may be present, but the parturient woman is surrounded by adult female relatives and neighbours, women who have themselves ‘crossed the river’.
The whole childbearing process is directed by an indigenous midwife, chhmob. The chhmob will carry out the same tasks as a medically trained midwife – check the position of the foetus, monitor the opening of the uterus, give comfort and encouragement during the labour, cut and bind the umbilical cord, and handle the placenta. But this does not mean that the two inhabit the same socio-medical universe. The chhmob is an indigenous practitioner, a specialist among other indigenous health specialists, kru, healing monks, and spirit mediums (see Chapter 5). To be a chhmob is not an occupation that one can choose in order to make a living. It is a calling that one takes upon oneself, more or less willingly, to perform a function essential to the community. The calling to become and to act as a chhmob is simultaneously social and spiritual, and the necessary physical and technical skills are learnt through apprenticeship and personal experience.
Socially, the calling is transmitted in the female family line, and the spirits that guide the *chhmob* in her work also tend to adhere to this line. The career of a *chhmob* typically starts when, as a young girl, she is chosen as an apprentice for her grandmother or another older relative. After puberty she will be sought out by her spirit, which she often inherits from her mentor. Only when she has had children of her own will she be regarded as a fully-fledged *chhmob*, because the ability to act as a *chhmob* is acquired also through the experience of being treated by one. She will then be known respectfully and affectionately as *yei mob* (‘elder female’ *mob*) or *mae da*.

Childbirth always has an element of danger; the risk of complications and ultimately of maternal and neonatal mortality are universally recognized. In the Khmer universe, these risks are expressed as the dangers of pollution caused by the birthing process itself, as well as the danger of attacks by evil spirits attracted by the physically and spiritually fragile state of both mother and newborn. Therefore, the *chhmob* needs powerful spirits of her own and one of her tasks is to secure the scene of the birth (the room, the bed), to ritually cordon it off by a *sima* – trailing a cotton thread or drawing a chalk line – to prevent the intrusion of evil spirits. Such spirits are typically *bray*, spirits of women who had been childless or had died in childbirth and are therefore jealous of the better fortune of others (Ang 1982: 100–102; cf. Jacobsen 2008: 139–140). As mentioned in Chapter 3, the *bray* were also held responsible for causing smallpox in children, so, appropriately, the *chhmob* were earlier charged with the task of variolation. The pollution associated with childbirth defiles the *chhmob*, and a few days after the delivery she has to be purified through a small ritual at which the new mother ‘apologizes’ to the *chhmob* for the pollution she has caused (Ang 1982: 107; Ebihara 1968: 447) by presenting her with betel and areca, rice and candles. The *chhmob* in turn gives her blessing to the mother and the newborn by tying a string around the wrist. The father of the newborn helps the *chhmob* prepare the placenta and takes care of its burial, and he is in charge of arranging and maintaining the fire over which the new mother should be reheated for some time after the delivery.

The fire, *ang pleung*, is indispensible as a means to restore the body of the new mother after the strains of pregnancy and childbirth. It is a widespread custom in Southeast Asia, rooted in ancient Brahmanic concepts. The period of heating over the *ang pleung* varies from three days to about a month. The *ang pleung* replenishes the bodily heat lost by giving birth and it ‘cooks’ the body’s conduits (*sasay*) which have become stretched and fatigued, and thereby ‘cold’ during pregnancy, labour, and delivery. It also prevents *toah*, a condition that includes
headache, diarrhoea, abdominal cramps as well as post-partum depression; *toah* is further prevented by dietary restrictions (cf. White 2002: 243). *Toah* is not only a hazard for postnatal women. It is a symptom of a blockage of the *sasay* that may be caused by exhaustion or by eating wrong food, among other things.

The role of the *chhmob* may be illustrated by the following case.

*Mae da Moeun* is a *chhmob* in Battambang Province, like her grandmother and great-grandmother before her. She has no formal medical training. As a young girl she accompanied her grandmother to assist her in the work. She inherited her grandmother’s spirit, but she also has a personal spirit named Ta Ong Tiat, whom she received from a male relative of her husband. She keeps a shrine where this spirit receives daily offerings of water and incense. She invokes him every time she is called to assist in childbirth, and the spirit stays with her as long as she attends to the woman.

As she arrives to the woman in labour she uses a white cotton thread to create a *sima* (border, threshold) to demarcate the ritual space around the *krae* (the low and wide wooden dais used as a bed or for entertaining).
where the woman will give birth. Female relatives and neighbours are invited to sit around the woman to support her by putting their hands on her back in order to restore the energy she is using up. The chhmob will check the mother, while chanting Pali mantras, and she will blow on the ‘centre’ and on the face of the mother to strengthen her. The ‘centre’ referred to here is the centre–stomach, or the ‘chest’. The mantras combined with her breath are her main technique for guiding the woman through the labour. But she is also supplied with medical latex gloves and if necessary she will use these to check the cervix. In the later stage of labour she will support ‘the golden door’ and use her hands to push back in order to prevent ruptures, before receiving the baby.

After birth she cleans the baby, but leaves the grease on the skin to make it strong. She assists in washing the mother and applies turmeric to her skin to make it beautiful and glowing, and she prepares the nipples with lukewarm water and herbal ointment. She assists the father in cleaning and preparing the placenta with salt before it is buried somewhere near the house. The head of the placenta should always be in the direction of the northeast, since this is the cool direction. A small fire is made for the placenta on top of its burial spot. The diet of the mother is nothing but bobo (watery rice porridge) and salt for the first three days; the baby gets boiled water and honey.

After attending to the mother and child, she will help the father organize the fire of birth, ang pleung. When she has the fire burning, she will make a new sima to protect mother and child from evil spirits. This time she uses limestone and water. She keeps the limestone in her hand, marking the walls while walking clockwise around the mother, chanting the Buddhist invocations. Starting from the head, she marks the four directions and makes crosses on the wall to keep the evil spirits away.

| Phutang pith       | The Buddha will block [the intrusion of evil] |
| Thommang pith      | The Dhamma will block                        |
| Sangkang pith      | The Sangha will block                        |

| Phutang rang       | The Buddha will [offer] support              |
| Thommang rang      | The Dhamma will support                      |
| Sangkang rang      | The Sangha will support                      |

| Phutang chong      | The Buddha will tie [the sima]               |
| Thommang chong     | The Dhamma will tie                          |
| Sangkang chong     | The Sangha will tie                          |
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The fire of birth, the *ang pleung*, is interpreted by *mae da* Moeun as a gift to Neang Konghing Thorani (the Earth Goddess who supported the Buddha during his enlightenment), and prayers are whispered to inform her of the fact that her child and grandchild (i.e. the mother and the newborn baby) are now both resting on the fire:

*Neang Konghing, kum oay mien pan heak, kum oay mien chanh, oay soksabai*

Please look after them so that they are not frightened, so that they do not suffer skin rashes, please bring them happiness.

Three days after delivery her spirit expects its *som bon*, the ‘thanking gifts’ which also involve a ritual cleansing offered to her by the baby’s father. The gifts consist of rice, incense and candles, bananas, and some cooked chicken. Her fee of 30,000 riel for assisting the woman should ideally be included, but credit is usually extended for long time, and sometimes the fee is waived in exchange for other services.

Against this background, we can understand that the French scheme of recruiting young girls for midwifery education was inappropriate. Even if recruitment of a *chhmob* could take place at an early age, to practise as one required recognized spiritual seniority and continuity, which was manifested through the inheritance of the spirit of an elder relative, and which could not be compensated by following courses in French, anatomy, and obstetrics. Furthermore, the danger and pollution associated with being a *chhmob* is not something a young person will voluntarily seek unless she happens to belong to a family in which the role of *chhmob* is a potential destiny, and in which she is thereby also assured of the necessary social and spiritual support from close relatives. The *chhmob*’s destiny is hardly a desirable one, however. It may influence a young woman’s marriage prospects since the pollution of childbirth clings to the *chhmob* despite ritual purifications; and the ‘intimate’ relation of a *chhmob* to her spirit is a factor that may intrude into a normal marital relationship. The social status of the *chhmob* (like that of a spirit medium; see Chapter 5) is therefore ambiguous. On the one hand, she is treated with respect and affection in the local community, particularly by women, as a provider of crucial physical and spiritual comfort at the most critical passage of ‘crossing the river’. On the other hand, she is regarded as a marginal person because she engages in defiling activities.
From chhmob boran to TBA

It is understandable that the cultural character of Khmer indigenous midwifery was not recognized in the French medical modernity. But even after independence, it seems that the combination of social, spiritual, and technical features of the chhmob were not really appreciated. In 1963, at the height of Prince Sihanouk's medical modernization programme, the country had about 140 midwives (with a three-year education from l'École royale des infirmiers, infirmières et sages-femmes d'état) and about 400 rural birth attendants (accoucheuses rurales, trained for six months). These categories of medically trained personnel assisted at a total of about 55,000 childbirths during the year, of which 25,000 took place at a maternity clinic, the rest presumably in homes, with the help of a 'rural birth attendant' (Royaume du Cambodge 1964: 7, 13, 26). With a total population of about 5.9 million and a crude birthrate of 40 (i.e., 40 births per 1000 population; Desbarats 1995: 106–107), the total number of childbirths in 1963 would have been around 236,000. This means that about 23 per cent of all births were assisted by medically trained personnel, and less than half of these took place at a maternity clinic. The majority of Khmer mothers still depended on the services of the chhmob. Several of the chhmob we have spoken to related that they had been offered short-term medical training courses during the Sangkum period, but interestingly such public health initiatives were toned down in official records, as if the very existence of indigenous midwives was somehow an embarrassment to the modernization ideology. Thus, while certain efforts were made to educate mothers and prospective mothers in hygiene and pre- and postnatal care at some health centres, it was only mentioned in passing that sometimes ‘grey-haired matrons’ (i.e. chhmob) would listen in at the motherhood courses given at the health centres, even if they were 'still more attached to ritual prohibitions than to rules of hygiene’ (Royaume du Cambodge 1964: 31).

The proportion of births at a maternity clinic probably reached a peak, of about 10 per cent, in the mid-1960s and it no doubt declined sharply with the deterioration of the medical system during the civil war. During Pol Pot time many chhmob were co-opted by the Angkar to serve only cadres and the most reliable ‘base people’. The majority of parturient women were taken care of by pet padevat, which may well have been worse than having nobody at all, since their lack of skills, competence and experience was often combined with the absence of empathy instilled in them as part of their revolutionary ‘training’.

A number of chhmob who had left the country during or after Pol Pot and spent time in refugee camps along the Thai/Cambodian border were offered basic medical training by the international organizations that served the camps (Lipsky
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and Nimol 1993). As a result of the UNTAC mission in 1991–1993, Cambodia was opened up for international NGO activities. This was also the time when NGO ideology became attuned to the potential usefulness of ‘local knowledge’, and chhmob, together with most other varieties of indigenous midwives worldwide, became incorporated into the general category of ‘traditional birth attendant’ (TBA). This universal category became a favourite target of NGO projects concerned with reproductive health. It was felt that the culturally important local knowledge of the TBAs, and the respect and appreciation they commonly enjoyed in their local socio-cultural context, could usefully be harnessed and combined with a basic biomedical training in midwifery, so that both respect for indigenous cultures and the assurance of safe and sanitary childbearing could be achieved. Known today in Cambodia as chhmob boran (‘traditional’ chhmob), indigenous midwives are more or less willingly and enthusiastically being transformed into TBAs. An early example of a successful transformation is provided by the following case.

Mae da Phiroun was born in Svay Rieng Province, around 1945. The area in Battambang where she now lives is heavily infested with landmines but her family has received some recently cleared land from the authorities. Her husband works for the Cambodia Mine Action Center (CMAC) with a local demining team. He is not happy with her work as a chhmob, which he finds embarrassing, even if she is gradually and partially exchanging her traditional art and vocation for the modern skills and trade of a village injection doctor. She keeps a drug cabinet in her house, complete with serum bottles and syringes.

Phiroun was called to become a chhmob at the age of 14, when something strange happened to her. Her hair became matted, sak kantan [see Chapter 5], like a bird’s nest. She suddenly felt very strong, and she understood she was supposed to become a chhmob, because she was not afraid of the process of childbirth. She knew a little about it already, since she used to accompany her grandmother, a chhmob. When the spirit possessed her, she lost herself since the spirit took her soul away to study. The spirits who had called her as a chhmob also motivated her to become a ‘proper’ midwife, and they in fact urged her to become a student at Monivong Hospital during the time of Sihanouk, where she trained as a medical attendant and delivery nurse. Her main spirit is Yei Khmau, a big, strong, and black woman with wavy hair [see also Chapter 5]. Yei Khmau is surrounded by an entourage of three child spirits, who follow her wherever she goes, like kun cap, kun priap (‘young bird, young pigeon’).
When asked to assist in childbirth, Phiroun prays and invites her principal spirit, asking 'Please support me, do not turn away from those who are struggling with difficulties and suffering in childbirth'. The spirit will then enter her body and remain with her to guide her during the work. Nevertheless, during labour she can see no contradiction in using both indigenous and medical technologies to support the woman, following her spirit as well as the instructions from her teacher at the Phnom Penh Hospital. Her medical kit contains surgical gloves, a razor, syringes, and drugs from her cabinet. She uses her hospital training to check if the uterus is opening, using her fingers to measure. If the uterus is not opening as it should, she will inject discopan or oxytocin. She will remain with the woman for the duration of the labour in order to receive the baby and bring the placenta out. She uses surgical gloves and a razor to cut the umbilical cord. She regrets that she does not have a foetal stethoscope, since this would enhance her medical authority.

Several other chhmob we have met also related that their spirits encouraged supplementary training in biomedically based techniques. Not all chhmob, however, have been able to make such a smooth transition from chhmob boran to TBA, as not all chhmob spirits are also spirits of modernity. Although the NGO goal is to combine ‘tradition’ and ‘modernity’ in the figure of the TBA, many chhmob feel rather torn between the two poles. On the one hand, they want to do what they are convinced is in the best interests of childbearing women, to provide physical and spiritual comfort in the socially and emotionally safe home environment. On the other hand, they want to be recognized and appreciated for their skills and their socio-medical importance not only by other women in their local community, but also by society. They therefore covet the kits – symbols of proper medical status – they may receive from the authorities. They are uneasy, nevertheless, since they perceive themselves to be in direct competition with professional midwives because they feel that the latter have the advantage of the goodwill of the authorities although they lack the ‘natural’ qualifications of maturity, experience, and spiritual responsibility. The chhmob are very much aware that there are conflicting views of childbirth among different stakeholders, which reflect social change and increasing professional competition (cf. Collins 1999: 55–60). They realize that they now live in a new society and that this has generated new problems, not least in terms of new technology. The chhmob now has new duties as well as many difficulties for which she does not always feel sufficiently well prepared.
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Many *chhmob* see the new pharmaceuticals as causing problems for the women: ‘The new drugs make the uterus hard so that it does not open’. Many also blame modern family planning and birth spacing techniques for the fact that they have fewer clients now. They suspect that professional midwives actively draw clients away from the traditional Khmer birthing practices. District health authorities are increasingly allowing professional midwives to attend to home births. In provincial and urban centres the *chhmob* seem to be less in demand, especially in areas where mother-and-child centres have been established; such centres use the pre-natal check-ups to try to persuade young women expecting their first child to come to the hospital for a ‘safe and clean delivery’, as the slogan has it. Another area of conflict involves the customary postnatal *ang pleung*. Modernist biomedical authorities in the colonial period as well as the contemporary nation-state have never regarded this custom favourably. Most local health staff in Cambodia realize the centrality of this custom, however, and mothers are instead encouraged to shorten the ‘reheating’ period and to restore their energy by the additional use of strengthening injections. If poor living conditions make a proper *ang pleung* period impractical and the cost of injections too much of a strain on the household economy, the new mother will regain bodily heat by wearing a woollen cap and socks for the first several weeks after delivery. But according to a recent study from Pursat Province, even of those new mothers who had received antenatal care at the health centres, 87 per cent had observed the custom of *ang pleung* for at least a few days (Pugh 2008: 44).

Notwithstanding the medicalization of childbirth, the *chhmob* are still securely in the lead vis-à-vis biomedical professionals among Khmer mothers-to-be. In 2000, 89 per cent of all births in Cambodia took place in the home of the new mother (Kingdom of Cambodia 2001: 140), so the proportion of hospital births has only just returned to the level it had attained in 1963. Nationwide, 66 per cent of all births were assisted by a TBA in 2000, while medically trained personnel (doctor, nurse, or midwife) were involved in 32 per cent, compared to 23 per cent in 1963. In rural areas, the figures were 70 and 28 per cent, respectively (ibid.: 141). Such figures are a source of some frustration for NGOs working with reproductive health. Thus, the Reproductive and Child Health Alliance (RACHA) notes that that their Continuing Education Program (CEP) for midwives has not been as successful as they would wish.

The vast majority of rural women prefer to give birth at home with a trusted TBA. Consequently midwives working in health centers have very few opportunities to attend births and use the CEP training. Rural women
consider midwives to be too expensive and have too little experience with attending deliveries. Many midwives are indeed young and very inexperienced in comparison to TBAs. This further restricts their use of the CEP training. (RACHA 1999: 9)

Whether or not the cost of a professional midwife is a decisive factor, it is quite understandable that few new mothers are prepared to entrust their safety as well as that of their babies to a young and inexperienced midwife who has probably not even given birth herself and should therefore not be allowed to be present at a childbirth at all. Furthermore, such a young person probably does not have any idea of how to ward off the evil spirits. The psychological comfort that a chhmob provides, before, during, and after the birth, should not be underestimated. As related above, a French doctor observed already in 1931 that the ‘neighbourhood matron’, as well as older female relatives, tended to overwhelm the young mother with advice and recommendations that were not always congruent with those given by medically trained personnel (NA 2466). But to be overwhelmed with
advice and recommendations is also to be cared about and paid attention to as an individual, to be made aware that one's physical and psychological condition is also the concern of one's immediate social environment. Such very personalized care cannot adequately be compensated by two or three antenatal group consultations at the public health centre.

A study of the clients at antenatal clinics in Pursat Province has shown that almost 20 per cent showed ‘moderate to severe symptoms of antenatal emotional distress’, with half of the cases being of ‘psychiatric levels of severity’ (Pugh 2008: 71). This is not to say, of course, that the about 60 per cent of pregnant women who do not consult antenatal clinics do not suffer stress or depression; many most probably do, as ante- and postnatal depressions are clearly related to poverty (ibid.).

The chhmob and spirituality
Both Yeï Moeun and Yeï Phiroun’s stories, as well as the half-a-dozen others we collected, clearly indicate the crucial importance of the spiritual component of the practice of the chhmob. Curiously, in the small number of other studies that touch on midwifery in Cambodia, this component is hardly ever present and in
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some cases even explicitly denied. This discrepancy merits some reflection. Ang Chouléan conducted an early and pioneering study of birth practices among Khmer exiles in France (1982). Chouléan insists that all spiritual and ritual aspects of childbirth are taken care of by male kru. It is the kru who delimits the ritual birthing space with a sima, and it is he who attends to the ang pleung (Ang 1982: 98–99). The role of the chhmob is purely humanitarian and social, says Chouléan, ‘sans aucune connotation mystique’ (ibid.: 99). In Chouléan’s study, furthermore, there is no mention of Buddhist invocations, nor of a positive assistance of any tutelary spirits harnessed by either kru or chhmob, but only of the possible necessity of an exorcism of bad spirits by a kru (ibid.: 100–101). Chouléan’s study is based on interviews with seven (female) main informants; we are not told whether any of them was or had been herself a chhmob, but judging from the text as a whole, it seems unlikely.

The few other studies that to our knowledge touch on childbirth in Cambodia do not provide information from a chhmob point of view. May Ebihara (1968: 446–448) only relates that on the third day after birth there is a ceremony ‘to ask forgiveness of the chhmob’, on which occasion the chhmob receives a gift of betel, candles, and incense – items typical of acknowledgement payments for spiritual services – as well as some rice, fruit, meat, and a small sum of money. Ebihara (being young and single at the time) could not herself be present at any birth, and she appears not to have sought detailed information from the local chhmob (who lived in a neighbouring village). The study by Kimberley Townsend and Pranee Liamputtong Rice (Townsend and Rice 1996) from a refugee camp on the Thai border was based on interviews with thirty-one mothers (one of whom also had some medical training) and one kru, but no chhmob. Not surprisingly, we are given a detailed description of all the various herbal medicines the kru may provide (1996: 128–132), whereas the role of the chhmob is passed over in a short paragraph (ibid.: 137) describing how after the ang pleung she will perform a ritual of tying cotton threads around the mother’s and baby’s wrists and pray for their well-being. This is in order to tie the pralung (see Chapter 3) to the bodies of the mother and baby. The study by Patrice White (2002) of Khmer women’s perceptions of pregnancy and postpartum was conducted from a biomedical perspective and mentions only in passing the (seemingly biomedically irrelevant) fact that either a TBA or a traditional healer may tie strings around the wrists, make sima markings, or recite incantations (2002: 244). William Collins (1999: 55–60) and his team also supply only indirect evidence for the spiritual aspects of the chhmob’s role; their interviews focused on health-seeking decisions rather than on practitioners’ techniques. One informant, however, hinted that the
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*chhmob* puts herself at a spiritual risk when performing her midwifery, and that she would have convulsions if the betel, candles, and incense offered were not arranged properly (ibid.: 57). At the same time, Collins reports that the spiritual threats occasioned by pregnancy and childbirth are dealt with by *kru* and other male elders (ibid.: 58), thus neglecting the possibility of a female spiritual agency among the *chhmob*.

The closest we get to hearing *chhmob* voices is in the study by Sherry Lipsky and Ky Nimol (1993) of Khmer female medical practitioners in a refugee border camp. Of the 90 participants in focus group interviews, 4 were *chhmob*, while the rest were biomedical, mostly female, practitioners of various kinds and levels of education; the 4 *chhmob* were in their fifties and had little or no formal education; the 86 biomedically trained participants were mostly in their early thirties. Given this composition of the study population, it is understandable if the small minority of *chhmob* – being elderly, rural, and illiterate women – felt somewhat intimidated and did not volunteer details about their personal spirits, for fear, perhaps, of being ridiculed as superstitious. Instead they sought legitimacy among their peers by emphasizing that their practices were more hygienic now, and that they were less insistent on the practice of *ang pleung*, although they did not discourage it (1993: 378). They stated that one was chosen as a future *chhmob* by her relatives on the basis of her cleverness and willingness (ibid.: 377), and they hinted that they could seek spiritual and herbal knowledge from a *kru*, even if that was sometimes frowned upon by men (ibid.: 378).

There can be no doubt, on the basis of the above discussion as well as our own findings, that the practice of the Khmer *chhmob* is fundamentally both spiritual and technical. This proposition also makes sense in terms of socio-cultural logic. In her account of the cultural variation of the roles of traditional birth attendants in Indonesia, Anke Niehoff (1992) has distinguished two main types and related them to differing forms of social organization. In patrilineal societies (in eastern Indonesia) the important spirits are those of the lineal ancestors, and communication with them is the prerogative of male elders or ritual specialists; the role of female traditional birth attendants in these societies is technical only. In the major Indonesian societies, on the other hand, which have cognatic kinship systems, ancestral and other spirits are not clearly linked to descent groups and both men and women may communicate with the spirits on behalf of members of the community. In these societies, the traditional birth attendant combines manual skills and spiritual abilities (1992: 174). Khmer society is an example of this latter type, while Vietnamese society is an example of the former. This may also explain why young Vietnamese women saw no
cultural obstacles to enrolling in the French midwifery school and to seeking a living as privately practising midwives; for them, as for the French, midwifery was mainly an occupation that required technical skills.

But there can also be no doubt that the forces of male political dominance and biomedical modernity conspire to suppress the spiritual role of the Khmer chhmob. These forces are also supported by official Buddhism where the role of women is the mundane one of feeding monks and bringing offerings to the wat, while monks and achaa take care of spiritual matters. In public settings where male and female practitioners may contend for spiritual authority, the female voices are more easily muted; the study by Townsend and Rice (1996) is a case in point. The spiritual aspects of indigenous Khmer medicine in general were already scorned by the French (‘a lot of superstitions and ridiculous invocations’).

As we saw, the French did not succeed in reaching the Khmer chhmob, but rejected them as potentially serious medical practitioners, not because they were guided by their spirits (the French did not know anything of that) but because their practices were deemed unhygienic and therefore dangerous. Judging from the case of Yei Phiroun, it is quite possible that the basic training in hygiene and obstetrics offered to chhmob under Sihanouk represented a genuine complement to indigenous (technical as well as spiritual) practices.

Paradoxically, the advent of the discourse accompanying international development aid to the health sector highlighted its own epistemologically dubious nature. As Stacy Pigg has pointed out, the term ‘traditional birth attendant’ (TBA) does not have any specific empirical referent since it is not used for any particular practitioner in any language; it ‘stands for a hypothetical person about whom health development planners might usefully know more. While seeming to describe an empirical reality, it operates as a theoretical construction of a role that is believed to exist in those societies labelled traditional’ (1995: 52). The reason why health development workers need to know more about TBAs is that they are supposed to work with them in order to successfully implement health development schemes. ‘Construing [TBAs] as a resource instead of an obstacle is a way to show “respect” for “other cultures” while still controlling them’ (ibid.).

But in order to become proper working partners of international health experts, TBAs need some medical training. Contrary to the basic anthropological insight that ‘the social aspect of birth can never be separated from its physiological aspect’ (ibid.: 58), TBA training is based on the notion that this separation can and should be made. Training programmes,
while careful not to interfere with beliefs and customs if they are deemed ‘harmless’ […] introduce a biomedical understanding of birth through the back door by focusing on a physiological realm divorced from social considerations […] The medicalization of birth attendants, tacitly enacted through training, requires trainees themselves to fragment their practices, to distinguish between the ‘medical’ and the ‘social’ aspects of what they do. (ibid.)

When a chhmob becomes a TBA she is, by definition if not always in social reality, removed from her community context in which she is a respected and esteemed female elder who applies her technical skills with the consent and comforting participation of the spirits. Instead, she enters into a wider socio-political context in which she will necessarily become inferior on all scores: she is both educationally and economically inferior to her medically fully trained midwife colleagues who suspect her practices to be harmful. And since her spiritual practices may easily be equated with superstitious and therefore ‘harmful’ ones, she becomes spiritually inferior to the male kru whose spirituality has always been more visible and enjoyed greater respectability as a ‘learned’, male tradition.

Faced with such discursive and policy-created attacks on their identity, the strategy of many chhmob seems to be to go along with the imposed division between the ‘social’ and the ‘physiological’ dimensions of childbirth; they tend to keep the spiritual aspects of their practices as a private matter between themselves, their clients, and their spirits, and to try to meet their medically trained colleagues on their own ground by ascribing the problems they encounter in their practices to new pharmaceuticals and biomedical technology. But it is becoming increasingly difficult to recruit a new generation of chhmob, as daughters and granddaughters appear unwilling to take on the vocation. As one of our chhmob informants said, ‘when I die, my spirit will disappear for it will have nowhere to go’.

NOTES
1 The maternity was named after E. Roume who had been Governor-General of Indochina in 1915–1916.
2 ‘Mr Doctor-in-Chief, at the Mixed Hospital in Phnom Penh
 I the undersigned, Marie Louise (Canavy), aged 17 years, daughter of Canavy (Léon), resident at Kep (Kampot),
Have the honour to most respectfully request your esteemed benevolence to consent to put me down on the list of midwife students at the newly created establishment at Phnom Penh.

In the hope that you will favourably receive my application, allow me most respectfully, Mr Doctor-in-Chief, to assure you of my unalloyed and profound gratitude with which I have the honour of remaining

Your most humble and obedient servant.
Marie Louise (Canavy)’

3 ‘Mr Doctor-in-Chief at the Mixed Hospital in Phnom Penh

Mr Director

I the undersigned Marie Canavy, midwife student at the Roume Maternity. I have a family matter that does not allow me to follow the course. I beg you, Mr Local Director of Health, to grant my resignation of 28 January 1925.

In the hope that you will favourably consider my request.

Allow me, Mr Doctor-in-Chief, to express my profound respect.

Marie Canavy most obediently’

4 Léon Canavy was one of the few colons in Cambodia (see Chapter 2). He had started as an employee of plantation owner Kieffer and had acquired a modest estate (eight hectares) of his own in 1887. In 1909, two years after the birth of Marie Louise, he had acquired a further 40 hectares (Forest 1980: 259). In 1913, ‘during an exceptionally volatile period of rural unrest’, Canavy had survived an attack by locals (Tully 2002: 165).

5 Juliette was registered as a French national. Her father, Maston Pakiry, then soldier, second class, of the 11th Colonial Infantry Regiment, had reported the birth of Juliette to the municipal authorities in Phnom Penh on 11 October 1909, the day after her birth, and in the presence of two witnesses he had declared himself the natural father. At the time of her application to the midwife school (December 1926), Juliette was still living with her parents (NA 11288).
Biomedically, leprosy is seen as an unimportant disease. It is not even taken up in *The Western Medical Tradition, 1800 to 2000*, the celebratory standard biomedical reference (Bynum et al. 2006). Leprosy is presumed infectious but it is not easy to become infected. It has never affected more than a tiny minority of the population in any society. Compared with older menacing epidemic diseases – smallpox, cholera, and the plague – and contemporary mass killers – tuberculosis, malaria, and AIDS – leprosy is insignificant as a public health issue. It no longer even presents interesting challenges for frontline medical research; when diagnosed in time, it can often be efficiently and inexpensively cured with antibiotics, and because infection is infrequent and seemingly random, prospects of developing a vaccine are not very promising. However, in resource-poor countries like Cambodia leprosy has until recently continued to cause gross disfigurement and disability, particularly among the most vulnerable part of the populace whose lives are beset by poor hygiene and malnutrition.

Yet leprosy has loomed disproportionately in the minds of people, both in Europe and in Cambodia. In Medieval Europe the disease had cosmological dimensions; it was regarded as a divine punishment for sinners, rendering the afflicted person not only polluted but also so polluting that he or she should not be allowed anywhere near the non-afflicted. Mary Douglas (1990) suggested the parallel between accusations of witchcraft and ‘accusations’ (classification or diagnoses) of leprosy as instruments of social exclusion. Douglas demonstrates how the branding of individuals as witches or lepers capable of insidious harm may be understood in relation to the character of their political society. In Europe in the twelfth century, for instance, as centralized power and the feudal system gradually eroded, the greater mobility of the masses was seen as a threat to the social order. Large numbers of vagrants, beggars, and heretics were rounded up...
as ‘lepers’ and confined to leprosariums. Notions of this hitherto minor disease were transformed and leprosy was now believed to be contagious, ‘lepers’ were said to indulge in all manner of depravity, and they were basically stripped of their civil rights (Douglas 1990: 732). From the fifteenth century onwards, leprosy gradually declined, or at least the leprosariums lost their social importance and were eventually closed down (Foucault 1973, Ch. 1).

As modern medical research engaged with leprosy in the mid-nineteenth century, however, the disease was once more brought to public attention. The modern medicalization of leprosy was initiated in 1873 with the discovery by Norwegian physician G. Armauer Hansen of the Mycobacterium leprae that was presumed to be responsible for the disease.¹ Hansen’s discovery led to, or at least coincided with, a remarkable change in the perception of the disease that was once again deemed not only incurable but also highly infectious. A dramatic increase in alleged leprosy cases was reported and this created fears of a worldwide pandemic. A purported outbreak among Chinese coolies in Hawai‘i led to deportations, and calls for ‘ethnic cleansing’ of Chinese were heard from both the United States and Australia during the 1880s and 1890s (Gussow and Tracy 1971: 699, 706).² The medical consensus was on the need for the strict isolation of lepers. Religious charities were galvanized into action, and soon leprosy treatment in isolated leprosariums and leper colonies became virtually a monopoly of religious organizations. This rather intensified the stigmatization of people with leprosy, since they were now regarded as not only incurable but also, as in Medieval times, as polluting. The interdependence of medical opinion and diagnosis and socio-political measures indicate that there is indeed, as Mary Douglas suggested, ‘scope for a partnership between cultural theory and medical history’ (Douglas 1990: 735).

LEPROSY IN PRECOLONIAL CAMBODIA

In contrast to Europe, Khmer indigenous medicine had a long tradition of precise diagnosis and specific treatment of leprosy. An ancient Khmer palm-leaf manuscript, for example, lists the more than 20 herbal ingredients needed for the medicine to treat, among other things, ‘the 100 categories of leprosy’ (Chhem and Antelme 2004: 37).³ According to a popular legend in Cambodia, one of the kings of Angkor contracted leprosy. The very idea of an association of a king with leprosy is intriguing, given that political and/or spiritual leadership in Cambodia presupposes bodily perfection.
David Chandler has suggested ‘that the knowledge that a reigning king was afflicted with this disease […] would have called into question the legitimacy of Cambodian kingship’, and ‘that a king’s leprosy would be interpreted, throughout the society, as a judgement and a curse’ (1996: 13–14). We find this interpretation doubtful. If the legend was meant to imply a political critique – a natural assumption in our own contemporary society – one would expect hints of this in the story itself. But no such hints are found. In the version related by Chandler, the king had summoned his ministers; one of them, ‘named Neak (i.e. “naga”, or dragon) refused to prostrate himself. Filled with anger, the king took his sacred sword and smote the minister. When he did so, venomous spittle fell on him, and he became a leper’ (ibid.: 5). In a similar version the king is infected by the poisonous breath of the King of the Serpents who was furious because the king had destroyed the cult of serpents (Khuon 1958: 22). A different version tells of a powerful king, young and handsome, who was riding among the cheering crowds when an old woman in filthy rags suddenly threw herself upon him; the king fell to the ground and the horrible old crone clung to his arms and rubbed her flaccid flesh against him. The king was extricated and the woman was killed on the spot (ibid.).

In none of these versions are the people who caused the king’s leprosy portrayed in a heroic light. We would rather conclude, therefore, that the legend tells of a righteous ruler who, through no fault of his own, was attacked by insidious forces of evil. Chandler’s interpretation further rests on the premise that leprosy is seen as a divine punishment. This is also a (Western) notion that was not, and is not, found in Cambodia. In Cambodia leprosy is believed ultimately to be inherited from ancestors, but at the same time it is realized that contagion, or rather physical taint (Au 2008: 127), may be the cause of the affliction. This implies that the person with leprosy is himself not to blame for his condition. As in the West, leprosy carries shame (because of the physical disfigurement it causes) but it is not also associated with guilt or sin. The Khmer ascribe a similar aetiology to certain other diseases, such as tuberculosis, syphilis, and, more recently, AIDS, which also carry sentiments of shame.

As mentioned in Chapter 1, the Chinese envoy Chou Ta-Kuan related that leprosy was common among the population of thirteenth-century Angkor, and that lepers apparently were not subject to discrimination. If we accept that this was an accurate observation at the time of Chou’s visit, we may speculate as to why it was not true in the nineteenth century, just as it is not true today. Mary Douglas’s insights about the relation between the social and political structure of society and mechanisms of social exclusion may be fruitfully applied to the
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Cambodian case. At the time when the legend of the Leper King emerged (no later than Chou Ta-Kuan’s visit in the late thirteenth century), Angkor was at the peak of its glory. It was a centralized, strictly hierarchical polity, endorsed by a class of Brahmanic priests, the stability of which seemed assured (Mabbett and Chandler 1996: 209). The king was a devaraja, a semi-divine ruler who delegated some of his absolute power to his ministers and provincial governors on the principles of patron–client relations. These officials in their turn would act as patrons to their local clients further down the political hierarchy. Access to political power in this divinely instituted hierarchy was through affiliation to a superior and not through overt opposition. But the legend of the Leper King is a reminder that not even the ruler could be immune to insidious harm perpetrated by evil or politically illegitimate individuals. In the Cambodian legend, however, such individuals, rather than the Leper King, are the ones who are accused and who take on a role equivalent to that of witches.

After the Siamese conquest of Angkor in 1432, the Khmer kingdom was severely weakened and territorially reduced. During the following four centuries it was continually threatened and encroached upon by its more powerful neighbours, Siam and Annam. Internally, the once all-embracing political hierarchy gradually lost conviction; there was a ‘decline in importance of [the] brahmanical priestly class that had effectively linked landholdings, control of slaves, religious practices, education, and the throne’ (Chandler 1992: 97). At the same time new forms of wealth, independent of the divinely instituted hierarchy, had emerged through the foreign (Asian as well as European) traders who had settled in the trading port of Phnom Penh. We would expect that this gave rise to new social distinctions. If the combination of health, wealth, and beauty remained the desirable ideal (as it does today), its antithesis would be an obvious candidate for social exclusion; the sick, poor, and ugly became despised.

In any case, it seems that the Cambodian attitude to leprosy changed. From the mid-nineteenth century, at least, the shame that had always been conferred on the individual leper (including the king) had hardened into stigma. Lepers were, and still are, considered unclean and disgusting, and physical and social contact with them was avoided. In 1867, for example, a British visitor observed that among the people at the market in Phnom Penh, ‘[a] shock of disgust is felt as a loathsome leper brushes past’ (Thomson 1868: 247). The lepers epitomized the sick, poor, and ugly. The disease by itself exacerbates poverty through the patients’ diminished ability to carry out normal work, and it directly causes hideousness by the disfigurement of facial and bodily extremities. Furthermore, in precolonial times, similar disfigurements were used to brand offenders against
the law; common punishments included the mutilation of feet, hands, fingers, ears, and nose (Aymonier 1900: 87). The medically well-known condition of leprosy was still not in itself associated with guilt, however, and lepers no doubt felt the injustice of their plight, since they had committed no crime. The legend of the Leper King perhaps held some hope for the redemption of their human dignity by sending the message that once even a king had suffered this affliction.

Traditionally, a leper would be cared for by his or her immediate family and usually confined, or confine him/herself, to the house and its immediate surroundings. But when or if the physical disfigurement became too much of an embarrassment for the family, the leper would be banished to a small hut in the forest outside the village, and the family would place rice outside the hut as long as the leper was still there. Alone in the forest, it was thought that people would soon be eaten by tigers (Menaut and Baisez 1919: 132). Instead of passively awaiting this fate, many lepers left to become vagrant beggars.

THE COLONIAL PERIOD

In October 1897, Dr Angier, médecin-chef in Phnom Penh, reported to the résident supérieur that there were 129 known cases of leprosy in the country, of which 34 were in Phnom Penh. Dr Angier noted that since the Cambodians believed that the disease was inherited from the ancestors, many lepers lived with their families and even married without regard for the possibility of infecting their closest relatives. Since the infectious nature of leprosy was universally recognized, Dr Angier concluded, prophylaxis consisted essentially of isolating the lepers, and the establishment of leprosariums was the only means of checking the spread of this terrible disease (NA 2174a). Dr Angier’s report was faithful to the biomedical consensus at the time, and he did not comment on the discrepancy between the statistically modest occurrence of the disease and the fact that generations of lepers had been living in families that were presumed hotbeds of contagion. Common sense would seem to favour the Khmer rather than the French theory of causation.

With the insistence on isolation as the sole yet urgent measure, however, the medical treatment of leprosy was transmuted into a problem of social hygiene, that of how to deal with lepers, particularly those who had no family ties. In June 1900, the police superintendent of Phnom Penh had addressed the mayor, Dr Hahn, concerning the 20 or so ‘ulcerous and otherwise diseased natives’ who were living as beggars around the markets and gambling houses and who
spent the nights on the pavement or in market stalls. Both humanitarian and public health interests would be best served, the superintendent suggested, if these unfortunates could be confined in order not to transmit their diseases to healthy people. He proposed the construction of a large hut surrounded by a fence, allowing the inmates some fresh air, behind the hospital of the religious sisters of la Providence. The sisters would no doubt be happy to take charge of these people, since they had already repeatedly tried to bring them in off the streets for treatment; but most of those habitually hanging out at the gambling houses would scarper as soon as they were well enough to walk (NA 2174b).

The Commission for Hygiene convened to discuss the superintendent’s letter. Although the superintendent had actually not specifically mentioned leprosy, Dr Angier’s report was brought up as central to the discussion. Several members of the commission pointed out that a fair proportion of the diseased mendicants were Chinese and that their charge should therefore be the social and economic responsibility of the Chinese congrégations. The Khmer and Vietnamese (as proper colonial subjects) should be delivered into the sisters’ charge with an indemnity from the government of 25 cents per person and day (NA 2174b). After the meeting the résident supérieur asked the mayor to prepare a detailed administrative and economic plan for the implementation of the proposal, after which he would take up the matter with the sisters (NA 2174b).

A year later, Adhémard Leclère (who had succeeded Hahn as mayor) wrote a nine-page letter, in his usual pedantic style, to the résident supérieur detailing the requested plan (NA 2174c). The matter had now become exclusively one of leprosy. Like in twelfth century Europe, leprosy was again used as a catch-all for socially undesirable individuals, but this time on the authority of medical science. Leclère noted the desirability of creating one or more leprosariums in the country, preferably on one or several islands, for the isolation of all the lepers. To attain that goal, however, the government would need a detailed survey conducted by vaccination doctors with the powers to force all mesrok to surrender all suspected lepers to them for examination and eventual confinement, but the government would no doubt be reluctant to engage in such a major operation. The issue at hand, however, was the more restricted one of ridding (débarrasser) the city of Phnom Penh of vagrant and mendicant lepers. For this purpose, three measures seemed called for. First, all lepers who were Chinese should be referred to the Chinese communities who should bear the costs of taking care of them. Second, Khmer and Vietnamese lepers from the provinces and who had resided in Phnom Penh for less than five years should be sent back to their villages. Third, the rest should be confined and left in the care of the religious sisters.
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After a detailed discussion of suitable locations and building options for a leprosy ward of 20 beds, Leclère concluded that the cost of establishing an appropriate institution would be about 2,000 piastres, to which should be added the annual cost of about 2,500 piastres for running the establishment, covering salaries for one French sister (1,200 piastres) and one native assistant (375 piastres) as well as the allowance of 25 cents a day per patient.

Although Leclère had presented his plan as reasonable and the costs as warranted and modest, it is doubtful if a proposition with costs of that magnitude would appeal to the résident supérieur; after all it was a question of less than 20 individuals who caused the city administration some aesthetic inconvenience. It seems that the scheme was tacitly given up; it may be that several of the remaining mendicant ‘lepers’ lived up to Leclère’s expectation and left their habitual digs for fear of confinement as their Chinese and provincial fellows were being rounded up. Perhaps the embarrassment caused by a few lepers in the streets turned out to be a lesser problem than their envisaged ‘debarrassment’. After the establishment in 1905 of l’assistance médicale indigène, we may assume that the issue became void, as the religious sisters were not given any new official tasks by the secular colonial government.

THE LEPROSARIUM AT TROEUNG

Leprosy as a problem of public health rather than of public order was reintroduced by Dr Bernard Menaut who had energetically engaged himself in both the medical and social aspects of leprosy treatment. In 1919 he had published a detailed study, together with a colleague, of leprosy in Cambodia (Menaut and Baisez 1919). On both humane and medical grounds Menaut strongly opposed the prevailing attitude of the authorities, which he summed up as follows, ‘The doctor says to the leper, “I can do nothing for you”. And society says, “Go away, you’re hideous; if we see you again, we will lock you up”’ (Menaut and Baisez 1919: 138). Menaut’s interest in leprosy was awakened in 1907 when, as a young médecin du service d’hygiène he had made the acquaintance of the indigenous healer kru Pen.

In late 1907, while undertaking a vaccination tour, I was travelling on horseback along the cart-track that has now become the road from Kampong Cham towards Phnom Penh and Angkor, when at about fifteen kilometres from Kampong Cham a sudden thunderstorm obliged me to leave the track and cross the forest to seek shelter near Khel Chey village.
The unknown path that I took without a guide led me after about 400 metres to a large thatched hut in front of which I stopped. Imagine my consternation when, on entering the hut, I found that all its inhabitants were lepers. I realized that the hut belonged to a *kru khleng*, presumably *kru* Pen who lived a hundred metres away, in the village proper.

When the storm had passed, I searched the village house by house but did not find *kru* Pen. He had been absent for several days, the villagers told me, probably, they added, being in the forest in search of herbs for his medicines. In actual fact, Pen was about in the village, and he later told me that he had himself supplied the villagers with the motive for his purported absence.

At the time, there were 26 lepers in *kru* Pen’s care. They had come from diverse regions of Cambodia, from all districts of the *circonscription* of Kampong Cham, and from Prey Veng, Baphnom, Romeas Ek, Kampong Leang, etc.…

No administrative pressure had been exerted on these unfortunates to come and live in such a dreary region as Khel Chey. The rumour of *kru* Pen had reached them in their villages or in the course of their endless peregrinations as mendicants chased from place to place. They had gravitated towards this healer whose therapeutic methods had been praised by everybody, bringing to him their afflictions about which no-one had been able to do anything. They professed to be happy that they had come. Totally free to leave or stay, they stayed, surrounding their *kru* with absolute respect mingled with an affectionate fellowship. Profound gratitude – a sentiment rare among the natives, but one that every doctor has met among Cambodians when his intervention has led to the relief of long-endured suffering – imparted to the group a steadfast submissiveness to all ordeals. A serene confidence seemed to have chased from their hearts the hateful distrust otherwise so common among lepers.

Instead, they had attained a sense of peace, rather like that of a hunted animal at its chance discovery of a safe shelter; the consolation of being able to feel like a human being among others in a milieu where everyone is similar to his neighbour; the certainty of not having to endure sufferings other than those ensuing from their leprosy, and the certainty that tribulations caused by cowardly egoism borne of an inequitable society can no longer assail them; but also the certainty of knowing that the one man who was able to combat their accursed leprosy and to wrench them free of its persistant torture was close to them, has restored in them the sociability that lies at the heart of every man whose morale is intact even if his body is afflicted.
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Pen received all who desired his treatment. None of those who stayed with him were obliged to pay him with money. He did not sell his medicine except to the most well-to-do, or to those who came to consult him and wanted to return home to treat themselves with the medicines they had procured. The hospitalized generally paid him in kind, working for him in his rice fields or helping him clear new ones, for until his death Pen never ceased to work the land himself. Those who could not take part in the arduous tasks that rice cultivation demanded stayed in the lazaret hut performing menial work. In exchange for their work, Pen fed and treated his patients.

Already prosperous in 1908, Pen was flourishing by 1913. Every year the clearing of new land had increased the extent of his rice fields. Being earnest and frugal, he had simultaneously managed to increase his herd of livestock. In 1914 the hut he had inhabited in 1907 had become a comfortable wooden house, built on solid piles of hardwood with a tiled roof.

On 17 June 1915, by decree of the Governor-General, he was appointed Directeur indigène de la Léproserie du Protectorat. That was to be his downfall.

The ineptitude and injustice of the intervention of our administration was soon to shatter the eminently laudable efforts of this man who, on the pretext of his illiteracy, was branded an ‘exploiter of lepers’, and to destroy this private colony which asked only to exist, in order to replace it with something official and subject to rules, of which the least one can say is that it burdened the Protectorate with excessive expenses and only led to a piteous failure, and, moreover, that it drove Pen back to his savage mistrust characteristic of the primitive.

Pen died of cholera on 3 June 1919.

My unfailingly kindly attitude to this man who was highly regarded by all of his race, the respect with which I have treated him from the day I first met him and until his death, the way I have always sought to protect his interests that were too unjustly and too brutally sacrificed, won me the unfailing trust and confidence of Pen. It was because of this confidence that I obtained the knowledge of his medicines. (Menaut 1930: 21–24)

Although Dr Menaut’s passionate (and carefully crafted) account implicitly realized the importance of the indigenous kru tradition of focusing on the total social situation for the treatment of lepers, he was also true to his own biomedical background. He described kru Pen as a médecin empirique, in contradistinction to those kru who dealt in magic (ibid.: 27). But the word médecin empirique
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also signifies one who relies on trial-and-error in contrast to the ‘rational’ and ‘scientific’ procedures of proper doctors. Rather than the purported ‘100 categories of leprosy’ of the ancient manuscript, kru Pen recognized the unitary nature of the disease, but he distinguished between two initial manifestations, khlong peh, ‘leprosy of ashes’, and khlong pleung, ‘leprosy of fire’. The former showed white blotches on the skin; the latter showed red or blackish skin patches often with swollenness, and it progressed more rapidly than the former (Menaut and Baisez 1919: 134).

Dr Menaut was to direct his efforts towards both the medical and the social dimensions of leprosy treatment. The medicinal knowledge he had acquired through winning the confidence of kru Pen led him to seek the active ingredients of Pen’s herbal concoctions. Pen’s main remedy turned out to be the seeds of a species of a tree called krabao. This tree (Hypnocarpus heterophyllus) was also found in other parts of Asia, where the oil of its seeds was known by its Bengali name chaulmoogra. After thorough chemical and pharmacological analyses and clinical tests carried out in the early 1920s by Menaut and pharmacist Alexis under the auspices of the Local Director of Health, Vallet, it was concluded that the Cambodian variety of krabao (Hypnocarpus anthelmintica) was by no means medically inferior to other Asian varieties (NA 1348; NA 11839). For this reason, Vallet in 1924 proposed to the résident supérieur, Baudoin, that means should be provided for the controlled production, locally, of krabao oil which would be economically profitable for the protectorate (NA 1349). As résident of Kampong Cham, Baudoin had already shown an active interest in medical matters – he had pioneered the boîtes de secours in 1905 (see Chapter 3), and in 1908, following Menaut’s discovery of kru Pen’s practice, he had brought about an upgrading of his leprosarium – and it seemed he was favourably disposed towards the idea. His goodwill was perhaps further enhanced by Vallet’s sycophantic statement that ‘it would be an honour for Cambodia to have perfected, under your auspices, the medical solution to a problem of interest for the whole of Indochina’ (NA 1349).

Locally produced krabao oil was eventually exported to Vietnam, Tahiti, and New Caledonia (Khuon 1958: 51–52; Huard 1963: 679). Until the advent of antibiotics, krabao, administered orally or through intramuscular injections, remained the most efficient treatment for leprosy patients.

The official rules that Dr Menaut found so detrimental to kru Pen’s establishment were laid down in a decree of 7 June 1915 by the Governor-General. According to this decree (cited by Menaut and Baisez 1919: 136–137), a separate village, named Troeung, was to be created by subdividing the village of Khel Chey. Troeung was to be inhabited by people who had been certified as

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lepers by the Local Director of Health and who either asked for admission, lived as mendicants, or were considered unable to manage on their own. Troeung was to function administratively as an ordinary Cambodian village, with kru Pen as the village chief and Directeur indigène de la léproserie du Protectorat, until further notice. The colonial administration was to construct simple houses or huts for the inhabitants, ‘easy to disinfect or destroy by fire’; each house should have no more than ten inhabitants, and the space for each inhabitant should be eight cubic metres. The inhabitants of Troeung village were subject to a number of restrictions. They were not allowed to leave the village territory; those able to work might engage in farming, herding, or manual labour on village land, but their produce must under no circumstances be marketed outside the village. Each inhabitant was entitled to a monthly allowance of five piastres; they would receive a blanket and material for making two sets of clothes every year, a sleeping mat every three months, lamp oil, and soap. Healthy newborn babies were to be taken from their parents within 48 hours of birth and be placed in a nursery isolated from the leprosarium where they would be bottle-fed. The decree also stipulated a monthly allowance of five piastres for kru Pen as well as for his ‘brother’ and assistant, kru Tep (Menaut and Baisez 1919: 144; see also Guillou 2006 for a biographical entry on kru Pen).

The work of establishing Troeung as a leprosarium was finished in late 1916, and this was the occasion for the administration to manifest its ‘ineptitude’: kru Pen was asked to resign, his monthly allowance was terminated, and he was ordered to refrain from activities that would compete with those of the official leprosarium. The leprosarium was overseen by a medical attendant from l’assistance médicale. Some of the lepers were put to work in a stone quarry at a place called Meat Mong (volcanic rock is close to the surface in many parts of the area), where they were overseen by another medical attendant. Apparently these overseers were likely to abuse the lepers in various ways. The resident doctor at Kampong Cham, Dr Fabry (see Chapter 3) addressed the problem in his 1924 annual report. The task of supervising the leprosarium and the quarry was not a demanding one, Fabry said, and the attendants easily developed a habit of idleness and assumed a domineering attitude towards the lepers. Since a doctor might easily fail to notice the abuse of power by his subordinates, Fabry had decided to rotate the schedule of the attendants on duty at Troeung and Meat Mong in order to avoid the unfortunate consequences of permanent abusive relationships (NA 630).

Au Sokhieng (2008: 124–125) has argued that the French colonial authorities in Cambodia actually introduced the stigma surrounding leprosy at the same
time as Western medicine more generally was trying to efface its stigma by medicalizing leprosy into ‘Hansen’s disease’. This is an interesting suggestion, but it is not fully borne out by the empirical circumstances. The stigma that attaches to physical disfigurement did not originate with the French, but their overzealous reliance on biomedical germ-theory led to added social suffering: lepers were excluded from society, their newborn babies were taken away from them, and they were mistreated and put to hazardous work crushing stone. Dr Menaut was the one who most vocally objected to the French policy. Apart from the government’s deplorable handling of kru Pen, Menaut severely questioned the whole concept on which Troeung was constructed, that of the mandatory isolation of the lepers. Isolation of lepers as a general measure, Menaut argued, was unjust, inefficient, dangerous, and onerous (Menaut and Baisez 1919: 138–144). He illustrated the injustice perpetrated against the lepers through compulsory isolation by a comparison with tuberculosis.

Leprosy is infinitely less infectious than tuberculosis; and from a social point of view tuberculosis is also more serious. The society, however, does not dare do anything against the tubercular patients because they are so numerous and count many personalities who know well how to defend themselves. Instead, society treats persons with leprosy as it pleases because in the majority of cases the sufferer is isolated, poor, and without support. (NA 1356)

Isolation was an inefficient preventive measure, Menaut argued, and it was also very costly for the colonial government. The 40 lepers who were living voluntarily under Pen’s care had cost the government nothing. But the establishment of Troeung as a leprosarium in 1916 incurred almost 5,000 piastres of the colonial budget per annum (Menaut and Baisez 1919: 144). If this level of expenditure were to be applied generally, it would mean that the government should spend the incredible amount of 100,000 piastres annually on leprosy care in the protectorate.

But the colonial government continued to run the leprosy village of Troeung as a kind of showpiece. In 1929 it had about 150 inhabitants and its annual budget was 7,000 piastres. The existing huts (‘easy to destroy by fire’) were replaced by wooden houses with corrugated iron roofs (‘easy to disinfect’), but whether this was an improvement for the inhabitants is an open question. Menaut noted that the single inhabitants occupied a large communal hall; they had no individual beds but slept on a long bench along the wall. Married lepers had small individual
It seems that the strict rules of confinement had been relaxed, whether by design or by necessity. In 1931 it was officially stated (in an English language publication, probably authored by Menaut) that the ideal form of leper care, which was being generally implemented in Indochina, ‘is the leper-village where the victim lives, not under the regime of compulsory internment, but in liberty, so to speak, with normal occupations and life in common, similar, as far as possible, to usual conditions of native life’ (Government General of Indochina 1931: 11). This enlightened attitude to leprosy care was not unanimously applauded, however. The very same year as the government’s international publication celebrated the liberal treatment of the leprosy victims, the annual report of the medical service expressed severe misgivings. Unfortunately, the report said, this leprosarium which is rather a leprosy village has three main defects: it has an inadequate water supply; it is not subject to surveillance; and it is open to whoever wants to enter and, much more seriously, to whoever wants to leave. Since surveillance is impossible because of the lack of fencing, nothing prevents the sick from going to the main road and getting a lift from a passing car. It would have been much better, the report continued, if the leprosarium was in a more inaccessible location, on a riverine island, for example, since it is impossible to find a sufficient number of committed personnel to accomplish efficient surveillance (NA 2466).

Despite this critique from within the ranks of l’assistance médicale, Menaut’s line apparently prevailed. At Troeung, the lepers now stayed voluntarily, on the condition that they submitted to treatment with krabao (NA 1356). It is probable that the compulsory removal of newborn babies was relaxed; at least we know that Troeung was later inhabited by both leprosy sufferers and their healthy children. The French made further efforts to modernize the village; they installed a water supply system, paved the village streets and erected low walls with gates around the major buildings. The village land was delineated as one square kilometre, and each inhabitant or family was given a small plot of farmland. An irrigation dam was built near the village. Among the lepers who came to live in Troeung were several Buddhist monks, and at the initiative of one of them, Ven. Yush Yeam, a small wat was built in 1940; its walls were built of rough-hewn volcanic rock in-filled with plaster in the style of some French farm buildings.

After Cambodia’s independence in 1953 Troeung was administered by the provincial government of Kampong Cham and was specially sponsored by Sihanouk who made sure food was provided to the lepers; they had rice every day, beef on Thursdays, and pork on Sundays. Antibiotic treatment seems to have been introduced either just before or just after independence. A sulphanilamide
known as Bicelone became the standard drug, but at least until 1958 it was used in Cambodia only as a complement to the injection of krabao that remained the basis of the treatment (Khuon 1958: 91). During the Khmer Republic, life became difficult for the inhabitants because their food supplies gradually dwindled, there was almost no medicine available, and people were scared of the American bombings. By 1973 the Khmer Rouge controlled the area and the food supplies from Kampong Cham town were cut off completely.

*Troeung during Pol Pot time*

The fate of the inhabitants of the leprosarium under Pol Pot has been related by Ly Den, who was conscripted by the Khmer Rouge to serve as pharmacist in Kampong Cham (see Chapter 4). In 1976 Ly Den was ordered to start producing vaccines, based on the methods once used by the Vietnamese guerrillas of mixing cholera vibrios, salmonella, and smallpox virus. These micro-organisms were obtained from the (apparently still existing) Pasteur Institute in Phnom Penh (Ly 1982a: 198–199). When the first batch of the vaccine was ready, it was decided to try it on humans, since there were no animals available for experimentation. The regional director of health decided that the inhabitants of the leprosarium at Troeung would do very well as guinea pigs. The leprosy village now housed about 800 people because the DK authorities had turned it into a concentration camp in which were confined not only lepers and their healthy family members but also people suffering from tuberculosis, cancer, and venereal diseases. They were all injected with the vaccine, but after a couple of weeks no effects could be detected on anyone. It was then decided that the inhabitants of the leprosarium who were not sick should be sent to work in the collectives. All the patients, for whose bouches inutiles it would now be difficult to find food, were massacred in late June 1976, on the orders of the regional director of health: ‘L’infirmérie de Troeng […] a fermé ses portes’ (ibid.: 200).

This latter conclusion, however, was an assumption on Ly Den’s part. In fact, the hospital at Troeung continued to exist throughout the DK period, and Troeung was reopened as a leprosarium in 1979. At that time about ten of the original inhabitants had survived, and seven or eight were still there when we visited Troeung in 2005.

**Chea Touch** was born in 1940 in Kampong Chhnang. He was diagnosed with leprosy at the age of ten, and three years later (in 1953, the year of Cambodia’s independence) his parents put him on a bus for Troeung where he has lived ever since. He still works as a farmer despite his crippled
hands, living with his wife and two grown-up sons, none of whom have leprosy; one son produces palm sugar and the family has a good life.

When he first arrived at Troeung, all by himself, he was met by a number of old disfigured lepers who leered at him, saying, ‘Look at this little one, he will be thrown to the tigers’. He was terrified, of course, until he realized they were joking and he was given a place to sleep; several of the inhabitants were actually glad to have him around because they wanted company and because he could help the severely disabled with practical tasks such as fetching water. His parents never came to see him. But when he was 20, he went to Kampong Chhnang to see them; he had been able to save some money for the fare from his work crushing stones. Up until Pol Pot time he visited his relatives about ten times.

In 1973 the Khmer Rouge came to Troeung; people were asked whether they would work or whether they were sick and would prefer to stay at the ‘hospital’. Touch distrusted the offer of ‘hospitalization’ and said he was not sick but wanted to work. Together with some others he was then evicted from Troeung and sent to a place in the forest on the other side of the lake created by the dam; they were told to clear the land and start farming. In 1975, the place became a *sahakor* called Boeng Thom (‘big lake’). Touch said that before Pol Pot he was free of the disease, but the hard work under Pol Pot made it break out again. While living at Boeng Thom he heard that most of the inhabitants of Troeung had been killed at Skon, some 40 km down the road. He met his wife at Boeng Thom, they were both widowed and decided to live together.

Touch was among the first of those gradually transferred to Boeng Thom. At least six of the about a dozen leprous monks then living at Troeung disrobed and joined the community as farmers. One of the survivors had a quite special story to tell, which deserves to be related in some detail, as it adds significantly to Ly Den’s published account.

**Leang Nam** was born in 1952 in Phnom Penh. He lives alone in a neat little whitewashed house in Troeung. Each day except Sundays he gets on his bicycle to attend to his ‘business’, which consists of collecting plastic and metal refuse that he sells for recycling. On Sunday afternoons he attends service in a nearby Christian church. Nam is Sino-Khmer; his parents raised chicken, ducks, and pigs and sold them at the market just south of Monivong bridge in Phnom Penh. He was diagnosed with leprosy at the age of 15 and three years later he decided to leave his home in order that his presence would not harm his parents’ business, and he settled in
Troëung just after the Lon Nol coup. When the food supplies to Troeung were discontinued in 1973, it became hard for him to get food; he had no family and his hands were severely crippled. He contemplated making his way to the Mekong and swimming to Phnom Penh to join his relatives; but the river was patrolled by marines and he would probably be shot. Instead he set out towards Kampong Cham town in search of food, but he was stopped by a couple of Khmer Rouge soldiers; he narrowly avoided being killed but was sent back. When the civil war was over in 1975, he looked forward to going to Phnom Penh to live with his relatives, but his hopes were soon dispelled, ‘like soil dissolving in water; the people had been evicted from the city and the Angkar had started establishing collective farms so the people had little to eat.

One day in June or July 1976, cadres from the district came to Troeung and called a meeting. It was said that all the disabled inhabitants would be taken to a hospital in Phnom Penh where Dr Thiounn Thioeu would take care of them. All were to collect their clothes and wait for a truck that would take them to the nearby Wat Tropeang Krol, where a doctor from the high office (tnak loeu) would be in charge. When Nam arrived at the wat around six in the evening, it was already full of people. The cadre who was leader of their group (krom) called the names of the people to go on the first truck; Nam was called together with two friends of his, Ton and Chrouk, former Lon Nol soldiers. They were optimistic and calculated that if they left at 6.30 p.m., they could be in Phnom Penh by 9 p.m. The truck, an uncovered GMC, moved slowly, it was raining heavily and the passengers were soaked and cold on the open bed. There were no local people on the road.

They arrived at the Skon district office at about 7.30 p.m.; the truck stopped for a while and the passengers were guarded by armed soldiers. A jeep with eight people (khamaphibal and soldiers) and two Honda motorbikes with two men on each set out to the west to lead the way. It was dark so Nam could not see which road they were taking, but they were obviously in a forest. One of the motorbikes signalled for the truck to stop and the driver was asked for his destination and his permission letter. The driver answered that he had been ordered to go this way and did not know any more. The man on the motorbike then punched him in the face, tied his hands and put him in the jeep. The men shone their flashlights on the passengers. ‘Yie’, they exclaimed, ‘they’re all lepers, men, women and children! Where would they be going?’ Some answered that the Angkar has allowed us to go to a hospital in Phnom Penh. But they were told that nobody from a sahakor can go anywhere without a permission letter, and they were therefore regarded as enemies, not trusted by the Angkar;
they would be detained overnight and searched for weapons, and in the morning they could go to the hospital.

The lepers trusted the men and allowed them to tie their hands. But Nam was reminded of a Khmer Rouge slogan that he had heard often from one of the spies (chhlop, militia) in the village, and which ended, ‘if your hands are tied you will die.’ Nam therefore pretended that the string hurt his damaged hands and argued that since he was a cripple there was nothing he could anyway; so the soldier tied him rather loosely. When all had been tied, the soldier reported to the khamaphibal, who said, ‘Now bring them to be cured so there will be no more leprosy. Sangkum and Lon Nol could not cure the disease, but Democratic Kampuchea will cure it’. People now began to understand what was going to happen and called out for their relatives in despair.

The truck turned south, off the village road, but after about a hundred metres it got stuck in the mud. Four soldiers took the first five people off the truck to a spot nearby and clubbed them to death with guns and wooden poles. Nam could move his hands a little and in the meantime he managed to reach for his small knife and cut his strings as well as those of his friends Ton and Chrouk and another, Hong, who sat close to him. He told them to take the strings and not to leave them on the truck. Ton and Chrouk wanted to fight the soldiers, but Nam persuaded them that it was no use, it would only mean that all the people of their sahakor would be killed. They should flee so they could make it back and warn the villagers of what was happening. Before the soldiers returned to take them away, they jumped off the truck and hid in the bushes. The soldiers searched with their flashlights and asked who had escaped. One of the lepers on the truck, a fisherman named Ok, tried to cover for them and said that nobody could escape, they were all tied. Ok was immediately taken away and killed. Around midnight, Nam heard one of the soldiers calling, ‘It is finished now!’ The soldiers discussed what to do with the lepers’ belongings that were left on the truck and decided they should be given to another sahakor. The truck turned to go back to the national road.

After a while Nam called out to his three friends but got no response, so he started out towards Troeung on his own. He was convinced that when he got to Troeung he would be killed, but he wanted to tell the truth to the people before he died. When he approached the district office at Skon, there was a lantern and he saw some people outside, so he hid beside the road. A man on a Honda motorbike was approached by two lepers (possibly his two friends) and he asked them where they wanted to go. They said, to Troeung. ‘They said they would take us to hospital
but they took us away to be killed instead’. The man said, ‘Who is the enemy who would kill lepers? I will take you to Region 42 to see comrade Sen Sok’. But when the motorbike took off in the opposite direction, the lepers jumped off. The driver stopped and clubbed the two to death with his gun. Shaken, Nam continued towards Troeug. He had nothing to eat except what little he could find or steal on the way. He moved by night and hid during the day. After three days he arrived at Wat Tropeang Krol where he hid in a chedi (stupa); he opened the lid of a coffin and slept with the ghosts. He was in hiding for a few months. Then he implored the appointed leaders for the disabled, Ta Preim (called Meas), Ta Toeun (called Wan), and Yei Sroi (called Mut Srei, ‘female comrade’) to be admitted into the sahakor Boeng Thom. They agreed but said that since his name had been on the list of lepers ‘sent to Phnom Penh’ he officially did not exist and had no rights in the sahakor, so he should go to the Angkar and tell the truth. He did so and was allowed a place of his own at the edge of the sahakor. He was given an ear of maize to sow and a rhizome of sweet potato to plant, and admonished that if he ever broke any rule he would be killed. He was left to his own devices, only suffering occasional harassment by the cadres. He lived in Boeng Thom until 1979 when he returned to Troeug. He spent the first year at Wat Troeung as a kmeng wat but married in 1980. His wife died of dengue fever in 2004 and his life has now again become a lonesome one.

While there can be no doubt that the massacre was meticulously planned by the Angkar loeu, Nam’s story of the multiple deceptions raises questions about the degrees of complicity among various lower level cadres. According to Nam, there were at least two trucks going to the killing fields at Skon that night, others said there were five. It was also said that further transports took place six months later, some went to Skon and three or four truckloads were driven to Phnom Pros and Phnom Srei (male mountain and female mountain), a couple of hills just west of Kampong Cham town). One truckload was taken to Prey Tmor Poun, also in the vicinity of Kampong Cham town. The victims were not only lepers but also former government soldiers, police, and traders, both Vietnamese and Cham as well as Khmer.

Despite the killings, Troeug continued as a hospital during DK. It was one of the largest munti pet in the area; apart from lepers, people with cancer were sent there. The vihear was converted into a factory and storage for herbal medicine. The herbs were cooked in a large metal cauldron. The regular inhabitants of Troeug were confined to the sahakor Boeng Thom; the Khmer Rouge did not want to disperse them due to the fear that they might contaminate others. Troeug itself
also became a secluded area, inaccessible to outsiders. The current deputy village chief was conscripted as a chhlop (militiaman, commonly perceived as an Angkar spy) for duty in the area at the time. In late 1976 he went to the Troeung munti pet because he was feeling weak and hoped for treatment at this major local hospital, since he was trusted by the Angkar. He was given an IV drip directly from a bottle, with a gross needle (‘size 22’) which left a big hole in his arm; this frightened him and he soon reported back for work. Our informants also hinted that medical experiments (other than, and probably medically less sophisticated than those demanded of Ly Den) were conducted at Troeung. It was said that some of the medicine produced contained poison but that people were afraid to talk about it, and that Troeung was a hospital for killing rather than for curing. The current head achaa of the Troeung wat lost a child at the hospital; the boy was injected with water. They also produced an ‘all-purpose medicine’ that was injected into the afflicted part of the body irrespective of the nature of the disease. Nobody was ever cured by that. In 1978, most of the patients were wounded soldiers from the battlefields along the border with Vietnam.

**Troeung today**

The village of Troeung is situated just off National road no.7, about 15 km west of Kampong Cham town. It is inhabited by leper families and individuals. Not all members of every family has or has had leprosy; most of the lepers have recovered, or the disease has run its course. Most of the younger inhabitants are non-leprous children or grandchildren of leprous or mixed leprous and non-leprous couples. A relatively large proportion of the leprous inhabitants are single and elderly. The village chief and the abbot of the wat are also lepers. Most of the inhabitants are poor; irrigated paddy land is scarce, and some have a diminished capacity for agricultural work because of their disability.

A few of the long-time inhabitants of Troeung have heard about the founder of the leprosarium, kru Pen, and they are even more familiar with his successor, kru Chhun (Pen’s grandson, whom the French had been obliged to employ as guérisseur indigène after they had dismissed Pen [Khuon 1958: 50]). He treated sufferers with herbal medicine and magic. They have fond memories of the place in Sangkum times. The last doctor in charge was El Chheng, possibly a médecin indigène. He was a very kind man and managed Troeung very well, he taught and encouraged the self-care of the patients, rewarding them for bathing and washing themselves, if they were reluctant to do so. People had good food, thanks to the deliveries sponsored by Sihanouk. The greatest problem for several of the older residents was that they had no children to help them in practical
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daily life; the draconian measure of removing newborn babies from their parents was still a painful part of the collective memory.

None of the original buildings from the colonially created village of Troeung remains, apart from the vihear; when people came back in 1979, its roof had been damaged, but the walls still stood. The cauldron for boiling herbal medicine had been left inside. The inhabitants are fond of their vihear and with self-deprecating humour comment that it is probably the smallest vihear in the whole country. The oldest wooden building still standing was built in 1983. It carries a weathered sign saying ‘Léproserie de Troeung’. It is now used for storage and as a workshop for the village’s two shoemakers, who cater for the many persons with leprosy who need specially made shoes to fit their deformed feet. In front of

Figure 7.1. Inhabitant of the leprosy village of Troeung.

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this building is a large pond, at one end of which there is a tiled platform with a brightly painted statue of the Leper King overlooking the entrance to the village. Villagers worship the Leper King by burning incense in front of the statue.\textsuperscript{10} Along the main street there are still remnants of low stone walls and gate posts built by the French, and the French tarmac on the street remains almost intact. The French water supply system no longer works, however; nowadays people get water from pumped wells, and one person is employed to help the disabled fetch water.

The total population of the village is 993, of whom 402 (or 43 per cent) are under 15 years of age (conforming to the nationwide proportion). The village has 57 hectares of irrigated paddy land, which is just over half of the area that would
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be needed for rice self-sufficiency. The landless mostly do agricultural wage labour. For lepers the traditional work was in stone quarries, and some still do it today. That the lowly paid but very hard work of stone crushing is traditionally given to lepers is doubly cruel; because of numbness in their extremities, many lepers have suffered accidents that have damaged them further.

Troeung is gradually losing its special character as a leper village since none of the descendants of the original inhabitants are lepers, most of the lepers are old, and only a very modest proportion of the population growth is due to immigration of new leprous inhabitants. Forty-six young persons from Troeung currently work as wage labourers in Phnom Penh, the women in garment factories and the men as construction workers and the like. The villagers are happy about these income opportunities and are not worried about the safety of the young people; they come back to visit the village about once a month as well as for major festivals. One man remarked that the shortage of youngsters has made the village a very quiet, almost dull place. The stay in the capital, however, gives the young the opportunity to meet people of their own age without the stigma of belonging to a village of lepers.

LEPROSY TREATMENT IN CONTEMPORARY CAMBODIA

Leprosy in Cambodia has been ‘eliminated’ since 1998, according to the official (WHO) definition of elimination as a prevalence of the disease of less than 1 case per 10 thousand inhabitants (Ministry of Health 2005: 1). In other words, it is not the disease as such that is eliminated, only its status as a public health problem. The prevalence rate has for the last few years been around 0.3 per 10 thousand. Every year 400–500 new cases are detected. In 2004, a total of 789 cases were being treated. Children under 5 accounted for about 10 per cent, both of total and new cases (ibid.: 2, 12).

Nowadays leprosy can be treated with antibiotics and sometimes cured, if treatment gets under way sufficiently early. The early symptoms are mostly light-coloured patches on the skin accompanied by a loss of feeling in the area. The standard treatment is MDT (multi-drug therapy) and is given for six or twelve months, depending on whether the infection is PB (paucibacillary) or MB (multibacillary). If treatment is neglected or turns out to be ineffective, the patient may develop nerve infections with resulting numbness and eventual disfigurement of hands, feet, and face and even loss of extremities. Treatment of advanced leprosy is mainly by surgery.
As already mentioned, after Pol Pot, the leprosarium at Troeung was reopened by the Kampong Cham provincial health department. In the beginning, the leprosarium received financial support from Poland, and later from France (from 1982) and Switzerland. But it was not long before Christian NGOs were able to reclaim the privilege of leprosy treatment that had been denied to them ever since the sisters of la Providence were ousted from the medical service. Currently, the main financial and technical support is given by the Catholic organization Ciomal (Committée international de l’ordre de Malte) and an Evangelical charity, the Korean Welfare Foundation. In 1994/95 Ciomal started a livestock scheme, giving two cows for ploughing to a selected number of families; the calves would be given to other families. This scheme has now run its course and presently Ciomal supervises the leprosy clinic in cooperation with the provincial health department. A new clinic building was donated by an individual Korean in 2002; it consists of a reception/office and a small infirmary with seven beds. Ciomal sponsors the monthly salaries of a small number of village functionaries, two shoemakers, an ulcer nurse (US$50 each), a clinic maid (US$30), and someone to pump water (US$12). Children in the village are financially supported by the Korean Welfare Foundation that channels donations from individuals to specific children. Two hundred children between the ages of 8 and 18 receive 57,800 riel (about US$16) every 3 months.

In addition to the permanent residents, the clinic continually treats a small number of in-patients. These patients receive a daily allowance of 1,000 riel from the province and 3,000 riel from Ciomal. At the time of our visit the clinic had four patients, two male and two female. One of the patients was a man of about fifty who had been a vagrant; his leg was badly damaged, he had already been treated at Kien Khleang National Rehabilitation Centre in Phnom Penh (of which further below) and he was waiting to go back for a check-up and possibly surgery. Ciomal would arrange for his permanent residence at Troeung. And the man seemed already to have adapted socially to life in the village; rather than just sitting on his bed in the clinic, he mostly spent his time around the village or at the wat sitting below the abbot in the sala with other elderly lay persons. Ciomal helps provide housing and land and also offers a loan of up to US$200 for those who want to start a ‘business’ enterprise to new leprous residents in the village, like that of Leang Nam, for example. Several lepers outside Troeung currently receiving medication prefer to come to the Troeung clinic for their monthly supply of medicine, rather than get it from their local health centre, because in that way they do not have to reveal the nature of their disease to fellow villagers.
The clinic administers MDT and gives basic treatment. The clinic is run by a male nurse; he is a native of Troeung and has been in charge of the clinic since 1979. He was trained as a nurse in Kampong Cham in 1993–1996. One afternoon while we were talking to him in his office, a woman in her mid-forties came in for consultation. She was brought by a small NGO ambulance and the driver delivered a slip from the organization saying they suspected PB (paucibacillary) leprosy. The woman was living with her husband and three children. No one in her family had had leprosy. The first patch on her skin appeared five years ago, but she had felt no pain nor any other inconvenience. She had consulted a kru who had given her herbal medicine but no diagnosis. She had contacted the organization the day before, this was the first intimation she had had about the nature of her disease. She believed her condition might be caused by her having ‘bad blood’. The nurse tested the feeling in the skin patches on her thigh and lower back (according to the standard procedure) and confirmed the diagnosis. He filled in a test sheet for the clinic records and sent the patient away with a PB blister pack for a month’s medication together with a brief explanation.

The main institution dealing with leprosy in the country is the Kien Khleang National Rehabilitation Center. It is situated in Kien Khleang, a district of Phnom Penh, on the Chrui Changvar Peninsula. It forms part of the Kien Khleang compound, which also houses a number of other facilities for disabled people run by various NGOs, including a prosthetics clinic. The leprosy centre is run by Ciomal; it was established in 2000. The centre provides surgery, mainly on deformed hands and feet, treatment of ulcers and other active reactions (with steroids), physiotherapy, and has a self-care programme. The running of the Troeung clinic and village is also administered from Kien Khleang. The centre has a staff of about 20 (expat manager, doctors, nurses, physiotherapists, medical attendants, and menial staff). During the first half of 2005, the centre had about 150 admissions. The staff also perform out-patient consultations (Ministry of Health 2005: 4). Despite the medical advances in treatment and rehabilitation, popular awareness of a possible cure is rudimentary, which implies that the time that elapses between suspicion, qualified diagnosis, and initiation of treatment is often detrimental to the patient’s health. The Ministry of Health has therefore collaborated with Ciomal and a number of other NGOs to organize leprosy awareness campaigns through the mass media and tours to communities and workplaces (ibid.: 3–4).

When we visited the Kien Khleang centre in 2005 it had about 30 in-patients. The following selection of a few of the patients’ stories that we collected at the
centre may illustrate something of the conditions under which lepers live. The stories tell of vulnerability, poverty, and stigmatization, but also of agency under harsh circumstances and a sense of social obligation.

**Suan Thok** is a 70-year-old woman from Kampot. She was born in Phnom Penh but married a man from Kampot and moved there when she was sixteen. Her husband was a fisherman; but he was very handsome, and the Khmer Rouge thought he was a Lon Nol government official, so they killed him. She had had 10 children: 6 boys and 4 girls, they all died under Pol Pot, starved or were killed. After Pol Pot she came to live with her husband’s relatives. In 1980 she discovered a patch on her skin, and it was eventually diagnosed as leprosy. She came to Kien Khleang in 2000 and received medication for one year. When she came back to Kampot, she tried to make a living from selling second-hand clothes; she walked around carrying the clothes on her head. But soon after, her legs swelled and she developed sores on her legs that went right to the bone, which made it difficult for her to walk. When her illness became apparent, her husband’s relatives no longer wanted her in their house, and other people in the village also avoided her, because of the illness but also because she was very poor. In 2003 she moved for a while to Koh Kong, where other relatives of her husband were living; she lived by selling durians. Later she returned to Kampot and lived in a small house by herself. She attempted self-medication, had neighbours buy ‘lanco’ for her at a pharmacy near the market, a sheet of ten cost 4,500 riel. Eventually she could no longer afford the medicine and had hardly any money for food; sometimes people in the village would give her some food. She decided to go back to Kien Khleang in 2005 as her legs were steadily worsening. When we met her, she had recovered after surgery on both feet. She had had specially designed sandals that made it possible for her to move despite her deformities, and she was ready to leave the centre. She said she would leave the next day. After her first treatment, the centre had offered to help her settle at Troeung and to lend her US$200, but she had declined; she did not want to live in Troeung because it was not home to her. She also declined the offer of a loan because she did not believe she would ever be able to pay it back. Her plan was to borrow 50,000 riel from a moneylender and run a business selling fruit outside a school near her house in Kampot. The terms of the loan are to pay back 2,000 riel every day for a month – a total of 60,000 riel (which means an interest rate of 20 per cent per month), she hopes the profits from her sales will allow her to do so. She counts on getting food from her husband’s relatives.
When we came back to the centre the following day, Suan Thok was gone.

**Yeng Navuth** is a young man of 21 from Kandal Province. He has had surgery on one foot, and both his hands are damaged, he cannot use his thumbs and his little fingers are bent. His face has become disfigured, his mouth is skewed and the muscles of his eyes are weakened; he is awaiting an eye operation. Navuth is currently employed half-time at the centre as a teacher. He teaches literacy and mathematics to other patients. Both he and the staff of the centre hope they will be able to offer him full-time employment. He had been a monk in his village but he left the monkhood because of his illness.

Because his parents were poor, he had lived with his grandmother since he was about 10 years old. He spent much of his time in the Wat Chey Mongkol, Prey Takeo, Kandal Province since his grandmother’s husband was head *achaa* of the *wat*. Eventually he became a monk there, his grandparents sponsored his ordination. He was encouraged by the *achaa* to pursue religious studies and attended the Pali primary school at Wat Moni Sakor in 2002–2003. After a year of studies he found a white spot on his left arm. He accidentally held his arm over a burning candle but did not notice because he felt no pain. The next day the burn had blistered and turned into an ugly wound. The provincial health centre referred him to the National Institute of Skin Disease at the Preah Ket Mealea Hospital in Phnom Penh where he was diagnosed with leprosy. He was put on MDT for a year, the medicine was delivered from Preah Ket Mealea to the district hospital, from where he received it once a month.

Navuth was ashamed. He remained in the *wat* but stayed in his *kuti* for the duration of his medication and did not want to go out to meet people. At that time he was still in good physical condition, but later he started to develop some irregularities in his facial expression and movements. He was especially disturbed by not being able to control his mouth and eye movements. Eventually his hands changed too, his thumbs were affected and he could not keep them straight. His family used to come and see him. But he told them not to come any longer because he did not want to infect them. His friends now came to see him only rarely. Some of his fellow monks treated him as normal, but others avoided him, mainly because of a lack of understanding about the disease. He was gradually giving up hope of continuing his education. He felt increasingly weak, more disabled, and more ashamed of himself. With increasing anxiety he anticipated future unpleasant and painful meetings with lay persons, being confronted by their questions about his condition, his uncontrolled movements, and other features pertaining to his illness. The abbot advised...
him not to go on alms rounds, because one has to go barefoot and he
might accidentally hurt his feet without noticing it. He also began to feel
insecure in his relation to his fellow monks; no one would criticize him
directly, but those who were his juniors might harbour ill feelings towards
him, feelings they would not express because one cannot openly criticize
one’s elders or superiors. He left the monkhood and came to the Kien
Khleang centre in 2004.

His new career is as a teacher for other patients at the centre. He
teaches for two hours a day. It is not easy to teach fellow patients because
many have psychological problems and they are homesick and find it
difficult to concentrate. Apart from literacy and mathematics, he teaches
about the disease and how to take care of oneself. He tries to provide
comfort to the patients and enliven their daily lives by telling jokes and the
like. The classes are also important because they provide an opportunity
for social interaction.

**Sopheak** is a 14-year-old boy from Siem Reap. He is quite small for his
age, and his legs are rather short, possibly a result of constant malnutrition.
He and his 6-year-old brother now live with their maternal grandmother.
She is very poor but has gotten help to build a small house from the **angkar**
(NGO) Kdai Sangkheim Thmey (‘New Hope’), and the two children
each get US$15 and 10 kg rice per month from the organization. Both his
parents are dead. His father had been a mechanic in Siem Reap and his
mother a market vendor. When he was 10 (i.e. in 2001) his parents decided
to move to O Smach, a place in the forest towards the Thai border. An
uncle and aunt had already moved there and it was believed that the place
offered better income opportunities; they would have land to clear and
cultivate but the main attraction probably was the possibility of searching
for gemstones. But when they got there, it seemed to Sopheak that his
parents did not do anything, they were just sitting in their house. He was
the only one who worked; he and a friend made money carrying luggage
and goods for the customers at the local market; people often remarked
that this work was too heavy for such a small boy. It turned out that his
parents were suffering from malaria, which was why they did not work.
Fairly soon both the uncle and aunt had died from malaria, and soon
after his mother also succumbed to the disease, and after a couple of years
so did his father. The boy felt that one went to O Smach to die. Both his
parents were cremated at O Smach, and he hopes to be able to afford to
go there in the future and erect a **chedi** for their ashes. After the death of
his parents, the boy moved back to Siem Reap, first to live with an elderly
uncle who is a moto taxi driver, but the NGO had organized a house
where he and his little brother could live with their grandmother. He helps his grandmother to grow potatoes and tend the chickens and he takes care of his little brother. He also goes to school and before his disease forced him to be absent from school for long periods, he was top of his class.

Sopheak’s symptoms began three years ago with a wound on his foot, after he fell from his bicycle. He went to a monk at Angkor who diagnosed leprosy. He was brought to Kien Khleang by the angkar. He received medication at the provincial health centre and returned to the centre in January 2005. His grandmother and little brother came to see him once, but they only stayed for three or four hours because they had to go back the same day. After the Khmer New Year in 2005, his hands developed signs of clawing and he was again brought to Kien Khleang by the organization for the third time. When we met him, he had been there for two months. He said that when he was cured he could go back by himself. He misses his schoolmates but he will stay until he is cured because he is ashamed to see his friends in his condition. He wants to finish school and hopes to find work with an NGO.

Sopheak relieves his homesickness by reading books and talking to the other people, and sometimes he sings; he regularly attends Navuth’s classes. He believes that perhaps he was infected by a man in O Smach who was disabled (missing an arm or hand). He had touched the man’s arm and asked what the matter was; the man told him that he had had an accident with a landmine, but perhaps he was really a leper and infected him. But on the other hand, he had discovered patches on the skin on his chest even before moving to O Smach.

Nhon Ploeun is about 45 years old and lives in Pursat Province with an elderly aunt and a younger sister, whom she is looking after and sending to school. She does not stay in the village itself, but in the mountains where she takes other villagers’ cattle out to graze in the forest. She is permitted to stay in the small houses that people have built in their forest gardens. At the time of the rice harvest, she comes down to the village to help.

Before Pol Pot time, she lived with her family in another part of Pursat Province, but they were all sent away to work in the mountains. She was in a mobile team (kong chalat) that carried soil for the construction of a major irrigation dam. Her parents and siblings died of starvation in the mountains in 1978, and in 1979 when the Vietnamese came she went to stay in her present location despite the fact that she knew that some of her relatives remained in her old home area. She said that the people in her new village accommodated her because they had already two families suffering from leprosy. These elderly people have now died.
Nhon Ploeun has never married. By the end of Pol Pot time, when her parents had already passed away, a man asked to marry her. She turned the offer down, however, since she did not trust the man, and suspected he might use her only as a way to get at her younger sister, and feared he might do bad things to her, the only close family member she had left. Since then she has had no offers of marriage, she says that she is not considered attractive because she is dark-skinned and very poor. She does not want her sister to marry either, but insists she goes on with her education. She is trying hard to look after herself while taking on responsibility for her small family.

Ploeun has long been recognized as a leper, but neither she nor anybody else knew that treatment could be found. She was medically diagnosed only a few years ago at the provincial hospital. To begin with, the doctors found her skin symptoms benign. But eventually she was given medication and she has had surgery on her feet and left hand at Kien Khleang. She came back to Kien Khleang this time because she worried about the large black spot on the bridge of her nose and was afraid that her condition would deteriorate further which would make it even more difficult for to make a living and take care of her aunt and her younger sister. But now she is very anxious to leave the centre and go home to the village for the rice harvest and be with her sister.

Unlike in most other parts of the world, leprosy treatment and care in Cambodia was never a monopoly of Christian missionary organizations. The French ‘civilizing mission’ was based on enlightenment ideals of scientific rationalism and left no scope for religious missionary involvement in the medical service, and up to the early 1990s, the postcolonial regimes were no more accommodating of Christian charities than the French. Christian notions of sin and guilt were thus never applied to lepers in Cambodia. However, the stigma that became attached to the disease in the wake of political and economic transformations during the fifteenth to eighteenth centuries was also shaped by the Theravada Buddhist continuation of the originally Brahmanist ideas of bodily perfection and karma. The plight of Cambodian lepers may be compared to that of the contemporary victims of landmine injuries, analysed by Lindsay French (1994). Far from being shown (the expected Buddhist) compassion, lepers (like amputees) are generally despised by the public. Their condition of obvious bodily imperfection is seen as a result of their karma and sentiments of pity are therefore not appropriate. The stigmatization and social suffering that leprosy entails in Cambodia may appear
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similar to that in most other parts of the world, but the reasons are historically and culturally specific.

NOTES

1 Following this discovery, leprosy also became known as ‘Hansen’s disease’. But the precise connection between the bacterium and the disease is not determined. “[I]nfection [with \textit{M. leprae}] does not necessarily lead to any symptom or lesion specific for the disease of leprosy. In fact, it is assumed that \textit{M. leprae} is not very pathogenic and that most infections do not result in symptoms” (Visschedijk et al. 2000: 388).

2 The death in 1889 of Belgian missionary Father Damien, who worked in a Hawai’ian leper colony, contributed to the anxiety about the disease in the West.

3 The figure of a hundred should probably not be taken literally, but it indicates the somewhat obsessive concern with quantity characteristic of indigenous Khmer medicine, both with respect to classification of diseases and production of medical substances. As we saw in Chapter 5, even today an indigenous healer’s skill is judged by the number of botanical species he knows and uses in his decoctions.


5 The superintendent’s wording was ‘\textit{les indigènes infirmes, ulcèreux et autres}’.

6 The forwarding letter now talked about ‘\textit{les indigènes infirmes, ulcèreux et lepreux}’ (instead of ‘\textit{autres}’).

7 The letter began, ‘I have the honour to submit the file concerning the lepers…’

8 In older usage, an ‘empiric’ was synonymous with a quack doctor.

9 The Khmer Rouge disseminated political propaganda through more or less standardized slogans and sayings, not all of which were immediately intelligible, but were memorized through rhyming and alliteration. Henri Locard (1996) has collected and analysed a large number of these slogans. The one referred to here is not in Locard’s collection; it might have been added as a sequel to the one urging people to both work in the fields and be ready to fight the enemy: ‘One hand for production, the other for striking the enemy’ (ibid.: 133).

10 Statues of the leper king (an Angkorean original and several modern cement replicas) are nowadays found both in Phnom Penh and at Angkor (Hang 2004). These statues are worshipped by ordinary people as figures of cosmological power rather than by virtue of any concrete relation to the disease of leprosy. The spirit of the leper king has even become a \textit{boramey} that possesses a spirit medium (Bertrand 2004: 157). The statue at Troeung, on the other hand, is functionally different in that the worshippers are lepers whose focus is on the suffering from the disease. It is also different in form in that no effort has been made to make it resemble an Angkorean sandstone statue.
Since the early 1990s, Cambodia has seen a dramatic increase in the availability of biomedical pharmaceuticals and a proliferation of private health clinics. It is a commonplace observation that the global production and marketing of pharmaceuticals is very big business that is only tenuously linked to the real healthcare needs of developing countries. National as well as global economic and political inequalities are directly reflected in the standard and availability of healthcare, including people’s access to appropriate and adequate medicines. Paul Farmer (2003) has documented instances of the deplorable state of healthcare for poor people in poor countries as an indication of structural violence, while Nguyen and Peschard summarized the health impact of transnational inequalities as the production of a ‘striking culture of indifference to affliction in areas of extreme inequality’ where ‘the poor trade in their long-term health for survival while the rich […] are able to purchase better health’ (Nguyen and Peschard 2003: 448–449).

In this chapter we focus on the resources that ordinary Cambodians – poor people in a poor country – have for meeting their immediate medical needs. When seeking a cure for common diseases or relief from minor ailments, the majority of Cambodians, both urban and rural, will first resort to self-medication, either through vernacular methods or by purchasing drugs from a nearby drug shop or pharmacy. If self-medication is inadequate, most people will then turn to a local village doctor or an indigenous healer, or perhaps a trained physician at a private or a public health facility.

In Khmer society, the health of each person is a family matter and individual health decisions about medical treatment are commonly made after deliberations within the family. Minor ailments such as headaches, colds, fevers, and stomach aches, may be diagnosed individually or in the family according to humoral,
’Ayurvedic’ ideas. In practice, this means that symptoms are found to be caused by bad winds (khyol) and/or blocking of bodily conduits (sasay). Popular methods of letting bad winds out of the body (kos khyol) include massage, cupping, and coin-rubbing. Cupping is done by placing heated small glass cups on the chest and upper arms or on the forehead. As the air inside the cup cools and a vacuum is built, the wind may pass through the cupped area of the skin; the treatment leaves circular red blotches. A similar effect is achieved by vigorously rubbing the neck, chest, back, shoulder, and upper arms with the edge of a silver coin (silver has anti-khyol properties, but for lack of a coin a bottle top may do) and applying ointments of camphor or mentholated oil, such as Tiger Balm or similar brands. The winds that cause headaches are let out by massage and the application of ointment; the exits for the winds, the forehead and temples, are then marked with bits of white plaster. If oral medication is called for, people may go to a herbalist or a pharmacy or drug shop where the diagnosis may be discussed and medication suggested.

PHARMACISTS AND DRUG-SELLERS

Most village shops carry a small selection of pharmaceuticals; amidst the dried noodles, biscuits, batteries, washing powder, and sweets, one will find jars of pills (painkillers, vitamins) and colourful capsules of antibiotics. When people in a village need remedies for minor ailments or a slight fever, they go to a shop in the village market and buy a couple of pills and capsules, depending on what they can afford.

There are always several such drug shops in the vicinity of district central markets. They all display the word ‘pharmacy’ and the associated sign, a green or blue cross on a white background, but one should not expect to find a qualified pharmacist behind the counter. Officially, the green cross should signify a proper pharmacy, while the blue cross denotes a drug shop with a more limited selection of essential drugs. Nowadays the blue cross is also used to announce a private clinic. Both pharmacies and drug shops should have a licence held by a fully qualified pharmacist, but such people are few and far between in the countryside. Realizing the need among the local population for access to pharmaceuticals (as well as the lucrative potential of the drug trade), elected district officials will not make unreasonable demands when mutually beneficial arrangements can be made. In fact, the majority of both pharmacies and drug shops are unlicensed. Thus, in Kampong Chhnang Province, for example, there are 90 pharmacies and drug shops, of which only 10 are licensed (seven pharmacies
and three drug shops); nine of these, moreover, are located in the provincial capital. An unlicensed shop is not considered illegal, and unlicensed shops are actually economically more advantageous, both for the shop owner and for the local authorities, than licensed ones. For a medium-sized unlicensed drug shop, the authorities may levy an annual fine/fee of about US$500 while a licensed one may be charged about US$10 per month in tax; but the shop owner then has to pay US$50–100 per month to the qualified (absent) pharmacist for the licence.

A representative small drug shop in a district in Kampong Chhnang is run by a Khmer couple in their mid-forties, neither of whom has had any pharmacological training. The owners do not buy supplies from the various pharmaceutical companies whose vans pass by regularly. The companies only sell in fairly large quantities, and the couple has little money and a modest sales volume. Instead, they get their supplies from the man’s older sister who is a trained pharmacist working at the provincial health centre; she also runs her own private pharmacy in the provincial capital. The sister can offer short-term credit, unlike the companies, and she also recommends what to buy for the shop and explains the various drugs. So when supplies are needed, the man travels on motorbike to see his sister.

A larger drug shop in the same market area is run by a Sino-Khmer couple, who also have no formal pharmacological education. The wife explains that vans from at least seven different pharmaceutical companies call in about once a week. They deliver directly if they have the goods in the van; otherwise, the shopkeepers fill in order lists, and delivery is made on the following visit. This is a very convenient arrangement; until a year ago, the wife had to go to Phnom Penh for supplies, but now she saves time and money for transport, and can concentrate on running the shop, which also offers intravenous drips for rehydration, and vitamin injections. She buys supplies from several companies; Indian and Malaysian products are popular since they are relatively inexpensive. Many pharmacy owners tend to buy only from one or a few companies, preferably those that offer a discount or free samples on large orders, or reward orders over a certain amount with gifts like T-shirts, electric fans, or rice cookers.

The distribution of pharmaceuticals by companies themselves began in the late 1990s, as main roads were improved and travel became safer. Attacks by remnant Khmer Rouge groups ceased and checkpoints manned by demobilized soldiers who extorted money from travellers were abolished. Earlier, pharmacies in the districts had to fetch their supplies from larger pharmacies in Phnom Penh or the nearest provincial towns, but they are now supplied by air-conditioned vans direct from the pharmaceutical companies. This means that larger private
pharmacies are now bypassed as suppliers, and control of the market has shifted to the companies. Only rather remote and/or small pharmacies are still supplied by larger provincial ones.

Neither the companies nor larger pharmacies are obliged to sell only to licensed shops, and the situation has been described as one of ‘pharmaceutical anarchy’ (Gollogly 2002: 793). There is also a substantial problem of counterfeit or substandard drugs. According to a study by the Ministry of Health (2001), 13 per cent of all drugs found on the market are counterfeit or substandard; the percentage among registered drugs was only 5.2 while among unregistered drugs it was 20.9.² By far the largest proportion of counterfeit and substandard drugs was found in unlicensed shops in the countryside – which is where the majority, and the poorest people, get their supplies. The Ministry study notes that none of the substandard or counterfeit drugs were domestically produced. Most customers, however, whether literate or not, still tend to believe that foreign drugs are better than those produced in the country, because originally most imported drugs were French. Today, the unregistered drugs most likely to be counterfeit come from other Asian countries – but they are still foreign (and therefore desirable), and they are often the cheapest.

Indigenous attitudes to pharmaceuticals

The recent realization by biomedical authorities that pharmaceuticals may in themselves be harmful (when substandard or counterfeit) has long been common knowledge in the premodern medical world in which healing and sorcery are two sides of the same coin. This attitude pertains equally to indigenous remedies and modern pharmaceuticals. When explaining his business of selling herbal medicine in the market, a herbalist emphasized that ‘medicine is a weapon with two faces, it can kill and cure, heal and harm’, implying that the beneficial or harmful effects depended on the provider.

The apparently massive dominance of modern pharmaceuticals on the Cambodian drug market does not imply that the consumers and providers of these pharmaceuticals are necessarily ‘modern’ people, any more than clients of ‘traditional’ healers are completely premodern. The majority of the Cambodian population still orient themselves along the parameters of a premodern medical world, in which physical or mental illness is associated with social or moral transgression, and in which healing is a process actively engaged in by both healer and sufferer that leads to the mending of social and spiritual relationships and thereby to the restored health of the person. Such indigenized attitudes are common even among educated urbanites who may express disdain for ‘traditional’
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medical practices. In no sector of the Cambodian population may a modern medical world view informed exclusively by the principles of biomedicine be taken for granted.

The idea that one should have a physician’s prescription to buy certain drugs is foreign to most Cambodians, even though it has been claimed that in the 1960s and ‘70s, only over-the-counter drugs could be bought without a prescription (Ministry of Health 2001; Gollogly 2002: 793). This does not mean that it is immaterial to have a prescription. On the contrary, such slips of paper are highly valued, for both practical and conceptual reasons. For practical reasons, having the name of a product written down is convenient in case you need it again; also, even if you cannot read it yourself, the shopkeeper can, and he will be able to quickly dispense the right product without engaging in a long conversation about symptoms and the like. Conceptually, having the name of a drug in writing represents in a certain sense ‘knowledge’ that has been transmitted by the shopkeeper in his expected role as (the modern equivalent of) a kru. Equally importantly, the name of the medicine in writing is itself magical, insofar as the efficacious principle of magic rests on a conflation of signifier and signified. For the illiterate customer, the possession of a slip of paper with an incomprehensible name written on it in an unfamiliar alphabet inspires the same sense of confidence as (other) charms and amulets. Clutching such a slip of paper (together with a handful of riel) is more than half the way to securing the product itself from the jungle of hundreds of equally exotic-sounding alternatives at the pharmacy. A common complaint by customers is that they only rarely get written names on the small quantities of different pills they purchase. When doing ‘exit interviews’ with pharmacy customers, we were often asked to write down the names of the products a person had purchased. This complaint may also be interpreted as a complaint on a more profound level, namely that the patient/client is denied his or her active role in the healing process, in that necessary knowledge is being withheld while the curative substances are passively received.

Another customer expectation which, on the other hand, is almost always met, is the dispensing of several kinds of medicine, no matter what condition is to be treated. This idea represents a popular biomedical indigenization. The decoctions of indigenous herbalists (kru phsom thnam) are made by ‘combining medicines’ from a variety of different ingredients. The more ingredients they add, the greater their knowledge and reputation. The same expectation is applied to pharmacy shopkeepers, who are known as kru pet phsom thnam. Although trading in biomedical pharmaceuticals, many shopkeepers diagnose client conditions and dispense medicines according to indigenous medical notions, derived partly
from Ayurvedic principles (see Piat 1965; Martin 1983; Chhem 2001). An important principle is the unobstructed flow of fluids, matter, and wind through the conduits (sasay which include blood-vessels, nerves, tendons) in the body. A common cause of ailments is the blocking or jamming (stea) of these conduits, and in most pharmacies one will find a ready-made mix of remedies to unblock the flow: little transparent bags containing a couple of sedatives, antibiotics, painkillers, and vitamins, each in a distinctive colour. Many people incur such blocking in the course of a week of arduous work and need the medication to re-establish the flow over the weekend. Also for other conditions, the shopkeeper will have to provide a culturally suitable mix of products, preferably of different colours. Thus, if an antibiotic and a painkiller are indicated, he will often double both, giving for example both amoxillin and ampicillin, and both paracetamol and aspirin, and throw in a couple of different vitamin B and C preparations for good measure.

One unfortunate effect of this synthesis of premodern and modern attitudes is that the small amount of money the average customer has at his or her disposal will be spread over quite a few non-essential products. When many people, for example, cannot afford a full dose of antibiotics in the first place, it does not improve things that they will also have to spend money on biomedically unwarranted products. It gets even worse when the supplementary products include potentially harmful drugs, such as corticosteroids that are increasingly popular amongst both doctors and drug sellers and their clients. Another effect of the demand for ‘combination’ medicine is that the market is flooded with numerous products containing the same formulae and differing only in brand name and price.

Pharmacists without pharmacies
The risks that patients run at a pharmacy or drug shop of getting insufficient doses, or even potentially harmful drugs, are exacerbated by the unregulated market for pharmaceuticals, and by the consequent growth in fake or sub-standard drugs. Trained pharmacists represent only a tiny proportion of the many people who sell pharmaceuticals. Among them, an even smaller group works actively for their professional identity and increased recognition for their profession. In contrast to a mere occupation, a profession carries ‘connotations of disinterested dedication and learning’, which may be used to legitimize ‘the effort to gain protection from competition in the labor market’ (Freidson 1994: 18).

Not surprisingly, professionally committed pharmacists direct much of their ire to the competition from their traditional rivals, the physicians. According to
the president of the Pharmacist Association of Cambodia, a major problem is that many government-employed physicians not only run a private clinic on the side (which is against the law) but have a pharmacy attached to the clinic, often run by the doctor’s wife. Given the higher status of the medical profession, the authorities turn a blind eye to the fact that strictly speaking, only professional pharmacists (and not physicians) may have a pharmacy licence. Such physicians may augment their salary not only from their private practice but also from the substantial bonuses paid to them by certain pharmaceutical companies.

The Pharmacist Association currently has almost 600 members, about 95 per cent of all active, professionally trained pharmacists in the country. By contrast, the Medical Association, as the president of the Pharmacist Association notes with some satisfaction, has only about 10 per cent of the eligible physicians as members. A more serious problem than competition from physicians is that only about 5 per cent of professional pharmacists have their own pharmacy, despite several thousand pharmacies in the country. This paradoxical situation of having many pharmacists without a pharmacy, and an even larger number of pharmacies without pharmacists, is the result of historical peculiarities. After 1979, there were only about two dozen professional pharmacists in the country; of those who were students abroad (in France, mainly) in 1975 virtually none returned, neither during the DK nor during the PRK, while the majority of educated pharmacists in the country had perished under Pol Pot. The first of the new generation graduated in the late 1980s, but by then the trade was already dominated by business people with no pharmaceutical training. Some of these traders secured their urban properties in 1979, when people were allowed to return to the cities, and houses were vacant (because in many cases, their previous inhabitants had died under Pol Pot). Others invested their savings from the pharmaceutical trade in landed property around 1994 when the government banned the trade in pharmaceuticals from ordinary markets. In contrast, very few trained pharmacists had the financial resources to set up a place of their own. Some pharmacists are employed in production, research, or development by domestic pharmaceutical companies; others take out a licence and lease it to non-educated pharmacy owners.

Some newly graduated pharmacists with whom we spoke described their circumstances as rather bleak. Their identity had been formed through imbibing high professional standards during their training, and real-life work conditions came as something of a shock. The jobs available to them are mainly as sales representatives for pharmaceutical companies (an option also open to newly graduated physicians), which require uncomfortable compromises with their
identity and professional ethics. Few stay in such a job for long, and many leave the profession altogether.

**Hang Luong** is a pharmacist, currently director of a domestic (French–Cambodian) pharmaceutical company in Phnom Penh. He began pharmaceutical studies at the university in 1971 and was in his final year when the Khmer Rouge invaded the city in 1975. He and his brother were sent for compulsory manual labour in Kampong Cham Province where the regime was relatively lenient; his mother and sister and a cousin were sent somewhere else, and he never saw them again.

He returned to the capital in January 1979 and volunteered to work in the state pharmaceutical company, the Laboratoire pharmaceutique du Cambodge. He saw evidence that the Khmer Rouge had used the factory in their own way; jars of placentas in alcohol (used as fortifying tonic) were among the articles left on the shelves. He enrolled at the medical faculty as soon as it reopened in 1980, finished his education the following year, and continued working at the company.

In 1985 the company was temporarily closed and Luong was ordered to serve as the personal pharmacist for the highest leadership of the party, including Heng Samrin, Chea Sim, and Hun Sen. In 1993 he resigned from all his public duties, because he wanted to have no more to do with politics, and took a job doing blood tests at the Calmette Hospital laboratory. He was among the first to conduct HIV tests in Cambodia and to call attention to the rapid spread of the virus. In 1996 he was offered a job at his present company; to begin with they sold only five products, painkillers and antibiotics, now they produce more than 70 items. They produce mainly for the domestic private sector – as the (now reconstructed) CPE has most of the contracts with the Ministry of Health for the public sector – but they also have modest exports to Vietnam and Togo. At the company Luong now places less emphasis on increasing production or market share, concentrating instead on quality control, which he sees as a professional responsibility that few other people take seriously. Apart from his company duties he lectures at the medical faculty, and he still does blood tests at Calmette. Formally, it is the physician’s responsibility to give their patients the results of their HIV tests, but many shrink from this, and Luong feels he has to take on this duty instead. This is not something he is happy about, as sometimes people kill themselves after getting the result. Luong has not encouraged his children to become pharmacists; he sees it as a demanding profession with heavy responsibilities.
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Pharmacists’ motivations for choosing their profession vary. Many younger pharmacists and pharmacology students had wished to become doctors but their exam grades proved insufficient for admittance to medical studies and they saw pharmacology as an acceptable alternative. One slightly older pharmacology student from a poor rural family background was motivated by the fact that his mother had died because the family could not afford proper medical treatment, and he wanted to do his best that this should not happen to others. Among an elder generation, several were motivated by their experiences under Pol Pot, having been forced, for example, to participate in medical malpractice or deliberately administer injections of poison to patients. To make up for such bad deeds and to some extent restore their karma, they had committed themselves to seek a proper education and practice medicine or pharmacy for the benefit of the health of others.

Pharmacies without pharmacists

As noted, the majority of pharmacy operators are shopkeepers with no pharmacological training. Many entered this business in the volatile period following the Vietnamese invasion in 1979. In the provincial capitals, the larger pharmacies tend to be situated around the main markets. The woman behind the counter of one such pharmacy in Pursat, a Sino-Khmer, is also the owner of the pharmacy.

*Hon Nam* has been in the pharmaceutical trade since 1981. In 1980 she had attended a midwifery course for one year, and her husband had trained as a health worker. Her monthly salary was 13 kg of rice, which was insufficient, and both she and her husband decided not to continue studying any longer; during Pol Pot time they had both ‘studied’ agriculture, she says with a smile, and now they wanted to work for themselves and have a family. Her husband got a job at a bank, since he had studied at the Faculty of Science in Phnom Penh before Pol Pot time. She herself chose to do business with hygiene and medicine, of which she knew a little from her hospital training.

She opened a small stall at the market selling soap, washing powder, and medicine. People did not always have money then, so they bartered rice and sometimes gold in exchange for medicine. The people who supplied her with medicines came from Battambang and Phnom Penh, they were ordinary people who had decided to do business, and like herself they were tired of studying. In the early 1990s she bought a property opposite the market with her first savings, and had the house built little by little.
In 1994, when trading in pharmaceuticals was banned from the markets, she was able to open her pharmacy in the new house. She leases the name of the pharmacy from a pharmacist in Phnom Penh whose name is on the sign. The pharmacist used to visit once every month, but now she is busy running her own shop in Phnom Penh, and since Hon Nam’s business is well established, she seldom visits. Hon Nam pays US$50 a month for the lease and finds it expensive – she knows that others pay only US$20. Apart from individual customers, she sells to retailers (drug shops) in the outlying districts. At the time of our visit her children were in the back of the shop preparing goods for a customer in a neighbouring district. The drugs would be sent by a taxi pick-up to a stop along the road where

Figure 8.1. Pharmacy, a family business: both old and young family members may help.
the customer collects the goods. This customer comes in every week and places an order varying from US$120 to US$500. She has several other customers in various districts. She estimates her monthly turnover at about US$10,000 but claims not to have done proper calculations.

She loves her work and her business and has never regretted her choice. She likes the drugs themselves, they are pure and beautiful, and she can keep the shop clean and well organized; and, of course, she adds almost as an afterthought, we should not forget that drugs can help people sometimes. She is proud of her business. She owns the house and she can send her children to school. The two youngest are still in high school and they help her in the shop. The oldest studies computer science in Phnom Penh and is now in his second year; during the first year he was best in his class.

The above example illustrates a female drug seller’s commercial yet housewifely attitude to the provision of pharmaceuticals. But lest we deprecate commerce and housework in connection with healthcare, we should bear in mind that in the indigenous Khmer conception, firstly, commerce and petty trade is considered primarily female (and Chinese) activities and, secondly, that women (of the family) are the ones expected to care for the sick. We should also remember that to the Khmer the moral dimension of health and sickness is closely linked to orderliness, and that ‘hygiene’ is less a question of avoiding invisible microbes than of maintaining symbolic purity, as Mary Douglas (1966) pointed out long ago. Keeping a house (or, in this case, a shop) tidy and making sure that every item in its proper place is in itself conducive not only to health but also to wealth and beauty. The inherent purity of pharmaceutical products is signalled by their industrial packing (sheets of individually separated pills and capsules, for example) and the distinctive colourings of various preparations facilitate not only recognition by drug sellers and customers but are also aesthetically satisfying and symbolically meaningful. So by running a tidy and well-ordered pharmacy, and by acquiring wealth in the process, the drug seller implicitly imparts health and good morality to her customers.

The following case of Ta Heang contributes a more existential dimension to the drug seller’s career.

**Ta Heang** is in his late fifties (Ta is an honorific meaning ‘grandfather’); he owns a pharmacy in the provincial town of Kampong Chhnang. His father was a Chinese petty trader, his mother Khmer. As a small boy he often visited a playmate whose father had a pharmacy. Heang was
absolutely fascinated with all the medical products he saw: with all the different bright colours they looked like candy. If only he could have afforded to study he would have become a pharmacist. Instead he learnt to do business from his father.

During Pol Pot time he was sent to do slave labour in the countryside with a mobile construction unit. One day his group was called to a meeting, where they received new clothes along with the information that they would be taken to another work site. As they walked along the road in the splendid new clothes and blue kramas (chequered scarves), he met an old man who looked at him, admiring the new outfit, and seemed particularly fond of the krama. As if in a vision Heang suddenly understood: one krama, one life. The new clothes made the people stand out and he realized that they were all to be taken away and killed. The old man said that he wouldn't mind exchanging his own worn krama for the new one; it was the offer to replace him. They exchanged their kramas and shirts. Heang continued to work when they arrived at the new destination and nothing happened to him. All the others in his group disappeared. It seemed to him that the old man on the road knew that the new kramas were a sign to the Khmer Rouge cadres, and that he had deliberately saved Heang’s life by suggesting they exchange clothes. Heang never knew what happened to the old man but he decided to try and make his new life worthwhile.

In 1979 he started with a little gold and entered the gold/rice/pharmaceuticals trade in his hometown of Kampong Chhnang, and as a skilful businessman, he was soon able to expand his pharmaceutical business. After plying his trade in half-a-dozen stalls at various markets – constantly forced to move by the authorities – he was able to buy a house with a shop near one of the main markets in 1995. For the past three or four years he has had a licence, leased from a pharmacist for US$100 per month; he also has to pay about US$10 per month in tax to the government. He finds this a bit unfair since drug sellers without a pharmacy licence can get away with paying only US$500 a year (presumably to the local authorities).

Very few of Ta Heang’s clients come with a prescription. Ta Heang explains that most physicians make a deal with the pharmacy shopkeepers, offering to direct their patients to a particular shop, in exchange for 20 per cent of the proceeds. Ta Heang refuses such deals, even if it results in fewer customers; it would mean raising prices, which he finds unethical. Most of his clients are poor, many are ethnic Vietnamese (fisherfolk) from across the river, or from the floating villages on the Tonle Sap. Ta Heang often recommends Chinese herbal medicine (mostly in the form
of pills, packed in bottles like biomedical products), because they may be a cheaper alternative. These products also have become more popular lately, he explains, because they do not create resistance like antibiotics. Ta Heang’s concern for his clients’ well-being also extends to sexually transmitted diseases; condoms are prominently displayed in his shop, something which attracts customers, and he is proud that he sells the cheapest condoms in town.

In contrast to a number of other shopkeepers, Ta Heang was not averse to our spending time in his pharmacy, observing the trade and asking customers about their purchases, symptoms, and treatment histories. In the provincial capital of Battambang, on the other hand, we were turned away from several larger pharmacies, and our Cambodian assistants were intimidated when attempting to do exit interviews with customers. We mentioned this to the deputy director of the provincial health centre, who was not surprised. The provincial drug inspection committee, of which he was chairman, had lately managed to reduce the number of illegal pharmacies/drug sellers around the central market from twenty to six. However, with the upcoming local elections (in July 2003) there was no scope for further action, as the governor and other officials running for re-election were not disposed to initiate any measures that could negatively affect their relations with important people in the electorate. The committee also had been unable to enforce the rule that licensed pharmacies may only sell pharmaceuticals; most also offer currency exchange services and sell amulets, jewellery, cosmetics, and shampoo, all ‘magic’ articles that in the popular world view are included in the sphere of health, wealth, and beauty.

The deputy director gave an example of one of the largest pharmacies in the city (to which we had been vigorously denied research access); it was owned by a big businessman whose fortune had been built on trans-border trade (i.e. smuggling) with Thailand. The main export article was gemstones, in exchange primarily for second-hand cars and pharmaceuticals. As the gemstone deposits became depleted, the merchant began dealing in rice, and he was now chairman of the provincial branch of the rice-millers’ association. In that capacity he was recently appointed Cambodia’s representative to an international rice-producing conference in Singapore, with all expenses paid by the United Nations Development Programme as part of an agricultural development project. His shady business activities are well-known, but the authorities cannot touch him. Another problem, according to the deputy director, is that the companies do not comply with the law. Instead of paying taxes to the government, they bribe...
the auditors and reward large customers with desirable gifts; one company was known to have rewarded repeated purchases worth US$10,000 with the gift of a motorbike. He cannot place blame for the whole situation on anyone in particular, but concludes that if you abide by the law, you are unlikely to succeed as a businessman in Cambodia.

VILLAGE DOCTORS

People in the countryside are generally reluctant to frequent district hospitals or even communal health centres. As already mentioned, a nearby pharmacy or drug shop is normally the first choice. For more serious illnesses, typically malaria or diarrhoea in children, people will normally call on a local village doctor (pet phum, ‘village medic’), who offers treatment for 500 or 1,000 riel (about 15–30 US¢), plus the cost of medicine. Such people often have rudimentary medical training, acquired either before or after Pol Pot, while a few are ex-Khmer Rouge medics who rely on their DK treatment experience. The treatment provided mostly consists of injections of antibiotics and vitamins.

One day when we were visiting Ta Heang’s pharmacy, three Vietnamese people from a distant floating village on the Tonle Sap came in with a long ‘prescription’; it was obvious from the number of products that the purchase was not for their personal use. Ta Heang afterwards explained that they were buying for a Vietnamese doctor who had recently settled in the village. To follow up on the case, we asked Ta Heang for directions and the next day made our way, by car and boat, to the village.

We boarded the houseboat of doctor Ngo Tang Thi just as the family was finishing a meal. The doctor welcomed us kindly, but was reluctant to talk about his medical practice; he seemed rather intimidated by our visit. His wife was even more obviously frightened and became quite agitated; she complained loudly about Cambodian authorities’ continual harassment of the Vietnamese in general, and of her husband in particular. In rapid succession she stuck under our noses an impressive number of papers: licences, passports, identity cards, and the like, all the time insisting that her husband was doing nothing wrong. But, she said, the Khmer would probably come to kill them all, as they had tried before. We repeatedly explained that we did not work for the government, nor were we out to nail her husband in any way, and eventually we managed to talk to doctor Thi.
Far from being a recent arrival, the doctor had been living in the floating village since 1981. In 1983 Khmer Rouge soldiers had poured petrol over the houses and burnt the whole village. The family escaped by swimming ashore and hiding in the forest. Several people died and many were injured. The doctor was now 68 years old, he had been in the Vietnamese army since the early 1950s, and he finished training as an army surgeon in 1958. He had come to Cambodia with the Vietnamese troops in 1979 and had retired two years later. To begin with he claimed that he no longer practised medicine; the government did not allow Vietnamese doctors to practice, and besides he had not renewed his licence (which was for doing ‘mobile business’ as a pharmacist, i.e. practising in the floating village). According to the rules, he was not even allowed to do emergency treatment or to treat his own family. The two medical cabinets in the room, however, told a different story, and doctor Thi related how difficult it was for the villagers to reach the commune health centre ashore. Most of the time, moreover, there was nobody at the health centre; then people had to go all the way to the district clinic, which took a long time and cost even more money for transport. Sometimes, the commune health centre held courses or workshops for local medical personnel, but he was not allowed to attend because he was Vietnamese [or perhaps because his licence had lapsed]. Some Vietnamese practitioners would occasionally bribe the authorities to attend courses because they too needed the new knowledge.

While we were talking, another boat called at the house and a young mother brought in a 2-year-old baby who had suffered an accident. The mother had been chopping coconuts and the boy had managed to get his hand too close to the chopping board; his index finger had been split lengthwise. The doctor’s wife immediately went into action, producing bandages, iodine, instruments on a tray, and a plastic basin of hot water. Meanwhile, doctor Thi tried to ignore the scene and continued talking to us. We suggested he had better attend to his patient, and with great relief he immediately did so, disinfected his hands and went to work. The cut in the baby’s finger was quite serious and the wound was bleeding profusely. The doctor gave two injections (painkiller and anaesthetic, presumably), cleaned and stitched the wound; it might not have been state-of-the-art finger surgery, but preferable to going by boat all the way to the health centre, where the competence would probably not have been greater, and the kindness of the reception certainly less. After bandaging, the baby was given a tetanus shot. Doctor Thi prepared three doses of pills, para (paracetamol), ampi (ampicillin) and Baralgine, plus a couple of unidentified pills from a large plastic jar, probably
aspirin. The mother and baby left with her father who had brought them in his boat. Now that we had seen the doctor in action, there was no more pretense, and he was visibly more at ease. We asked for the price of the treatment; it was 15,000 riel (just under US$4), to be paid later. We said that as the woman was probably poor, it would be a pity if she should incur this extra expenditure, and so we offered to pay doctor Thi on her behalf. He eventually accepted, gratefully, and with immense relief. As we had in this way made ourselves complicit to the illegal treatment, even his wife became completely transformed at this gesture, and we took our leave as valued visitors.

On our way back to town in the early afternoon we passed the communal health centre and found it closed. Having seen the condition of medical services in this isolated community, we thought kindly of Ta Heang who had covered for his colleague (by implying that as a newcomer he had not yet managed a licence). Later on we got a bit worried about the baby when we learned that Baralgine was a rather dangerous drug that had several years earlier been retracted completely by the Ministry of Health.

Sok Pham is a *pet phum* in a roadside village along a national highway. Born 1953 in a Sino-Khmer family in Takeo Province, he moved to Phnom Penh in the early 1970s for studies. He had completed his one-year course as medical assistant and was continuing medical studies when the revolutionary forces took Phnom Penh. He was put to compulsory labour in Kampong Chhnang Province but his life was spared because he was useful to the Khmer Rouge cadres by being able to read and translate the French labels on the medicine bottles that the Khmer Rouge had collected from hospitals and private clinics. These medicines were stored to be dispensed to the cadres only. After the Vietnamese takeover the authorities wanted him to continue his medical education, but by that time he had started to raise a family and did not want to study further.

Doctor Pham treats ordinary, everyday diseases with injections and medication from his small stock of pharmaceuticals. Because his house is along a national highway, he is frequently called upon for first aid in connection with traffic accidents. He owns a motorbike and in contrast to the personnel in the public health sector, he, like other village doctors, mostly treats people in their own homes, which is highly appreciated. Usually the family will send one of its members, often a child, to notify doctor Pham that his help is needed, and he will set out on his motorbike. Another advantage from the patients’ point of view is that he may give credit, and many people are happy to be able to postpone payment, for example, until after the harvest. In complicated or serious cases villagers
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usually seek his opinion before going to the hospital or a private clinic at the district centre.

Village practitioners like doctor Pham are often referred to as ‘injection doctors’, *kru pet chak thnam*, because of the prevalence of this method of treatment. This category of practitioners was first given scholarly attention in Clark Cunningham’s (1970) study from central Thailand in the mid-1960s where healthcare had many similarities with that of contemporary Cambodia. Like the drug shops/shopkeepers, village or ‘injection’ doctors are brokers of medical modernity, ‘antibiotic mediators’, in Cunningham’s words. They belong to the category of *pet* because they deal in biomedical pharmaceuticals, which they mix (*psom*) or push (*chak*), often with only very rudimentary biomedical education. They conduct their practice in ways that are culturally appropriate for their tasks, providing a combination of several ingredients, treating patients in their domestic milieu, and complying with the popular demand for injections even when oral medication may be adequate. They are members of the indigenous community rather than representatives of a basically foreign medical profession. Below we give two further examples of village doctors.

**Ta Sem** is 75 years old and still practices as a village doctor in his native area. He lives in a modest house next to a *wat* in the countryside, some kilometres from the main road. After graduating from the francophone school in the district town, he was selected by the commune leadership and the village elders for medical training. So he studied medicine during 1951–1953. His studies included a six-month course at the provincial hospital where he worked with American doctors and learnt to give injections, administer medicine, and dress wounds. Since the Khmer Issarak movement was very active during this period (just before independence), the security measures for recruiting medical personnel were strict, and there were many casualties due to the movement’s violence.

After independence he returned to his native village where he was appointed resident medic of the commune and his house became the health centre. Medicine and bandages were supplied by the Americans. He was surprised at the large number of patients who sought him out, and when he became aware of their expectations, he decided to divide his activities into two parts. The one was supported by the government and carried out officially from his house. People could come for a consultation and obtain medicine and treatment free of charge, but medication was restricted to tablets that could be taken orally. The second part of his work was his private consultation. If people wanted to consult him privately,
they could ask him to come and pay a visit at their own house. In such cases he could also offer injections, which was what most patients wanted. His private patients would send for him and they would at the same time send the money to cover his travel costs, as well as for his trips to the central pharmacy in Phnom Penh or to the district pharmacy where he bought the necessary drugs and medical equipment.

Sem considers himself an innovator, he says that he was the first doctor in the area and the first generation of doctors to supply injections. During Pol Pot time he was forced to close down his practice; the Khmer Rouge let him live and ‘only’ made him do agricultural labour, and he could remain in his home area. During PRK the authorities tried to persuade him to do medical work for the government and offered him employment first at the district health centre, then at the provincial hospital, and finally as medical instructor for the Phnom Penh municipality. When he declined all these offers, the authorities insinuated that he was refusing to do his duty to society and only wanted to practice for personal gain. He therefore had to stop his medical practice altogether, and instead set up a barber shop in the district centre. After five years as a barber, he returned to his village and reopened his private clinic, as most of his former adversaries in the local administration had been changed and his politically motivated recalcitrance had been forgotten.

Eng Phay is in his mid-forties and lives on the opposite side of the wat from Ta Sem’s house. He too is a not-particularly-prosperous village doctor and a native of the area, but in many other respects they are opposites. Phay joined the revolution as a young boy when the area was ‘liberated’ by the Khmer Rouge in 1973. In 1977, while Sem’s medical competence was wasted on slave labour, Phay was given brief medical training at Regional Hospital 31 (i.e. Kampong Chhnang provincial hospital). He became army medical assistant at division headquarters and treated injured soldiers and learnt to give injections. When the Vietnamese invaded, his unit retreated to the northwest, and he spent time in Siem Reap, in the Dangrek Mountains and in a camp on the Thai side of the border. During that time he was taught surgery by Thiounn Thioeun. In 1991 he worked with his unit in the jungle in Kampong Chhnang, but decided to return home because he felt the DK leaders had failed their soldiers. Moreover, he missed his home and his family. When he arrived in his village, he was afraid of the local authorities because he had just returned from the Khmer Rouge. But he had no other way of earning money for his family since he had no paddy land, so after the 1993 elections he started to offer injections to local people. He claimed that the villagers had confidence in
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his treatment skills because they knew he was trained in medicine in the Thai camps. In the beginning he walked to his patients’ houses, later on he got a bicycle, and now he owns a motorbike.

Neither Sem nor Phay has any shortage of patients, but each has his own clientele among the families in the area, and they do not cooperate. This has to do both with the indigenous idea of a personalized relationship between patient and healer, and with these two village doctors’ very different outlook and life experiences. Sem’s contempt for the officials of the PRK regime is matched by that for the Khmer Rouge and former Khmer Rouge medics; ‘they never study and never learn, they only practice’, he says. As for Phay, even though he defected from DK in 1991, his habitus is fundamentally shaped by his DK experiences; his account of how he diagnosed various kinds of malaria sounded very much like a recital of lecture notes from a Khmer Rouge medical crash course, and he ended our interview with the slogan-like statement ‘Our experience inspires our work’.

PRIVATELY PRACTISING MEDICAL DOCTORS

Apart from pharmacy and drug shop operators, indigenous healers and village doctors, private medical practitioners also include trained physicians who run private clinics, either full-time or as a lucrative addition to their meagre salaries as doctors in public hospitals. Many private clinic operators also have an unlicensed drug shop attached to their clinic in order to save their patients an additional visit to another pharmacy/drug shop and to make money by selling over-the-counter pharmaceuticals.

Kan Cheng Ol is a medical doctor at a provincial hospital. He lives at a district centre some 30 kilometres from the provincial capital and runs a private clinic and pharmacy shop at his house. The clinic is open from 6 A.M. to 7.30 A.M., a couple of hours in the late afternoon, and at weekends, but people sometimes come to see him in the evening or at night, which he sees as a sign of their trust and confidence. Often people want him to do house calls, which he does if he has the time or if the case is serious. His consultation fee is 2,000 riel (compared to 500 or 1,000 for a village doctor), and he adds 30–40 per cent on the price of pharmaceuticals from his shop. Antibiotics, painkillers, and vitamins are his main products, and he treats mostly malaria, respiratory tract infections, and typhoid, which are also the most common diseases among patients at the hospital. Very
often the patients cannot afford to buy a full week’s dose of antibiotics, but when they have purchased pills for three days, doctor Ol always admonishes them to find more cash and come back for the rest of the dose; this, however, does not always happen.

One afternoon, in a village in the north of Battambang Province, a young man was injured while working with a threshing machine. He was taken to a private clinic at the nearby district centre. The villagers said that this clinic had the best reputation and that it was not too expensive. The next day we visited the clinic, which did not look like a place for poor village people. Behind the drug shop front were a reception room, an examination room, a couple of rooms with beds, and a laboratory; walls and floors were tiled and everything was spotlessly clean. The young man had had his wounds dressed and had been kept overnight for observation but was now discharged.

The clinic was owned and run by Leng Chhai who was in his mid-fifties. He had been trained as a nurse in the late 1960s and had worked at the Preah Ket Mealea Hospital in Phnom Penh where he had been responsible for the hospital’s radio communication. During Pol Pot time he was sent to the countryside in Battambang Province. In 1979–1980 he participated in the rehabilitation of the hospital in Battambang; most of the equipment was missing, he had to go to people’s houses to find the hospital beds that had been taken, and ask for them to be returned. The only available medicine was penicillin and streptomycine from Vietnam. At that time there was an epidemic of anthrax (peh), and many people died; because the people were starving after the Vietnamese takeover, some had eaten cattle carcasses and had become infected. Because of his opposition to the PRK government, he went to a camp on the Thai border around 1982 where he briefly joined one of the several non-communist armed resistance groups. In 1983 when he had gone back to Cambodia to fetch his wife, they were prevented from legally leaving the country by the border police. Chhai then decided to stay on in his country and enrolled in the army to be able to follow its medical education programme. This was also his ticket to Phnom Penh and a further medical education under the cours accélérés scheme. He finished that education in 1986 and became military doctor for Battambang Province until he retired some years ago.

Chhai is now a member of the Sam Rainsy Party; he is the party’s chief medic in Battambang Province and its advisor on health issues. In 1997 he found himself in trouble because the CPP accused him of having been implicated in the grenade attack on an open-air rally of the
Sam Rainsy Party (then Khmer Nation Party) in Phnom Penh on 30 March 1997. Despite intimidation from the CPP, he decided to stay in politics but is now more wary than ever of the physical dangers that active opposition politicians are facing.

He established the clinic together with his son-in-law, but after a while the son-in-law set up a new clinic elsewhere and left him in charge. He is well off; one of his daughters is married to an American and lives in Portland, Oregon. The American family has given his wife US$100,000 as an investment in the clinic. He himself would like to retire, but he has obligations to his family and to the party, since he is also a political asset as long as he treats poor people and charges little. When he worked with his son-in-law, they treated all sorts of cases, but now he only takes uncomplicated cases, the difficult ones he refers to Battambang Hospital. Apart from offering inexpensive treatment, he sometimes helps the poor by transporting them to Battambang in his own car, and for complicated cases he may use his party connections to ensure priority treatment in Phnom Penh. Chhai’s personal interest in medicine seems to be primarily in its technological dimension. His clinic is equipped with both an ECG machine (cost US$3,500) and an X-ray machine (cost US$6,800), and he enthusiastically showed us a catalogue announcing an ultrasound machine which he plans to acquire for US$13,000. The price is not a problem, but to use the machine, one has to follow a course in Phnom Penh, and he does not have the time for that; he was thinking of sending his son.

The location of Leng Chhai’s clinic in a rural district is not typical. The clinics of the vast majority of privately practising physicians are found in Phnom Penh, and in the country’s provincial capitals. In the early years of the twenty-first century, the Ministry of Health estimated the number of privately practising physicians in Phnom Penh at between 1,000 and 1,300 (Rose et al. 2002: 14). According to the 2002 National Health Survey (Ministry of Health 2002: 3.9–3.10), among the country’s urban population 15.4 per cent of those seeking first treatment for an illness turned to a private clinic, compared to 10.9 per cent among the rural population (we shall return to the statistics on treatment options below). The Ministry survey states that ‘in many cases, households with ill members are taken advantage of since unqualified private providers prescribe unnecessary and costly treatments that frequently do not result in the ill member’s recovery’ (ibid.: 3.7). While this is certainly true, it does not, unfortunately, follow that this risk is eliminated by consulting a qualified private provider. The study by Greg Rose and his colleagues (2002), based on 200 simulated consultations with private providers (qualified physicians) in Phnom Penh, concluded that approximately
half of all the consultations were potentially hazardous. The study further noted that very few practitioners informed patients of their diagnosis; that inappropriate prescribing of corticosteroids for both children and adults was common; that antibiotics were almost universally prescribed in courses of inadequate duration; that polypharmacy (i.e. prescribing several drugs with identical effects, in order, as we have suggested, to satisfy clients’ wish for a desirable ‘mix’) was the norm; that the cost was directly related to the number of items prescribed; and that potentially hazardous consultations carried the highest cost (Rose et al. 2002: 34).

To successfully run a private medical enterprise, be it as a pharmacy shopkeeper, a village doctor or an owner of a private clinic, one has to meet customer expectations. These expectations are generally shaped by the indigenous health cosmology as well as by the popular demand for medication of immediate efficacy, a demand that was noted already by the French colonial physicians. But unlike the French and their successors within the public sector today, private practitioners have to accommodate patient preferences for house calls, injections, IV drips, and a ‘mix’ of several medicinal products. The demand for ‘efficacy’
implies a possibility that the medical treatment at private clinics focuses mostly on relief of symptoms and enhancement of general well-being, and that medically unwarranted products such as corticosteroids are prescribed.

**PUBLIC HEALTH FACILITIES**

The PRK government’s efforts to maximize the number of primary health centres (‘health bases’) staffed with poorly educated medical personnel was perhaps adequate for the immediate purpose of dealing with the medical emergency created under Pol Pot. But the long-term result, as emergency measures were turned into normal routine, was the emergence of a public health sector which was overstaffed with underqualified and underpaid personnel. The persistent shortage of pharmaceuticals and medical equipment in the public sector during the entire Vietnamese occupation encouraged private entrepreneurship that eluded state quality control. As during the DK period, the PRK version of ‘socialist health’ was a bureaucratic rather than a social concern and the emphasis was on treatment rather than on care. The legacy of the DK and PRK regimes
Cambodians and Their Doctors

in terms of poorly educated personnel and bureaucratic and non-caring attitudes still marks the public health system, which has been slow to develop efficiency and user-friendliness.

The Ministry of Health has overall responsibility for the delivery of healthcare services, but it has been systematically underfinanced; in 2003 it received only 60 per cent of its budget (Locard 2005: 137). This has both encouraged and facilitated the appearance of a host of non-state actors as providers of medical services.

The most problematic aspect is the provision of health services by over one hundred NGOs that tend to work independently of each other, often with little interactions among themselves as well as with public health services, thus giving the impression that donor presence in Cambodia is creating a very fragmented funding of health and is dictated by donor priorities. (Michaud 2005: 22)

Not only do the foreign NGOs rarely coordinate their efforts (among themselves or with the Ministry), their varied ideological persuasions occasionally lead to a certain rivalry between them (Crochet 2008: 393). Rivalry is no less a feature of the commercial actors on the medical scene, where national and foreign pharmaceutical companies are contracted by the Ministry for deliveries to the public sector.

Under its own auspices, the Ministry, with WHO assistance, started in 1996 to implement a Health Coverage Plan, a structural reform to render the public health system more efficient and improve the physical accessibility of services and facilities for the whole population. The reform is based on the concept of Operational Districts. The country has been divided into 69 (later 76) medical operational districts, which cut across the administrative district and commune (but not provincial) boundaries and are based on actual population distribution. Each operational district has a population of 100–200 thousand and is served by a referral hospital and a number of health centres. The ambition is that people should never have to travel more than 10 km to the nearest health centre. To further improve the quality of rural medical services, the Ministry in 1997 secured support from the World Bank and the Asian Development Bank for five-year assistance packages for two projects, the ‘Cambodia Disease Control and Health Development Project’ and the ‘Basic Health Services Project’.

Consultation at a public sector medical facility (health centre, referral hospital, provincial hospital) carries a modest user fee. (See opposite for a list of user fees.)
## List of User Fees at a Provincial Hospital, Posted at the Entrance to the Hospital Reception

Exemption available for poor people

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>2,000</td>
</tr>
<tr>
<td>Ambulatory services</td>
<td></td>
</tr>
<tr>
<td>Injuries</td>
<td>10–15,000</td>
</tr>
<tr>
<td>Stitching</td>
<td></td>
</tr>
<tr>
<td>Less than 5 stitches</td>
<td>10,000</td>
</tr>
<tr>
<td>More than 5 stitches</td>
<td>15,000</td>
</tr>
<tr>
<td>Cleaning of wound</td>
<td>3,000</td>
</tr>
<tr>
<td>Cleaning of ear, nose, throat</td>
<td>15,000</td>
</tr>
<tr>
<td>Psychological consultation</td>
<td>5,000</td>
</tr>
<tr>
<td>Emergency, 24 hour service</td>
<td>30,000</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>2,000</td>
</tr>
<tr>
<td>In-patient services</td>
<td></td>
</tr>
<tr>
<td>General ward, adults, up to 1 week</td>
<td>60,000</td>
</tr>
<tr>
<td>—, children, up to 1 week</td>
<td>50,000</td>
</tr>
<tr>
<td>Traumatology ward, up to 1 week</td>
<td>60,000</td>
</tr>
<tr>
<td>Additional week</td>
<td>30,000</td>
</tr>
<tr>
<td>Special room, per day</td>
<td>10,000</td>
</tr>
<tr>
<td>Maternity, women’s diseases</td>
<td></td>
</tr>
<tr>
<td>Delivery</td>
<td>50,000</td>
</tr>
<tr>
<td>Abortion</td>
<td>50,000</td>
</tr>
<tr>
<td>Cleaning after abortion</td>
<td>50,000</td>
</tr>
<tr>
<td>Removal of placenta</td>
<td>50,000</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>Major operations</td>
<td>250,000</td>
</tr>
<tr>
<td>Caesarean section</td>
<td>200,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medium operations</td>
<td>100–150,000</td>
</tr>
<tr>
<td>Minor operations</td>
<td>30,000</td>
</tr>
<tr>
<td>Eye treatment</td>
<td></td>
</tr>
<tr>
<td>Artificial eye</td>
<td>240,000</td>
</tr>
<tr>
<td>Operation, water in the eyes</td>
<td>200,000</td>
</tr>
<tr>
<td>Yellow spot</td>
<td>120,000</td>
</tr>
<tr>
<td>Eyelid operation</td>
<td>100,000</td>
</tr>
<tr>
<td>Other</td>
<td>20,000</td>
</tr>
<tr>
<td>Ambulatory technical services</td>
<td></td>
</tr>
<tr>
<td>X-ray</td>
<td>15,000</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>10,000</td>
</tr>
<tr>
<td>ECG</td>
<td>10,000</td>
</tr>
<tr>
<td>Administration</td>
<td></td>
</tr>
<tr>
<td>Admission</td>
<td>3,000</td>
</tr>
<tr>
<td>Birth certificate</td>
<td>3,000</td>
</tr>
<tr>
<td>Physical examination</td>
<td>10,000</td>
</tr>
<tr>
<td>Health certificate</td>
<td>30,000</td>
</tr>
<tr>
<td>Health assessment letter</td>
<td>20,000</td>
</tr>
<tr>
<td>Ambulance transport</td>
<td></td>
</tr>
<tr>
<td>Distance less than 5 km</td>
<td>15,000</td>
</tr>
<tr>
<td>Distance 5–10 km</td>
<td>20,000</td>
</tr>
<tr>
<td>Distance 10–25 km</td>
<td>30,000</td>
</tr>
<tr>
<td>Distance 25–50 km</td>
<td>50,000</td>
</tr>
<tr>
<td>Distance 50–75 km</td>
<td>80,000</td>
</tr>
<tr>
<td>Distance 75–100 km</td>
<td>100,000</td>
</tr>
<tr>
<td>Distance more than 100 km, or transfer to Phnom Penh</td>
<td>200,000</td>
</tr>
</tbody>
</table>

*Prices listed in Cambodian riel; 4,000 riel = US$1*
A fee is also levied on medication if it is provided by the facility. In principle, payment of those fees may be deferred and/or relinquished altogether, an option mostly available to poorer patients (Ministry of Health 2002: 3.18). This does not mean, however, that treatment in the public health sector may be completely free of charge.

First, there are no ministerial rules or guidelines as to who may be entitled to deferred payment or exemption, except that they should be ‘poor’, so decisions about the matter are taken locally and are mostly ad hoc. Second, a system of unofficial user fees operates in most facilities, so that even people who get an exemption from the official fees will have to pay unofficially – among other things for obtaining the exemption. The result is that patients’ payments will supplement the income of the medical personnel instead of contributing to the Ministry’s costs of running the public sector medical services. Third, the dispensing of medicines at the health centre or hospital is subject to availability; often the stocks of pharmaceuticals at hospitals are depleted or insufficient, partly because supplies are sometimes diverted to drug shops connected to private clinics run by hospital physicians. So if a needed drug is not available at the hospital, patients will have to purchase it at market price from a pharmacy or drug shop. Fourth, a fairly recent trend is that hospital physicians will occasionally offer patients private treatment at the hospital premises; this means that the physician may determine his fees outside the constraints of the Ministry’s regulations while using hospital equipment and personnel to assist such private practice, and avoiding the costs of running a private clinic. Another advantage for the physician is that being officially employed by the Ministry gives him or her legitimacy in the eyes of the patients (Mel 2004: 53).

**Health equity funds**

Against this background, it is understandable that the system of exemption from user fees does not always work according to the authorities’ intentions. Indeed, a Cambodian colleague who had done several weeks of research at a provincial hospital reported that he had not once met a patient who had been granted exemption, but had seen many poor patients desperately asking for it, but being refused by the hospital staff (Lath Poch, pers. comm.). It has been noted (in Cambodia as well as in other developing countries) that ‘exemption mechanisms are often ineffective and generally fail to protect the poor’ (Hardeman et al. 2004: 22). In contexts, such as that of Cambodia, ‘where health staff find themselves in a market-oriented setting, a conflict of interest may arise between granting
exemptions and raising income, especially when user fees serve to top up health workers’ income’ (ibid.).

In order to overcome such obstacles and improve the healthcare situation for the poor, the concept of health equity funds was launched in 1999 (ibid.: 23). The basic idea was that rather than being granted exemption from user fees, the poor should have their fees paid for them. ‘An equity fund involves a third party identifying the poor and paying user fees on their behalf by reimbursing the service provider, thus relieving health staff of [the] responsibility [of making socio-economic assessments of their patients]’ (Jacobs and Price 2006: 27). The ‘third party’ was to be a local NGO, and the money was to be provided by bilateral and international donors. The Ministry of Health was quickly convinced of the merits of this idea, and already in September 2000 a health equity fund was put into practice in a district in Siem Reap Province (Hardeman et al. 2004). Since then, a number of similar schemes have been initiated in various parts of the country, all with allegedly encouraging results (Jacobs and Price 2006; Noirhomme et al. 2007): the rate of hospitalization among the poor has increased significantly. By late 2006, 26 health equity funds were in operation, covering one-third of the country’s operational districts (World Bank 2008). The practical management of the equity funds is, as mentioned, left to a local NGO, who will assess the social and economic situation of the families who have applied for inclusion in the scheme. If the family is deemed sufficiently poor, the organization will issue an equity fund certificate with a photo of the whole family; members will present the certificate when treated at the hospital, and the costs will be billed to the organization.

The health equity funds have been almost unanimously applauded by all stakeholders. The Ministry is happy because more patients visit the hospitals; the donors are happy because they can show that their (taxpayers’) money is put to good use; and the local NGOs are happy to participate in projects that almost by definition are successful. While the schemes have certainly led to significant improvements in terms of medical treatment for the poor, however, a couple of reservations should be noted. First, coverage is partial. More than two-thirds of Cambodia’s poor are still not covered by a health equity scheme. The selection of districts for equity schemes is made by particular donors and/or NGOs and the criteria for selection are not always transparent. Second, there is a question of long-term sustainability. The schemes are totally dependent on external funding, and most donors, be they bilateral or international organizations or major NGOs, tend to work with a planning and budgeting horizon of a couple of years for their various programmes. The same is true of the local NGOs that implement
the schemes. The smooth running of the schemes, moreover, depend on the cooperation and trust between the donor and the implementing NGO. Not all NGOs are equally capable and well-organized, and even donor expectations may vary. Disagreements between donor and NGO may jeopardize the whole scheme. Third, almost all schemes cover only fees levied at provincial and district hospitals. And even if transportation costs may also be covered by the fund, people (not least poor people) are reluctant to go to the hospital unless their condition is really serious. This means that diseases that might have been diagnosed and treated early on at a local health centre are not necessarily discovered until they have developed into more serious conditions, which is unfortunate from a public health perspective (cf. Crochet 2008: 404).

Finally, also with respect to the public health dimension, hospital treatment tends to be sought for acute rather than chronic diseases, while the latter account for an increasing proportion of ill health among the population. A study of Russey Keo District, a relatively poor area on the outskirts of Phnom Penh, by medical anthropologist Men Chean Rithy has shown that by far the largest number of cases of serious illness that received qualified diagnosis during 2005 concerned chronic diseases. Hypertension topped the list with 23.8 per cent of all cases, followed by diabetes and gastric ulcer with 8.6 per cent each, and heart disease with 7.8 per cent. While these four conditions alone thus accounted for 48.8 per cent of all cases, typical acute conditions like typhoid, cholera, dengue fever, and need for surgery together only amounted to 6.3 per cent. (HIV/AIDS scored only 1.6 per cent; malaria was negligible as the city is not a malarial area) (Men 2007: 33).

The significant increase in ‘lifestyle’ diseases such as hypertension and diabetes is, of course, not unique to Cambodia but can be observed in many developing countries where dietary habits and work conditions change with urbanization and the decline of a subsistence economy. But despite the public health issues that such diseases raise, their prevention (through dietary and nutritional education, for example) and continual treatment is not given high priority. Both international donors and NGOs are primarily interested in the ‘visibility’ of their efforts, and to increase hospitalization among the poor by 50 per cent (in itself certainly a very important result) is likely to make a greater impression on their constituencies than attempts to prevent hypertension and diabetes by influencing people’s lifestyle. We may be reminded of the French success of their réclame médicale in 1909–1911 that brought a tenfold increase in consultations at the Phnom Penh clinics (see Chapter 3), while the efforts of the service d’hygiène to improve water supply and sanitation in towns and marketplaces attracted little
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attention and met with little success. An exception from the donor and NGO preference for treatment over prevention is the remarkable success achieved in the prevention of the spread of HIV infections in Cambodia (Michaud 2005: 5). But in this case the very words HIV/AIDS were already sufficient to ensure public interest and channel donor funds to almost any project that had those words in its title.10

HEALTHCARE CHOICES AND THE SOCIO-POLITICAL ECONOMY OF HEALTH

The healthcare choices people make are influenced by a number of factors. The most important are the severity of the illness; the nature of the disease; and the economy of the household of the sick person (cf. Mel 2004). Generally, the more severe the condition, the more likely people are to seek treatment at a hospital or health centre. The same is true if the initial choice of going to the pharmacy or consulting a village doctor or qualified private practitioner does not lead to the desired result, i.e. being cured. The perceived cause of an illness may also influence the initial choice of treatment. As we saw in Chapter 1, diseases are thought either to be caused by the spirits or to have natural causes. Certain diseases, such as mental illness, for example, are most certainly inflicted by the spirits and may therefore be successfully treated only by an indigenous practitioner, a kru. But in most cases the causation, and thereby the appropriate treatment, needs to be established. This is usually accomplished by a process of trial and error (Mel 2004: 99), that is, if the first choice of treatment does not work, people will try a different kind for a second or third treatment.

Since most Khmer inhabit the premodern universe of the indigenous health cosmology, their choices are dictated more by the trust they have in various kinds of practitioners (as well as their perceptions of causation) than an attempted calculation of the risk associated with the treatment chosen (see Giddens 1990 on trust and risk). Another word for such trust is familiarity, and the general outlook is aptly captured in the title of David Craig’s study of medicality in Vietnam, Familiar Medicine.

Choice of medical care […] is a complex negotiation between systemic biomedical knowledge (as accessed from doctors and pharmacists) and the family’s own pool of knowledge, experience, and resources. Choosing which course to follow thus takes place within fraught and contested domains of social and familiar relationships, economic opportunity, local knowledge, and available local resources (Craig 2002: 161).
The fundamental trust that Khmer people have in indigenous healing practices is seldom shaken by individual experience of treatment failure. These healing practices belong to the Khmer field of ‘doxa’ (Bourdieu 1977: 168–169), that which is taken for granted and cannot be evaluated or subjected to opinion. Therefore, indigenous practitioners are rarely blamed for failure, nor does failure to cure lead to doubts about the indigenous system as such. On the other hand, modern biomedical treatment belongs to the field of ‘opinion’ (as opposed to doxa; ibid.); it is usually evaluated on a case by case basis, and any failures or shortcomings are blamed on the individual doctor, on Cambodian doctors in general, or on the biomedical system. In the Cambodian a-modern medical world, doctors continually have to earn people’s trust and struggle to overcome their poor reputation. A surgeon at a provincial hospital related with frustration that he had just had to amputate the arm of a patient. The man had broken his arm and gone to an indigenous bone-setter (kru bakbeg); but an infection of the wound had developed into gangrene and when the man finally got to the hospital, amputation was the only option. Back in the village, the lesson learnt

Figure 8.4. Elderly patient at home. The village doctor has tied the serum bag for the IV drip to the house post, and the woman has her basket with betel and areca within reach.

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from this case would possibly be, ‘If you break an arm, don’t go to the hospital, they will only chop it off’. At another provincial hospital we talked to a man with a broken leg. He was the only patient in the sickroom and was feeling miserable with no relatives around and no nurses in attendance. His leg was in plaster and he said the doctors had inserted a metal rod in the leg and that made him fearful; he wanted to go home and be treated by a kru.

The unsociable ambience of the public health facilities is a major reason why people wish to avoid them (cf. Collins 1999: 27–42; Mel 2004: 115–118). They are perceived as places that are both unfamiliar and unfamilial as well as unhomely, even sinister and eerie (as in the German word *unheimlich*). Common complaints are that the smell is bad and the cooking shoddy; such shortcomings are understood by the Khmer to signify lack of morality. The staff is uncaring and sometimes impolite or disrespectful. An added drawback is the economic uncertainty associated with hospital treatment. User fees (where no health equity fund is available) are levied prior to treatment. Because of their low salaries, doctors, nurses, and menial staff are likely to demand payment for the services they are supposed to deliver. This makes the costs unpredictable; and unpredictability is not only an economic inconvenience, it is also a corollary of disorder, which by itself constitutes a health risk (see Chapter 1). Furthermore, advance payment goes against the grain of the indigenous social morality according to which healthcare is not a commodity but a social obligation, to be rewarded in due course according to the means of the patient and the outcome of the treatment. In other words, biomedicine as practised by the Cambodian public health sector is still indigenized mainly according to the bureaucratic medical regimes of DK and PRK, rather than in accordance with the indigenous Khmer health cosmology and moral values.

For statistical purposes, people’s healthcare choices are categorized with reference to which ‘health sector’ the practitioners belong, i.e. the ‘public sector’, the ‘private sector’, or that of ‘traditional’ practitioners. In this classification, the private sector includes both pharmacy/drug shop operators, village doctors, and private clinics or hospitals run by biomedically qualified personnel. According to the 2002 National Health Survey, when people first seek treatment for an illness, only 23 per cent turn to a public health facility, while just over 70 per cent consult a private practitioner, primarily a drug-seller (33 per cent) or a village doctor (25 per cent). Only just over 5 per cent rely on indigenous healers for their first treatment. That may seem a small percentage for a purported medically premodern population, but it is significant that if a second treatment is necessary, 14 per cent turn to a kru; and for a third treatment the figure has
gone up to almost 18 per cent. These increases are at the expense mainly of consultations with private medical practitioners; the reliance on the public health sector increases for second and third treatments (to 29.8 and 31.4 per cent, respectively) (Ministry of Health 2002: 3.10). In other words, if the efforts of the local pharmacist or village doctor prove inadequate, the family decides to turn either to a public health facility (often on the advice of the village doctor or perhaps the pharmacist) or to a kru, if the illness is suspected to be caused by the spirits. We should also remember that people consult indigenous healers for a number of conditions, such as life crises, that are not defined as illness in the national health survey. Furthermore, it is not uncommon for people to seek treatment or advice from both indigenous and biomedical practitioners for the same condition; in such cases it is likely that only the biomedical treatment is recorded in the official statistics.

The biomedical profession in Cambodia is probably not quite as bad as its general reputation. The legacy of DK and PRK medical regimes (poorly educated personnel, bureaucratic attitude to treatment) of course has something to do with it, but there is also an element of self-fulfilling prophecy. It has long been routine for expatriates to be evacuated to Thailand for treatment of almost any acute illness. King Sihanouk used to be absent for extended periods for the medical attention of his physicians in Beijing, and members of the Cambodian elite and urban middle classes tend to follow the royal example of seeking treatment abroad. Thailand is still a preferred destination, but Vietnam is an alternative even for less well-to-do people in Phnom Penh; one may get on a bus to Ho Chi Minh City, where inexpensive guesthouses can be found in the vicinity of the university hospital. But most ordinary people have to make do with the domestic options. Many do so reluctantly. Even for acute and severe conditions, people tend to seek treatment at a public hospital as a last resort, so the perception that the hospital is where you go to die is too often confirmed.

We met Sor Phany when she was staying temporarily in her elderly mother’s house in a village outside Phnom Penh. Three weeks earlier her husband had died of lung cancer and she was now alone with two young children. The husband had worked for several NGOs before he got a job as a security guard at the US embassy in Phnom Penh. He neither smoked nor drank. His steady income had enabled Phany to support the high school education of her youngest sister. When he fell ill he was taken to a private clinic (said to be Japanese) and was diagnosed with tuberculosis, but as his condition did not improve after three weeks of treatment, he transferred to the Calmette Hospital. Lung cancer was suspected and
eventually confirmed after tests at the Russian Hospital. At the Calmette he was seen only by young doctors, except for once when an older doctor saw him and advised surgery. But by then he was already very weak. Phany had wanted to send him to Vietnam for surgery, but the diagnosis came too late for that. She took her husband home and he died shortly after. She claims that the 42 days of treatment at the Calmette had cost the family more than US$10,000. She was devastated and had completely lost faith in all Khmer doctors, at the Calmette and elsewhere.

Whether the man’s life could have been saved by an earlier diagnosis and Vietnamese surgery is impossible to say. But it is significant that Phany in her anguish primarily blamed the public hospital (whose physicians were ‘young’ and therefore assumed to be less competent), rather than the private clinic that initially failed to make the correct diagnosis.

Considering that a large part of the population was severely traumatized after the horrors of the Pol Pot regime, the inchoate state of modern psychiatry in Cambodia is noteworthy (Van de Put and Eisenbruch 2002: 147–152). One reason is probably the common assumption that mental illness is caused by the spirits and that treatment therefore must be provided by spiritual means by an indigenous healer. Indeed, some people believe that an attempt to treat spiritually caused conditions with modern medical (including psychiatric) methods may be counterproductive, as it ‘will only arouse the anger of the spiritual cause and bring greater damage to the patient as well as the patient’s family’ (Mel 2004: 99).

Lim Sophan lives with her husband in a peri-urban village some 15 km outside Phnom Penh; it is a resettlement village for people evicted from the city’s slums. The family is extremely poor. Sophan’s husband is rather frail and had recently had mental problems. It started with headaches and numbness in his hands and feet, then he had fits and became disoriented, did not recognize people around him, muttered incomprehensibly and would wander off and get lost. When we met him, he was apathetic most of the time, scratching himself and staring into space, with brief lucid moments. Sophan told us that he had been a soldier in the early 1980s, stationed in a forest area in Kampot and had suffered from frequent bouts of malaria. (‘Too many people died’, the husband suddenly exclaimed in a pained voice, after which he reverted to apathy).

After his military service he had been drinking heavily, but had now stopped. In her search for a cure for her husband, Sophan had first consulted a female spirit medium (kru chol rup) who diagnosed the
condition as the result of wrongdoing against the ancestors (kos chi don chi ta), against the spiritual authorities (kos samdech preah kru), and against the local guardian spirit (kos neak ta). She then consulted a monk in a nearby wat who said that it was a mental disease that had nothing to do with the ancestors and recommended her to go and see a doctor. Two more kru were then consulted and both confirmed the diagnosis of the first kru. It was decided to hold an expiatory ceremony which was performed by an achaa in the village. The cost of the ceremony was US$50, and afterwards the husband improved slightly, but he soon had a relapse.

Sophan then went to a pharmacy and explained her husband’s symptoms, his general weakness and his past history of malaria and alcohol consumption. She came away with a tube of effervescent pills of sodium bicarbonate, two different preparations of calcium (pills of ‘Calcibronat’ and ‘Calcium corbière’ in liquid form), and softgel capsules of Gingko Biloba. The dose was meant for three days and cost US$10. She explained her strategy of going to both indigenous healers and the pharmacy as akum phsom obakech (‘the magic of combining attitudes’), i.e., a deliberate effort to combine what the two different medical systems had to offer. When asked why she had not gone to see a proper doctor, Sophan explained that she had not managed to get a family photo for an equity fund certificate, and besides she had heard that the organization was soon going to change the certificates anyway, or maybe abolish the fund altogether; that she was unfamiliar with the locations of the hospitals; and that she had money neither for transport nor for a stay at the hospital.

The economics of healthcare

Illness often implies a considerable strain on the family income, irrespective of the kind of treatment. In Cambodia, it is estimated that about 75 per cent of all healthcare expenditure is covered by out-of-pocket payments, i.e. paid for with the patients’ own money; government spending amounts to only about 7 per cent, and the rest is covered by international donors (Van Damme et al. 2004; Michaud 2005). This proportion of out-of-pocket payments of the total health expenditure is among the highest in the world. In a study of rural livelihoods, Chan Sophal and Sarthi Acharya have shown that by far the most frequent cause of economic crisis in rural households is illness (Chan and Acharya 2002: 117). To pay for medical treatment, poor households will often have to sell some of their productive assets, livestock, and land. Of households that have sold land, 50 per cent have done so because of illness in the family (ibid.: 24). The need to sell productive assets arises primarily in cases of severe illness, which may then
constitute a ‘catastrophic health expenditure’, defined as expenditure amounting to more than 40 per cent of the household’s capacity to pay. For poor households, even a minor bout of ill health may upset the household economy. ‘Indeed, any unforeseeable expenditure for people living on less than one dollar per day would automatically be catastrophic’ (Van Damme et al. 2004: 278).

Nationwide in 2002, just over 92 per cent of all households covered out-of-pocket expenditure with their own money. Among those 8 per cent who had to look for outside sources to meet medical expenses (even after having sold land or other assets), almost 7 per cent turned to a moneylender (commonly at an interest rate of 10–20 per cent per month), while only 1 per cent received donations or a loan from relatives (Ministry of Health 2002: 3.20). For the 30 per cent of the households classified as poor, the proportion was 8.9 per cent for moneylenders and 1.5 per cent for relatives (ibid.: 3.18). There are considerable variations between the various provinces and districts as to the proportion of own means, loans, and help from relatives for financing medical treatment. But the general trend is clearly that the more ‘traditional’ (and poor) the district, the greater the reliance on moneylenders and the lesser the frequency of help from relatives. In 19 out of the 69 Operational Districts none of the needy households received any financial help whatsoever from relatives to meet medical expenses but had to take loans from moneylenders (ibid.: 3.19–20).

Such statistics may be discouraging to those who like to think of ‘traditional’ Cambodian rural society as local village communities interwoven by close bonds of kinship in which relatives ‘help each other in a variety of ways, including [...] donating or lending cash [and] providing emergency financial and other assistance’ (Ledgerwood 1998: 140–141). Even if failure to provide financial assistance is due more to lack of means than to lack of concern for relatives and neighbours, as Ledgerwood claims, it is statistically doubtful if more than 80 per cent of all the poor people who get sick would have only equally poor relatives. We suggest that the main reason why mutual assistance between relatives comparatively rarely materializes in cases of illness is that the temporary or permanent loss of work capacity that a severe illness entails affects the household’s ability to fulfil the obligations of reciprocity on which traditional mutuality between households rests. Traditional reciprocal labour exchange is strictly balanced (Ebihara 1968: 182); nowadays labour input is often calculated in monetary terms, and even paid directly in money. When an adult person suffers from a chronic and perhaps debilitating disease (such as tuberculosis or severe hypertension, for instance), this will diminish the family’s ability to engage in reciprocal labour exchange, and the family will be dropped from the network of mutuality. To
take a private loan is often the only option. The monthly interest rate of 10–20 per cent usually charged by a private moneylender may be condemned as usury. But the moneylender is in most cases a member of the local community and sees himself (or commonly, herself) more as a patron whose access to capital may benefit the poorer members of the community. Apart from not having to beg money from relatives, the poor, in their turn, see an ‘advantage’ in the fact that the moneylender is usually willing to defer both payment of interest and repayment of the principal. The moneylender, in her turn, will have to weigh the (considerable) risk of never getting her money back against her standing in the community. The relationship between borrower and moneylender is no less an instance of ‘traditional’ Khmer sociality (Aymonier 1900: 86; Ebihara 1968: 328–338) than (purported) kinship solidarity, even if it has less romantic connotations.

Transportation costs are often cited as the reason for not seeking medical treatment, particularly at public health facilities. For very poor people whose actual treatment may be covered by an equity fund, even the modest cost for a motorbike ride to the nearest referral hospital (or even health centre) may sometimes be prohibitive. But on average, transport accounts for only about 5 per cent of the total treatment cost (Kingdom of Cambodia 2001: 36–40). And with a health centre no more than 10 km away, the distance and the time spent on travel (half an hour on a motorbike, or a two-hour walk, at most) is hardly crucial. Citing transportation costs as prohibitive may well be a shorthand for a number of obstacles related not only to economy but more pertinently to the mental distance to the biomedical facility: the unfamiliarity with the setting, the uncertainty about the reception one is going to get, and thus the unpredictability about the whole undertaking. It should also be noted that in most cases a person will not go alone to the hospital but will be expected to be accompanied by a relative, on whom the sick person will consequently have to impose the same inconveniences.

Two-thirds of all patients travel to their place of treatment in less than half an hour. Travelling time does not vary according to the socio-economic status of the family, but it varies significantly according to what kind of practitioner one seeks. To reach a private practitioner, 75 per cent spend less than half an hour, while to get to either a public health facility or an indigenous healer, less than 50 per cent can make it within 30 minutes (Ministry of Health 2002: 3.15). In other words, a village doctor or a pharmacy shop is generally to be found close by, while a health centre or a kru may be further afield. Nationwide, only 6.5 per cent of people seeking healthcare treatment spend more than two hours getting
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	here, but virtually all of those who do are going to either a public health facility or an indigenous practitioner. Of those who seek public sector medical treatment, 12.5 per cent travel for more than two hours (ibid.), which probably means that the severity of their illness demands treatment at a referral or provincial hospital, or in Phnom Penh. An interesting feature of this statistic is that no less than 18.5 per cent of those who seek an indigenous healer travel for more than two hours. Apparently the logistics of travelling present considerably less of an obstacle if the aim is to get to a kru, compared to reaching a public health facility: notwithstanding the physical distance there is no mental distance to be overcome, no unfamiliarity to be encountered. The ministry statistics do not correlate socio-economic status with choice of practitioner on the issue of travel time, so the figure of 18.5 per cent could cover both the case of a wealthy man going from Phnom Penh in his private car to see his favourite kru in Battambang, and that of a poor farmer going by oxcart to the neighbouring district to consult a kru who is reputedly a specialist on his particular affliction. We have come across both scenarios in the field, and as we saw in Chapter 5, indigenous healers will often point out that their clients often come from far away. The common denominator in these cases is that a kru builds his personal reputation not on proven curative success but on the confidence shown by his clients – which in the case of ritual healing is the sine qua non of success.

On the whole, healthcare choices in the Cambodian a-modern medical world are mediated by the indigenous health cosmology as well as by practical and economic considerations and by habits of familiarity. But the circumstances under which choices are made vary with socio-economic status, level of education, and place of residence: the poorer and less educated you are, and the farther you live from an urban area, the lower the quality of healthcare you are likely to get, and the more (relatively) it is going to cost you.

NOTES

1 The figures are from 2001 and according to a list compiled by the Provincial Health Department; the list even includes the name of the owner and other particulars of each shop, something which no doubt facilitates the collection of the appropriate fees or fines for each store. In 2000, there were 892 licensed pharmacies/drug shops in the country as a whole, and the number of unlicensed ones was estimated at about 2,800 (Ministry of Health 2001: 6).

2 A national system of drug registration was introduced in 1994. Of the about 5,000 pharmaceutical products currently on the market, nearly 40 per cent are unregistered; all unregistered drugs are (illegally) imported (Ministry of Health 2001: 7).
Sophisticated urbanites may instead go for novelties such as the domestically produced Kinal®, a mix of paracetamol and caffeine, marketed in white packaging for the busy executive, and blue for the stressed housewife.

Corticosteroids are medically indicated for conditions such as asthma and arthritis. One of their effects is increased appetite and consequent weight gain, which is helpful for many clients. Other potential side-effects, however, include restlessness, menstrual irregularities, insomnia, indigestion, and peptic ulcers. Shopkeepers are not the only culprits here; a recent study (Rose et al. 2002) has shown that unnecessary corticosteroids are routinely prescribed by physicians at private medical clinics in Phnom Penh. Allegedly, even some indigenous herbalists add corticosteroids to their ready-made herbal tonics.

Established in 1963 as the Pharmacie d’approvision khmère, it was subsequently renamed Cambodia Pharmaceutical Enterprise (CPE). After economic liberalization in 1989 the company dwindled and almost closed down, until it was resurrected by Hong Kong Chinese capital in 1998 and could operate in market conditions. It is now the major domestic pharmaceutical company and has contracts with the Ministry of Health for the delivery of more than 30 different drugs.

According to the Vidal handbook of pharmaceuticals, Baralgine is a powerful analgesic to be used mainly in post-operative emergencies on (for example) severely traumatized soldiers on the battlefield. It should be used only when no alternatives are available, due to the high risk of haemorrhaging, which can cause shock and even death, regardless of blood transfusion. It seemed that the good doctor was relying on his old army surgeon routines.

Peh was originally the Khmer version of the French word for plague, la peste (Au 2006: 50–51). In the present context our informant explained it as equivalent to the French word charbon, i.e., anthrax.

It is widely assumed that the attack, during which assassins threw a couple of grenades into the crowd, killing 20 and maiming about a 100, was engineered by the CPP. The less credible official CPP line was that the attack was instigated by members of the Khmer Nation Party itself in order to lay the blame on, and thereby discredit, the government.

The same year, the Ministry of the Interior received 167 per cent of its budget and the Ministry of Finance 199 per cent (Crochet 2008: 404).

It is significant that the study by Men Chean Rithy (2007) was only carried out because the ILO project that commissioned it (with funds from the Rockefeller Foundation) was about ‘social protection and income security for HIV vulnerable and HIV positive households’, even though it turned out that HIV was relatively insignificant in the study area.
Chapter Nine

Conclusion

In this study we have attempted to trace the dynamics of the articulation of Khmer indigenous ideas of health and illness with contemporaneous (initially ‘foreign’) biomedical knowledge. Because of the dearth of practical interaction between the two medical systems, such articulation has rarely been explicit but may be inferred through medical ethnography.

French efforts to create a public health system through l’assistance médicale indigène and (later) le service d’hygiène were stunted not only because insufficient resources were allotted to the task, but also because the French medical personnel generally lacked ethnographic knowledge of Khmer society that would have allowed them to better indigenize their programmes and practices. The programme for the education of ‘native’ medical personnel largely failed for the same reasons. Medical modernity under Prince Sihanouk ostensibly kept up the French public health efforts, but in reality focused more on clinical and curative practices and reached a limited proportion of the population. The socialist medical modernity of Democratic Kampuchea abandoned the social and spiritual component of indigenous medical treatment and left it to incompetent revolutionary medics to deal with common people, while the elite was served with proper medicine by the few educated physicians left alive in the country. In spite of the small number of competent medical personnel, the PRK successor regime relied largely on quantitative measures; the larger the number of perfunctory consultations, the more successful the public health system. The violence that Cambodian society suffered during the 1970s and 1980s had serious negative consequences for the health of the population. The civil war, the US aerial bombardments, the DK terror regime, and the displacements of people, internally under DK and to the border camps under PRK, each caused life-long damage to a large number of people. Comparative evidence has shown that generally, armed conflict has
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profound direct and indirect impacts on the long-term physical and mental health of both combatants and bystanders, and that displacement has similar consequences (Levy and Sidel 2009).

In the Cambodian medical a-modernity since the 1990s, the state is no longer the major provider of medical services for a population that needs such services more than many others. People are now thrown upon their own resources to buy their healthcare, or to get it from international donors through foreign or national NGOs. At the same time, socio-economic inequalities have increased in Cambodian society, a fact that is in itself pathogenic (cf. Nguyen and Peschard 2003). In Soizick Crochet’s words, ‘It appears that Cambodia has only ever known preludes to a public health system, the dysfunctional nature of which has contributed to aggravate social tensions’ (Crochet 2008: 416). One thing is that the state has failed its obligation to provide medical services to the population, but in the medical field the ruling party has not even followed its own example of providing services masked as personal donations from its leaders (Hughes 2006: 472); while the Prime Minister has taken on the role of a ‘meritorious benefactor’ of his people by ‘donating’ schools, bridges, and roads, public health facilities like hospitals and clinics seem rarely if at all to be included in his generosity programme. Instead, the medical arena is largely left to foreign donors who have created a patchwork of more or less long-term healthcare projects, implemented and managed mostly by NGOs according to their particular visions of the population’s medical needs. Of the more than 120 western NGOs active in Cambodia in 2003, about half were concerned with healthcare (Trannin 2005: 246–256). The actual operation of these NGOs has hardly been scrutinized. Janes and Corbett have warned of the general trend that NGOs recruit competent personnel from the countries’ public health services (by offering higher wages) and thus undermine local control of health programmes, to the effect that ‘international NGOs intensify unequal social relations on the local level’ (Janes and Corbett 2009: 175–176). This trend is very obvious in Cambodia.

For the Khmer, care for a sick family member is a moral obligation, and to fulfil that obligation people are prepared to risk their own future well-being; if necessary, they will sell land and other productive assets and they will place themselves hopelessly in debt in order that their relatives get the best possible treatment. For most somatic illnesses there can be no doubt that the ‘best possible’ treatment may be offered by biomedically educated professionals in the public sector rather than by exorcists, herbalists, pharmacy shopkeepers, village injection doctors, or commercially motivated owners of private clinics. Nevertheless,
more than half of people’s medical expenses currently go to this latter group of practitioners (Kingdom of Cambodia 2001: 35–40). The reason is probably that these practitioners come across as familiar and therefore trustworthy. The main divide is not between indigenous and biomedical practitioners; people are quite prepared to resort to ‘the magic of combined attitudes’, as one informant put it, that is, to seek treatment simultaneously from both indigenous and biomedical providers. The main divide, from the patients’ point of view, is – and has always been – between practitioners who try to accommodate the norms of Khmer social obligations and those who carry out their work as biomedical professionals as if it were, and should be, separate from the ethos and worldview of the people they treat.

Cambodia’s political history since the 1960s has implied repeated backlashes for public healthcare. But the population has had no choice other than to try to cope with the hardships, medical and other, in accordance with their habitus, sociality, and cosmology. We do not believe that the political events and hardships have imbued Cambodians with a particular resilience not found elsewhere under comparable conditions; nor do we believe that the Khmer are, or because of their past experiences are now emerging as, particularly virtuous (whether in ethno-nationalist or neo-moralist terms). Essentialist concepts like resilience and virtue sit uneasily with social science analysis. But we do believe that the social and mental structures shaped by sociality and cosmology are played out in habitus and agency. The structural divide between the political elite and the common people has been constant through the several socio-political transformations of Cambodian society. The habitus of the current political leadership is geared to the twin concerns of extracting material resources and winning votes (Hughes 2006: 469), while that of the common people is geared to caring for the family and seeking tolerable positions in patron–client networks. In the medical sphere, the Cambodian people, like everybody else, want efficient and affordable medicine. They do not expect compassion, but look for decent treatment by doctors who are concerned for their well-being and respect their social and personal integrity. The extent to which they find, or do not find, this in the public health system or with private practitioners in some sense reflects Cambodian society at large.
The exact number of people who died between 1975 and 1979 as a result of the policies of the regime of Democratic Kampuchea is impossible to determine. The currently accepted estimate among journalists and academic commentators is 1.7 to 1.8 million people alleged to have been ‘killed by Pol Pot’. But this consensus has been reached by persistent repetition rather than by assessment of evidence.

The evidence, such as it is, is necessarily based on population estimates from before 1975 and after 1978, since no proper census was conducted between 1962 and 1980 (and the latter was dubious). The various assessments by a number of demographers have been summarized by Ben Kiernan, who concludes that the death toll was between 1.671 and 1.871 million people (Kiernan 2003: 587). A relevant question is what is meant by ‘death toll’. For Kiernan it seems to mean that the regime ‘took the lives’ of the specified number of people (ibid.: 585). His source for the ‘consensual’ figure of about 1.8 million is a paper by Judith Banister and Paige Johnson (1993). They, however, arrived at the figure not as the number of people who lost their lives (let alone ‘were killed’) but as a ‘statistical loss’ of population when comparing the 1975 population estimate with the statistically projected figure for early 1979 (Kiernan 2003: 586). According to Banister and Johnson this statistical loss was made up as the sum of a ‘net emigration of 218,000 people; a dearth of 570,000 births compared to the expected level; and excess deaths totalling about 1.05 million’ (1993: 90). Needless to say, the 218,000 emigrants were not killed; and to equate a diminished birth rate with the taking of the lives of the corresponding number of statistically unborn is dubious.

The study by Marek Sliwinski (1995: 60) suggests that about 60 per cent of the ‘excess deaths’ resulted from executions and disappearances, and 40 per cent were due to starvation and exhaustion. In other words, if we accept Banister
and Johnson’s estimates, about 630,000 people were killed outright by agents of the state while 420,000 people died because the regime had undermined their health. For the same reason about half a million pregnancies did not happen or ended in abortion or stillbirth.

Apart from the technicalities of demographic statistics, we want to make the anthropological point that figures have not only a numerical but also a semantic value. And when a figure of ‘statistical loss’ is transformed into a ‘death toll’ we are clearly in a semantic rather than a numerical domain. Edwin Ardener was probably the first anthropologist to propose a critical scrutiny of the meanings that analysts attribute to statistical information. He suggested that people’s conceptual structures are generally built up by naming rather than by numbering, and that even when we are consciously relying on what we take to be demographic data, such data may merely give us another mode of expression for phenomena whose import lies outside demography (Ardener [1974] 1989: 120).

In the case of the Pol Pot regime, the import of the assumed demographic data is most clearly political. After the invasion, the Vietnamese quickly established that three million people were killed, and this figure was the official estimate throughout the PRK regime, although it was raised to 3.3 million in a government report from 1983 (Slocomb 2003: 163, 187, 302 n.4). As part of the Vietnamese and PRK political damage control, this ‘numbering’ tallied with the ‘naming’: ‘Genocide’ was the accusation against Pol Pot and Ieng Sary at the August 1979 tribunal, and the reasoning seemed to be that the more victims that could be claimed, the more guilty of genocide the DK leadership would be.

And for the popular imagination it is tempting to conclude that if a regime has killed three million people it must be three times as bad as one that ‘only’ killed one million. Because of the conceptual primacy of names over numbers, the latter are easier to adjust to current concerns. The name ‘genocide’ is still with us in academic and journalistic reporting (irrespective of the definition of the UN Convention). But the number has been scaled down to 1.8 million, possibly in the interest of ‘objectivity’, as the Vietnamese/PRK figure may too easily be dismissed as ‘propaganda’. Nevertheless the memorial at the execution ground at Choeung Ek, a tourist destination popularized as the ‘Killing Fields’, still advertises ‘many millions’.
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