TURNING THE TIDE

Cambodia's Response to HIV & AIDS 1991-2005

- Markus Bühler
- David Wilkinson
- Jenne Roberts
- TAP Catalla Jr.

August 2006

Supported by:

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR UNICEF WFP UNDP UNFPA
UNODC ILO UNESCO WHO WORLD BANK

Front cover photo by: UNAIDS/Mith Samlanh/O.O'Hanlen

FOREWORD

Cambodia represents one of the few 'success stories' in reversing the trend of the HIV epidemic, as shown by the declining prevalence among adults from 3% in 1997 to 1.9% in 2003. This achievement is particularly significant in the light of Cambodia's nation building and development challenges.

The study presented in this report describes the trajectory of the epidemic in Cambodia, and identifies the key elements that contributed to its reversal. In particular, the study demonstrates how an effective collaboration between Cambodia's government, civil society and development partners helped to turn the tide of the epidemic.

While we should be proud of our achievements, we should also be aware that much remains to be done, and that new challenges lie ahead. We must avoid complacency, and demonstrate our commitment to meet these challenges with creative solutions and adequate resources.

By providing a historical perspective on how key elements of the response have combined successfully in the past, this study can help to enable policy-makers, programme managers, decision-makers and implementers to build on the successes to date.

The study was guided by a Reference Group, composed of individuals who have been involved in various aspects of Cambodia's response over the last 15 years. I wish to thank the Reference Group, UNAIDS and the authors for showcasing Cambodia's achievements and for enabling us to share the valuable lessons learned in Cambodia with our national and global partners.

Dr. Hong Sun Huot
Senior Minister
Chairman, National AIDS Authority

ACKNOWLEDGEMENTS

This retrospective study provides insights into Cambodia's response to the HIV epidemic over a 15-year period. We are grateful to the key informants in Cambodia, whose recollections of events were invaluable in informing us of what transpired over that period. In the world of humanitarian aid and development assistance people come and go, and we had to trace key informants who long ago moved on – many of whom were involved in the early days of the response in Cambodia. Our thanks go to them for taking their time to respond to our emails and talk with us by telephone, and for showing their continuing interest in Cambodia.

This study was guided from the outset by a Reference Group, consisting of people who have been closely involved in the response, often from the very beginning. Their commitment and continuing passion has been an inspiration. Our deepest thanks go to Hor Bun Leng, Chun Bora, Tan Sokhey, Sok Bunna, Panhavichetr Pok, and Maurits van Pelt for their participation and contributions throughout the process.

Numerous people have commented on various drafts of the report and have helped to ensure accuracy and comprehensiveness. Special thanks go to Tia Phalla and Geeta Sethi who have provided comments from afar.

The UNAIDS Secretariat team, and in particular Tony Lisle and Matthew Warner-Smith in Cambodia, and Geeta Sethi in Geneva, have provided unstinting support and encouragement throughout the study.

Finally, our deepest gratitude goes to the people living with HIV and those who are exposed to HIV, either through their work or in their personal life. Without their contributions we could not have captured the human side of the epidemic.

Markus Bühler
David Wilkinson
Jenne Roberts
TAP Catalla Jr.

ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
AusAID	Australian Agency for International Development
BSS	Behavioural Sentinel Surveillance
CDC	Communicable Disease Control
CDC-GAP	Centre for Disease Control-Global AIDS Program
CoC	Continuum of Care
CPN+	Network of Cambodian People Living with HIV/AIDS
CRC	Cambodian Red Cross
100% CUP	100% Condom Use Programme
DFID	U.K. Department for International Development
DHS	Demographic and Health Survey
DSW	Direct Sex Workers
EPI	Expanded Programme of Immunisation
EU	European Union
FHI	Family Health International
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People with AIDS
GPA	Global Programme on AIDS
HACC	HIV/AIDS Coordination Committee
HBC	Home-based care
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
ICRC	International Committee of the Red Cross
KHANA	Khmer HIV/AIDS NGO Alliance
MDM	Médecins du Monde
MoH	Ministry of Health
MSF	Médecins sans Frontières
MSM	Men who have sex with men
NAA	National AIDS Authority
NAC	National AIDS Committee
NAP	National AIDS Programme
NBTC	National Blood Transfusion Centre
NCHADS	National Centre for HIV/AIDS, Dermatology and STIs
NGO	Non-Governmental Organization
OD	Operational District
PAO	Provincial AIDS Office
PHD	Provincial Health Department
PLHA	Person/People Living with HIV or AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
RHAC	Reproductive Health Association of Cambodia
SNC	Supreme National Council
SOC	State of Cambodia
SSS	STI Surveillance Survey
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNTAC	United Nations Transitional Authority in Cambodia
USAID	United States Agency for International Development
VCCT	Voluntary Confidential Counselling and Testing
VTC	Voluntary Testing Centre
WHO	World Health Organization

CONTENTS

Figures

Boxes

Tables

EXECUTIVE SUMMARY

Cambodia is one of the few developing countries that are on track to meet Millennium Development Goal 6 – to halt and begin to reverse the spread of HIV/AIDS by 2015. Estimated adult HIV prevalence has decreased from a high of 3% in 1997 to 1.9% in 2003[1]. The incidence of HIV infection has been consistently declining among most sentinel groups, while mortality due to AIDS appears to have stabilized. In contrast with other apparent "success stories" (such as Thailand, Brazil or even Uganda), Cambodia had neither a functioning public health system nor a stable political environment to provide bases on which to build the response. Cambodia's success in combating the HIV epidemic is therefore all the more impressive. There are indications that the initial response to the onset of HIV in Cambodia, although limited in scope and resources, was critical in turning the tide of the epidemic.

Elements of Success

There were a number of key elements that facilitated, and continue to facilitate, Cambodia's success in combating the spread of HIV. These include:

- Early initiation of surveillance, research and analysis
- Evidence-based programming targeting key populations
- Dynamic condom social marketing and distribution
- Good collaboration between government and civil society
- Enabling institutional and political envi ronments
- An emerging civil society response cou pled with strong civil society advocacy
- Early piloting of care, support and treat ment projects by NGOs
- Government responsiveness in assuming ownership and facilitating scale-up
- Financial resources mobilised at the right time

Lessons Learned

Cambodia's response to the epidemic illustrates the effectiveness of a collaborative and pragmatic programmatic approach, in the setting of a developing country recently emerging from over twenty years of civil and political conflict. Some of the key lessons learned in initiating and scaling up this response are highlighted below:

People matter – Cambodia's response was initially led by a small group of dedicated individuals, driven by a conviction that HIV posed a serious threat, long before it was visible or properly researched.

[1] It is anticipated that data from the recently completed Cambodian Demographic and Health Survey (DHS, 2005) will demonstrate a continuing decline in HIV prevalence.

Institutions are important, but… – In the absence of a functioning public health system, the early response relied extensively on NGO/civil society initiatives. Their work benefited significantly from enabling institutional and political environments. The political environment could best be described as one of non-interference, bolstered by high-level support when it was needed.

Partnership pays off – Good partnerships, drawing on the comparative advantages of government and NGOs, proved effective in combating the epidemic. Civil society/ government partnerships were based on trust and a pragmatic recognition of what needed to be done. This provided room for experimentation and innovative approaches, where the government allowed NGOs to initiate pilot interventions, and was quick to adapt these and take them to scale when they proved effective.

Outreach works – Outreach was a novel and untested approach in Cambodia when it was initiated in the early 1990s, and has been a crucial element of successful prevention efforts in Cambodia's response to the epidemic.

Information is crucial – Cambodia quickly established a nascent surveillance system, and information was used consistently and successfully by key stakeholders to guide the response and to advocate change with political leaders and donors.

The rapid increase in awareness about HIV and AIDS among the general population, over a relatively short period of time can be attributed to a combination of intensive awareness-raising activities by credible key individuals, coupled with hard-hitting messages broadcast on mass media to a population that had previously existed in an information vacuum.

Policy can wait – Cambodia's rapid and effective response targeting high-risk groups did not require a policy framework in which to operate. On the contrary, programmes largely informed policy development. However, programme approaches were significantly enhanced and sustained through the extensive debate and discussions that accompanied policy development.

HIV is an increasingly costly disease – The response has received considerable resources over the last 15 years, including multiple rounds from the Global Fund. In the early days of the response the resources available were minimal, but generally perceived as adequate. Major increases, however, have occurred in the last 4-5 years, and the available surveillance data suggest that averting new infections among more dispersed populations, and providing access to care and treatment, has become increasingly difficult and costly.

Looking ahead

Cambodia faces new challenges in sustaining its successful response to the HIV epidemic. These are outlined below, together with some suggested approaches to address these challenges.

Addressing systemic issues:

Sustaining and improving the political commitment – Continuing declines in the prevalence rates among sentinel groups could easily give rise to complacency. It will therefore be crucial to maintain

the current level of political commitment, as reduced prevention efforts can quickly lead to a renewed surge in infections.

Improving the quality of surveillance and other monitoring systems – The current surveillance system continues to be hampered by high refusal rates, inconsistent quality control, and the limited number of groups surveyed. Furthermore, the behavioural and HIV surveillance systems cover different sentinel groups in different geographical locations, thus limiting the cross-validation of prevalence and behavioural information. Adding drug users and men who have sex with men to the sentinel populations and standardising these populations across both types of surveys will help to improve the quality and consistency of the surveillance. There is also a need to supplement surveillance with further qualitative research, especially on masculinity in the Cambodian context, which may help to increase understanding of the underlying risk behaviours that continue to fuel the epidemic.

Ensuring blood safety – The blood donation system continues to be infiltrated by paid donors, while coverage and quality of blood screening remain variable. The recent grant from the Global Fund to improve the management and quality control of blood screening provides a real opportunity for the Ministry of Health to ensure blood safety throughout the country.

Integrating health services – Despite the potential for synergies, there is little integration of HIV and maternal and child health/birth-spacing initiatives, either at policy or service delivery levels. This is a critical area, especially as mother-to-child transmission is likely to become the major mode of HIV transmission in the coming years. There is a need to move away from a model that delivers services through vertical programmes, and work towards developing client-focused models that meet the needs of communities and address the rights of individuals.

Mainstreaming HIV programmes – HIV programmes remain to a large extent in the health arena, with the Ministry of Health bearing the major burden for responding to the epidemic, and focal persons for HIV being located within departments/bureaus of health within other ministries. There needs to be an acknowledgement that all ministries have to take responsibility for addressing HIV and AIDS, and ministries that do not yet have specific policies or strategies for responding to HIV should be encouraged to develop these.

Improving coordination – While the MoH has achieved considerable success in coordinating initiatives at the provincial level, this is largely health-sector driven and coordination across different sectors remains weak. A possible approach to improving coordination would be to focus on key issues such as addressing stigma, meeting the needs of orphans and vulnerable children, reaching migrants, or improving referral mechanisms.

Expanding social welfare services – The government provision of social services remains weak, and consequently, impact mitigation is limited and fragmented. While numerous pilots have exhibited innovative approaches, none of these has so far demonstrated the capacity to go to scale. The lack of a regulatory framework leaves questions on which type(s) of social service delivery the Cambodian government

would eventually want to adopt to address issues of vulnerability and impact mitigation.

Mobilising resources – While the financial contribution of the government to the response has remained fairly steady, the government has not yet demonstrated the financial commitment needed to ensure sustainability of programmes. Although Cambodia's response does not experience resource constraints at present, it is conceivable that donor resources will become increasingly more difficult to leverage – particularly as the prevalence rate continues to fall. The search for synergies, cost effective approaches and key interventions should therefore be made a priority. An improved tracking system for resources spent on HIV and AIDS will help to facilitate this.

Identifying and reacting quickly to emerging risks:

Responding to changing patterns of sexual behaviour – The BSS and other studies are beginning to reveal changing patterns of sexual behaviour of men, women and youth:- men are increasingly seeking commercial sex from women other than brothel-based sex-workers; a significant proportion of men who have sex with men, especially in the provinces, are also buying and selling sex with women; sweetheart relationships with various degrees of transactional sex pervade all age groups; and increasing numbers of young people are engaging in casual and commercial sex, often in conjunction with substance abuse. There is a need to better understand and respond to changing patterns of sexuality and their associated risk behaviours.

Addressing the needs of young people – Cambodia has an increasingly youthful population, with 60% below 25 years of age and 36.5% between 10 and 24 years of age. Increased disposable income has allowed young men greater access to recreational drugs and to casual and commercial sex, and changes in cultural norms are allowing both young men and women to be sexually active, with the attendant risks of acquiring sexually transmitted infections.

There is a clear need to address the causes and consequences of risky behaviours of young people, through expanding existing training, peer-education, sensitization and youth-friendly service initiatives. In particular, there is a need to develop and expand innovative approaches to reach vulnerable and hard-to-reach youth populations such as street-children, orphans and out-of-school youth, and respond to the sexual and reproductive health needs of a rapidly evolving youth culture.

Harm reduction – Qualitative studies indicate that the sharing of non-sterile injecting equipment may be increasing in Cambodia, especially given its porous borders, availability of cheap drugs and the rising disposable income of young people. There are concerns that increasing illicit drug use, and especially sharing of non-sterile injecting equipment, could act as new potential drivers of the HIV epidemic in Cambodia. There is a need for a strategic and comprehensive approach to harm reduction that includes needle exchange, reduction interventions, support to voluntary detoxification, drug substitution and support to socioeconomic reintegration, among others.

Incorporating the needs of men who have sex with men – This group is highly diverse, and has multiple contact points with the general, heterosexual population. There is a need to promote better understanding of risks and behaviour change to encourage consistent condom use among this group. There is also a need to involve men who have sex with men in the planning and implementation of prevention interventions.

Reaching mobile populations – There are strong indications that Cambodia's population is increasingly mobile, although the full extent of internal and external mobility is presently not well understood. The response needs to draw upon the expanding knowledge-base of these groups to develop targeted prevention programmes for these hard-to-reach and potentially at-risk mobile populations.

Safeguarding and enhancing rights:

Ensuring rights to information, services and freedom from discrimination – HIV and AIDS interventions have largely been based on the right of people to access information and services protecting them from infection with HIV. There is a need to guard against any erosion of rights while seeking to improve the rights of those most vulnerable to HIV and its impact on society. There is some concern that the successes of Cambodia's evidence-based prevention programmes could be eroded by "abstinence programmes" that stigmatise those living with HIV/AIDS and deny people information about condoms. Rather than constraining condom use there is a need to strengthen reproductive health services as an essential element of reducing HIV infection, and provide women with the knowledge to make informed decisions about child bearing and sexual health.

Focusing on gender - High levels of sexual violence and high-risk sexual behaviour of men, exacerbated by a culture of impunity and acceptance, coupled with gender dynamics that limit women's ability to negotiate sex and condom use, make women especially vulnerable to contracting HIV. There is a critical need for more interventions that address these underlying factors that continue to propagate the spread HIV. At the same time, there is a need to foster socio-cultural practices and strengthen policy and legal environments to empower women and girls and promote and protect their rights.

Finally…

"Everything flows, nothing stands still." Heraclitus of Ephesus – Cambodia's government, civil society and development partners have achieved considerable success in turning the tide of the HIV epidemic. However, it will be necessary to guard against complacency, and sustain earlier successes by continuing to respond to the tide's ebb and flow. While building upon these successes, there is a need to re-energise and broaden the response, and develop innovative and strategic approaches and partnerships to address emerging challenges.

Other countries, in nascent stages of the epidemic, need to guard against another kind of complacency – that they will not be seriously affected by HIV. As the UNAIDS Executive Director Peter Piot has

noted, “globally there is more than one pandemic – there is a multiplicity of epidemics at different stages”. A key lesson learned in Cambodia is that a proactive and dynamic response pays major dividends – in terms of efficiency, cost-effectiveness, and above all in helping to ensure that men, women and children have a future that is free of HIV.

1 OVERVIEW

"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has." Margaret Mead, Anthropologist

1.1 Introduction

Cambodia is one of the few developing countries on track to meet Millennium Development Goal 6 – to halt and begin to reverse the spread of HIV and AIDS by 2015. Estimated adult HIV prevalence has decreased from a high of 3% in 1997 to 1.9% in 2003. The incidence of HIV infection has been consistently declining among most sentinel groups, while mortality due to AIDS appears to have stabilized. These achievements are particularly remarkable in a country that has recently emerged from over 20 years of violent conflict, and which is still in the process of rebuilding human resources and rehabilitating physical infrastructure. Post-conflict Cambodia was characterized by weak health infrastructure, limited public health expertise and a fragile political environment, but a high level of commitment and action from both the government and civil society to address the HIV epidemic.

This study outlines the trajectory of the epidemic in Cambodia and describes the key elements that contributed to its reversal. The study identifies the resources that were mobilized and utilized in the response, highlights the roles of key actors, and outlines the decisions on strategy, programmes, resource allocation and policy formulationthat have been most effective in the response. The study also reflects on lessons learned for Cambodia, and how these may apply to other countries at various stages of the epidemic. Finally, the study outlines some approaches to address emerging challenges.

While the study involved extensive research of documentation going back over 15 years, the authors acknowledge that this may not have been exhaustive, as some early documents were untraceable. As a retrospective review the study drew heavily on the recollections of a diverse set of key informants, some of whom are no longer in Cambodia. It is well known that memory is predisposed to recall achievements and successes, and that failures and disappointments are more easily forgotten. The authors therefore acknowledge that Cambodia's response, as presented in this study, may appear measured and seamless, whereas the reality was likely more ad hoc and reactive. However, this should not detract from the achievements and commitment of those who overcame personal and institutional setbacks, and pioneered and sustained the response.

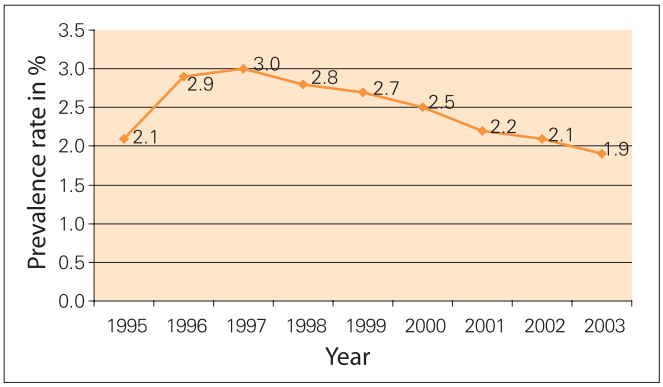
Cambodia's response to the epidemic illustrates the effectiveness of a collaborative and pragmatic programmatic approach in the setting of a developing country recently emerging from civil and political conflict. There are indications that the initial response

to the onset of HIV in Cambodia, although limited in scope and resources, was critical in turning the tide of the epidemic.

1.2 The Trajectory of the Epidemic

Since HIV was first identified in the blood supply in 1991 it is estimated that 94,000 people have died of HIV-related causes (NAA, 2003) and currently 123,000 people (66,000 males and 57,000 females) are living with HIV or AIDS (NCHADS, 2003). The most recent estimates indicate that adult prevalence rates of HIV have decreased from their peak at 3% in 1997 to 1.9% in 2003. Trend estimates from successive rounds of the HIV Sentinel Surveillance (NCHADS, 2004) suggest that HIV incidence peaked in 1994/95 and has now stabilised (Vonthanak et al, 2004). Reduced risk behaviour, improved STI management and an increasing numbers of deaths in recent years as the epidemic matures have all contributed to the drop in prevalence (Vonthanak et al, 2004). The estimated number of adults infected by HIV dropped from more than 158,000 in 1997 to 123,000 in 2003, with the number of new infections running at an estimated 8,000 a year in 2003.

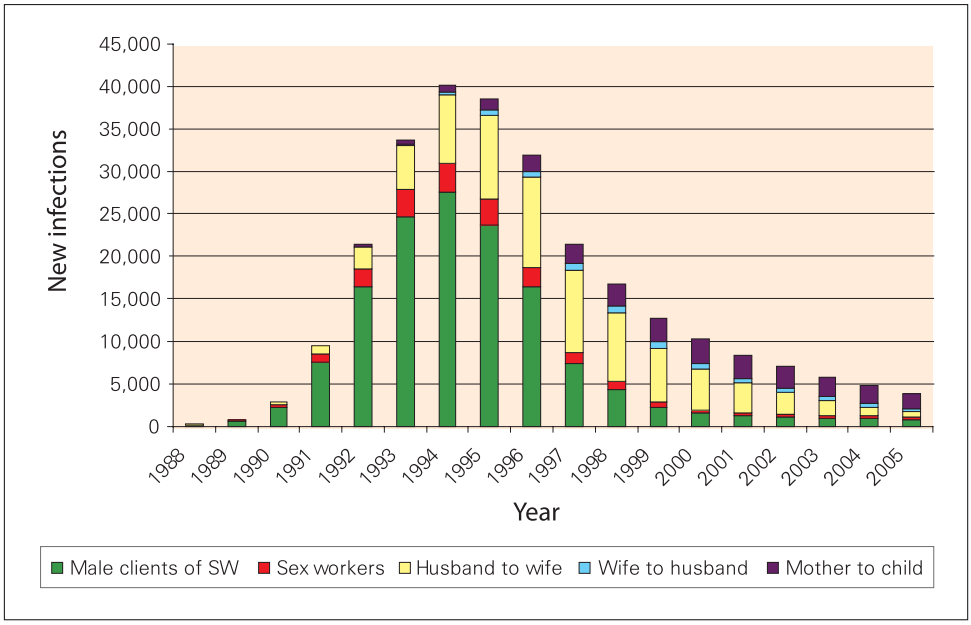
Figure 1: Estimated National HIV Prevalence among Adults Aged 15-49, 1995-2003



Source: NCHADS, 2004. Generated by EPP-Multi software and based on trends in prevalence

Prevalence rates have dropped in all high-risk populations included in HIV surveillance, except pregnant women attending ante-natal centres (NCHADS, 2004). Although the prevalence rate in this group appears to be stable, women make up an increasing proportion of people living with HIV or AIDS, and the major modes of transmission of HIV are now from husband to wife and from mother to child (Figure 2).

Figure 2: New infections by transmission routes



Source: Cambodian Working Group on HIV/AIDS Projection, 2002. Generated by EPP-Multi software and based on trends in prevalence

1.3 Elements of Success

There were a number of key elements that facilitated, and continue to facilitate, Cambodia's success in combating the spread of HIV. These include the early initiation of surveillance, qualitative research and analysis leading to evidence-based programming that targeted key populations, coupled with a dynamic condom social marketing and distribution programme. The response was significantly assisted by informal but good collaboration between government and non-governmental partners. While the early response was largely driven by donors and the UN, and implemented by NGOs, their work benefited significantly from enabling institutional and political environments. The political environment could best be described as one of non-interference, bolstered by high-level support when it was needed.

An emerging civil society response, including strong civil society advocacy, led to the early piloting of care, support and treatment projects by NGOs in the face of initial donor reluctance to support these initiatives.

The government established appropriate institutional bases to support the development of innovative NGO projects, and was responsive in assuming ownership and facilitating scale-up of successful initiatives.

Cambodia has been able to attract significant financial resources to address the epidemic, and while these were limited

in the early days of the response, financial resources were mobilised at the right time and were generally adequate to meet programmatic needs.

The major elements of success of the response are reviewed in the following sections.

a) Early initiation of surveillance

Surveillance was a critical factor driving Cambodia's response to HIV. In 1992, HIV testing of small sample populations revealed an HIV prevalence of around 10% among sex workers. The first comprehensive round of HIV Sentinel Surveillance (HSS) in Cambodia in 1995, which included eight different population groups across nine provinces (including those along the Thai border), provided evidence of a concentrated epidemic with HIV prevalence rates up to 38% among female sex workers, 8% among the police and military and 2.6% among women attending ante-natal clinics (ANC). In 1995, the first, admittedly limited, Behavioural Surveillance Survey (BSS) was undertaken. In the following year the HSS was expanded to 18 provinces, although it was limited to five population groups (brothel-based female sex workers, military, police, TB patients and women attending ANC).

In addition to providing essential data on the evolving pattern of the epidemic, the information provided a powerful advocacy tool for programmers to use in convincing politicians, policy-makers and donors to support early HIV interventions.

In 1996, the HIV Sentinel Surveillance Programme was expanded to include a STI Prevalence and Behaviour Survey. This survey provided the first insight into the epide-miology of sexually transmitted infections in Cambodia, and identified high risk groups and behaviours. In 1997, a comprehensive Behavioural Surveillance Survey (BSS) was conducted, which provided the baseline data used to establish the sexual behaviour trends in Cambodia (NCHADS, 2003).

The BSS measures and tracks trends in the sexual behaviour of sentinel groups, which include brothel-based sex workers, police, military, motorbike taxi drivers and women working as beer promoters or in the entertainment industry (colloquially known as "indirect sex workers"), using a consistent methodology.

To strengthen Cambodia's surveillance system, the World Health Organisation (WHO) promoted the idea of consensus workshops, where a group of experts comes together with local surveillance teams and interprets the data in countries with limited HIV surveillance experience. Unlike some other countries, Cambodia welcomed the input from experienced epidemiologists and surveillance experts, and made good use of them as a resource. Long-term relationships were established that facilitated Cambodian doctors securing scholarships for post-graduate study in public health and epide-miology, thus gradually building local capacity.

Good surveillance continues to be a key component of Cambodia's response to HIV. HSS and BSS are undertaken every 12-18 months, and have been expanded to include 10 population groups with an increased geographical coverage. Cambodia is considered to have one of the most advanced surveillance systems among developing countries.

b) Innovative qualitative research

The national surveillance system has been supplemented by a number of in-depth qualitative studies and surveys of knowledge, attitude, behaviour and practices. Some key studies, undertaken by the Municipal Women's Association, Redd Barna, Pharmaciens Sans Frontiers, WHO and Care International, were completed by 1994. These studies identified high risk behaviours, together with the values and attitudes that perpetrated them, thus providing an evidence base that ensured that programmatic responses were appropriate and well targeted.

A seminal study undertaken by Care International in Cambodia, "Men are Gold, Women are Cloth" (Phan and Patterson, 1994), revealed significant high-risk sexual behaviour of men and highlighted the effect of gender inequality on vulnerability to HIV in Cambodia. The study found that there was a widespread belief that men have uncontrollable sexual needs that generally cannot be satisfied by their wives, thus necessitating visits to sex workers (male or female).

Unfortunately, gender inequality is probably the area in which the least progress has been made during the 15 years of the response in Cambodia, and it continues to fuel the epidemic to this day. The Care report was also the first to highlight the complexity of attitudes and behaviours in Cambodia related to men who have sex with men, another area which remains inadequately addressed by HIV prevention initiatives in Cambodia.

c) Evidence-based targeting of key populations

A major outcome of the early surveillance and qualitative research was the identification of key populations, which facilitated targeted interventions that were instrumental in helping to contain the disease in its early stages. Early surveys revealed large regional differences in condom use, and highlighted the need to target female sex workers and their clients, especially uniformed servicemen and mobile men (men working away from their places of residence). Later surveys revealed changing patterns of high-risk sexual behaviour, including a gradual evolution from brothel-based sex to relationships with women in the entertainment industry. More recently, surveys and other qualitative studies revealed low levels of consistent condom use by non-commercial sexual partners, colloquially known as 'sweetheart relationships'.

Early prevention efforts therefore focused heavily on brothel-based sex workers and their clients, predominantly in the encapsulated brothel areas of Phnom Penh and the border towns. Early interventions by NGOs and the Phnom Penh Municipal Health Department included renting rooms in the brothel areas and providing STI services, condoms and information to sex workers and their clients. There are indications that these intensive and focused efforts were instrumental in helping to contain the early epidemic.

These limited, but possibly critical, interventions were the early predecessors of the 100% Condom Use Programme (100% CUP) that is considered to be a central component

of Cambodia's prevention efforts. The rapid uptake in condom use has played a significant role in turning the tide of the HIV epidemic and achieving the early peak in incidence.

Early prevention efforts also focused on the uniformed services. In 1995 the HIV prevalence in the military was 5.9%, and by 1997 this had increased to 7%[2]. Effective programming, including peer education supported by strong advocacy by key personnel in the Ministry of National Defence, together with a dynamic condom distribution programme, resulted in a notable increase among the military in consistent condom use with sex workers – from 43% in 1997 to 70% in 1999. In the same period, the percentage of military men reporting accessing sex workers in the previous month fell by half, from 65% to 33% (NCHADS, 1999). Prevention efforts among the police have also demonstrated some impact on consistent condom use with sex workers, although this is less marked than that demonstrated by the military.

As the civil conflict receded, Cambodia opened up to trade and migration, and the epidemic became more generalized. While brothel-based sex workers and their clients continued to be a major focus of prevention efforts, programmers and policy makers identified the need to develop prevention approaches to reach other at-risk and vulnerable groups.

As the epidemic moved into the general population, and married women and their children became numerically the largest "at-risk" groups, there was a need to develop appropriate prevention interventions to reach these increasingly vulnerable populations. While this became a growing concern for programmers in the late 1990s, the retrospective estimations of new infections indicate that husband to wife transmission may have been the largest source of new infections as far back as 1997.

The rapid expansion of access to Voluntary, Confidential Counselling and Testing (VCCT), from 6 centres in 1996 to 109 in 2005 (NCHADS, 2005), and the establishment of a Prevention of Mother-to-Child Transmission (PMTCT) programme are key initiatives helping to reduce HIV transmission to these vulnerable groups, although this approach is constrained by the low numbers of women attending ante-natal care and giving birth in medical facilities. Other vulnerable groups that are now being targeted for prevention efforts include mobile and migrant populations, factory workers, hospitality workers, uniformed services, and people in institutional settings such as prisons and orphanages.

d) Effective condom promotion

A key component of the response was the highly effective condom promotion, social marketing and distribution programme. Number One, the condom brand socially marketed by Population Services International (PSI) was launched in December 1994 and is the most widely used and available brand in Cambodia. In the month of its launch, 99,000 Number One condoms were sold, and sales to date are in excess of 160 million.

[2] No data on HIV prevalence in the military is available after 1997, due to design changes in the HSS.

Approximately 20 million Number One condoms are sold annually, with a significant proportion being used by sex workers and their clients, as part of Cambodia's 100% Condom Use Programme (100% CUP). There is evidence that the 100% CUP is playing a major role in containing the epidemic among brothel-based sex workers, with the most recent data demonstrating that approximately 95% of sex workers report consistent use of condoms with clients. However, the data also reveals much lower consistent condom use (54%) by sex workers within longer-term relationships (sometimes know as 'sweetheart relationships') (NCHADS, 2004).

A strength of the 100% CUP was the involvement of a number of key ministries, which helped to provide a supportive institutional environment. However, an unintended consequence of the success of the 100% CUP is the strong association of condoms with illicit sex and HIV prevention. It is thought that condom use in marital relationships and longer-term relationships remains low, in part because of this association and in part because most men are not prepared to use condoms with their regular partners or wives.

While Cambodia's HIV prevention programmes have clearly demonstrated success, prevention activities addressing the causes of risky behaviour are presently limited, and there are few programmes specifically targeting married men and women or addressing condom use in long-term relationships.

e) Piloting of care, support and treatment programmes

By the mid-1990s the number of people living with HIV had risen to around 150,000. It was estimated that about 7,000 people developed AIDS in 1997 (Cambodia Working Group on HIV/AIDS Projection, 2002), and there was an increasing need to address the care and support needs of people living with AIDS. However, this was not yet on the national agenda and was consequently given low priority by government and donors. Furthermore, Cambodia's health system had inadequate infrastructure to deliver even basic health services, and was woefully ill-equipped to accommodate any additional disease burden.

It was against this backdrop that in 1998 a pilot home-based care project for People Living with HIV or AIDS (PLHA) was launched in Phnom Penh, implemented by a partnership of the Ministry of Health and NGOs. In February 1999, at the end of a successful pilot phase, the AIDS Care Unit of NCHADS took over the responsibility for implementation and scale up of the project, with Khana providing technical and financial support to local implementing NGOs.

Under the leadership of NCHADS, the home-based care programme has since undergone a rapid scale-up, with organisations such as World Vision, Care, Servants and Khana supporting home-based care teams. With the support of municipal and provincial home-based care networks, 261 home-based care teams are now providing services to PLHA in 56 operational districts located in 17 provinces. (NCHADS, 2005).

Underpinning the development of the home-based care programme was the concept of the "Continuum of Care" (CoC), which was envisaged as a dynamic set of support services that PLHA and their families could access. The Ministry of Health's Strategic Plan for HIV/AIDS 2001-2005 emphasized the importance of the CoC in addressing the needs of PLHA and their caregivers, but it was only in 2003 that the Operational Framework for the Continuum of Care was launched.

A critical element of the CoC is the effective participation of PLHA. The first PLHA support group was established by World Vision in 1995 as part of the Ponleu Chivit Testing Centre. The centre provided free testing and counselling and psycho-social support services by PLHA, to PLHA. The number of PLHA support groups has grown rapidly, to 24 in 2002 and to 415 in September 2005 (NCHADS, 2005). There are 38 PLHA support groups in Phnom Penh, with the remainder spread across more than half of the provinces. While linkages between these groups and to health services are variable, these linkages are being improved through the institutionalization of the Continuum of Care. An innovative component of the CoC was the establishment of Mondul Mith Chouy Mith, (Friends Helping Friends), or MMM in 2003. The MMM units, which are attached to referral hospitals, health centres or Wats, provide an enabling environment for health staff and PLHA support groups to answer questions, share experiences, and provide nutrition education and psycho-social support to PLHA and their families. To date, 20 Operational Districts (OD) in 16 provinces have established a CoC operating with at least home-based care, VCCT, treatment or referral capacity for responding to opportunistic infections, CoC Coordinating Committee, and MMM (NCHADS, 2005).

Despite initial donor resistance, NGOs in Cambodia took the lead in providing anti-retroviral therapy (ART) to the poor, with MSF and MDM initiating pilot projects in 2001. The government carefully monitored the projects, and once their concerns were alleviated, the national programme assumed responsibility for scale-up. The number of active patients on ART has increased dramatically in the last three years, with more than 50% of the total number of adults with AIDS on ART by the end of 2005. As of 30 September 2005, 12,355 active patients were receiving ART, of whom 1,071 were children (NCHADS, 2005).

f) An emerging civil society response

Civil society in Cambodia is generally understood to mean all organisations, associations and interactions that exist outside of government. The main manifestation of civil society in Cambodia has been non-governmental organisations (NGOs).

NGOs working in the health sector (including HIV and AIDS) generally enjoy stronger relations with the government compared with other sectors. Three networking NGO organisations play a key role in the HIV/AIDS arena: MEDiCAM, which was established in 1989 is an umbrella/networking organisation for health NGOs, whose large membership helps to build credibility with the Ministry of Health. The HIV/AIDS Coordinating Committee (HACC), which was first established in 1993, has evolved into an umbrella organisation for NGOs working in HIV/AIDS. The Network of Cambodian People Living with HIV/AIDS (CPN+) is a young and growing umbrella organisation. All three organisations are currently represented on the Country Coordinating Mechanism (CCM) of the Global Fund.

While civil society in Cambodia can presently be described as both nascent and fragile, NGOs have been instrumental from the early days of the HIV epidemic in advocating for, and implementing, interventions. Civil society advocacy led to the early piloting of care, support and treatment projects by NGOs, in the face of initial donor reluctance to support these initiatives. Acting on the advice of key technical staff, the government provided political space for NGOs to initiate innovative projects, and established appropriate institutional bases to support the evolution of these initiatives, as outlined in the section below. The government was also responsive in assuming ownership and facilitating scale-up of successful NGO projects.

Civil society continues to play a critical role in the response; the success of the Mondul Mith Chouy Mith (MMM) Units and the broad implementation of the Continuum of Care rely on the effective participation of civil society, and particularly on support groups for people living with, or affected by HIV or AIDS.

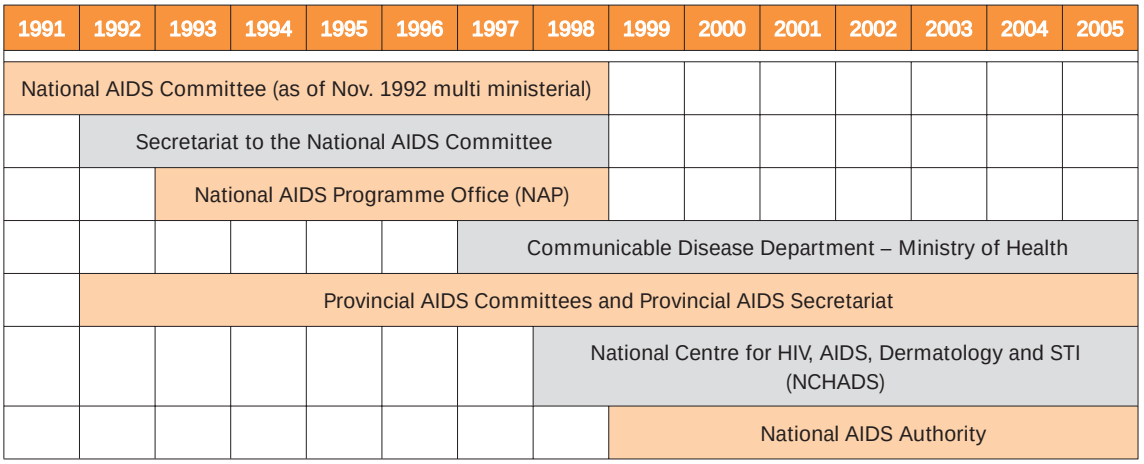
g) An enabling institutional and political environment

Following the detection of the first HIV case in 1991, the government reacted swiftly. Despite a difficult and unstable political environment, institutions and planning frameworks were quickly established by the technical staff of the Ministry of Health (Figure 3).

In 1996, as part of negotiations for a World Bank loan for HIV prevention, the central-level institutions coordinating the HIV/AIDS response were revised. While a Communicable Disease Control (CDC) Department was created in the Ministry of Health in 1997, the National AIDS Programme was never integrated into this structure, and instead, in 1998, the National Centre for HIV, AIDS, Dermatology and STI (NCHADS) was set up. The multisectoral National AIDS Authority (NAA) was established by Royal Decree on 1999, headed by the Prime Minister.

Provincial AIDS Committees (PAC) and Provincial AIDS Secretariats (PAS) were

Figure 3: HIV and AIDS: National institutions in support of HIV/AIDS



quickly established, designed to act as multisectoral committees under the leadership of a deputy provincial governor. However, observers noted that these committees were not functional in most provinces. At the same time, Provincial AIDS Offices were established within the Provincial Health Departments of the Ministry of Health. These proved to be more effective and they presently provide the major thrust for provincial HIV and AIDS interventions under the direct supervision of the National Centre for HIV, AIDS, Dermatology and STI (NCHADS). Recognising the potential threat of HIV to Cambodia, a short-term plan on AIDS was drawn up in 1992, followed by a Comprehensive National Plan in 1993. These plans provided broad but useful guidance in the early days of the response. Despite the absence of policy and legislation, key officials in selected ministries, notably National Defence and Interior, recognised the threat posed by HIV, and began to initiate prevention programmes.

1.4 Resourcing the Response

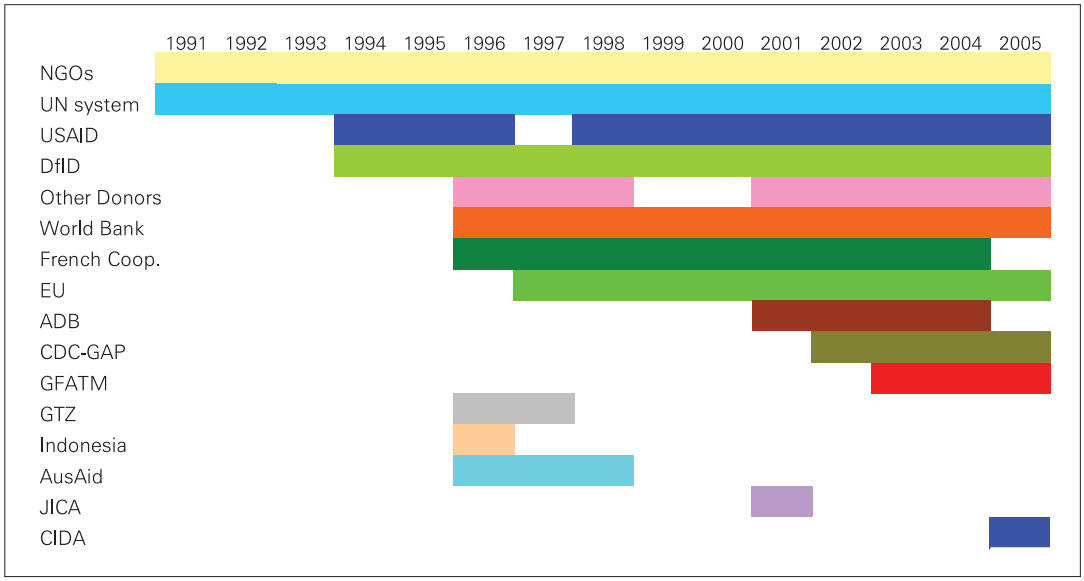
In 1991, WHO was among the first international organisations to support early HIV interventions in Cambodia, through the Global Program on AIDS (GPA). The initial funding supported capacity building and the establishment of the first institutions. Subsequent funds from the GPA supported the establishment of a technical working group and a small office in the Ministry of Health, and sending key staff to Thailand for training. A medical officer in charge of AIDS was based in the WHO office from 1992. The implementation capacity of the government institutions was very limited at this stage, and only small amounts of funds could actually be programmed and spent.

USAID, which was providing assistance to rehabilitation and relief efforts in the country, contributed about $1 million to the response in 1994. USAID and DFID supported Population Services International (PSI) to launch their condom promotion and social marketing programme, targeting sex workers concentrated in various parts of the country. In the following year, the French Cooperation (FC) launched the National STD Programme, further strengthened by European Union (EU) support through the Institute of Tropical Medicine, Antwerp, in 1997. Also in this year, a loan from the World Bank facilitated the implementation of the first Behavioural Sentinel Surveillance (BSS).

These major donors have continued to support the response to Cambodia's HIV epidemic, (although USAID funds were temporarily withdrawn in 1997 as a result of political instability in Cambodia). NGOs have provided their own funding since 1991/1992, when Redd Barna (Save the Children-Norway) and World Vision first supported HIV/AIDS-related projects. In 2001, the Asian Development Bank (ADB) began providing substantial funds to the response, and in 2003 Cambodia successfully attracted the first of several rounds of funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Direct financial support has also been provided by the governments of Indonesia, Australia, Japan, Canada, and Germany (Figure 4).

As a proportion of total overseas development assistance (ODA), resources for HIV and AIDS were a miniscule 0.2 percent in 1993. This has changed over time however, and funding support to HIV and AIDS has shown a steady increase, reaching 12.8 percent in 2005 (Figure 5).

Figure 4: Donor timeline



Investments in HIV and AIDS grew steadily, but accelerated rapidly after 2000. It must be noted that some problems were encountered in establishing the resource allocation from 1998 to 1999, and the figures in the graph below (Figure 5) are based on best estimates. Nevertheless, the increase is certainly more pronounced as of 2001, which can be explained by the scale-up of prevention programmes and the emerging emphasis on treatment.

Figure 5: Share of HIV/AIDS resources to total ODA in Cambodia, 1993-2005

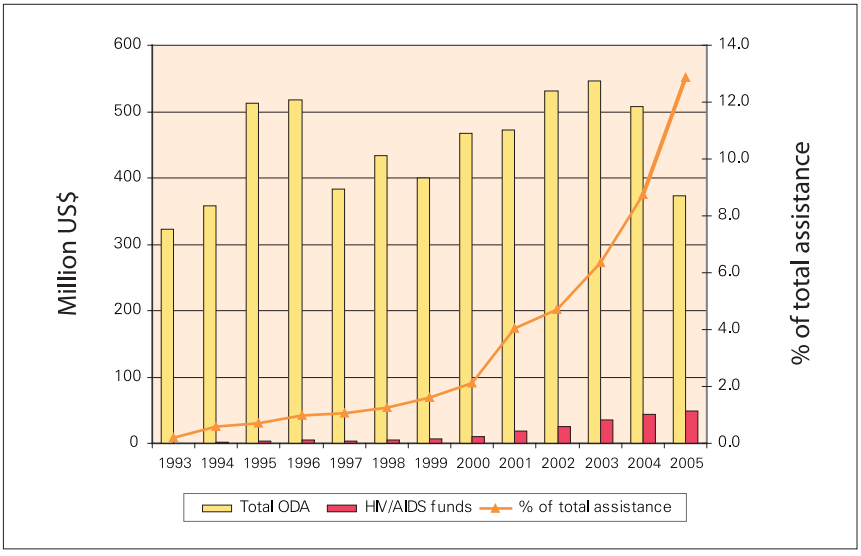
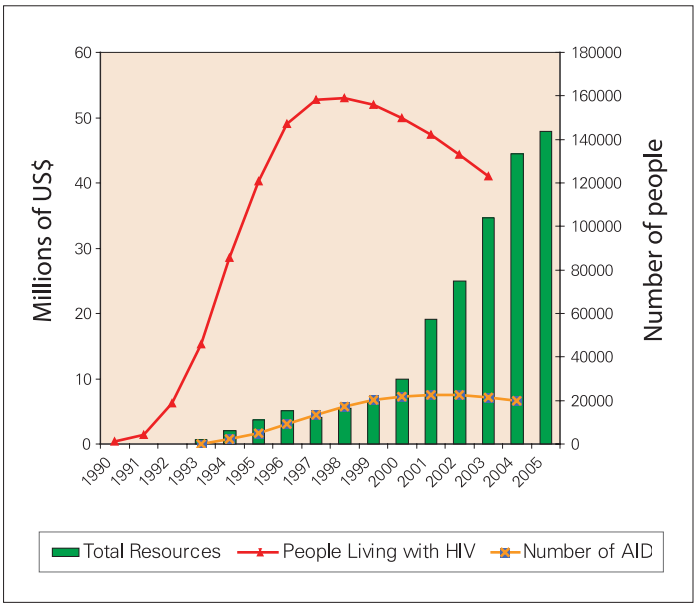
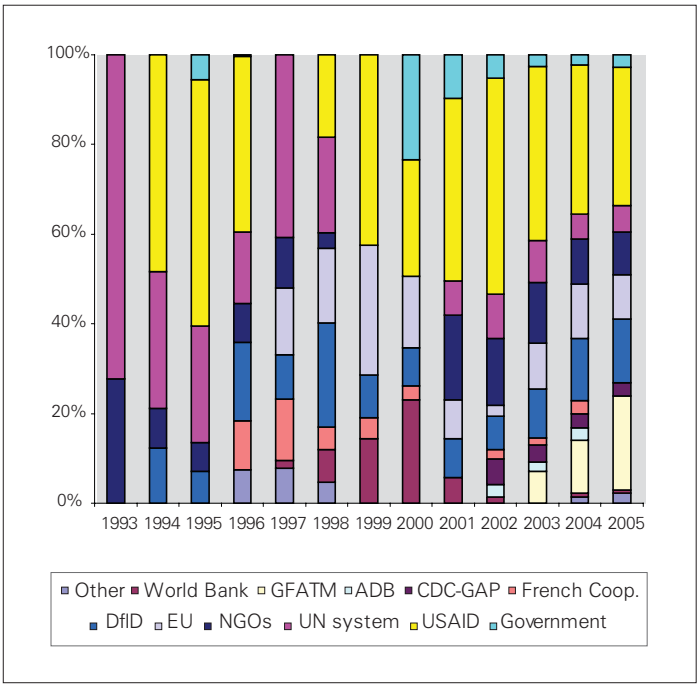


Figure 6: People Living with HIV, number of AIDS cases, and total resources, 1990-2005



It is important to note that the major investments in HIV/AIDS arrived well after the peak in prevalence. The peak in incidence occurred even earlier, and it can be assumed that the prompt and effective allocation of resources available at that time, while limited, contributed significantly towards this turn around in the epidemic (Figure 6).

Figure 7: Distribution of resources by source, 993-2005



With the increasing amounts available from a growing number of donors, the weight of individual donors to the response changed considerably over time. From an initial UN-driven response, soon complemented by USAID funds, the portfolio of donors has diversified substantially. While USAID remains the single largest donor, other bilateral donors as well as the Global Fund provide for an increasing share of the response. The government contribution remains modest in both total and percentage.

2

PRE 1991 - CAMBODIA FACES A NEW DRAMA

Key features

- *civil war, isolation and embargo*
- *physical infrastructure severely damaged or destroyed*
- *lack of qualified human resources*
- *absence of reliable health information*

From an institutional and political perspective, Cambodia was ill prepared to face an HIV epidemic. While the epidemic was already well established in neighbouring Thailand by the late 1980's, Cambodia was only just emerging from more than 20 years of civil war and isolation. In a period of less than four years the Khmer Rouge had destroyed the fabric of the society and inflicted serious damage on the infrastructure of the country. During the 1980s Cambodia was under a United Nations-supported embargo, and its contacts with the outside world were reduced to countries aligned to the Soviet bloc. Only a few selected international organisations ran emergency operations in the country. Since the government of the State of Cambodia was not recognised by the United Nations, UN agencies, with the exception of UNICEF, did not have a field presence in Cambodia in the 1980s. Nevertheless, programmes aimed at rehabilitating infrastructure and building human resources to fill the gaps left from the Khmer Rouge period started in the 1980s. However, the needs were tremendous and resources were limited. Moreover, the continuing civil war along the Thai border absorbed large parts of the government budget for defence.

Cambodia started opening up to the rest of the world following the initial withdrawal of a portion of the Vietnamese troops in 1989 and the collapse of the Soviet Union which had basically financed the Cambodian government through the 1980s. This paved the way for negotiations of a comprehensive peace settlement. In anticipation of the peace agreement, UN agencies started opening liaison offices in Phnom Penh in 1990.

Health information on this period is scarce, and no information on HIV is available. The Pasteur Institute in Phnom Penh had carried out HIV testing among 257 blood donors in 1987 and in 50 children of female sex workers in 1991, and no HIV was detected. The time and method of introduction of HIV into Cambodia remain unknown. However, the strains of HIV found in early surveillance were of a regional variety, indicating that it was being spread through contact with neighbouring countries. There is evidence of a well-established sex industry within the country in the mid-1980s. There is anecdotal evidence that cross-border exchanges occurred through smugglers on an island off the coast of Thailand and Cambodia and that sex workers were available on that island. The Cambodia civil population in the area was largely confined to refugee camps along the Thai-Cambodian border, and little is known about contact between the Thai population and the armed units of the Cambodian factions operating along the border areas.

Box 1: Cambodia's public health system in the 1980s and reform of the 1990s

The Khmer Rouge period saw the health system depleted of skilled human resources. Educated Cambodians—teachers, managers, doctors, nurses and other skilled professionals—were specifically targeted by the Khmer Rouge and almost completely wiped out. It is estimated that only 50 medical doctors remained in the country after the fall of the Khmer Rouge in 1979. While the Vietnamese and other socialist countries provided technical advisors and support to train a new generation of medical and nursing personnel, the emphasis was placed on quantity rather than quality in order to fill vacant positions as soon as possible. Furthermore, the choice of students who had completed secondary and high school was limited, due to the long interruption of education services. UNICEF and a handful of NGOs provided training, support for service delivery, and funds for infrastructure rehabilitation. However, this assistance was geographically limited, as large parts of the country remained inaccessible, often due to the presence of land mines.

The State of Cambodia had a strongly decentralised system of governance, due to the dilapidated infrastructure, limited communication technology and the continuing insecurity. Staffing and financing of health facilities were delegated to the provincial governors. Grant (1989) noted the following short-comings of the public health system:

- *lack of a clear public health policy;*
- *lack of health information systems and planning capacity;*
- *lack of resources, including trained human resources;*
- *existence of a vertical service delivery structure in areas such as malaria and Expanded Program of Immunisation, which was parallel to existing health structures; and*
- *lack of coordination among different units of the Ministry of Health. In the 1990s the Ministry of Health embarked on a reform of the public health system. Assistance through UN Agencies and International NGOs has been consistent and important in size. As a result, the health sector is often considered as more advanced in its reform efforts. The coordination among donors, international health service providers and national institutions has generally a better reputation than in other sectors. Investment in human resources has been important, and the number of health personnel has consistently increased in the last 15 years.*

The framework for health development was provided through national health development plans (see Figure 8). While there was no overriding planning document guiding health interventions from 1997 to 2002, many innovative interventions were piloted and rolled out, such as the population-based operational health districts, decentralised planning approaches and contracting of entire districts to private, not-for-profit service providers.

Figure 8: Health – National health planning and strategic approaches

1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Transitional Health Plan													
		National Health Development Plan											
				Operational Health Districts, District Operational Plans, Contracting									
											Health Sector Strategic Plan 2003-2007		

3

1991-1993 SETTING THE STAGE & IDENTIFYING THE ACTORS

Key features

- *first cases of HIV detected*
- *huge economic and social changes due to presence of 20,000 UN Peacekeepers*
- *350,000 people returned from refugee camps are resettled and reintegrated*
- *information on HIV prevalence starts being collected, but not yet systematically*
- *a few key actors initiate small-scale HIV awareness programmes and targeted interventions*
- *HIV/AIDS Coordinating Committee (HACC) formed*
- *development aid concentrates on rehabilitation of physical infrastructure*
- *HIV prevalence begins to decrease in Thailand and Uganda*

The Paris Peace Agreement, signed in 1991 by the four Cambodian factions, called for a comprehensive settlement of the Cambodian conflict. The factions agreed on the establishment of the Supreme National Council (SNC) to act as the Cambodian sovereign body during a transition period. The United Nations Transitional Authority in Cambodia (UNTAC) was given the authority to place all administrative agencies in the fields of foreign affairs, security, finance and information under its orders until an elected constituent assembly was in place. Elections were held in 1993 and were widely hailed as successful and declared as free and fair. There were critical voices however, and Grant notes: "Although election campaigns the world over often feature little debate, Cambodia's UN-sponsored election campaign was devoid of substance, including any real vision of the future of the country" (Grant, 1998, p19).

Box 2: The blaming game

At that time, UNTAC was the biggest UN operation ever initiated. Over 20,000 military and civilian personnel were deployed in Cambodia. The budget of the entire operation exceeded US$ two billion, and up to 60,000 Cambodians were employed, paid in US dollars and often stationed away from their families. A number of voices, including Cambodian politicians, initially blamed UNTAC for the spread of HIV in Cambodia, in part because UNTAC personnel were seen extensively in brothel areas. However, it has been demonstrated that HIV arrived earlier in Cambodia and that the virus was of a regional variety. Nevertheless, data received from UNTAC for late 1992 indicated a dramatic increase in the number of UNTAC personnel diagnosed with STIs. From 161 cases in September 1992 the number rose to 666 cases reported in December 1992 (Ministry of Health, 1993).

The UN mission did not have a strategy on HIV, or even a code of conduct. This was deplorable in a highly visible mission that was of crucial importance for the credibility of the UN. The inference is that while UNTAC may not have been responsible for the arrival of HIV in Cambodia, its personnel may have played a major role in the escalation of the epidemic.

The elections of 1993 resulted in a power sharing arrangement, and law-makers and politicians were preoccupied with consolidating their power bases. This was a major constraint to pursuing a coherent development agenda. In addition, the terms of the power-sharing agreement required the integration of substantial numbers of partisans of the different factions in the civil administration. While the armed forces pursued a similar approach, the separation of units was in some cases maintained, which led to continuing tension between units who were aligned to different political parties.

The Peace Agreement opened the door for aid to flow again to Cambodia. Parallel to the deployment of the UN mission, the technical agencies of the UN began opening offices in the country. Initially, major efforts were directed towards the rehabilitation of infrastructure, demining, and the reintegration of 350,000 returnees from the border camps. NGOs played an important part in this effort as the government had an open door policy to non-governmental actors, and many NGOs that operated in the border camps set up programmes in Cambodia.

Box 3: The blood business

Blood collection prior to 1991 included collection from military personnel, as well as paid donations from the civilian population. In April 1991 the International Committee of the Red Cross (ICRC) assisted the National Blood Transfusion Centre (NTBC) to introduce HIV screening in the blood donation programme. HIV was detected in the blood supply immediately and provided the first reported HIV case in Cambodia. By December 1993, HIV prevalence among blood donors had reached 1.97%.

The introduction of screening was supported by a new policy of recruiting from relatively low risk populations and stressing voluntary donation. This was done mainly through mobile collection units. However, replacement and family donors continued to be accepted by the NTBC, and these types of donors continue to be the dominant form of donations to date, representing about 80% of all donors. These donors are often paid for their donation and tend to carry a higher risk than voluntary donors. The recruitment of voluntary, low-risk blood donors remains an ongoing challenge.

The ICRC ended its support to the Blood Bank in 1996. Continued technical support was provided through WHO and CDC-GAP,

while the Korean Red Cross supported the Cambodian Red Cross (CRC) programme to recruit voluntary donors in Phnom Penh and Battambang. All blood donations collected at the NBTC in Phnom Penh are routinely screened for HIV, Hepatitis B and C and syphilis. Counselling for blood donors is available at the NTBC in Phnom Penh, although only 20% of blood donors return for post-donation counselling; no counselling is provided at the provincial blood banks.

Between 1991 and 1993, the number of blood donors who tested seropositive for HIV increased dramatically, and although these prevalence rates cannot be generalised to the whole population, they constituted an important part of the information available to planners and health workers at the time.

Following the first detection of HIV in donated blood in 1991, the health authorities, with support by WHO, responded swiftly. A National AIDS Committee and a Technical Working Group were established. In November 1992, the National AIDS Committee was restructured to include other ministries. At the same time, a Secretariat, located within the Ministry of Health, was established and mandated with the implementation of the National AIDS Programme. While the Secretariat was staffed initially by only a handful of people, they were well chosen and proactive in leading a nascent response, driven by their beliefs that a potentially disastrous epidemic was developing. With the tacit agreement of the political leadership, they initiated Cambodia's response. Although there was little or no pre-existing expertise in HIV among government staff, study visits to Thailand and other countries already affected by HIV proved to be a highly successful in fostering an understanding of the epidemic and its potential consequences.

Data collected in Phnom Penh in 1992 revealed the level of awareness of AIDS was reasonably high; 80% of those surveyed had heard of the disease. However, understanding was limited: 72% thought HIV could be transmitted through casual contact; 77% did not know that condoms could prevent HIV transmission; 60% thought that AIDS could be cured, and 44% felt that people living with HIV should be isolated from the general public (Ministry of Health, 1993).

Only limited information on the prevalence of STIs was available. The 1991/92 Short Term Plan reported on the STI data from the Institute of Dermatology and Venereology, which showed that 1,300 cases of STI were reported for 1989 and a further 848 reported in 1990. The Comprehensive National Plan for AIDS Prevention and Control (referred to as the Medium-Term Plan) for 1993–1998 reported on STI data from the Institut Pasteur, showing that a few patients per week sought STI testing in 1991, while by 1993 they were providing testing for at least 10 people per day.

The government allowed and even encouraged NGOs to establish the first HIV-prevention programmes. In 1993, the HIV/AIDS Co-ordinating Committee (HACC) was established by a consortium of international and national NGOs and community-based organisations (CBOs). HACC was initially a largely informal confederation of NGOs, but key government officials used HACC as an NGO reference point, participating in their meetings and drawing on their resources.

The initial response to the HIV epidemic in Cambodia relied heavily on the actions of a small number of dedicated and innovative individuals, who quickly developed an understanding of HIV transmission and the current situation in Cambodia and the region. Through attending training workshops, leadership development programmes and international exposure meetings, provided or supported by Redd Barna, WHO and other UN agencies, this group of innovators raised awareness about HIV prevention and transmission, lobbied politicians and policy makers to establish surveillance systems, national plans and institutions. This small group of individuals sought to mobilise people to join the response and change their behaviour. They also intervened when some governors and other political leaders exacerbated the difficulties of prevention efforts by closing down brothels and driving the sex industry underground. Many of these key individuals continue to provide leadership to the response today.

Box 4: A leading light

From the outset, Tia Phalla was a pivotal figure in Cambodia's response to HIV. When the National AIDS Committee (NAC) and a working group were established in 1991, they initially consisted only of Dr Phalla, who occupied a small office in the Ministry of Health. Dr Mam Bun Heng, then Director of the Dept. of Health, encouraged Phalla to select the best people to assist him. Drs Hor Bun Leng and Seng Sutwantha were the first to join Phalla, and the NAC was eventually expanded to seven members.

Phalla was quick to realise the threat posed by HIV to Cambodia, and noted that "my country was already destroyed once by Pol Pot; I was afraid it could be destroyed again by AIDS."

Phalla's passion and personal investment in addressing this threat provided inspiration to the small but committed group of individuals who formed the core of the early response, while his technical expertise, social vision and political acumen made him the ideal person to lead the response.

Phalla drew on lessons learned from Africa to raise awareness and formulate ideas, and noted that,"1992 in Cambodia looked like 1982 in Africa. In 1992 Cambodia had no AIDS patients and so this was an invisible disease". Phalla also noted however, that "there was an open society which helped discussion and the quick transmission of ideas".

As well as being a source of creative ideas, Phalla was not hesitant in translating these into personal action. He devoted a significant amount of time to travelling around the country, spending time with children and communities affected by AIDS, and transforming what he learned to advocate, sensitise and educate political and community leaders about what needed to be done to respond to the epidemic.

When municipal and provincial governors closed down brothels in 1995, forcing the sex trade underground, Phalla personally intervened with key government authorities to have the establishments re-opened so that the nascent 100% Condom Use Programme could continue.

Realising the potential of mass media to effect changes in knowledge and attitudes, Phalla convinced the Ministries of Information and Education to broadcast HIV and AIDS information on television and radio in the early 90s. Phalla appeared in a number of TV and radio broadcasts, where his high professional credibility provided an authoritative voice to reinforce messages about safe sex and use of condoms.

Condom promotion was still a sensitive issue in the early 90s, and Phalla remembers being summoned to the Council of Ministers and having to justify the need for condom posters to the members of the coalition government. Phalla recalls, "I had to answer to two Prime Ministers". Phalla explained about the need for innovative and courageous approaches to combat this new disease, and the PMs were swayed by his arguments.

As Secretary General of the National AIDS Authority H.E. Tia Phalla continued to be a key figure in the fight against HIV and AIDS, and epitomizes for many the personal commitment that has characterised Cambodia's response to the epidemic.

These key innovators also initiated the first outreach programmes, by interacting with key populations affected and infected by the epidemic. They often worked directly with sex workers and their clients, providing them with information, access to condoms and support to use condoms in brothels by teaching sex workers how to use condoms and negotiating with brothel managers to make condoms available and let their staff have access to them. The sex workers in turn spread the message to other women working in brothels outside of Phnom Penh, as they moved to brothels outside the capital.

Box 5: They would threaten us with guns, but we kept on talking

Dr Ouk Vong Vathiny has always had a special interest in women's health, and is presently the Executive Director of the Reproductive Health Association of Cambodia (RHAC). Back in the early 1990's, Vathiny worked in the Phnom Penh Municipal Health Department (MHD), and recognised the need for a sexual health clinic in the dyke area of Toul Kork, which had a large concentration of sex workers. Vathiny recalls,"there were more than 1,000 girls, maybe as many as 2,000, and the brothels were very close together."

Together with VSO doctor Liz Anderson, Vathiny persuaded the MHD to open a clinic in the middle of the brothel area on Tuol Kork dyke, with technical and financial support from WHO. Vathiny had realised that the sex workers would not come to her, but that the health services would have to go to the people she wanted to reach.

The Deputy Director of the Health Department, who was in charge of women's health in the Municipality, wasn't sure that the clinic in the brothel area was a good idea. Vathiny recalls: "She said to me 'Vathiny, I don't want to see my women doctors go to the brothels, I am not allowing you to go there'. But I explained to her that with an infectious outbreak, if we find the source we have to cure the source. She didn't want me to go there; none of my staff

wanted to go there. I said to them, 'if you don't want to go, it's your choice, but I will go. I don't know if your husband or my husband goes there, maybe they all go there, so I will go there to teach them about AIDS, before it spreads'. The other staff saw that I was not going to stop going there, so they took turns to go with me."

We rented a small brothel room once per week, and used it as a community health clinic. Soon we were opening three days per week. Liz and I would walk out along the dyke, going from brothel to brothel and talking with the girls and the brothel owners. We told them about this new disease and invited them to come for a sexual health check and free condoms. Still they did not come at first, so we held some meetings for male and female brothel owners to talk about HIV and AIDS. We asked the brothel owners to show compassion. With their permission, we made a schedule and organised the girls to come as a group from each brothel.

Some brothel owners responded well, but some were very suspicious of us. There were times when we would have to lock ourselves in the clinic, because if a girl escaped from a brothel, the owner would think we had her or that we may know where she is. The men would come and beat furiously at the door with a large stick and shout 'open the door! open the door! I want to see if my girl is here'. At other times they would try to intimidate us. For example they would put their gun on the table when we went to ask them to let the girls come to the clinic. We would go around in the morning, targeting the brothels belonging to the high-ranking officials who would not let the girls come to the clinic. They would say angrily, 'I don't have time for you'. I would smile and say 'I wont take much of your time, I am just coming to tell you about this free treatment; she will be very healthy'. They would threaten us with guns, but we kept on talking."

Early prevention efforts therefore focused heavily on brothel-based sex workers and their clients, predominantly in the encapsulated brothel areas of Phnom Penh and the border towns. Early interventions by NGOs and the Phnom Penh Municipal Health Department included renting rooms in the brothel areas and providing STI services, condoms and information to sex workers and their clients. Innovative and humorous education campaigns were devised, using comedians who travelled up and down the national highway routes, often before the roads were actually safe from Khmer Rouge strikes. Community activists went into the family homes of their staff and answered questions from worried parents and husbands.

Box 6: Who is this woman, talking about sex as if she was a man?

Kein Serey Phal, or 'Madam AIDS', as her friends nicknamed her more than 10 years ago, has been a driving force behind awareness-rasing and HIV prevention since the first mention of HIV and AIDS in Cambodia. Through innovation and sheer determination, she was spreading the word about not spreading the virus. On 24 May 1993, the day after the first free elections in 30 years, she received a letter from the King, recognising her group - the Cambodian Women's Development Association (CWDA) as one of modern Cambodia's first NGOs. Not content with establishing the first women's NGO run by and for Cambodian women, which has grown from a few women to a staff of over 100, she

has advocated for the involvement of women at all levels of decision making and implementation in the response to the HIV epidemic.

Serey Phal recalls how she first heard about HIV and AIDS. "I went to a social gathering in 1992; that night the TV was on, and the news was about AIDS, and Dr Tia Phalla confirmed that the first cases of HIV had been found in Cambodia. I heard talk about a HIV prevention training program being run by PDA in Bangkok. I thought about what they were saying, and HIV, and I thought 'it is going to be dangerous if people do not talk out, especially in my country where sex is a strange thing to talk about.' I knew I needed that training. Redd Barna sponsored me and two other Cambodians, including Dr Tia Phalla, to attend the training in Bangkok."

On her return from Bangkok, Serey Phal started her education programme in the brothel areas of Tuol Kork, providing free condoms and talking openly with the girls about sexual health. She was talking to men in the brothels too, and as long as they didn't know she was a health worker, they were happy to hear about condoms and HIV prevention from her. Serey Phal recalls the early days of HIV awareness raising: "I would sit in the brothels and order a drink and start talking to the girls working there, as a friend. This wasn't easy for me; it was hard to talk about sex. I would lie to them, saying 'I feel sad, I have a boyfriend but he left me, and I need a place where I can sit and relax. I feel proud that I could go to that area. I had never been near a brothel before that. Sometimes I felt concerned about my safety. I was the target of gossip and strange looks from people; they said 'what is that woman doing, talking about sex as if she is a man?'"

Under Serey Phal's leadership, CWDA has established itself at the forefront of empowering women through literacy and vocational training. They have anti-trafficking and women's rights programmes, and provide prevention education and counselling to reduce violence against women.

Serey Phal has maintained her commitment to human rights and to engaging and empowering sex workers. She has also provided training and support to hundreds of community volunteers, as part of the national response to HIV and AIDS. Serey Phal doesn't just talk about sex like a man; she gets things done like a women.

There are indications that these intensive and focused efforts were instrumental in helping to contain the early epidemic.

Box 7: Surrounded by epidemics

The presence of HIV was already well established in the region and neighbouring countries by the time HIV was detected in Cambodia, and it is likely that HIV took hold among the population between 1988 and 1990. The World Health Organization released figures on 1 July 1994, estimating that the number of people living with HIV in south and southeast Asia had reached 2.5 million. They projected that the cumulative total number of cases in south and southeast Asia was expected to escalate to 10 million by the year 2000 (Glob AIDS News, 1994).

In neighbouring Thailand, over 3.5% of military recruits aged 21 years were infected, and in the northern provinces, close to the Cambodian border, HIV prevalence exceeded 8% among women attending ante-natal clinics, while 20% of military recruits were infected (Glob AIDS News, 1994). In Vietnam, on Cambodia's eastern border, HIV infection levels were significant among injecting drug users (IDUs) in Ho Chi Minh City, increasing from 2% in late 1992 to more than 30% at the end of 1993 (Glob AIDS News, 1994).

The predominant mode of transmission driving the epidemic in Cambodia has always been heterosexual sex. The epidemic was initially concentrated in sub-populations whose behaviours put them at risk, and initially most new infections were contracted during commercial sex. A limited HIV Surveillance in early 1992 included brothel-based sex workers, police, military, women attending ante-natal care, and hospital TB and STI clinic patients. A total of 1,017 people were tested; HIV prevalence among STI patients was 4% and prevalence in the 207 female sex workers tested in Phnom Penh was 9%. All other groups had zero prevalence. In addition, samples collected from sex workers tested for syphilis showed 11% were HIV-positive.

The following year a small sample of brothel -based sex workers and STI patients in Phnom Penh were tested, and prevalence in the sex workers had dramatically increased to 39%, while prevalence in STI patients had increased to 9%. This indicated that HIV was spreading rapidly among those at highest risk.

From the early days of the epidemic the sex industry in Cambodia was centred on brothel-based activities. The commercial sex industry was seen as pervasive, and in the early 1990s, brothels were known to exist in every area of the country. Female sex workers generally lived in the brothels, where they were either indebted to the owner or paying some of their earnings to the owner. Many sex workers were, and continue to be, required to be available for sex any time of the night or day and they tend not to leave the areas where brothels are concentrated. In 1993, turnover of sex workers was reportedly high, and rotation of sex workers every 2–12 weeks was noted among some Phnom Penh brothels. In a survey conducted in 1993, sixty women from 57 different brothels operating in Phnom Penh reported that clients came from all walks of life – 72% had clients who were government workers and 18% had clients working as professionals, 9% had clients who were students and 9% had UNTAC soldiers as clients. Of the sex workers interviewed in 1993, 30% said they did not use condoms with their clients (Phan and Patterson, 1994).

Box 8: A not so new industry

When HIV was introduced into Cambodia there was a well-established sex industry, and a high proportion of men were patronising sex workers. Kien Serey Phal, then Vice President of the Phnom Penh Municipal Women's Association, noted in 1993 that "prostitution first began to reappear in Cambodia with economic reforms in the mid [nineteen] eighties. With the arrival of UNTAC [in 1992] there has been an increase, but it has not been that great. From six or seven thousand prostitutes in 1991 now it is closer to ten thousand." (Nette,1993)

Khmer society has been described as one where idealised traditional expectations of women coexist with sexual exploitation and domestic violence; where legislation and regulation are compromised by poverty and corruption; and where opportunities for women's economic independence are shadowed by sexual trafficking and the HIV epidemic (Hill and Ly, 2004). It is therefore not surprising to find a high level of commercial sexual activity combined with limited sexual health knowledge among women.

4

1994-1996
RAISING THE CURTAIN

Key features

- *the highest increases in new infections*
- *civil society response takes off*
- *some backlashes, with closing of brothels and arrests of sex workers*
- *first substantial condom promotion programmes*
- *surveillance is institutionalised and data utilised for programming and advocacy*
- *UNAIDS becomes operational and establishes an office in Cambodia*

In the mid-1990s, the political situation in Cambodia could be described as a complex emergency (Bernander, 1995), and it was thought that Cambodia needed to move along a relief-rehabilitation-development continuum. The presence of considerable amounts of money, limited implementation capacity of national agencies, a scarcity of local human resources and a government absorbed with other priorities left the development agenda to a large extent in foreign hands. As the Development Cooperation Report 1994-1995 (Council for the Development of Cambodia, 1995) stated: "It may be advisable for donors to continue, over the next 3-5 years, with the direct delivery of services and direct execution of projects either by donor staff or by NGOs, while Cambodian counterparts are still in the progress of enhancing their own knowledge and implementation skills."

The most recent epidemiological model indicates that new HIV infections peaked between 1994 and 1996, even though the extent and pervasiveness of the epidemic was not known at that time. The epidemic was spreading fast among those most at risk, and first indications emerged that the epidemic was taking foothold among the general population.

With technical and financial support from WHO/GPA, the Cambodian Ministry of Health developed an HIV Sentinel Surveillance (HSS) Programme in 1994. The programme has been conducting surveillance for HIV infection since 1995, and for high-risk behaviour since 1997. Based on the available data (which was limited in the early HSS), estimates of national HIV prevalence are made, along with estimates for the actual number of people living with HIV and the number of deaths from AIDS. From this data, estimates of incidence among adults and children, disaggregated by gender, are calculated.

Over the last 10 years, Cambodia's surveillance systems have undergone continual refinement and quality improvement. At first, the focus was on identifying which groups to sample, what data to include in the reports and how to ensure trends could be monitored over time. Some decisions were pragmatic; for example, it has always been difficult to find a group from whom estimates can be made about men, both high risk and in the general

population. Uniformed servicemen were chosen as the sentinel group, as much for their representation of men engaged in high-risk behaviour, as for the ease with which they could be included.

In August 1995, the World Health Organization revised the estimate of Cambodian HIV prevalence to 30,000 from the previous figure of 5,000. The figure was revised upwards again in November 1995 to between 50,000 and 90,000. “The estimated figure for HIV-infected persons in 1996 is 120,000 cases and for people suffering from [advanced] AIDS ... we [have] estimate[d] a least 1,000 cases,” Dr Hor Bun Leng of the National AIDS Programme was quoted as saying in June 1996 in AIDS Weekly Plus. “It’s a very, very serious problem. We know how to handle it, how to get the information out to the people, and how to get success, but we need more money – we need funding from any donor agency which could help”. The National AIDS Programme believed that 40,000 people or more could be AIDS patients by the turn of the century. “The WHO says we should spend at least $1 per person for the anti-AIDS campaign. In Thailand the government spent $80 million for a population of about 65 million people. But I have 10 million people and only between $200,000 and $300,000,” Hor Bun Leng said. “[In 1995] we only heard about AIDS cases in Phnom Penh, but now we get reports from the provincial level throughout the country”. He said most provincial hospitals report new AIDS cases every month (AIDS Weekly Plus, 1996)

The majority of new infections between 1990 and 1996 were in male clients of female sex workers, and a significant and growing rate of infections was taking place among married women. The 1996 HIV Sentinel Surveillance Survey found that 5.5% of police and 5.95% of the military were HIV-positive. Their reported numbers of visits to brothels were the highest of all men: 50% had visited a sex worker in the previous month and 81% had visited a sex worker in the previous year. 50% of married men and 73% of single military/police men reported having had sex with at least one brothel-based sex worker in the previous month (National AIDS Programme, 1996).

Box 9: Empowering sex workers

In 1995, Médecins sans Frontières Belgium (MSF-B) set up a clinic in the brothel area of Svay Pak on the outskirts of Phnom Penh, operated by a local NGO, the Cambodian Urban Health Care Association (CUHCA). The purpose of the clinic was to provide primary health care to sex workers, the majority of whom in Svay Pak were minority ethnic Vietnamese. The clinic staff worked closely with brothel owners and pimps to convince them to promote the use of condoms in the brothels and allow their sex workers to come to the clinic. The staff also provided life-skills training and psycho-social support to the sex workers, and educated them about their rights. A drop-in centre was established and empowerment of sex workers became an increasing area of focus of the project, providing the women with education and skills, including enabling them to better negotiate safe sex with clients. The clinic staff expanded their reach through outreach visits to the sex workers and to their male clients.

The first comprehensive round of HIV surveillance in Cambodia in 1995, which included eight different population groups across nine provinces (including those along the Thai border), provided evidence of a concentrated epidemic, with HIV-prevalence rates up to 38% among female direct sex workers, 8% among the police and military, and 2.6% among women attending ante-natal clinics.

In 1996, nine new provinces were included in the HIV surveillance. These newly included provinces had significantly lower HIV prevalence rates than those in the provinces first selected, which reduced the overall prevalence rates in 1996. However, it is possible to compare the data from the provinces along the Thai border, which were included in both rounds of surveillance. A worsening epidemic then becomes apparent. For example, in 1995, 38% of female direct sex workers in these provinces were HIV positive, and by 1996, this figure had risen to almost 47%. The mean rate in the nine newly-added provinces was significantly lower, at 34% (Phalla, Leng et al, 1998).

Table 1 provides a summary of HIV prevalence rates found in selected sentinel groups in 1995 and 1996. The table illustrates the HIV prevalence rates in selected sentinel groups in those provinces that were sampled in both rounds. These HIV prevalence rates were among the highest found in those sub populations in Asia, and exceeded the rates in neighbouring Thailand (Gorbach et al, 1997).

Table 1: Summary of HIV prevalence rates found in selected sentinel groups in 1995 and 1996, Cambodia

	Direct Female Sex Worker		Police		Military		ANC clients	
	1995	1996	1995	1996	1995	1996	1995	1996
9 original provinces	37.9	46.8	8.1	9.4	8.4	7.4	2.6*	2.5*
								3.0**
9 new provinces		33.6		3.2		4.9		1
Total	**37.9**	**40.9**	**8.1**	**5.5**	**8.4**	**6.0**	**2.6**	**1.7**

* *based on 6 provinces reporting HIV for ANC in 1995,*

** *based on 9 provinces included in 1996*

During this period people became personally confronted by HIV and AIDS, and many started to realise they knew or came into contact with people living with HIV or AIDS (PLHA) in their daily lives. The most common response was to shun PLHA and their family members, causing families reliant on commerce to lose customers, individuals to become isolated and depressed, and children to be withdrawn from school. School attendance became unfeasible for a combination of reasons: often there was not enough money to pay teachers, or the children were needed to help generate food or income for the family through working or farming. Some children experienced so much discrimination as a result of people being aware they were living with an infected person that attending school was considered too severe a burden (Men, 2005).

Teams of outreach workers from organisations such as World Vision, Care, and Save the Children-Norway (Redd Barna), conducted awareness-raising and HIV-prevention activities among people at the community level. The initial response of the people was to call their children inside and shut their doors on the outreach workers. People were too afraid of being associated with the "evils" that caused AIDS, and they thought they would get HIV from the NGO workers. Gradually however, the outreach teams gained the confidence of their target audiences and people would let them in, and even call their neighbours to come and listen.

Box 10: Confronting the challenge

Chun Bora worked for World Vision from 1993 until 1996 as the Programme and Training Coordinator, in the HIV/AIDS Prevention and Care Programme. This was one of the very first dedicated initiatives to raise awareness of HIV and AIDS and undertake prevention activities in Cambodia. They worked alongside the few other NGO's involved in responding to HIV, and the staff got together whenever possible to share training and experiences. The World Vision team used a community-based approach to their prevention work (Busza and Schunter, 2001; Dooley, 2003).

Bora describes HIV prevention as a 'hard sell' issue. He says: "Everyone thought HIV was a terrible thing, and it was hard to talk about, because it was perceived as talking about bad things, bad people, bad behaviour. No one wanted to be associated with the bad things that HIV was associated with."

Nevertheless, Bora and the three other workers went from house to house, talking about HIV and AIDS with anyone who would listen. Gradually, people would let them in or even call their neighbours to come and listen, and an awareness session would be held right away. They covered brothel areas as well as residential areas.

The outreach approach utilised in HIV prevention and awareness-raising activities gained popularity. The concept of taking the education and information, and even the services, to where people lived and worked was novel in Cambodia, and was only employed by sexual health and HIV workers. Outreach programmes were originally developed for brothel-based sex workers with very limited freedom of movement, and because people were not interested in hearing about HIV and AIDS and so would not leave their neighbourhoods to access information. The outreach approach became an essential component of the HIV response in Cambodia and has been expanded to encompass outreach to sex industry clients, garment factory workers, and staff in entertainment venues, as well as places where young people gather.

Box 11: Bringing the message home

One day a young university student was dropped off at the World Vision office in a cyclo, his name was Sopheap. He was very thin and had a bad skin disease, and he was very sick. He asked for Bora. Everyone was afraid of this sick-looking, young university student, and they would not let him inside the building. The World Vision team tried to bring him into the office while they located a hospital that would provide him with a bed. The other staff were afraid to have him inside the office, and would only allow him to stay in the parking space beneath the building. They were already ostracising the HIV/AIDS Prevention and Care team, avoiding them in the office for fear of contracting HIV from them. Sopheap's arrival at the gate was the first time any of the staff had actually seen a person visibly suffering from AIDS.

Bora and the team eventually took Sopheap in the car to try and find a service that would accept him. No one wanted to have any contact with a person with AIDS, and none of the hospitals would take him in. Sopheap's skin was flaking off and the driver did not want him in the car, as he thought he would be infected by Sopheap. Bora said to the driver, "let him sit in my seat, next to me, I am the closest to him." Eventually, late in the afternoon the Sisters of Charity agreed to accept him.

Bora went to visit Sopheap every week; he would talk with Sopheap and touch his hand to his face. When Sopheap was really sick he would cry out for Bora, and the Sisters would call him on the telephone. One day, after about 6 months, Bora was out at the Dike Road, running a training session, and the Sisters called him and asked him to come. Sopheap was ready to die, just holding on until Bora came. Shortly after Bora arrived and touched his face, Sopheap passed away. Bora recalls thinking "he was only a young man, a university student, but now he is gone." This was a tremendous turning point for the World Vision staff, who stopped shunning the HIV/AIDS team and instead asked for training and education. The compassion followed the increased understanding and brought the message home. (Busza and Schunter, 2001).

World AIDS day 1995 provided the opportunity for the first highly publicised action on HIV and AIDS. King Norodom Sihanouk hosted a "garden-party" in which youth and HIV experts participated in a question/answer session. While the King did not speak out publicly in favour of more HIV interventions, the media attention ensured that the issue received wide-ranging coverage.

Box 12: Gender dimensions of an epidemic

"Women in Cambodia do not enjoy equal access to education, paid employment, land ownership and other property rights. Women also suffer from poor reproductive health services. They are generally in a disadvantaged position in both family and society" (Council for Social Development, National Poverty Reduction Strategy, 2002, p22).

In 1994 women were described as being in a difficult situation, as prior to marriage they are expected to be virgins and innocent of sexual knowledge, and once they are married they are blamed for not having enough sexual expertise to keep their husbands faithful (which in turn justifies continued visits to brothels). Beauty was equated with youth and virginity, and sex between husband and wife was seen to be for procreation only (Phan and Patterson, 1994; Kumar et al, 2000). A more recent study of sexual behaviour and HIV/AIDS among the uniformed services (military and police) in 2002 showed that these attitudes continue to prevail. (Ramage, 2002).

Guillou (2000) interviewed 47 women working in the social sector, political parties and education. She intentionally chose a sample of educated and well-informed women to seek their views on the sexual behaviour of Cambodian men, including their own husbands.

She concluded that these women, despite their education, believe that:

- *men have a sexuality that necessitates having several partners;*
- *men who are away from home seek sexual services and accept this as normal;*
- *prostitution is often a lesser evil, as it still gives the wife control over the budget, and does not involve any longer-term engagement of the husband with another woman;*
- *a marriage needs to be maintained at all costs regardless of suffering and humiliation; and*
- *it is not possible to talk with the husband about the use of condoms and it is therefore best to educate the men to use condoms when they have extramarital sex.*

Guillou also concludes that these Cambodian women have established a separation between their personal and professional life. While they can stand in front of a male audience promoting the use of condoms, they maintain a traditional approach in their real life.

Limited family planning services and modern contraceptives, supplied by international NGOs, became available for the first time in 1991. However, Cambodia was in the midst of a baby boom by then, with many people seeking to establish families and rebuild the population after three decades of war (Walston, 2005). This was supported by a Government eager to increase the size of the population after the terrible losses of life during the Khmer Rouge period. The first contraceptive prevalence study in 1995 indicated that only 7% of women were using contraception. The government, supported by UNFPA, introduced family planning services in health centres in 1994. This included family planning education and training for public health staff. The Maternal and Child Health Plan 1994-1996 was developed along with the first Birth Spacing Policy in 1995 (Walston, 2005).

In 1994, PSI introduced the social marketing of condoms, selling them at about one tenth of their commercial competitors, thus ensuring that cost was not a barrier. Over 5 million Number One condoms were distributed in Cambodia during the first 12 months of the programme. PSI also collaborated with a range of governmental and local NGO partners to provide information at the community level, including MSF, FHI, CARE and KHANA. Concurrently, PSI supported training for all teachers in the country, as well as the distribution of an education kit that aimed to inform primary pupils and secondary students about HIV and AIDS. Pursuing this same objective, educational broadcasts on HIV and AIDS were also being developed and aired on local radio (Cambodge Soir, 1995). These broadcasts found an avid audience in a population that had been starved of information during the Khmer Rouge period.

The 1995 Knowledge, Attitudes and Practices (KAP) Survey on Fertility and Contraception in Cambodia rated the unmet need for contraceptives among women at 84%. Sex workers, like married women, had little knowledge of where to obtain or how to use modern contraceptives. The vast majority of women surveyed knew that condoms could prevent HIV transmission, but they did not recognise them as a contraceptive method (Walston, 2005). Robinson, in the Phnom Penh Post, reports examples of misinformation by the Khmer press prior to 1995, e.g. linking condom use to breast cancer, reporting HIV transmission through nail clippings and false cures for AIDS (Robinson, 1995).

Early prevention efforts also focused on the uniformed services. The Cambodian Red Cross (CRC) initiated HIV prevention education in 1995, focusing on the military and police, with technical and financial support from AusAID and the Australian Red Cross. Information from the extensive KAP survey of the uniformed services provided the evidence base to develop and implement a life-skills and peer-education programme that reached uniformed servicemen of all levels through a cascade approach.

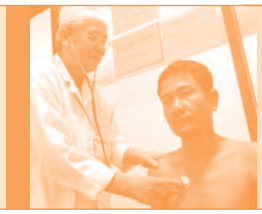
The openness by the military to such programmes is considered a major factor in the early fight against the spread of HIV. In 1995, the HIV prevalence in the military was 5.9% and by 1997 this had increased to 7%[3]. Effective programming, including peer education supported by strong advocacy by key personnel in the Ministry of National Defence, together with a dynamic condom distribution programme, resulted in a notable increase among the military in consistent condom use with sex workers – from 43% in 1997 to 70% in 1999. In the same period, the percentage of military men reporting using sex workers in the previous month fell by half, from 64.7% to 32.6% (Family Health International, 2001).

During the mid-1990s, the first larger-scale initiatives emerged that addressed the wider, multisectoral aspects of the epidemic. A UNDP-financed programme provided support to form a group of core trainers on HIV in selected ministries, as well as NGOs. The ministries included social affairs, education, tourism, interior and defence. Most of the selected government trainees

[3] No data on HIV prevalence in the military is available after 1997, due to design changes in the HSS.

came from the health departments within their respective agencies, which reduced the multisectoral ambitions of the initiative. The majority of the interventions continued to be delivered through NGOs. A review undertaken in 1997 estimated that 80% of the donor resources were allocated to programmes implemented by NGOs (National AIDS Programme, 1997). Funding came from a number of sources, and donor coordination was weak. Recognising the need for better programme coordination, the NGOs initiated coordinating meetings in 1993, and this forum grew into the HIV/AIDS Coordinating Committee (HACC). They also called for improved coordination between government and NGO programmes (CCC, 1996). Coordination, while informal, was extremely effective, and people remember the unofficial exchanges between government and civil society organisations as excellent.

5



1997 PLOUGHING ON THROUGH THE INTERVAL

Key features

- *factional fighting leads to suspension of some donor funding*
- *first review of response highlights urgency of situation*
- *peak is reached, but not known*
- *response goes on despite turmoil*

By 1997, there were an estimated 102,000 HIV-infected people in Cambodia. This equates to an adult prevalence rate of 2%. Alarmingly, this indicates that Cambodia took only six years to reach the same prevalence rate that took Thailand 13 years to reach (Chhuon Samrith, 1998; Phalla, Leng et al, 1998).

The factional fighting of July 1997 led to disruption of the government functions and a temporary end of the power sharing arrangement of the two leading political parties. Following the fighting, some leading donors suspended their funding to government institutions. While most donors resumed their assistance in the year following the unrest, the hiatus instigated a rethinking of donor priorities and approaches, notably by USAID, which started channelling all of its funds through the non-governmental sector. In the coming years, this change in programming further entrenched service delivery through NGOs.

Interestingly, and rather surprisingly, the respondents contacted as part of this study did not think that the provision of HIV services was adversely affected by these events. The long term prevalence trend would support this view. In fact, 1997 was quoted as a successful year where a number of important pilot programmes were initiated. During this time most foreign technical advisors withdrew from Cambodia. Some NGOs, such as RHAC (Reproductive Health Association of Cambodia), used the opportunity to demonstrate that they could operate effectively as independent organisations, and went on to become direct grant recipients without the need for international NGOs as intermediaries. The negotiations with the World Bank regarding a loan for HIV came to a halt, but they resumed quickly, and by 1998 the loan agreement was signed and implementation started.

The health sector saw the beginning of many innovative interventions, such as the creation of population-based operational health districts, decentralised planning approaches, and contracting of entire districts to private service providers. These approaches sometimes encountered some resistance from the national programmes in charge of communicable diseases. The national programmes, which were meant to provide technical assistance to provincial and district health structures, retained substantial control over budgets. Donors found it easier to channel money through a central institution with a narrow technical focus, where they could also place technical assistance.

The HSS 1997 data show an overall prevalence rate of 40% among sex workers, with rates peaking at 58% in sex workers in Battambang (NCHADS, 1997; Ryan, 1997). Sexually transmitted infection prevalence rates were also rising fast among sex workers, and increases were echoed in other populations (Gorbach, 1997).

Women working in brothels surveyed during the first Behavioural Surveillance Survey in 1997 reported the lowest average mean age at first sex of any sentinel group (17.6 years) and an average of 3-4 clients per day. On average, each brothel employed 6.4 female sex workers, each earning a mean monthly income of US$ 59. This group was highly mobile, with only 7% reporting having been in their current brothel for more than a year and 30% had been there one month or less. By 1997, 42% of female sex workers reported always using a condom during sex, and another 45% said they use condoms most of the time with clients. This represents a significant change in behaviour from only a few years prior (Gorbach, 1997).

The first BSS provided a description of the sexual behaviour of people who are members of each of the three groups included in the surveillance: the core group; the bridging group; and the general population. By understanding the behaviour norms of each of these groups, prevention efforts could be better targeted. Following the trends in behaviour change among these groups provided insight into the progress of STI, including HIV.

In relation to STIs, a Core Group (of STI transmitters) is defined as a highly vulnerable group of individuals characterised by high numbers of sex partners, longer than average duration of sexual infection and highly efficient transmission of infection per exposure. During the first BSS, female brothel-based sex workers and urban men in the military and police were the core group. At this time about 39% of female brothel-based sex workers tested positive for either gonorrhoea or chlamydia, an almost 41% were HIV-positive.

In 1995, Condom Day was inaugurated and condoms were publicly promoted. The success of condom promotion efforts was already measurable. Men in the bridge population (i.e. men who are likely to have both core group partners, usually male or female sex workers, and sex with people in the general population) were still likely to have bought sex both in the last year (57%) and in the last month (42%). However, almost 90% reported condom

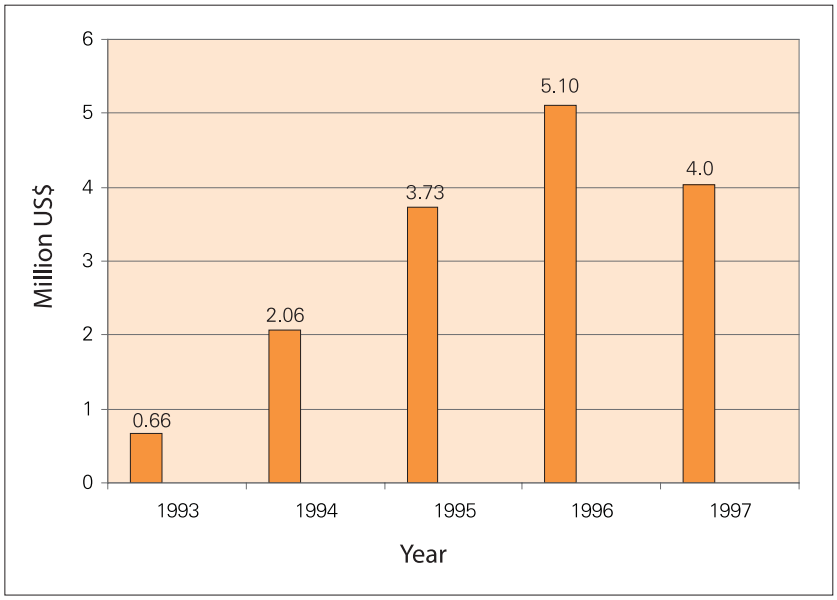
use at last sex, an extraordinary figure, considering how recently condoms had been introduced. 54% reported consistent condom use with sex workers, while 9% reported never using condoms with sex workers (Gorbach, 1997).

In contrast, 36% of men in the general population reported having accessed sex workers in the previous year, and 26% in the previous month. This group was, however, among the most likely to have sweethearts, regardless of whether or not they were married. The use of condoms with sweethearts is generally lower than with direct sex workers, although vocational students (representing the general population men) reported much higher use of condoms with sweethearts than any other male group, with 71% reporting consistent use and only 8% reporting never using condoms.

Sex workers have always (perhaps unjustifiably) been considered a major source of new infections. However, there are a small number of sex workers relative to the large number of male clients. Despite the high HIV prevalence among brothel-based sex workers, they do not make up the bulk of new infections. Prevalence rates among brothel-based sex workers were recorded at 38% in 1995, 39% in 1996, 40% in 1997, and they appear to have peaked in 1998 at 43%, as the prevalence rate had dropped to 38% in 1999 and has continued to drop since. The latest estimates show a prevalence of 21% among brothel-based sex workers in 2003.

In 1997, the surveillance data showed that HIV prevalence among ante-natal clinic attendees in some provinces was considerably higher than had been estimated previously. When this anomaly was investigated, it became apparent that some of the women tested were former sex workers who had married forestry workers. (Gorbach and Team, 1997). In 1997, mothers in villages close to Phnom Penh were surveyed on their knowledge of AIDS. At that time only 2% of women surveyed were using condoms, even though 68% of those who knew what AIDS was reported being aware that condoms could help prevent AIDS (Summers, 1997).

Figure 9: Funding for HIV interventions 1993-1997 in Cambodia



Source: Catalla Jr., 2006

In 1997, the first comprehensive review of the national AIDS response was undertaken as a collaborative effort with the participation of all major stakeholders from government, donors and implementing partners. It took place in the light of a demonstrated epidemic with an increasingly known pattern.

Figure 9 shows the funding available during the early response. Virtually all of the funds were provided by donors. There has been a consistent and important increase of funding for HIV activities since 1993, although overall sums remained relatively modest. Prior to 1993 no reliable data is available. The drop in 1997 is explained by the withdrawal of donors following the factional fighting in the second half of 1997. In view of the fact that prevalence peaked in 1997 and incidence peaked even earlier, the prevention interventions of the early years must have been relatively cost effec tive and efficient. However, as the review showed, there remained substantial gaps in services. Large parts of the country had a very low coverage of services, and for most parts of the country the range of services remained limited. The review also pointed out the need for improved institutional arrangements and policy.

6

1998-1999
EXPANDING THE RESPONSE

Key features

- *public political support is finally forthcoming*
- *dedicated HIV and AIDS national programme under the Ministry of Health is established to speed up government response*
- *national multisectoral agency is established, but has limited means to assume its role*
- *pilot programmes expand in size and diversity*

After 1996, the promise of a World Bank loan for HIV was accompanied by a review of the institutions in charge of HIV and AIDS. The initial agreement was that the Ministry of Health would promote the National AIDS Secretariat to the rank of a Department within the central Ministry. In 1997, the Ministry of Health established a Department of Communicable Diseases Control (CDC). When the loan negotiations with the World Bank were resumed, following the factional fighting, the newly formed CDC was never given the wide ranging mandate to oversee the implementation of all HIV and AIDS interventions in the health sector. Instead, the National Centre for HIV, AIDS, Dermatology and STI (NCHADS) was set up in 1998. While in principle a part of the MoH, NCHADS was given a large degree of freedom and quickly set up a vertical HIV and AIDS programme in which it controlled most resources, including those at provincial levels. The first years of NCHADS existence were also used to prepare the policies necessary for the scale-up in coverage and diversity of interventions.

Box 13: Getting the systems in place

When Dr Mean Chhi Vun was appointed as Director of the newly-established National Centre for HIV, AIDS, Dermatology and STI (NCHADS) in February 1998, his first challenge was to integrate the existing STI and HIV/AIDS programmes into a unified national programme. HE Dr. Chhea Thang, then Minister of Health, had recognized the need for integration and had identified Dr Vun as the best person to manage the process and to lead NCHADS. Dr Vun utilised his skills in systems management to successfully bring together the two programme teams, each with its own head, and achieve consensus on goals, objectives and working procedures within a single administrative structure. Vun recalls, "we learned as we went along; we let the different units develop their own strategic plans and we coordinated them".

Dr Vun has fostered ownership of planning and implementation, both at national and local

* Annual Operational Comprehensive Plan 2006 for NCHADS and Provinces

levels, and has played a major role in developing the systems to facilitate this. He encouraged provinces to develop their own HIV/AIDS plans, beginning with four border provinces in 2002, and expanding to all 24 provinces by 2004. Vun was insistent that the NCHADS 2006 Annual Operational Comprehensive Plan recognizes the contributions of all stakeholders and partners, and he notes, "The NCHADS programme is not just a programme directed by NCHADS alone – Provincial Departments and staff, OD staff and NGO partners all have a role to play".

Vun also advocated for, and led the development of the Continuum of Care – a comprehensive framework for improving access to care and treatment for people living with HIV and AIDS, and insisted that it should be suited to the Cambodian context. Vun is justifiably proud of the Cambodian ownership of the national programme, and has devoted significant effort to improving middle-management capacity within the programme.

When pressed to describe his personal role in the national response, Vun insists that it was a collaborative effort, highlighting strong political support and good collaboration between the government and civil society as key factors leading to the success of the response. He emphasizes the need for accountability and transparency, noting that "if there is no accountability and transparency, then there is no way to build trust between partners".

The establishment of a dedicated national health agency to combat HIV had several advantages. NCHADS rapidly became the major channel for the delivery of government led HIV and AIDS interventions in the health sector. While the government's role in service delivery remained limited in the first years, NCHADS had responsibility for the surveillance system, and received technical assistance to expand its training and management capacity. NCHADS could draw upon an established provincial network through the Provincial AIDS Office, which is located within the Provincial Health Department. A disadvantage was that this necessitated the establishment of separate reporting and management structures, which ran parallel to the existing Ministry of Health structures, notably the Health Information System (Bühler, 2004).

The World Bank loan proved to be a challenge for the newly established centre, since the loan included substantial funding for NGO interventions which were meant to be channelled through NCHADS. Eventually, it was decided to subcontract KHANA, a Cambodian NGO, to manage the non-governmental part of the loan. This led to improved disbursement and implementation (Box 9).

Box 14: A Healthy Partnership

A sub-component of the World Bank loan to Cambodia for HIV and AIDS involved the disbursement by the Ministry of Health of $700,000 through small grants to local NGOs/CBOs for HIV and AIDS prevention and care activities. This component represented a substantial part of the project and the World Bank believed that, if successful, it could be a model for government/NGO collaboration in HIV and AIDS programming, using World Bank funds.

However, it soon became clear that the management of NGO small grants would place a significant strain on the technical resources of NCHADS and the administrative resources of the Project Coordination Unit (PCU). The MoH therefore requested Khana (the Khmer HIV/AIDS NGO Alliance) to manage the NGO component of the loan. Khana was selected because of its mission and track record in identifying and supporting Cambodian NGOs/CBOs in HIV and AIDS prevention and care activities.

The approach has been cited by the World Bank as an example of best practice. A case study of this arrangement identified some major strengths. The partnership between Khana and the MoH was seen to have:

- *improved the efficiency of implementation of the project;*
- *contributed to the evolution of a change of mindset within the MoH - namely to contract out implementation to NGOs;*
- *helped to improve the capacity of a number of indigenous NGOs in HIV and AIDS programming;*
- *improved understanding and cooperation between the MoH and Khana, and by association, the local NGOs supported under the grants initiative; and*
- *helped to leverage further World Bank funds for Khana's programmes.*

However, the case study identified some weaknesses of the approach:

- *local NGO partners had minimal links to provincial activities;*
- *there was little formal coordination with NCHADS;*
- *the contract had no requirement for evaluation;*
- *the initiative demanded significant technical assistance from the International HIV/AIDS Alliance; and*
- *no budget provision was made for the International HIV/AIDS Alliance technical assistance.*

Source: Wilkinson, 2004; A Healthy Partnership – a case study of the MoH contract to Khana for disbursement of World Bank funds for HIV/AIDS in Cambodia.

The first noted public speech on HIV and AIDS by a senior politician occurred in 1999. During the first National Conference on HIV and AIDS Prime Minister Hun Sen came out in strong support of the fight against HIV and AIDS. In the same year the Prime Minister also endorsed the national scale-up of the 100% Condom Use Programme (CUP), which was seen as instrumental in the control of HIV infections in commercial sex work settings. While there are indications that the 100% CUP has maintained considerable success in increasing consistent condom use among brothel-based sex workers and their clients, it should be noted that the most significant increases in condom use by brothel-based sex workers occurred up to 1999, prior to the national implementation of the 100% CUP.

The multisectoral National AIDS Authority (NAA) was established by Royal Decree in 1999. The NAA was intended to spearhead the national response to HIV. However, in reality the NAA remained under-resourced and struggled to translate its mandate into concrete action. It also lacked the authority to enforce coordination among the multiple government ministries involved in HIV interventions, as it was administratively attached to the Ministry of Health. At the provincial level the coordination was even more challenging (Box 10)

Box 15: Decentralised Structures for HIV and AIDS in Cambodia

At the provincial level, the AIDS response is, in principle, promoted and coordinated by the Provincial AIDS Committees (PACs) with the assistance of the Provincial AIDS Secretariats (PAS). These structures are extended to the district level. The PAC is chaired by a deputy provincial governor and the PAS usually by a deputy director of the Provincial Health Department. This has the disadvantage that the response remains outside the main development arena at provincial level. The PAC can have up to 40 members, which does not allow for effective, results-oriented meetings. Furthermore, there are indications that, in several provinces, the PAC meets rarely or not at all. An assessment conducted in 1995 found that specific AIDS fora did not function in Battambang and Rattanakiri provinces and it was recommended to include HIV and AIDS into existing structures, notably the Provincial Rural Development Committee (PRDC) or the Provincial Coordination Committee (ProCoCom) for the health sector (Munz, 1996).

In late 1997, a support programme for selected PACs and PAS was initiated with financial assistance from UNAIDS, UNDP and UNICEF. A Central Advisory Team (CAT) was formed, consisting of participants from different ministries. The CAT provided technical assistance to the PACs and PAS. This programme has since stopped and there are indications that the meetings at provincial and district levels have stopped in the absence of financial support, i.e. per diems. Of late, more viable coordination efforts are beginning to evolve. In Pursat province, a Provincial AIDS Network is functioning which includes civil society partners. In other provinces the Continuum of Care (CoC) stimulates increased collaboration at the district level. The coordination around the CoC offers the possibility to include community-based organisations and PLHA in the planning, implementation and monitoring of interventions. These emerging coordination models are more pragmatic adaptations of the rigid and formal national and provincial structures. They include key stakeholders from government and civil society who are working actively in the HIV/AIDS arena and the mechanisms are small enough to enable effective meetings and ensure members are accountable.

National decentralisation efforts concentrate to a large extent around the establishment and strengthening of the elected Commune Councils. While it is intended that the Commune Councils will eventually play a role in information dissemination and the monitoring of maternal health, child mortality, infectious diseases such as malaria, and provision of care for persons suffering from disease, this has not yet materialised. In the absence of clear guidance regarding the role the communes should play in social service provision, the councils tend to concentrate on tangible activities, such as roads and school building as well as water supply (Rusten, 2004).

By 1998, there were an estimated 154,000 HIV cases, (90% via heterosexual intercourse). The prevalence rate continued to be highest amongst female direct sex workers at 43%, followed by “indirect sex workers” (women who work in the entertainment industry) at 19%. The younger sex workers were experiencing very high rates of infection: 44.5% among 20-24 year olds and 41% among 15-19 year olds. Among police the rate was 6% and the rate among married woman of reproductive age was 2%. HIV infected individuals were found in every province and there was no difference in the prevalence rate found in women from rural and urban areas. Cambodia was now identified as one of the most affected countries in Asia and the epidemic was already generalised.

The high prevalence rate among hospital inpatients in Battambang and Kampong Cham, the two biggest provinces, and the capital city Phnom Penh, indicates that the epidemic had progressed to a point where significant numbers of people living with HIV were symptomatic and presenting for treatment in health facilities.

While the surveillance provided adequate “snapshots” of the epidemic, the dynamics of the epidemic were not well understood. It was thought that HIV prevalence was still high in all risk groups and that the number of new infections would continue to rise for several more years. Methods of estimating incidence were not sufficiently accurate, and despite continuous improvements in the surveillance system, there were still many gaps in data.

Programmes followed the emerging needs of a maturing epidemic. While the first years of the response focused on prevention activities and raising awareness, there was an increasing need for programmes of treatment and care of affected families. Increasing numbers of people were becoming sick and the AIDS death toll was rising. Exact numbers were not known. Although HIV sentinel surveillance had been established in 1994, a national registry for HIV/AIDS had not been established and AIDS deaths were not routinely reported to any one institution. However, people were experiencing increasing mortality in their families and communities, and many people knew someone who had died of HIV-related causes.

By 1999, the range of interventions had expanded considerably beyond awareness raising and taking care of the sick. People living with HIV were aware that treatment for opportunistic infections was available in a small number of places, and they were organising themselves to advocate for the establishment of additional treatment services. The number of facilities providing VCCT increased during this period, albeit slowly. The number of people undergoing HIV testing was reported as 1,766 and 3,929 for 1997 and 1998, respectively (NCHADS, 2005). The number of people testing for HIV remained comparatively low, as treatment was very limited at that stage, thus reducing the motivation for testing.

Box 16: Reaching young women in garment factories

The mid-1990s saw the establishment of a number of garment factories in Cambodia. The majority of garment factory workers were young women who were from rural villages and generally poorly educated. Their isolation from their families and insufficient knowledge of sexual health made them vulnerable to unsafe sexual relationships and therefore infection. To address this issue, CARE International established a sexual and reproductive health education project for these young women. The project began in 1998 in five factories, in cooperation with Cambodian Health Education Development, Reproductive Health Association of Cambodia and the Women's Development Association, with funds from EU/UNFPA. The key elements were participatory learning and action and the provision of condoms and clinical services inside the factories. CARE's sexual and reproductive health programme has since expanded to reach over 120,000 young women in 35 garment factories.

Poverty is unequivocally linked with HIV throughout the world, and Cambodia is no exception. The poverty and survival issues affecting PLHA in Cambodia in the first few years of the epidemic have persisted. Poor people are more likely to be involved in high-risk activities and yet their involvement is characterised by an inability to reduce the factors that make them vulnerable to HIV and AIDS. Young women from poor families selling sex remain less likely to negotiate condom use than their predominantly wealthier and freer clients. They are also less likely to be informed about how to protect themselves and less able to access health and HIV/STD services.

Cambodia's capacity to respond to the escalating demand for care and treatment for HIV and AIDS, especially by the poor, was severely compromised by its weak health system, which had inadequate infrastructure to deliver even basic health services. The health system was characterised by a severe shortage of hospital beds, low management and technical capacity, low morale, poor salaries and a persistent high burden of communicable and non-communicable diseases. The system was therefore woefully ill-equipped to accommodate any additional disease burden.

Acknowledging the constraints on providing institutional-based care for PLHA in Cambodia, discussions on establishing home-based care for PLHA were initiated within WHO, and channelled through the HIV/AIDS Co-ordinating Committee (HACC) Sub-Group on Counselling and Care. These discussions sought to bring together local and international NGOs and involve MoH/Municipal Health Department (MHD) in developing a pilot project to be implemented initially in Phnom Penh. In bringing together the private and public sectors, it was felt that scarce resources could be shared, and the comparative advantage of different players could be utilised more effectively. However, there were a number of challenges to be faced in developing the home care project:

- the HIV epidemic in Cambodia was at an early stage, and care was not yet on the national agenda. It was therefore difficult to find funding or motivation for anything other than prevention activities;
- there was a need to bridge conceptual gaps between NGOs and the public sector, to build trust and to foster understanding of the limitations and potential resources of each of the players;
- there were few, if any, hospital outreach services to which homecare activities could be attached;

- existing CBO activities were neither strong nor well institutionalised;
- there were limited facilities for voluntary testing and counselling;
- there was limited commitment from MOH or MHD for home-based care for PLHA;
- there was little enthusiasm from either management or physicians in the referral hospitals to be part of the continuum of care;
- the National AIDS Programme was severely under-funded by the government; and
- although NCHADS had funds for AIDS-elated activities, there was no budget line for care and support to PLHA.

Despite these constraints, a one-year pilot home care project was launched in February 1998, implemented by a partnership of MoH and NGOs, with technical and financial support from DFID and WHO. The objectives of the project were foremost to pilot appropriate home care services for PLHA and other chronic conditions, but also to pilot a model of health care in which NGOs and government acted in partnership.

WHO support to the project ended in February 1999, at the end of the pilot phase. Co-ordination of the project was taken over by the Ministry of Health, and the AIDS Care Unit of NCHADS was given responsibility for implementation. KHANA, the linking organisation of the Alliance, assumed responsibility for providing technical and financial support to local NGOs, and continued to work in partnership with NCHADS.

The Home Care programme consisted of 10 urban Home Care Teams in Phnom Penh and a rural pilot of one team in Moung Russey District in Battambang Province. Each team was composed of two government nurses working 50% of their time on the programme, and three NGO staff. The urban teams were located at nine Municipal Health Centres spread throughout the city. The teams carried simple medicines and supplies in specially designed Home Care Kits and provided palliative care to chronically ill patients. Counselling, education and welfare support were also part of the constellation of home care services provided by the teams.

Monitoring was conducted by a committee, representing NCHADS, MHD, KHANA, Health Centre Managers and the participating NGOs. Each team was the responsibility of an NGO, and all team expenses, as well as salaries and transport costs of NGO staff, were administered through grants from KHA NA (seven teams) and World Vision (three teams). Salaries and transport costs of government staff were administered through the Municipal Health Department.

An evaluation of the home-based care programme conducted in 2000 by an independent consultant, found that:

- it reduced the suffering of PLHA and improved the quality of their lives and the lives of their families and caregivers;
- it increased understanding of HIV and AIDS and helped to forge links between care and prevention and reduced discrimination against PLHA in the community; and
- by providing social and economic support, it helped to empower some of the poorest and most disadvantaged individuals and families in the community (Wilkinson, 2000).

Many NGOs were providing food and psycho-social support to those living with and affected by HIV or AIDS, and the number of orphans was increasing, placing a further burden on extended families, pagodas and community-based organisations. Institution-based care for orphaned and vulnerable children is prohibitively expensive, and an emotionally difficult option for children

who are removed from their community and may be separated from their siblings. Despite this, children were being left at orphanages and pagodas as families and grandparents recognised their inability to care for additional children.

Save the Children Australia introduced a programme to support and encourage monks to play a more active role in the care of orphans and in responding to HIV/AIDS-related suffering, and organisations such as Wat Norea in Battambang established projects to care for children orphaned by AIDS. The Ministry of Cults and Religions, whose role includes advising, inspecting and controlling all religious establishments, developed a policy framework for religious institutional-based care for orphaned children.

NGOs such as Partners in Compassion and Dhammayietra, and those supported by Care International and Save the Children UK/Australia, were extending support to grandparent and child-headed households in the form of rice, school fees, seeds and fertiliser. Maryknoll established the Seedlings of Hope project to provide hospice care for people with AIDS, and subsequently extended this to children, through the Little Sprouts project.

In the last five years, a number of community groups, often including people living with HIV or AIDS, have sprung up across the country, partly in response to the increased availability of funding for HIV and AIDS. Many of these groups have evolved into community-based organisations (CBOs), which act as local implementing partners of international NGOs and UN agencies. They play a variety of roles, including expanding HIV prevention activities and home-based care services, helping to address the human rights violations being experienced by PLHA, and providing employment opportunities for people from vulnerable populations.

Box 17: Wat Norea Peaceful Children – Pagodas get involved

Wat Norea is a Buddhist monastery in Battambang Province in the northeast of Cambodia. As early as 1992, the Monks recognised that religious leaders can exert a powerful influence on the priorities of society and the policies of its leadership -- they can set the example for their communities to respond to those in need and show others how to behave with compassion.

In 1992 the monastery established Norea Peaceful Children (NPC), an GO that provides shelter and support to orphaned children. Since 1998 NPC has also worked to mitigate the impact of the HIV epidemic by providing care and support to children orphaned by AIDS, and by addressing the gender and human rights dimensions of the epidemic. NPC trained monks from Wat Norea to enable them to provide information in their local communities on HIV and AIDS, the importance of showing compassion for people living with or affected by HIV or AIDS, and the harm caused by stigma and discrimination.

NPC has established a provincial network to integrate human rights and gender issues into HIV programming interventions. Members of this network include provincial and district-level government authorities, NGOs, and other religious organisations. NPC has also established Gender and HIV/AIDS Teams and provides training to these teams on HIV/AIDS-related human rights and gender issues including domestic violence.

NPC's capacity building and community mobilisation activities contribute to the creation of a more enabling environment for the response to HIV and AIDS in Battambang province, through community-level activities that promote respect for HIV/AIDS-related human rights, and reduce stigma and discrimination.

In 2005 the Norea Peaceful Children Project became an independent NGO, known as the Hope of Children.

7

2000-2005
TAKING THE SHOW ON THE ROAD

Key features

- *surveillance confirms decreasing trends in prevalence and incidence*
- *national plans, policies and laws developed*
- *training prepares medical personnel for scale up*
- *large increase of funding*
- *expansion of VCCT and ARV treatment*
- *infections increasingly take place from husband to wife and from mother to child*
- *impact mitigation remains to be tackled*

Trends

After 2000, some good news started to emerge. The 2003 data of the HSS showed that HIV prevalence among sex workers was continuing to fall. Furthermore, the gap between HIV prevalence in younger and older sex workers suggested that incidence is falling as well (NCHADS and FHI, 2004). In 2002, prevalence rates were still quite high among sex workers who had been selling sex for less than one year. The prevalence rate among female sex workers under the age of 20 was 20%, and in sex workers over the age of 20 it was 30%.

Likewise, the prevalence rate among uniformed services had fallen, while the number of infected men in the general population had decreased sharply from an estimated 100,000 in 1998 to an estimated 65,000 in 2003. However, this was primarily due to mortality as the epidemic matured. The trend in new infections was more encouraging: from a peak of approximately 24,000 new HIV-infections per year among men in 1994, the number of new HIV-infections per year among men had decreased to approximately 1,500 per year. Unfortunately, the number of infected women remained practically unchanged at around 57,000 during the same period. The prevalence rate among pregnant women tested at ANC sites had stabilised. While this was a positive sign in principle, the overall situation now suggested that an increasing share in the overall number of infected persons were women. From 35% in 1997, the proportion of infected women rose to 47% in 2003. The main routes of transmission were now from husband to wife, and increasingly from mother to child.

The focus of scarce resources on preventing transmission among high-risk groups, where interventions can make the biggest difference, seemed to have paid off. However, Cambodia still needed to cope with continuing infections and the legacy of people living with HIV. It also had to cope with a generalised epidemic where targeted prevention interventions were becoming increasingly difficult and expensive, notably in the absence of a viable public health system. At the same time, it was estimated that approximately 5,000 women were currently working in brothels in Cambodia and were continuing to play a key role in the HIV epidemic.

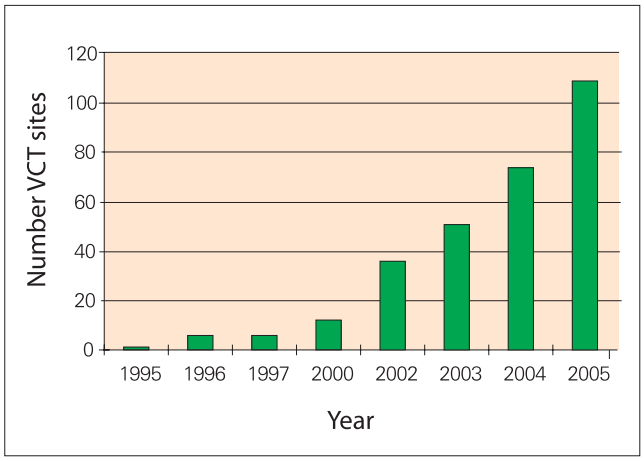
In a generalised, maturing epidemic, population density is a critical factor in determining the trend of the epidemic. High prevalence rates in certain provinces do not necessarily correspond to large numbers of new infections. Eight provinces contain 70% of Cambodia's population, and these provinces will have the highest case load to cope with in the coming years.

VCCT

Under the leadership of NCHADS, Cambodia has developed a strong Voluntary Confidential Counselling and Testing (VCCT) Programme. VCCT is seen as an important intervention to reduce HIV risk behaviour, and thus an important component of broader HIV prevention strategies. It is also an integral component of an ongoing, and rapidly developing, continuum of HIV care, support and treatment. It is the beneficiaries' entry point to those services, which include access and provision of ARVs, introduction of PMTCT, prophylaxis and treatment for opportunistic infections, and home and community-based care.

Cambodia's VCCT programme has grown rapidly over the past few years (Figure 10). In 1995, the Institut Pasteur was the sole provider of HIV testing and counselling services. In 1996, there were six VCCT centres, but by 2000 there were still only 12 sites providing VCCT services. However, 2002 saw the beginning of a rapid expansion in the VCCT programme and by December 2005 there were 109 VCCT sites, 86 of which are supported by the government, 18 by NGOs, and five are private. The government has achieved its target of having a VCCT site linked to each of the referral hospitals and former district hospitals in each of Cambodia's 24 provinces (NCHADS, 2005).

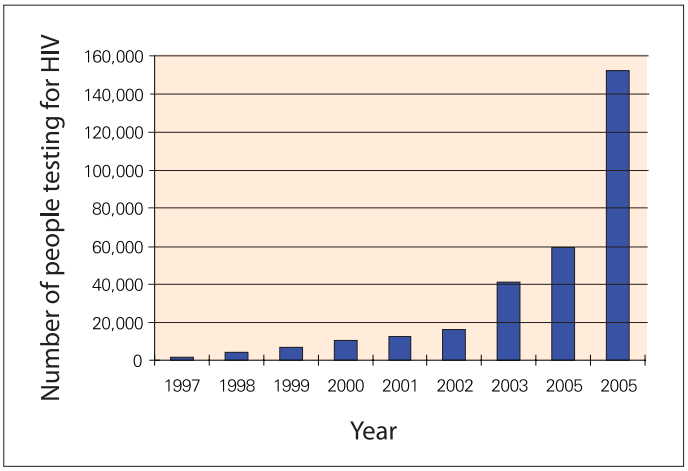
Figure 10: Growth of sites providing VCCT service in Cambodia – 1995-2005



Source: NCHADS, 2005

The number of people tested annually for HIV has also grown rapidly, from 1,766 in 1997 to 152,147 in 2005 (Figure 11).

Figure 11: Uptake of VCCT service in Cambodia – 1997-2005



Source: NCHADS, 2005

A comparison of figures 10 and 11 reveals a close association between the number of people being tested and the number of VCCT sites, indicating that improving access to testing facilities was a major factor in increasing utilisation. This hypothesis is corroborated by a study conducted by PSI in 2004, in which focus group discussions were held with people who had expressed an interest in being tested, and in-depth interviews were conducted with people who had undergone HIV testing (Wilkinson, 2004). The study revealed that local availability of VCCT services was a major factor in the decision-making process to go for HIV testing.

The study also revealed that talking to other people appeared to be a critical step in the decision-making process to go for HIV testing, and that spousal support was an important factor in the final decision to be tested. None of the interviewees who had been tested expressed any regret about their decision, whether the result was positive or negative. Men who had tested negative, as well as those who tested positive, reported an increase in consistent condom use and/or a reduction in the number of sexual partners after being tested.

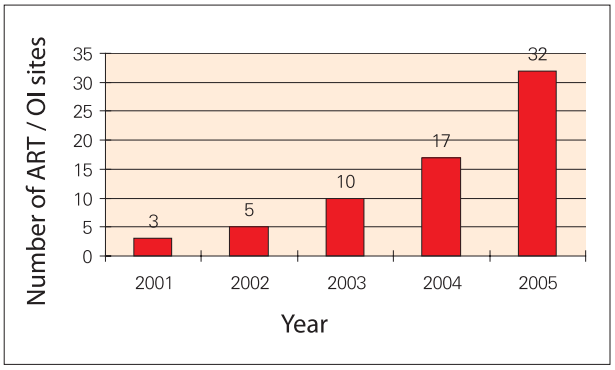
Both users and potential users of VCCT services expressed a high degree of preference for government-approved/public VCCT sites over private-for-profit clinics, which is contrary to the usual health seeking behaviour in Cambodia and a sign of perceived quality of the services. Reliability, confidentiality and provision of counselling were the major factors affecting this preference. Counselling was perceived as extremely valuable, and VCCT users said that they would recommend HIV testing to others only if good counselling was available. The success of the VCCT programme would seem to be linked to NCHADS' focus on quality improvement and development of standards.

ART

The majority of people interviewed in the study (described above) had first gone for HIV testing before antiretroviral therapy (ART) was widely available in Cambodia. The provision of ART was first piloted on a limited basis in Cambodia in 2001 by Médecins Sans Frontières (MSF), Médecins Du Monde (MDM) and the Centre for Hope, in the face of donor reluctance to support ART provision.

The government was also wary of the initiative, but allowed the NGO pilots to proceed, and monitored the process and outcomes. The MoH quickly became convinced that the ART programme could be viable if it was adapted to the Cambodian context, took ownership of the programme and facilitated rapid scale-up. In the last four years, there has been a dramatic increase in the availability of ART, largely as a result of Cambodia's success in accessing financial support from the Global Fund (Figure 12). At present, 30 health facilities spread across 16 provinces and 22 operational districts offer ART services, supported by government and NGO partners (NCHADS, 2005).

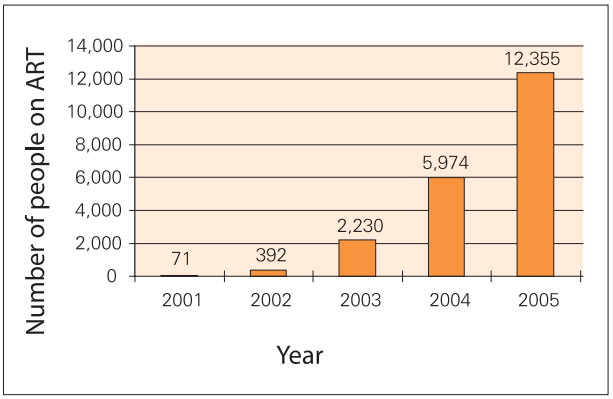
Figure 12: Expansion of sites providing ART and OI treatment in Cambodia – 2001-2005



Source: NCHADS, 2005 (figures for 2005 include 2 sites with OI only)

The number of active patients on ART has increased equally dramatically, and at the end of 2005, 12,355 active patients were receiving ART (Figure 13). This represents a significant achievement for Cambodia, and exceeds the national "3 by 5" target. The government estimates that more than half of the total number of adults with AIDS are now receiving ART.

Figure 13: Increase in number of people on ART in Cambodia – 2001-2005



Source: NCHADS, 2005

Of the 12,355 people on ART at the end of 2005, 1,071 were children. While this represents a significant increase since 2004, there are indications that the number of children with AIDS who are eligible for ART and currently seeking treatment is outnumbering government estimates, and there is a need to scale up provision of paediatric ART and consolidate the path to treatment for children.

PMTCT

In an effort to reduce the high incidence of paediatric HIV, the government is expanding access to services to prevent mother-to-child transmission of HIV (PMTCT). At present, there are 28 facilities spread across 18 operational districts providing PMTCT services. However, the effectiveness of this initiative is severely compromised by the relatively low numbers of women attending ante-natal care, (only 46% of all pregnant women have at least one pre-natal consultation)

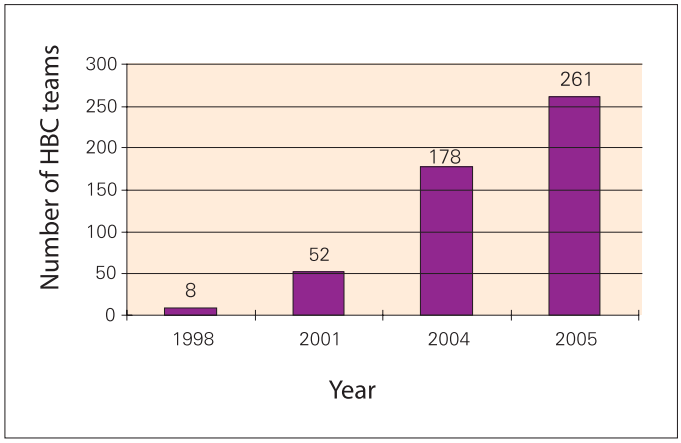
and the low levels of acceptance of ante-natal HIV testing. At present, pregnant women have to "opt in" to be tested for HIV. An alternative approach is to provide HIV testing as part of the ante-natal care package, with the option for clients to "opt out" of being tested. The MoH is presently weighing the relative advantages of the two approaches, bearing in mind considerations of cost and human resource limitations.

Impact Mitigation

As outlined earlier in this report, impact mitigation remains a largely neglected component of the national response. Existing interventions are largely limited to the provision of food and psycho-social support as part of a package of home-based care, implemented by local NGOs and CBOs. Partners in Compassion and Dhammayietra, and those supported by the World Food Program, Care International and Save the Children UK/Australia, have been extending support to grandparent and child-headed households in the form of rice, school fees, seeds and fertiliser. Many community-based organisations have evolved throughout the country, acting as implementing partners of larger local or international NGOs such as Khana, Care and World Vision, as well as UN agencies.

With the number of orphans increasing and placing a further burden on extended families, pagodas and community-based organisations have taken on the role of carers and provide support to child and grandparent-headed households. It was recognised that institution-based care for orphaned and vulnerable children was not appropriate as it is neither in the best interest of the child nor cost-efficient. Despite this, children are being left at orphanages and pagodas as families and grandparents recognised their inability to absorb additional children. Organisations including Save the Children Australia and the Salvation Centre introduced programmes to support and encourage monks to play a more active role in reducing stigma and providing care to orphans and in responding to HIV and AIDS-related suffering. Monks are now providing home visits, counselling services, meditation, and social and spiritual support to affected people at various stages, including when people discover their HIV status, during illness, when conflicts and discrimination arise, and when funeral services and support to surviving relatives are required. They are also intervening to assist PLHA and orphans to remain living in their communities.

Figure 14: Increasing number of HBC teams in Cambodia – 1998-2005



Source: NCHADS, 2005

Prevention

The last four years have seen an expansion of HIV-prevention activities throughout the country, the majority of which are implemented by many international and national NGOs. It is estimated that approximately 160 NGOs are currently implementing HIV or AIDS-related programmes, of which around 60 focus primarily on prevention activities (Pillai et al, 2004).

The highly effective condom promotion, distribution and social marketing programme remains at the forefront of Cambodia's prevention strategy. The social marketing initiative, led by Population Services International (PSI) has employed a range of media to foster acceptance and sustain the demand for condom use. Number One, the condom brand socially marketed by PSI was launched in December 1994 and is the most widely used and available brand in Cambodia. In the last four years, annual sales of PSI branded condoms have stabilised at around 20 million, which is equivalent to eight condoms per year per sexually active male aged from 15-49. While these figures represent a significant achievement, there is some debate as to whether there is still an unmet demand for condoms.

A significant proportion of condom usage is by sex workers and their clients, as part of Cambodia's 100% Condom Use Programme (CUP). There is some evidence that the CUP is playing a major role in containing the epidemic among brothel-based sex workers, with the most recent data demonstrating that approximately 95% of sex workers consistently use condoms with clients. However, the data also reveals much lower consistent condom use (54%) by sex workers with sweethearts, highlighting the need to focus on these relationships (NCHADS, 2003).

An effective component of the 100% CUP is the participation of sex workers as peer advisors in brothels and other establishments across the country. Peer education is employed by a number of agencies as part of their prevention approaches. The EU/UNFPA-supported Reproductive Health Initiative for Youth, implemented by seven European and 23 local partner NGOs elicited the participation of young people as peer educators. The Cambodian Red Cross implements a similar approach for youth and their families in 6 provinces, and for policemen in eight provinces. With support from NGO partners such as FHI, the Ministry of National Defense has developed an effective programme of cascade training for the military, where core trainers guide and support peer advisor trainers who in turn train and support peer advisors located in military units.

Other prevention initiatives employ cinema, mobile video units, puppet theatre, television and radio spots, televised soap operas and call-in radio shows to complement and reinforce the wide range of interpersonal communication approaches.

Outreach remains an integral part of many prevention programmes, especially peer education, and is a key component of the 100% Condom Use Programme. The outreach approach, which was pioneered in Cambodia in the early 1990's, has proven to be extremely effective over time. The concept of taking information and services to where people lived and worked was novel in Cambodia, and was initially unique to sexual

health and HIV/AIDS workers. Outreach programs were originally developed for brothel-based sex workers, who had very limited freedom of movement and could not, or would not, leave their places of work to access information or services. The outreach program became an essential component of the HIV response in Cambodia and has been expanded to encompass garment factory workers, pre-departure Cambodians going to work in other south-east Asian countries, staff in entertainment venues, clients of the sex industry, as well as places where young people gather.

Policies and National Planning

In 2000, the key development and health policies driving the national response were established. The National Poverty Reduction Strategies (NPRS 2000-2002 as an interim strategy, 2003-2005 as fully fledged strategy) recognised the threat the HIV epidemic posed to the overall development and poverty reduction efforts. With the adoption of the Cambodian Millennium Development Goals by the Cambodian government in 2003, the reduction in HIV prevalence became an official goal for the development agenda of the government (Figure 10).

The health sector has produced the bulk of the new policies in recent years, ranging from PMTCT and safe blood supply to the Continuum of Care and TB/HIV. However, other ministries also developed HIV policies. The Ministry of Cults and Religions passed the "Policy on Religious Response to the HIV/AIDS Epidemic in Cambodia". In 2003, the Ministry of Women's and Veteran's Affairs passed the "Policy on Women, the Girl Child and STI/HIV/AIDS" and the Ministry of Social Affairs, Labour and Youth Rehabilitation, supported by the ILO HIV/AIDS Workplace Education Programme, launched the Code of Practices Regarding HIV/AIDS in the Workplace. Meanwhile, the National

Figure 15: National Development: Rehabilitation, reconstruction and poverty alleviation

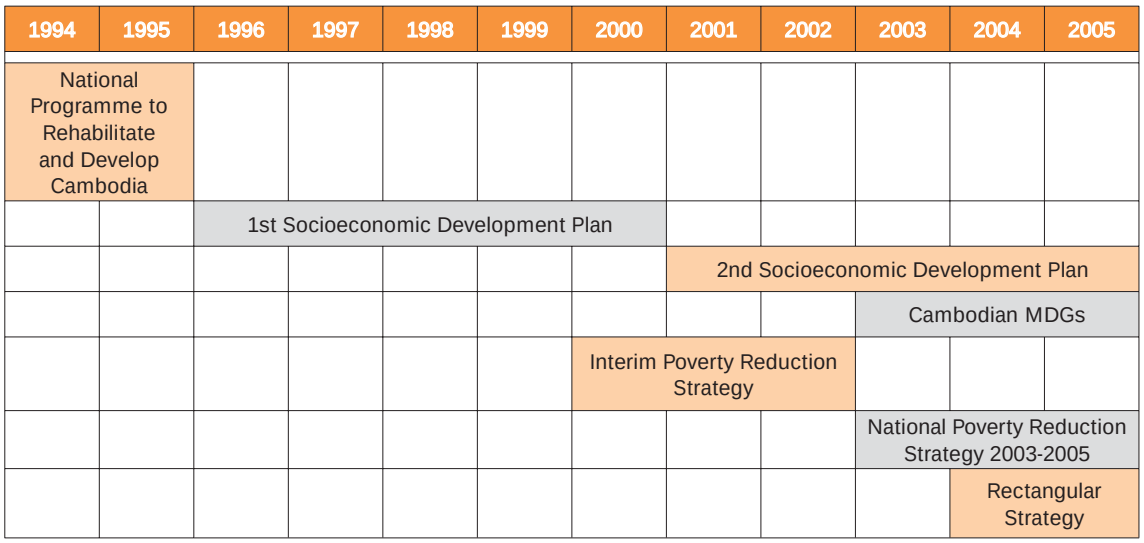
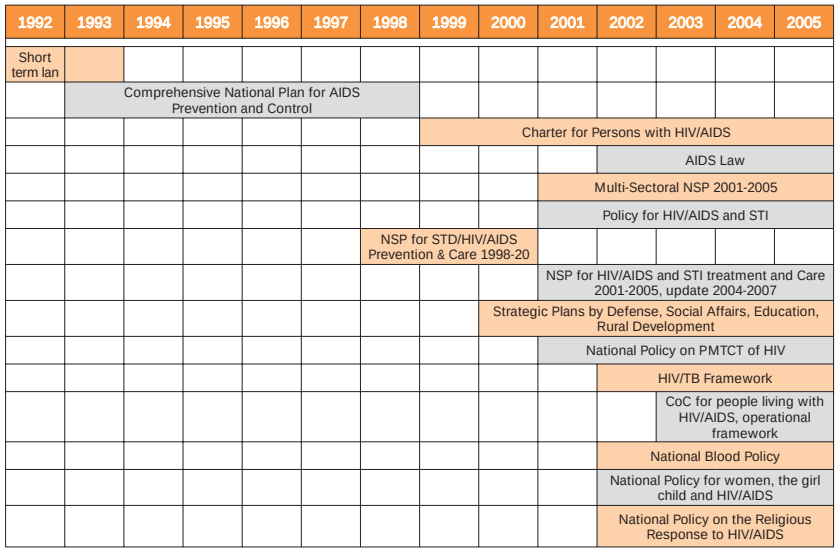


Figure 16: HIV and AIDS: Legislation, national plans, policies and guidelines



AIDS Authority drove the development of legislation which resulted in the promulgation of the "AIDS Law" by the National Assembly in 2002.

The NAA, with its broad membership of technical ministries, also encouraged and supported the establishment of ministerial strategic plans while developing a joint multisectoral National Strategic Plan for the period from 2001 to 2005. In addition to the Ministry of Health, the Ministries of Social Affairs, Rural Development, Defense, Education and Public Transport have all developed strategic plans on HIV. However, the degree to which these plans were operationalised, costed, and implemented varied widely. Moreover, the coordination between these different actors at national as well as decentralised levels remains problematic.

The recently launched National Strategic Plan for 2006-2010 (NSP-II) builds on the lessons learned from the previous plan by including Operational Plans for each strategy, with specific objectives, targets and major activities, together with the main government actors and potential partners for each set of activities. The NSP-II forms the basis for engaging in dialogue with donors about Cambodia's HIV/AIDS programming priorities, and emphasises integration of HIV and AIDS into the development programmes of government and civil society institutions.

Resources

Arguably, the existence of these policies and framework opened the way for donors to substantially increase their financial contributions. The funds available for HIV increased dramatically from about 10 million dollars in 2000 to 48 million dollars in 2005 (see Figure 8 and Box 12 for information about the health sector in general). Successful fund raising retained existing donors and attracted additional ones, most notably the new global players – the Clinton Foundation and the Global Fund, among others.

Figure 17: Resources available for HIV and AIDS and year by year increases in %

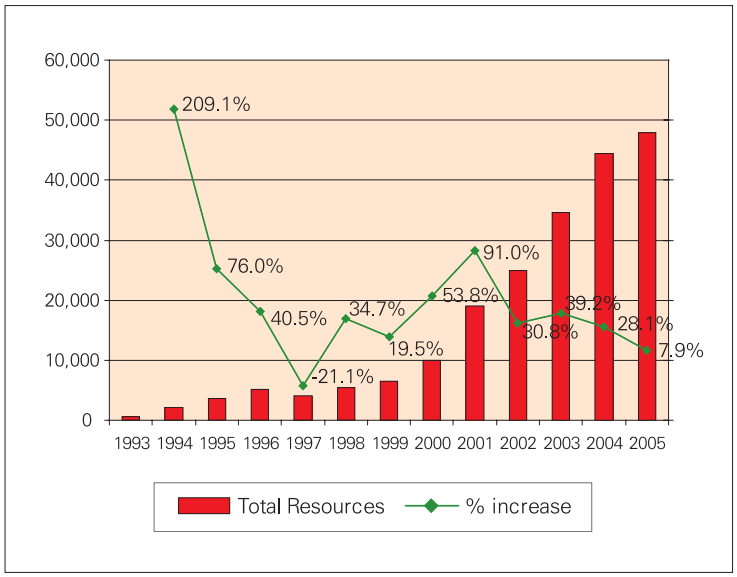
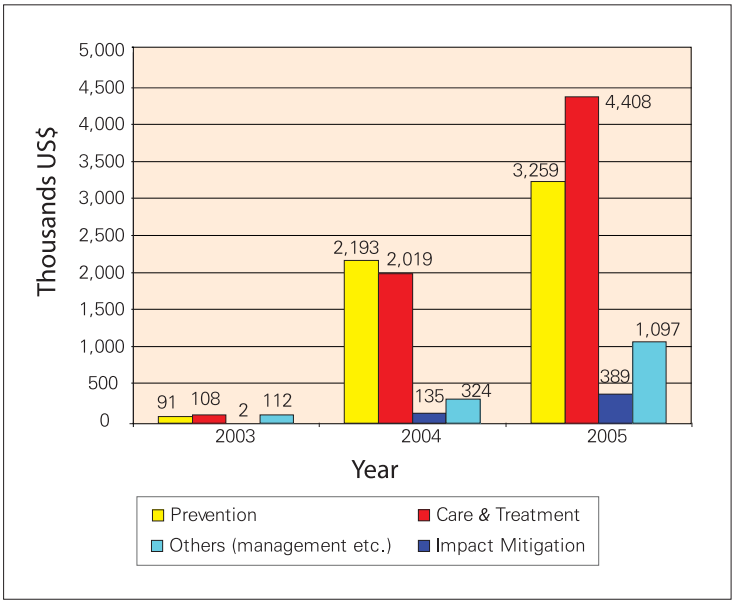


Figure 18: Distribution of PR expenditure (in thousands US$), 2003-2005



Source: Estimates based on data obtained from the Office of the Principal Recipient, Ministry of Health. Expenditure data by sub-recipient was 'assigned' by intervention based on the known programs/projects/ activities of the sub-recipients.

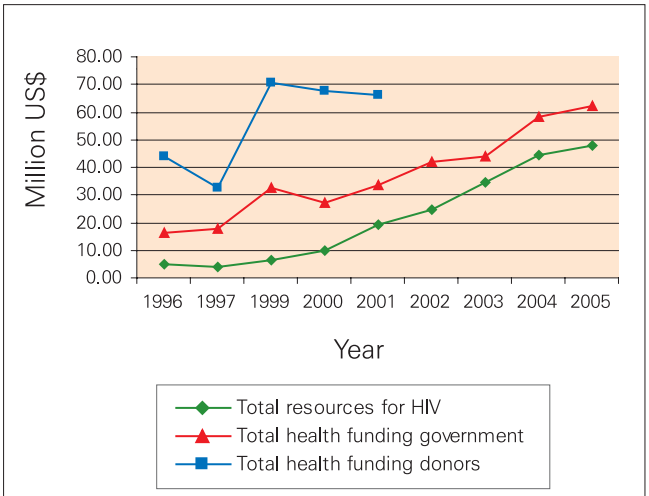
The resources made available by the Global Fund to Fight AIDS, TB and Malaria were the most significant addition to the existing fund base. They aimed, over consecutive rounds, to scale up VCCT, treatment of opportunistic infections and the provision of antiretroviral therapy (ART). Considerable funds were also earmarked for scale-up of home-based care as well as prevention activities, including treatment of STIs. Impact mitigation, however, has received little attention, and some affected groups, notably men who have sex with men and drug users, are yet to be included among the beneficiaries of these major funding sources.

Box 18: Sources and distribution of health funding

There are three main sources of funding for health services: government, donors and private, out-of-pocket expenditures. While there is some uncertainty about the relative contribution of each of these sources (World Bank and Asian Development Bank, 2003, p27), it is undisputed that of out-of-pocket contributions, paid by individuals, is by far the major source of funding for health services. While the government allocation of funds to the health sector has substantially increased over the last decade, donor funds still provide the major source of funding to the health sector. There are concerns that there is a very low percentage of the overall budget being allocated to salaries (10% of actual expenditures for 2002), and that a limited amount reaches the provincial health departments (57% in 2001) (World Bank and Asian Development Bank, 2003).

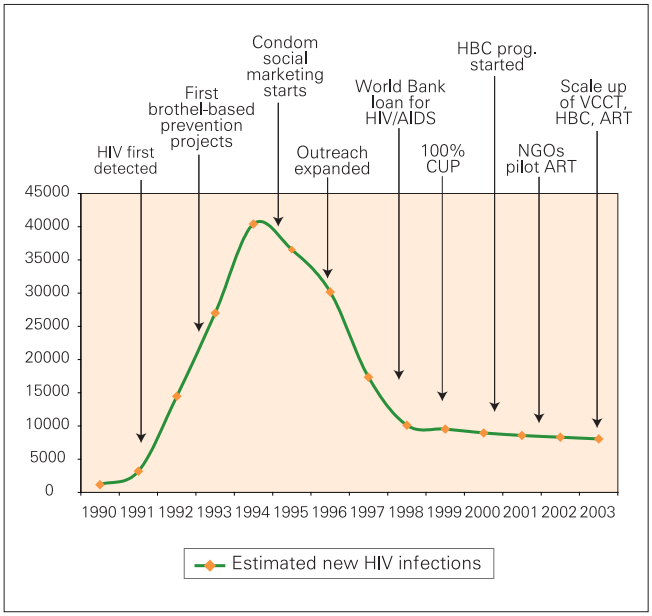
Furthermore, data from the Council for the Development of Cambodia (CDC) indicate that the donor contribution to the health sector peaked in 1999. The data provided for this study indicate that there is a significant increase in funding earmarked for HIV and AIDS, and it is not clear which parts of the health sector, if any, have experienced falling investments. An analysis of investment patterns should be undertaken urgently, in order to ensure an equitable development of health services.

Figure 19: Health and HIV/AIDS spending by source, million US dollars



Health data from: Ministry of Economy and Finance, Medium-Term Expenditure Framework for Cambodia, 2004; HIV/AIDS spending includes none health-sector spending on prevention, impact mitigation and others

Figure 20: Key Interventions



8

LOOKING BACK .... WHAT WE HAVE LEARNED

Although Cambodia still has the highest level of HIV prevalence in Asia, it is well on track to achieve its MDG HIV targets for 2015. In contrast with other apparent "success stories" (such as Thailand, Brazil or even Uganda), Cambodia had neither a functioning public health system nor a stable political environment to provide bases on which to build the response. Cambodia's success in responding to the HIV epidemic is therefore all the more impressive. Some of the key lessons learned in initiating and scaling up this response are highlighted below:

People matter – Cambodia's response was initially led by a small group of dedicated individuals, driven by a conviction that HIV posed a serious threat, long before it was visible or properly researched. The commitment of this group of people drawn from the government and civil society, with high motivation and energy to devote to social causes, was a major success factor in combating a rapidly escalating epidemic. In a country that had recently emerged from isolation, participation in leadership programmes and overseas exposure visits by key people at the early stages of the epidemic played a critical role in providing motivation, fostering understanding, and providing the innovators with ideas and tools to initiate interventions.

Institutions are important, but... – In the absence of a functioning public health system, the early response relied extensively on NGO/civil society initiatives, which were often donor-led, with support from key government officials. While national and provincial institutions to coordinate the response were quickly established, and enabled individuals to perform, it was the key individuals who drove the institutional agendas and proved to be critical for initiating and coordinating interventions.

Partnership pays off – Good partnerships, drawing on the comparative advantages of government and NGOs, proved effective. Civil society/government partnerships were based on trust and a pragmatic recognition of what needed to be done and an acknowledgement that there was enough work for everyone. This provided room for experimentation and innovative approaches. From the outset, the government was willing to trust NGOs to initiate pilot interventions, and was quick to adapt these and take them to scale when they proved effective.

Outreach works – The outreach approach has been a crucial element of successful prevention efforts in Cambodia's response. Outreach was a novel and untested approach in Cambodia when it was initiated in the early 1990s. The NGOs who pioneered the approach pursued team-based outreach interventions with the general public, as well as with high-risk groups, in the face of considerable challenges. The outreach approach has eventually found its way into government programmes, including the 100% Condom Use Programme.

Information is crucial – While an initial response was based to a certain extent on informed guesses, the need to rapidly establish effective surveillance systems was identified very early on. Cambodia quickly established a nascent surveillance system to guide the response. Information was used consistently and successfully by key stakeholders to advocate change with

political leaders and donors. Regardless of the quality of the system, surveillance could at best only provide a broad picture of the epidemic, and was supplemented by other qualitative and quantitative studies that helped to provide a deeper understanding of the underlying behaviours that fuelled the epidemic.

A second area in which information proved critical was the rapid increase in awareness about HIV and AIDS among the general population, over a relatively short period of time. This can be attributed to a combination of intensive awareness-raising activities by credible and fervent key individuals who toured the country advocating change with local administration and civil society, coupled with hard-hitting messages broadcast on mass media to a population that had previously existed in an information vacuum.

Policy can wait – Cambodia's rapid and effective response targeting high-risk groups did not require a policy framework in which to operate. On the contrary, programmes largely informed policy development. Cambodia's policies on HIV and AIDS, and in particular the highly acclaimed Law on the Prevention and Control of HIV/AIDS Epidemic in Cambodia, were nearly all developed after the epidemic had peaked (see Annex 4), and are largely in response to programmatic realities. However, programmes were significantly enhanced by the extensive debate and discussions that accompanied policy development – and the importance of policy in sustaining the response should not be underestimated.

HIV is an increasingly costly disease – The response has received considerable resources over the last 15 years, including multiple rounds from the Global Fund. In the early days of the response the resources available were minimal, but generally perceived as adequate.
Major increases, however, have occurred in the last four to five years, and the available surveillance data suggest that averting new infections among more dispersed populations, and providing access to care and treatment, has become increasingly difficult and costly.

While the increase in resources partly reflects the rising need for care, treatment and impact mitigation, this may also be partly influenced by donors choosing to "bet on a winner". Available resources have contributed to strengthening institutions as well as community-based groups and self-help groups. The quantity and quality of services being delivered in the public health sector have been expanded, and a growing pool of Cambodian professionals is available to coordinate the response.

The fact that the public health system in general has not seen substantial increases in donor funding, despite limited progress in the improvement of health indicators, raises some concerns about the sustainability of the investments in the HIV and AIDS response.

9

LOOKING AHEAD … WHAT WE SHOULD HEED

This section highlights the challenges that Cambodia faces in sustaining its successful response to the HIV epidemic, and suggests some approaches to best meet these challenges.

Addressing systemic issues:

Sustaining and improving the political commitment – Continuing declines in the prevalence rates among sentinel groups could easily give rise to complacency. It will therefore be crucial to maintain the current level of political commitment, as reduced prevention efforts can quickly lead to a renewed surge of infections. Monitoring of the implementation of The National Strategic Plan and continued quality research need to be undertaken in order to inform the political leaders and to advocate for continuing wide-scale HIV interventions.

Improving the quality of surveillance and other monitoring systems – The current surveillance system, while providing a sound foundation for evidence-based programmes, continues to be hampered by high refusal rates, inconsistent quality control, especially during the data collection stage, and the limited number of groups surveyed. The paucity of male sentinel populations, and the limited proportion of pregnant women accessing ante-natal care, and therefore contributing to the general population sample for adult women, remain problematic. Likewise, some essential sentinel groups are not included in the surveillance system, notably men who have sex with men and drug users.

The behavioural and HIV surveillance systems cover different sentinel groups in different geographical locations, thus limiting the cross-validation of prevalence and behavioural information. Comprehensive monitoring systems for tracking resource allocation and expenditures have not yet been established, and the cost effectiveness of various interventions has not yet been established. There is also a need to supplement surveillance with further qualitative research, especially on masculinity in the Cambodian context, which may help increase understanding of the underlying risk behaviours that continue to fuel the epidemic.

Ensuring blood safety – In 2003, the HIV-prevalence rate among blood donors in Phnom Penh was 3.3%, significantly higher than that of the general population. The majority of donations are from replacement donors and the system continues to be infiltrated by paid donors. The government has limited budget for ensuring blood safety, which remains a critical issue. Coverage of blood screening is variable and there are no set standards or procedures for ensuring quality. The recent grant from the Global Fund to improve the management and quality control of blood screening provides a real opportunity for the Ministry of Health to ensure blood safety throughout the country.

Integrating health services – Some progress has been made to integrate the HIV response into a comprehensive approach

to public and private health service provision, as part of ongoing health system strengthening. However, despite the potential for synergies, there is little integration of HIV and maternal and child health/birth-spacing initiatives, either at policy or service delivery levels. This is a critical area, especially as mother-to-child transmission is likely to become the major mode of HIV transmission in the coming years. There is a need to move away from a model that delivers services through vertical programmes, and work towards developing client-focused models that meet the needs of communities and address the rights of individuals.

Mainstreaming HIV programmes – Despite the best intentions, HIV programmes remain to a large extent in the health arena, with the Ministry of Health bearing the major burden for responding to the epidemic, and focal persons for HIV being located within departments/bureaus of health within the other ministries. There needs to be an acknowledgement that all ministries have to take responsibility for addressing HIV and AIDS, and ministries that do not yet have specific policies or strategies for responding to HIV should be encouraged to develop these. Initiatives developed by the Ministries of Interior, Defence and Education provide examples of how HIV programmes can be mainstreamed.

Improving coordination – While national coordination efforts are improving, HIV and AIDS interventions remain poorly coordinated at the grassroots level. In particular, the fragmented approach to service delivery requires improved coordination and planning. It is likely that this would lead to efficiency gains, which would enable the response to maintain present core interventions while moving into newly emerging areas. The fact that non-governmental organisations are providing many services and that civil society is playing an important role in many areas of the response calls for coordination mechanisms that include these actors meaningfully in the decision-making process. While NCHADS has achieved considerable success in coordinating initiatives at the provincial level, this is largely health-sector driven and coordination across different sectors remains weak. A possible approach to improving coordination would be to focus on key issues such as addressing stigma, meeting the needs of orphans and vulnerable children, reaching migrants, or improving referral mechanisms.

Expanding social welfare services – The government provision of social services has not greatly improved since the beginning of the response. NGOs and other civil society actors have largely filled the gap left by the under-resourced social

welfare ministries. There has been little public expression of political commitment to address this and, as a result, the approach to impact mitigation is fragmented and coverage is limited. The numerous pilots have exhibited innovative approaches, but none of these has yet demonstrated the capacity to go to scale. The extensive use of volunteers poses a major challenge to scaling up the response. The lack of a regulatory framework leaves questions on which type(s) of social service delivery the Cambodian government would eventually want to adopt to address issues of vulnerability and impact mitigation.

Mobilising resources – While the financial contribution of the government to the response has remained fairly steady, the government has not yet demonstrated the financial commitment needed to ensure sustainability of programmes. Although Cambodia's response does not experience resource constraints at present, it is conceivable that donor resources will become increasingly more difficult to leverage – particularly as the HIV prevalence rate continues to fall. The search for cost-effective approaches, pragmatic interventions, and synergies between these should therefore be made a priority. An improved tracking system for resources spent on HIV and AIDS will help to facilitate this.

Identifying and reacting swiftly to emerging risks:

Responding to changing patterns of sexual behaviour – The BSS and other studies are beginning to reveal changing patterns of sexual behaviour of men, women and youth: men are increasingly seeking commercial sex from women other than brothel-based sex workers; a significant proportion of men who have sex with men, especially in the provinces, are also buying and selling sex with women; sweetheart relationships with various degrees of transactional sex pervade all age groups; and increasing numbers of young people are engaging in casual and commercial sex, often in conjunction with substance abuse. There is a need to better understand and respond to these changing patterns of sexuality and their associated risk behaviours.

Addressing the needs of young people – Cambodia has an increasingly youthful population, with 60% below 25 years of age, and 36.5% between 10 and 24 years of age (National Institute of Statistics, 2004). Greater access to local and international media and a rise in disposable incomes have helped to fuel an emerging youth culture. Young Cambodians are being introduced to notions of individuality and materialism, and are experiencing a greater level of urban wealth and sexual freedom than ever before. Increased disposable income has also allowed young men greater access to recreational drugs and to casual and commercial sex, and changes in cultural norms are allowing both young men and women to be sexually active, with the attendant risks of acquiring sexually transmitted infections.

There is a clear need to address the causes and consequences of risky behaviours of young people, through expanding existing training, peer-education, sensitisation and youth-friendly service initiatives. In particular, there is a need to develop and expand innovative approaches to reach vulnerable and hard-to-reach youth populations such as street-children, orphans and out-of-school youth, and respond to the sexual and reproductive health needs of a rapidly evolving youth culture.

Harm reduction – The sharing of contaminated injecting equipment accounts for the majority of new infections in much of southeast Asia. While there is presently little quantitative evidence that this practice is widespread in Cambodia, qualitativestudies indicate that the sharing of non-sterile injecting equipment may be increasing in Cambodia, especially given its porous borders, availability of cheap drugs and the rising disposable income of young people. There are concerns that increasing illicit drug use, and especially sharing of non-sterile injecting equipment, could act as new potential drivers of the HIV epidemic in Cambodia.

There is considerable evidence from a number of countries that demonstrates that needle exchange programmes are highly successful in reducing HIV risk, without increasing rates of drug use. Ideally, needle exchange forms part of a comprehensive harm reduction programme, which includes drug use reduction interventions, support to voluntary detoxification, drug substitution and support to socioeconomic reintegration, among others. The fact that programmes of this type are contradictory to US policy calls for innovative programming and resource mobilisation in order to be able to react to growing drug use with an increasingly accepted programme of comprehensive harm reduction.

Incorporating the needs of men who have sex with men – This group is highly diverse, and multiple contact points with the general, heterosexual population exist. A significant proportion of men who have sex with men are young people and there are indications that they are homosexual by opportunity rather than by inclination. There is a need to promote better understanding of risks and behaviour change to encourage consistent condom use among this group. There is also a need to consider men who have sex with men, not only as a high-risk target group, but to involve them in the planning and implementation of prevention interventions (Catalla, 2003).

A study of sexual behaviours, STIs, and HIV among men who have sex with men in Phnom Penh, undertaken by Family Health International (FHI) in 2000, documented a HIV prevalence rate of 14.4%. This was approximately equivalent to the prevalence rate among informal sex workers at that time. Exacerbating the high prevalence rate was the finding that 24% of the sample population were using drugs, including 3% who were injecting drugs. (FHI, 2000). However, it is only recently that NGOs and community-based organisations have begun implementing programmes to reach men who have sex with men and substance users.

Reaching mobile populations – Cambodia's population is increasingly mobile. While the types of migration are reasonably well documented, the extent of mobility is presently not well understood. Migration to neighbouring countries, notably Thailand, is mostly illegal, and no official records on these movements exist. There is also evidence that cross-border migration in the border provinces is common. Legal migration for work purposes to other Asian countries is growing. At the same time there are extensive internal movements from south-eastern provinces to north-western areas of the country. The response needs to draw upon the expanding knowledge base of these groups to develop targeted prevention programmes for these hard-to-reach and potentially at-risk mobile populations.

Safeguarding and enhancing rights:

"AIDS is no longer [just] a disease. It is a human rights issue." Nelson Mandela

Ensuring rights to information, services and freedom from discrimination – Since the establishment of the UN mission in the early 1990s, Cambodia has been under close scrutiny regarding its respect for the fundamental rights of its citizens. While substantial challenges remain in securing economic and political rights, interventions for HIV and AIDS have largely been based on the right of people to access information and services protecting them from HIV infection. Legislation, policy and practice form a coherent package promoting Cambodians' rights to health.

An emerging challenge, however, stems from increasing pressure from the present US Administration to limit condom promotion to high-risk sex, thus contributing to an association of shame and stigma which discourages the use of condoms by sexually active youth, and among adults with multiple partners. There is some concern that the successes of Cambodia's evidence-based prevention programmes could be eroded by 'abstinence programmes' that stigmatise those living with HIV or AIDS and deny people information about condoms. Rather than constraining condom use there is a need to strengthen sexual and reproductive health services as an essential element of reducing HIV infection, and provide women with the knowledge to make informed decisions about child bearing and sexual health.

Focusing on gender – The disparity in expected gender roles, power relations, access to education and resources continues to compromise the sexual health of women. The recent Cambodia Gender Assessment - *A Fair Share for Women,* notes that Cambodian women and girls are increasingly at risk of contracting HIV (Asian Development Bank, 2004). High levels of sexual violence and high-risk sexual behaviour of men, exacerbated by a culture of impunity and acceptance, coupled with gender dynamics that limit women's ability to negotiate sex and condom use, make women especially vulnerable to contracting HIV. There is a critical need for more interventions that address these underlying factors that continue to propagate the spread HIV. At the same time, there is a need to foster socio-cultural practices and strengthen policy and legal environments to empower women and girls, and promote and protect their rights.

Finally…

Cambodia's government, civil society and development partners have achieved considerable success in turning the tide of the HIV epidemic. However, it will be necessary to guard against complacency and sustain earlier successes by continuing to respond to the tide's ebb and flow. While building upon these successes, there is a need to re-energise and broaden the response, and develop innovative and strategic approaches and partnerships to address emerging challenges.

Other countries, in nascent stages of the epidemic, need to guard against another kind of complacency – that they will not be seriously affected by HIV. As the UNAIDS Executive Director Peter Piot has noted, "globally there is more than one pandemic – there is a multiplicity of epidemics at different stages". A key lesson learned in Cambodia is that a proactive and dynamic response pays major dividends – in terms of efficiency, cost-effectiveness, and above all in helping to ensure that men, women and children have a future that is free of HIV.

ANNEXES

1. Documents Reviewed

AIDSlink (1993). "Global update: Cambodia". AIDSlink(23): 15.

AIDS Wkly Plus. (1996). "Cambodia seeks help for AIDS patients." AIDS Wkly Plus: 14.

Asian Development Bank. (2004).

Bernander, Bert et al. (1995). Facing a Complex Emergency: An Evaluation of Swedish Support to Emergency Aid to Cambodia. Stockholm SIDA.

Blanc, Marie-Eve, Laurence Husson, Evelyine Micollier (editors). (2000). Sociétés Asiatiques Face au SIDA. L'Harmattan.

Bühler, M. (2004). Case Study M&E Systems for HIV/AIDS – Cambodia. UNAIDS.

Busza, J. and B. T. Schunter (2001). "From competition to community: participatory learning and action among young, debt-bonded Vietnamese sex workers in Cambodia." Reprod Health Matters 9 (17): 72-81.

Cambodge Soir. (1995). "[Happy birthday, Number One] World AIDS Day 1995]." Cambodge Soir (Special No): 3.

Cambodian Working Group on HIV/AIDS Projections. (2002). Projections for HIV/AIDS in Cambodia: 2000-2010.

Catalla Jr., TAP, Kha Sovanara, Gerard van Mourik. (2003). Out of the Shadows – Male to Male sex Behaviour in Cambodia. KHANA/International HIV/AIDS Alliance.

Catalla Jr., TAP. (2006). Cambodia's Response to HIV/AIDS - An Analysis of Resources.

CCC (1996). Toward Genuine Partnership – NGO Strategies for Development in Cambodia 1996-2000.

Chhoun Samrith, M. D., Saphonn Vonthanak. (1998). Report on Sentinel Surveillance in Cambodia 1998. Phnom Penh, NCHADS.

Council for Social Development. (2002). National Poverty Reduction Strategy, December 2002.

Council for the Development of Cambodia. (1995) Development Cooperation Report 1994-95.

Curtis, Grant. (1989. Cambodia : A Country Profile, report prepared for the Swedish International Development Agency. Phnom Penh.

Curtis, Grant. (1998) Cambodia Reborn?. Brookings Institution Press.

Development Works. (2005). Evaluation of the Leadership Development Programme in Cambodia. UNDP.

Dooley, L., Oum Sopheap and Douglas Shaw. (2003). Ten Years of HIV/AIDS in Cambodia: Past Evaluations, Current Observations and Charting the Future. Phnom Penh, World Vision.

Family Health International (FHI). (2000). A study of sexual behaviours, STIs and HIV among men who have sex with men in Phnom Penh.

Family Health International (FHI). (2001). Behavioural Sentinel Survey 1997-1999.

Glob AIDSnews. (1994). "AIDS cases soar in past year." Glob AIDSnews(3): 1-3.

Gorbach, P. et al. (1997). The Cambodian Behavioral Surveillance Survey, First Round: 1997. Phnom Penh, National AIDS Program.

Guillou, Anne. 2000. Promotion de la Femme et Sexualité en Temps de SIDA. Le «Principe de la Coupure» Chez les Cambodgiennes Instruites. in Blanc, 2000.

Hill, P. S. and H. T. Ly (2004). "Women are silver, women are diamonds: conflicting images of women in the Cambodian print media." Reprod Health Matters 12(24): 104-15.

Klement, Julie, Paul DeLay, Tony Bennet, Michael Burkly. (1995) HIV/AIDS Assessment Cambodia October 8-27 1995.

Kumar, K., H. Baldwin, et al. (2000). Aftermath: Women and Women's Organizations in Postconflict Cambodia. Washington DC, Center for Development Information and Evaluation, USAID.

Lowes, David. (2003). Perceptions of the Cambodian 100% Condom Use Program: Documenting the Experiences of Sex Workers. Policy Project.

Men, M. (2005). HIV/AIDS in Cambodia: Stigmatization, Isolation and the Intervention of Buddhist Monks. Faculty of Arts, Development Program. Providence, Rhode Island, Brown University.

Ministry of Health / National AIDS Committee. (1993). Comprehensive National Plan for AIDS Prevention and Control in Cambodia 1993-1998. Phnom Penh, Ministry of Health National AIDS Committee: 43 pages.

Ministry of Health. (2000). Strategic Plan for HIV/AIDS and STI Prevention and Care in Cambodia 2001-2005.

Ministry of Health/National Centre for HIV/AIDS, Dermatology and STD. (2004). Strategic Plan for HIV/AIDS and STD Prevention and Care, 2004-2007.

Ministry of Planning. (1996). First Socioeconomic Development Plan 1996-2000.

Mith Samlanh-Friends. (2002). Drug Use and HIV Vulnerability: An appraisal of the links between drug use and HIV transmission among young people in Cambodia. International HIV/AIDS Alliance.

Munz, Monique. (1996). HIV/AIDS Local Implementing Capacity Baseline Study – for UNICEF Cambodia.

National AIDS Authority. (1991). AIDS Prevention and Control: The One Year Short term Plan for Cambodia 1991/1992.

National AIDS Authority. (2001). A Situation and Response Analysis of the HIV/AIDS Epidemic in Cambodia.

National AIDS Authority. (2003). Cambodian Report on Follow Up of Commitment on HIV/AIDS (UNGASS)

National AIDS Authority/Policy Project. (2005). Report by the Technical Working Group on Resource Mobilization: Joint Review of the National Strategic Plan for A Comprehensive and Multi-Sectoral Response to HIV/AIDS. Draft, 09 March '05. Phnom Penh.

National AIDS Authority. (2005). Implementing Guidelines of The Law on the Prevention and Control of HIV/AIDS.

National AIDS Authority. (2005). National Strategic Plan for a Comprehensive and Multisectoral response to HIV/AIDS 2006-2010.

National AIDS Authority. (2006). UNGASS: Monitoring the Declaration of Commitment – January 2004-December 2005.

National AIDS Programme. (1996). HIV Sentinel Surveillance, Cambodia. Phnom Penh, Ministry of Health.

National AIDS Programme, French Cooperation, EU, USAID, UNAIDS, NGOs. (1997). National Review of the HIV/AIDS Response in Cambodia, April-June 1997

National Institute of Statistics. (2004).

NCHADS. (1997). HIV Sentinel Survillance 1997 Cambodia. Phnom Penh, NCHADS: 33 pages.

NCHADS, WHO WPRO, FHI. (1999). Consensus Report on STI, HIV and AIDS Epidemiology.

NCHADS. (2003). Allocation of Funds for HIV/AIDS in the Health Sector. Phnom Penh; September 2003.

NCHADS. (2003). Continuum of Care for people living with HIV/AIDS: Operational Framework.

NCHADS. (2003). Report of the Mid-Term Assessment of the Ministry of Health Strategic Plan for HIV/AIDS and STDs Prevention and Care in Cambodia, 2001-2005.

NCHADS. (2005). Comprehensive Report on HIV/AIDS Year 2005.

NCHADS and FHI. (2004). HIV Sentinel Surveillance Report 2003. Phnom Penh, Ministry of Health.

NCHADS (2006) Annual Operational Plan Comprehensive Plan 2006 for NCHADS and Provinces: January – December 2006

Nette, A. (1993). The AIDS Epidemic may be Cambodia's next Pol Pot. The Bangkok Post. Bangkok.

Phalla, T., H. B. Leng, et al. (1998). "HIV and STD epidemiology, risk behaviors, and prevention and care response in Cambodia." Aids 12 Suppl B: S11-8.

Phan, H. and L. Patterson (1994). Men are Gold, Women are Cloth. Phnom Penh, Care International: 56.

Pillai, Gita, Barbara Donaldson, and Sok Keang. (2004). A Directory of Organizations Implementing or Supporting HIV/AIDS Activities in Cambodia and A Compilation of Abstracts Submitted to the XV International AIDS Conference July 11-16. Draft report. Phnom Penh: USAID/NAA/NCHADS/URC

PSI. (2002). Love, sex and condoms in the time of HIV. December 2002, Phnom Penh.

PSI. (2004). Knowledge, Attitudes and Behavior Regarding HIV/AIDS in Cambodia: Results of a 2003 National Survey.

Ramage, I. (2002). Strong Fighting: Sexual Behavior and HIV/AIDS in the Cambodian Uniformed Services. Phnom Penh, FHI

Robinson, K. (1995). "Fight against AIDS stacked with problems." Phnom Penh Post 4(25).

Rusten, Caroline, Kim Sedara, Eng Netra, Pak Kimchoeun. (2004). The Challenges of Decentralisation Design in Cambodia. CDRI Phnom Penh.

Ryan, C., P. Gorbach, et al. (1997). The STD/HIV Prevalence and Resistance Study in Cambodia: Final Report. Phnom Penh, ATDSCAP/USAID.

Saphonn V, Sopheab H, Sun LP, Vun MC, Vantha SS, Gorbach PM, et al. (2004) Current HIV/AIDS/STI Epidemic Intervention Programs in Cambodia, 1993-2003. AIDS Education and Prevention. 2004 (16).

State of Cambodia / Ministry of Health. (1992). Transitional Health Plan – Part One: Health situation analysis; A framework for development.

Summers, S. J. (1997). Evaluating Health Knowledge and Practices of Mothers and Caretakers from four villages on the Outskirts of Phnom Penh. Phnom Penh, Redd Barna, Central nursing School.

Tarr, Chou Meng and Aggleton. (1999). "Young People and HIV in Cambodia – Meanings, Contexts and Sexual Cultures." AIDS Care 11(3): 375–384, 1999

UNAIDS. (1999). Country Profile 1st Edition.

UNAIDS. (1999). Country Profile 2nd Edition.

UNAIDS. (2000). Country Profile 3rd Edition.

UNAIDS. (2001). Country Profile 4th Edition.

UNAIDS. (2005). Country Profile 5th Edition

UNAIDS. (2002). Actions and Opportunities – Cambodia's Response to HIV/AIDS. UNAIDS Best Practice Collection.

UNAIDS. (2005). Intensifying HIV Prevention. UNAIDS Policy Position Paper.

UNAIDS, WHO and International HIV/AIDS Alliance. (2003). Handbook on Access to HIV/AIDS-related treatment. UNAIDS Best Practice Collection.

UN Country Team. (2002). Developmental Implications of HIV/AIDS.

Vonthanak Saphonn, Heng Sopheab, Ly Penh Sun, Mean Chhi Vun, Seng Suth Vantha, Pamina M. Gorbach, and Roger Detels. (2004).Current HIV/AIDS/STI Epidemic. Intervention Programs in Cambodia, 1993-2003. AIDS Education and Prevention, 16, 64-67

Walston, N. (2005). Country Analysis of Family Planning and HIV/AIDS Programs: Cambodia. Phnom Penh, The Policy Project.

Wilkinson, D. (2000). An Evaluation of the MoH/NGO Home Care Programme for People with HIV/AIDS in Cambodia; International HIV/AIDS Alliance

Wilkinson, D. & G Fletcher. (2002). Love, Sex and Condoms: Sweetheart Relationships in Phnom Penh. Report prepared for PSI, Cambodia.

Wilkinson, D. (2004a). Talking About HIV- Testing and Counselling in Cambodia: Motivators, Barriers and the Decision-Making Process; Report prepared for PSI Cambodia

Wilkinson, D. (2004b). A Healthy Partnership – a case study of the MoH contract to Khana for disbursement of World Bank funds for HIV/AIDS in Cambodia; International HIV/AIDS Alliance.

World Bank. (2000). Cambodia Country Assistance Evaluation.

World Bank. (2004). Project Performance Assessment – Kingdom Of Cambodia – Disease Control and Health Development Project (CR. N005-KH), Report No.: 26648-KH.

World Bank and Asian Development Bank. (2003). Integrated Fiduciary Assessment and Public Expenditure Review (IFAPER) – Cambodia, Enhancing Service Delivery Through Improved Resource Allocation and Institutional Reform, Report No. 25611 KH, May 16, 2003.

II. Resource persons contacted*

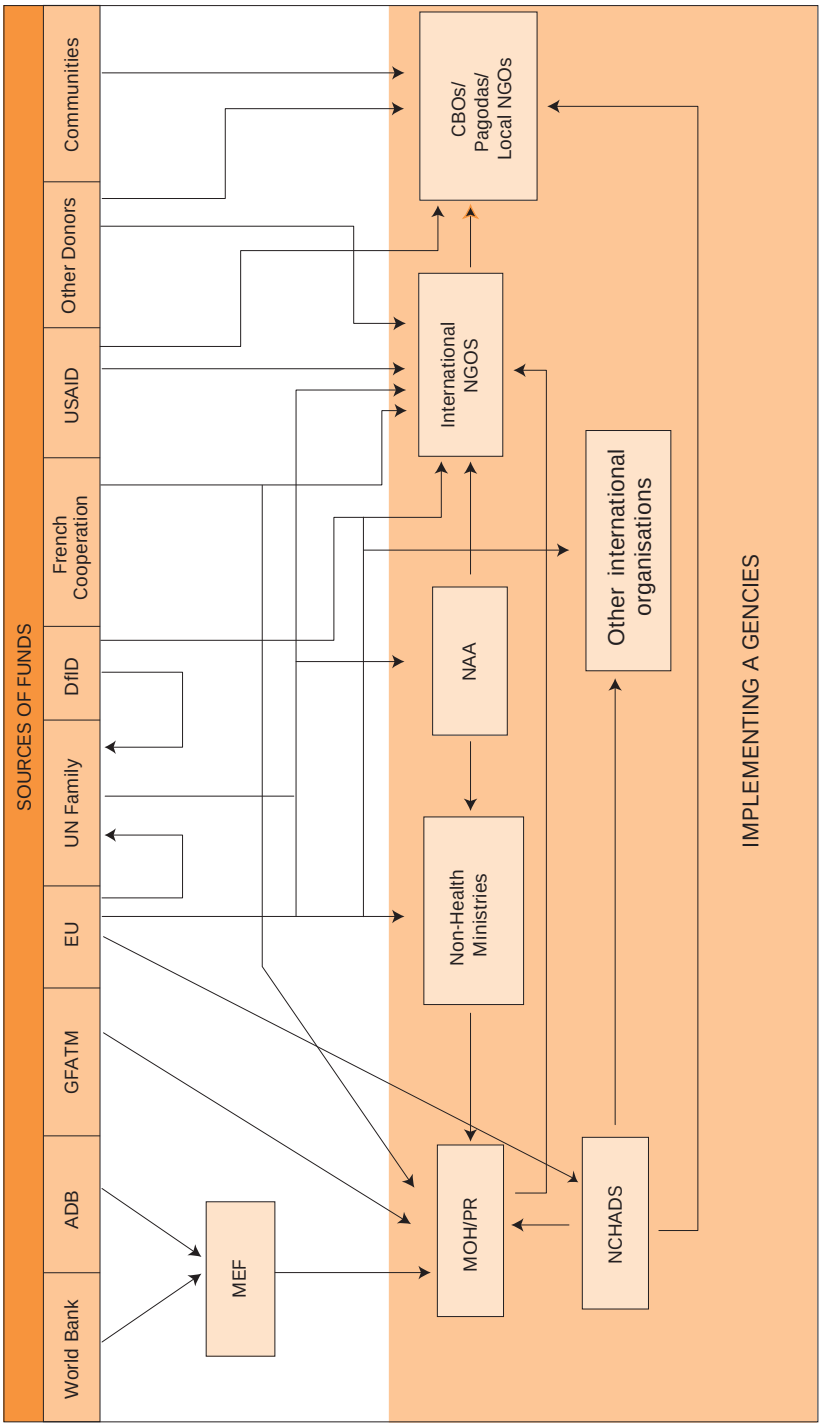
Name	Organisation
H.E. Hong Sun Huot	National AIDS Authority
H.E. Mam Bun Heng	Ministry of Health
Oscar Barreneche	WHO – Myanmar
Chun Bora	ILO
Noeun Bou	European Union
Sok Bunna	USAID
Michael Calabria	CDC-GAP
Thun Chamnan	Battambang PPN+
Eng Chanchum	Hope of Children (NPC, BB)
Hok Kim Cheng	NBTC
Ing Chivorn	Cambodian Human Rights and HIV/AIDS Network
Reuth Choeung	Korsang
Janet Cornwall	Servants
Julie David	UNESCO
Prun Den	Khmer Development Freedom Organization
Cecilia Francisco	WHO
Massimo Ghidinelli	WHO
Peter Godwin	NCHADS
Mikaela Grongvist	European Union
Arlys Herem	Dhamamyietra
Carol Jacobsen	UNICEF
John Kaldor	National Centre in HIV Epidemiology and Clinical Research - Australia
Dymphna Kenny	Care International - Myanmar
Ung Kim Heng	KHANA
Um Kimleng	Cambodia Development Association
Lumning	UN Centre for Human Rights
Fabrice Laurentin	UNICEF
Hor Bun Leng	CDC-GAP
Scott Leiper	Seila Programme
Kem Ley	GIPA
Jan de Lind van Wiijngaarden	Consultant / UNESCO
Sophea Mar	Asian Development Bank
Lyn Mason	Save the Children Fund Australia
Laksmey Metakaruna	MSM focus group
Ellen Minotti	Social Services of Cambodia
Pen Moni	Positive Women of Hope Club
Tep Monyratha	Salavation Children of Cambodia Battambang
Guy Morineau	FHI
Joanne Morrison	UNDP – Yemen
Monique Munz	Copenhagen
Joyce Neal	CDC-GAP
Rob Overtoom	Swiss Red Cross

* Note: some resource persons preferred to remain anonymous.

Sia Phearum	CEIDA
Taing Phoeurk	Korsang
Kein Serey Phal	CWDA
Sok Phalla	Toul Kork Clinic
Tia Phalla	UNDP - Thailand
So Phany	KANHNHA
Sok Pun	Care
Maurits van Pelt	Mopotsyo
Renato Pinto	UNDP
Som Pisey	MSM focus group
Etienne Poirot	UNICEF - Madagascar
Panhavichetr Pok	CIDA
Eav Pov	MSM focus group
Haritiana Rakotomamonjy-Langlois	UNICEF
Richard Renas	Oakland County Health Division - USA
Sheila Robinson	NAA
Geeta Sethi	UNAIDS - Switzerland
Kim San	COHD
Proeung Saran	Battambang PPN+
Van Saveth	NPC Battambang
Nuon Sidara	KANHNHA
Beng Simeth	World Bank
Keo Sitha	NCHADS Social Health Clinic
Elizabeth Smith	DFID
Pok Socheat	Buddhists for Development
Choub Sokchamreun	KHANA
San Sokhat	Battambang PPN+
Tan Sokhey	Ministry of Defence
Mao Sokhon	Peer Educator
Mean Sokun	Battambang PPN+
Mean Sokunthear	Battambang PPN+
Oum Sopheap	KHANA
Sun Sopheap	Battambang PPN+
Sorn Sothearidh	GIPA at Calmette Hospital
Cheam Sovanna	MSM focus group
Deap Srey	Battambang PPN+
Tep Sreypov	World Bank
Khov Sunhuy	Battambang PPN+
Seng Suthwantha	UNDP
Lun Tharat	WHO
Chek Thol	Battambang PPN+
Rasoka Thor	UNICEF
Huot Totem	Vithey Chivet
Sobil Tuy	Korsang
Ouk Vong Vathany	RHAC
Mean Chhi Vun	NCHADS

III. Flow of Resources

Figure 21: Flow of resources for HIV/AIDS



Designed by Graphic Roots: www.graphicroots.com.kh

UNAIDS Country Office
221, Street Pasteur (51), Khan Chamkar Mon, Phnom Penh, Cambodia
Tel: (855-23) 219 340 / Fax: (855-23) 721 153