

Care and Support for People with HIV/AIDS

Phnom Penh, Battambang and Banteay Meanchey

**Pollie Bith
Chan Kanha
Hean Sokhom
Nguon Sokunthea
Judith Zweers**

**Center for Advanced Study
Phnom Penh, Kingdom of Cambodia
March 2000**

TABLE OF CONTENTS

List of Acronyms.....	iii
Executive Summary.....	v
1. Introduction.....	1
1.1 HIV/AIDS in Cambodia.....	1
1.2 A need for care and support.....	1
1.3 Research Objectives.....	2
1.4 Research Methodology and Design.....	2
1.5. Research Limitations.....	3
2. Statistical information on HIV/AIDS in Cambodia.....	5
3. Response from the government.....	6
3.1 1993 – National AIDS Committee and National AIDS Plan (NAP).....	6
3.2 1997 – Review of the National Response and National Strategic Plan 1998-2000.....	6
3.4 1998 – NCHADS.....	9
3.5 1999 – National AIDS Authority.....	10
4. The Provincial Response.....	10
5. Bilateral and Multi-lateral support.....	11
5.1 Bilateral Support.....	11
5.2 Multilateral support.....	12
6. Programs and Facilities in Phnom Penh.....	13
6.1 Sentinel Surveillance Data.....	13
6.2 Safety Blood Donation.....	13
6.3 Blood Testing.....	15
6.3.1 Pasteur Institute.....	15
6.3.2 National testing centers.....	15
6.3.3 Private testing.....	16
6.4 Counseling and Social Work.....	16
6.5 Prevention of Mother to Child Transmission, and children with AIDS.....	17
6.6 Home Based Care.....	18
6.7 Other forms of community involvement.....	20
6.7.1 AIDS Support Groups.....	20
6.7.2 monks and nuns, and traditional healers.....	20
6.8 Hospital Care.....	21
6.8.1 Sihanouk Hospital.....	21
6.8.2 Calmette Hospital.....	22
6.8.3 Center of Hope.....	23
6.8.4 Other Hospitals.....	24
6.9 Hostels and Hospices.....	24
7. Battambang.....	25
7.2 Provincial structure.....	26
7.3 Blood transfusion, blood testing and counseling.....	26
7.4 Hospital care.....	27
7.5 Home Based Care.....	28
7.6 Monks and nuns.....	29

8. Banteay Meanchey.....	30
8.1 Sentinel Surveillance Data.....	31
8.2 The Provincial structure: cooperation with Thailand?.....	31
8.3 International NGOs.....	32
8.4 Local NGOs.....	33
8.5 Hospital care.....	33
9. Conclusions and Recommendations.....	35
9.1 Phnom Penh.....	35
9.2 Battambang.....	36
9.3 Banteay Meanchey.....	36
9.4 In general.....	37
9.5 Recommendations.....	37
10. Bibliography.....	39
11. Annex 1.....	41
12. Annex 2.....	44
12. Annex 3.....	45

List of Acronyms

AIDS	- Acquired Immune Deficiency Syndrome
BWAP	- Battambang Women • fs AIDS Project
CAAFW	- Cambodia Association for Assistance to Families and Widows
CAS	- Center for Advanced Study
CFDS	- Cambodia Families Development Services
COERR	- Catholic Office for Emergency Relief and Refugees
CRS	- Catholic Relief Services
CUHCA	- Cambodia Urban Health Care Association
CWDA	- Cambodian Women • fs Development Organization
DAS	- District AIDS Secretariat
DoH	- Department of Health
EU	- European Union
FAC	- French Cooperation
FHI/IMPACT Project	- Family Health International/Implementing AIDS Prevention and Care
HACC	- HIV/AIDS Coordinating Committee
HNI	- Health Net International
HSS	- HIV Sentinel Surveillance
ICRC	- International Committee of the Red Cross
IDA	- Indradevi Associations
IEC	- Information, Education, Communication
IDP	- In-Patient Department
JICA	- Japan International Cooperation Agency
KBA	- Khmer Buddhist Association
KHANA	- Khmer HIV/AIDS NGO Alliance
KRDA	- Khmer Rural Development Association
MDM	- Medecins du Monde
MoH	- Ministry of Health
MoSALVY Rehabilitation	- Ministry of Social Affairs, Labor, Vocational Training and Youth
MSF	- Medecins Sans Frontieres
MSF-HBS	- Medecins Sans Frontieres – Holland, Belgium, Switzerland
MSI	- Maria Stope International
NAA	- National AIDS Authority
NAC	- National AIDS Committee
NAP	- National AIDS Plan
NBTC	- National Blood Transfusion Center
NCHADS	- National Center for HIV/AIDS, Dermatology and STD
NGO	- Non Governmental Organization
OEB	- Operation Enfants Battambang
OPD	- Out-Patient Department
PAC	- Provincial AIDS Committee
PAO	- Provincial AIDS Office
PAS	- Provincial AIDS Secretariat
PMTCT	- Prevention of Mother to Child Transmission
PSF	- Pharmaciens Sans Frontieres

PSI	- Population Service International
QSA	- Quaker Services Australia
RHAC	- Reproductive Health Association of Cambodia
SEADO	- Social Environment Agriculture Development Organization
SCC	- Salvation Center Cambodia
SERVANTS	- SERVANTS to Asia • fs Urban Poor - Cambodia
SSC	- Social Services Cambodia
STD	- Sexually Transmitted Disease
SUPF	- Squatter and Urban Poor Association
TB	- Tuberculoses
TPO	- Transcultural Psychosocial Organization
UNV	- United Nations Volunteer
VDC	- Village Development Committee
WOMEN	- Women Organization for Economy and Nursing
WVI	- World Vision International

Executive Summary

Care and support for people with HIV/AIDS is a relatively new area in Cambodia. However, in the last few years more and more organizations have started activities and programs in this area. JICA asked the Center for Advanced Study to provide an overview of existing services of care and support for people with HIV/AIDS, and to study the main problems, gaps and needs. From mid December to the end of March, CAS interviewed almost 100 service providers in Phnom Penh, Battambang and Banteay Meanchey, and reviewed the existing literature.

Care and support for people with HIV/AIDS was discussed for the first time in 1998 in the National Plan. Since then, a program for home based care through mobile teams in Phnom Penh was developed. This program is considered a success, and at present Battambang is nominated to be the second province to receive home based care. Most facilities though are still located in Phnom Penh: at least three hospitals provide services to AIDS patients, there are ten home care teams, two hospices, two voluntary testing centers, and several counseling centers. There are two AIDS support groups in Phnom Penh, and at least one organization is helping children whose parents died from AIDS, and/or children who contracted the disease themselves. Two organizations in Phnom Penh are training monks to become health educators and counselors, although one mainly works in Takeo.

Despite the many organizations, programs and activities, Phnom Penh is still unable to deal with the fast growing number of people with HIV/AIDS. There is still a shortage of hospital beds, some hospitals face a shortage of drugs for opportunistic infections, and financial constraints limit the current home care program in a much-needed expansion. There is a fast growing need for hostels and hospices for those who are abandoned by their families, who had to sell home and land for expensive treatment, or for those who prefer to leave in order to decrease the burden on their families and stay among peers who can relate to them.

Cambodia has five voluntary testing centers, of which two are located in Phnom Penh, and one in Battambang. Battambang is the first province targeted by the national AIDS program for home based care. There is at present one home care team, and two more teams may soon be set up. There are, however, doubts as to what extent the Phnom Penh model can be used in the provinces, where the situation is entirely different from that in a city like Phnom Penh where the geographical location of people is more dense than Battambang and Banteay Meanchey provinces.

Banteay Meanchey seems, compared to Phnom Penh and Battambang, a largely neglected area. There are no programs and/or facilities for people with HIV/AIDS yet (except for several local NGOs that provide basic social and economic support to poor families), whereas the province has a high HIV prevalence rate. There is no testing facility, and private testing practices (without counseling and secured anonymity, and with a high chance of false results) are widespread.

Support and care for people with HIV/AIDS in both provinces officially are coordinated by the Provincial AIDS Office (PAO) under the Department of Health. However, the provincial structure in both provinces seems fairly weak, with the PAO largely being

unaware of activities and planning of other organizations in the area. Especially in Banteay Meanchey, international NGOs prefer to set up separate structures, since cooperation with the PAO and the provincial hospital, which apparently does not deliver good services to poor AIDS patients, is difficult. The blood bank of the provincial hospital in Banteay Meanchey is, in contrast to that of Battambang, of poor quality. The biggest problem with blood transfusion is getting low-risk blood donors.

In this study we found that both financial and technical support is still needed in all three provinces. More support is needed for the home care program, for the public health system, and for the provincial authorities coordinating AIDS activities. The need for hospices and hostels is high, as well as for a better training of counselors. Banteay Meanchey, having a high HIV prevalence rate, is at present lacking any facility for people with HIV/AIDS. We therefore recommend concentrating future activities in this area.

1. Introduction

1.1 *HIV/AIDS in Cambodia*

In 1998, an estimated 24% of the people newly infected by HIV, lived in Asia. By that time, over 7 million Asian people were already HIV+.^[1] Seven years earlier, AIDS did not seem a major problem in Cambodia, nor did anyone expect that it would be in the near future. However, after the first HIV infection was detected among the military through serological screening of donated blood in 1991, this picture changed radically. The first group of people with AIDS in Cambodia was diagnosed in late 1993, and from then onwards, the number of people with HIV has grown steadily.

The World Bank classifies countries with HIV epidemics as 1) nascent: HIV prevalence less than 5% in all known risk groups, 2) concentrated: HIV prevalence above 5% in one or more high risk groups but below 5% in urban antenatal clinics, or 3) generalized: HIV prevalence of 5% or more among women attending urban antenatal clinics.^[2] Initially, the epidemic in Cambodia was concentrated: the infection was to a large extent limited to particular well-defined risk groups, such as commercial sex workers, the military and police. From the beginning, the priority therefore has been given to prevent the epidemic from spreading to the general population.

In an attempt to control the epidemic, the Ministry of Health of Cambodia set up a National AIDS Plan, which focussed on STD/HIV education, condom promotion and STD treatment.^[3] In 1995, the NAP started to monitor the spread of HIV through surveillance data, and from 1997 onwards it initiated an annual behavioral surveillance survey to measure change in behavior among specified risk groups (sentinel groups) that influence the spread of STDs and HIV.

According to the HIV/AIDS estimates and projections as of March 1999, the prevalence rate in Cambodia among the adult population will be around 5.11% in the year 2000.^[4] This means that the epidemic is no longer concentrated, but has reached the general population. Entering the year 2000, Cambodia has the highest HIV prevalence and fastest growing rate of HIV infection in Asia.

1.2 *A need for care and support*

Within the last few years, slowly, more attention is given to support and care for people with AIDS. The estimated number of new AIDS cases was 10,000 for 1999, and will be more than 13,000 for 2000. It may reach a total of new cases of about 29,000 by the year 2005.^[5] However, little attention has been paid to the support and care for those who live with the virus. In 1998 only 3% of the estimated US\$ 5.5 million for HIV/AIDS activities in Cambodia was allocated to care.^[6]

There is a growing need for care and support for AIDS-patients and their families. The HIV/AIDS National Strategic Plan 1998-2000 discusses (for the first time) care and support strategies for people with HIV/AIDS, and several organizations have started activities in this area in the last few years. It is in this light that JICA requested the Center for Advanced Study to provide an overview of the existing programs and facilities for people with AIDS, the main problems and gaps, and needs for the immediate

future. The emphasis in this report is on care and support for people with HIV/AIDS, and not on the prevention of transmission of the virus. However, this does not mean that JICA/CAS do not attach any importance to prevention and awareness raising. On the contrary: the prevention of transmission is at least as important as care and support for those who have contracted the virus. Both activities in reality are, and should be, part of the same package.

1.3 Research Objectives

The terms of reference for this study emphasized one main objective: to find out existing programs being implemented by various agencies of humanitarian development assistance and to make recommendations for further assistance.

We were requested to accomplish the following tasks:

- a. Provide general information about the Cambodian situation regarding HIV/AIDS problems.
- b. Provide an outline of the National master plan/strategy regarding HIV/AIDS.
- c. Provide an overview of activities by the Cambodian Government for HIV/AIDS prevention and support for AIDS patients.
- d. Provide an outline of multilateral/bilateral assistance.
- e. Provide an outline of NGOs • f assistance.
- f. Provide an overview of community participation.
- g. Provide an overview of the current situation of the blood control system.

1.4 Research Methodology and Design

Our study consisted of a review of literature, documents, and • ggrey • h literature, and of interviews with service providers within organizations implementing programs and/or activities for people living with AIDS.

Our study sought samples on a purposive basis from the UNAIDS Country Profile for the initial point of contact. We sought health service providers in the Phnom Penh area, Battambang and Banteay Meanchey from governmental, non-governmental, and bilateral agencies to identify key service providers in the subject area.

- a. From the UNAIDS Country Profile, we selected service providers who have support and care programs for people with HIV/AIDS.
- b. From snowball sampling, we selected organizations that were recommended to us to contact for further interviewing.
- c. We visited organizations that provide support programs for people with HIV/AIDS.
- d. We visited villages, pagodas, and blood testing centers, hospices and hospitals.

Our sample was designed to include various subject areas, i.e. blood testing, counseling and social work, home based care, hospital care, and hostels/hospices. We sought service providers from each category to give an overview of the facilities and services available for AIDS care and support.

We conducted a total of 98 interviews with a total of 92 service providers. The large majority of service providers were from non-governmental organizations. However,

wherever possible we also conducted interviews with outreach workers who provide direct support services to AIDS patients at the village level.

In this research, semi structured interviewing was based on discussions prior to field research. The discussions intended to guide the questions and issues that had to be covered, although the order of topics discussed was left to the interviewer's own device. The purpose of the discussions was to have each team of interviewers cover the same topics in the same depth.

Interviews with government officials focussed on strategic planning, to what extent the plans are/can be carried out, what are the main problems encountered, what are the causes and what are the needs, what is the planning for the future, and what coordination/collaboration exists between governmental agencies and other organizations working in the field of AIDS. Interviews with bilateral, multilateral and non-governmental organizations focussed on the programs/projects/activities carried out, their approach to the HIV/AIDS problem in general, evaluations and lessons learnt from activities in the past, cooperation with other organizations, and on problems, causes, possible solutions and the main needs in this field. Interviews with hospitals focussed on the number/percentage of HIV+ patients and AIDS patients, their capacity to provide treatment to AIDS patients, the availability of drugs, any changes over the last few years, mental health care, main problems encountered, the causes and needs, and cooperation/collaboration with other organizations.

Our researchers presented themselves as members of an independent non-governmental organization, devoted to research. We explained the objectives of the research to the service providers as an effort to obtain information about existing resources and the availability of facilities for AIDS patients and their families, with the aim to make recommendations for the future.

Our researchers worked in two teams. One team consisted of a UNV research officer, Judith Zweers, MA and Chan Kanha, BA, with assistance from Hean Sokhom, Ph.D. The second team consisted of a Cambodian American medical anthropologist, Pollie Bith, Ph.D. Candidate, and Nguon Sokunthea, BA. The team members have extensive experience in in-depth qualitative interviewing.

The Research was conducted from mid December 1999 to mid March 2000, on a part time basis. A large portion of the interviews took place in Phnom Penh where the majority of the facilities are located for AIDS patients and their families.

1.5. Research Limitations

It was not always easy for service providers or key persons to reserve time for an interview. There are organizations and persons we should have talked to, but could not due to the limited time available for the research, and the fact that many key persons took vacations, field trips, were busy working, etc. We spent seven weeks for research in Phnom Penh, more than one week in Battambang, and one week in Banteay Meanchey. We therefore do not claim that this report gives an exhaustive overview of all organizations and activities.

This study focuses on care and support for people with HIV/AIDS in the broadest sense. Although many informants stressed the fact that awareness raising/prevention and care/support are inseparable, we tried to separate them in this study as much as possible. Providing an outline of all activities in prevention and education would require a much longer study. However, we do understand the complexity here, as care activities can open a door to prevention, and education and awareness raising can involve a greater understanding and acceptance of people with AIDS, and thus entail a decrease in discriminative behavior. In fact, both are often, and should be, part of the same package.

It is very important to stress that a study like this cannot answer questions like •gWhat facilities or services do people with HIV/AIDS prefer?• h and •gWhat improvements in these services and facilities would people like to see?• h i.e. interventions from the receiver • fs point of view. These are questions that can be answered by a second step of research involving an in-depth qualitative methodology, interviewing people with HIV/AIDS and their families. In order to find out the real problems and needs, both care and support providers and their clients should be given the opportunity to reflect.

Due to the limited time available for this research, we have not been able to make any comparisons between the approaches in Cambodia and those in other countries facing a similar epidemic. Such comparisons however may provide valuable findings and new insights, and could be an interesting next step for further research.

This research provides an overview of the facilities available for people with HIV/AIDS, the main organizations (national and international) that are involved in providing those facilities, and some of the main debates. Such an overview is an essential first step in deciding on future programs and activities, and possible areas of future cooperation and collaboration in this field.

2. Statistical information on HIV/AIDS in Cambodia

It is not easy to get accurate information on the AIDS epidemic in countries like Cambodia. The first figures usually are based on regular case reporting by health facilities. Case reports provide useful information, but are limited due to underreporting and under-diagnosis^[7]. The number of AIDS cases reported increased drastically over the years. However, little information is available on under-reporting. The estimations for South East Asia range from 10% underreporting to percentages as high as 90%.^[8]

Table 1: numbers of reported AIDS cases in Cambodia from 1990-1999

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999*	Total
AIDS	0	0	0	1	14	91	300	572	401	1456	4834
HIV	0	3	91	205	660	2611	4541	4674	7646	2691	24028

Source: STI/HIV/AIDS Surveillance Report, Special Edition, No. 14, October 1999, p. 8

- The figures for 1999 are from January 1999 until June 1999

Sentinel surveillance, a periodic prevalence sampling in selected groups in selected areas/locations, is a good complement to regular reporting. Sentinel surveillance makes it possible to get more accurate data, to monitor trends in HIV-infection over time, and to

reveal trends in transmission modes, risk factors or certain patterns among risk groups. Moreover, using surveillance data together with a mathematical model of transmission, HIV infections can be projected several years into the future. Accurate data are very important for developing good intervention designs.

The STD/AIDS program of the Ministry of Health in Cambodia started with an HIV Sentinel Survey (HSS) from 1995 onwards, with technical and financial support from WHO and other international organizations. In 1995, the first sentinel surveillance took place, including eight population groups in nine provinces along the Thai border.^[9] The addition of other provinces (in 1996 the surveillance system covered 18 provinces), other risk groups and larger sampling sizes made the data more representative. However, the surveillance has included different groups each year, making comparisons and detection of trends very difficult. In 1996 the system was evaluated and adjusted, also including certain rural areas. In 1999 a national strategy for surveillance was developed, with a simplification and standardization of target groups in order to facilitate comparisons.^[10]

The surveillance data for 1998 are as follows (results of 1999 will be available in May 2000):

Table 2: prevalence HIV+ among sentinel groups in 1998

Direct Commercial Sex Workers	42.6%
Indirect Commercial Sex Workers	19.1%
Police	6.2%
Married Women of Reproductive Age	2.4%
Hospital In-Patients	12.2%

Source: Report on Sentinel Surveillance in Cambodia 1998

In 1998 3.6% of the adult population in Cambodia was estimated to be HIV+. The estimations for 2000 run as high as 5.1%, but are not based on surveillance data as is the case with the 1998 estimation.^[11]

Since 1990, blood used for transfusions is routinely tested for HIV, both in Phnom Penh and in the provinces. Since 1997, 15 blood transfusion centers have to report their HIV test results monthly to the MoH. Prevalence of HIV in blood donors increased from 1991 onwards.

Table 3: percentage HIV+ tested among blood donors in Cambodia per year

	1992	1994	1996
%HIV+	0.44%	3.01%	4.0%

Source: Chin, James: Cambodia Trip Report-September 30-October 12, 1996, HIV Prevalence Estimates for Cambodia: Recommendations for Future HIV Surveillance, October 21, 1996, Berkeley, California

The percentages for the National Blood Transfusion Center in Phnom Penh over the years 1998 and 1999 were 5.6% and 4.1% respectively.

3. Response from the government

3.1 1993 – National AIDS Committee and National AIDS Plan (NAP)

The first governmental body created to provide an answer to the AIDS epidemic in Cambodia, was the National AIDS Committee (NAC), with representation from different Ministries and provinces. The aims were to reduce HIV transmission and reduce the morbidity and mortality associated with HIV infection. The NAC was set up to review the situation of HIV/AIDS and inform the Council of Ministers accordingly, to develop a multi sectoral policy regarding AIDS prevention and control activities, to ensure cooperation between different partners, and to monitor and evaluate the performance.

At the implementation level, the National AIDS Plan (NAP) was developed by the Ministry of Health in 1993. Created independently from the existing National STD Center, the NAP became responsible for implementing HIV prevention activities, and for conducting HIV prevalence and risk behavioral surveillance. The NAP's budget from 1993 to 1997 was approximately US\$ 1.05 million, of which the vast majority came from international donors (only US\$ 15,000 from the government). Around 80% of the funding resources went to NGOs; the remaining 20% to government programs.^[12]

3.2 1997 – Review of the National Response and National Strategic Plan 1998-2000

In 1997 the NAP and international donors undertook a national review of the HIV/AIDS response in Cambodia. The review recommended supporting the coordinating role of the government with regard to both NGO and government activities, and to make technical and financial support to the government available, as well as decentralizing funds to provincial levels.

Following the review, a National Strategic Planning workshop was held in 1997. This exercise resulted in 1997 in a new National Strategic Plan STD/HIV/AIDS, Prevention and Care in Cambodia 1998-2000. The National Strategic Plan prioritizes prevention and care activities according to identified needs and available resources, and recommends a focus on geographic areas and population groups with a high STD and HIV/AIDS prevalence. The idea of clustering certain provinces allows, according to the Strategic Plan, for bringing together and exchanging experiences and skills from neighboring provinces, which saves time, money, and the number of resource persons needed. Provincial strategies have to be developed which will allow for a sharing of technical resources and funding from government, private and NGO sectors.

The Strategic Plan acknowledges the importance of care and support for people with HIV/AIDS. Raising awareness of the need for future care is seen as an important part of prevention, as well as for preparing organizations, communities and families to play

an active, compassionate and supportive role in care and support for people living with and affected by AIDS. • h^[13]

Geographic priorities	Priority populations
1. <i>Central-south</i> : Phnom Penh, Kampong Thom, Kampong Chhnang, Kampong Cham, Kampong Speu	<ul style="list-style-type: none"> • Commercial sex workers (CSW) • Clients of CSWs, including military, police and fishermen • Mobile populations/migrant workers • Sexual partners of the above (including wives and girlfriends) • People living with and affected by HIV/AIDS
2. <i>North-west</i> : Battambang, Banteay Meanchey, Siem Riep, Pursat	
3. <i>South-west</i> : Koh Kong, Sihanoukville, Kampot	
4. <i>Central-east</i> : Kandal, Prey Veng, Svay Rieng, Takeo	

Source: National Strategic Plan STD/HIV/AIDS, Prevention and care in Cambodia 1998-2000, p. 11

The Strategic Plan chooses, due to limited resources a minimum package for prevention and care. This package includes: promotion of condom use, STD services, communication strategies and IEC materials, special interventions for people with high-risk behavior, and community participation in prevention, care and support.

Community participation in prevention, care and support entails:

- Strengthening existing community structures and resources at the local level;
- Securing higher level support and full community participation in assessing, planning and monitoring ways to reduce STDs and HIV/AIDS and provide care;
- Ensuring a linking and coordination between traditional and non-traditional health care, mental health/psycho-social support, and social services.

If more resources become available, more activities may be considered, among others: care and support for people living with HIV/AIDS and those affected by AIDS, blood safety, testing and counseling, and research.

Care and support entails:

- The finalization of National guidelines and protocols, providing training on its implementation, ensuring the integration of protocols and guidelines in (para-)medical school curriculums, and training of health care workers in the private and public sector;
- The mobilization of donor support (adding drugs for opportunistic infections to the essential drugs list and assisting in home care programs);
- Engagement of the traditional healing sector, ensuring that care provided is in line with people •fs culture and beliefs about diseases, and participation of the community, including traditional healers, monks, leaders and family members.

Blood Safety entails:

- Supplying and increasing technical equipment and materials to existing blood banks;
- Providing provincial hospitals without blood banks with a minimum package to perform rapid screening tests;
- Conducting media campaigns to encourage low risk groups to donate blood and high-risk groups to self defer and seek testing and counseling;
- Managing and monitoring permanent quality control (public and private) and guidelines on blood use;

- Conducting research on barriers to donating blood and translate the results into program implementation.

Testing and Counseling entails:

- Capacity building for testing and counseling services and the provision of sufficient resources;
- Improving the technical capacity and quality control of testing and counseling services;
- Promoting the use of voluntary testing and counseling centers;
- Network building and collaboration across sectors to develop a referral system that provides continuity of services from education, counseling, testing, health care and social services.

Research entails among others:

- Compile/disseminate in Khmer the epidemiology, behavioral sentinel surveillance and completed socio-behavioral research study findings across interested agencies in Cambodia;
- Conduct socio-economic impact research on HIV/AIDS;
- Provide assistance through provincial workshops on understanding how to use socio-behavioral research findings in program planning and implementation;
- Conduct research on clinical care aspects (institution- and home-based care) to identify effective and efficient approaches;
- Conduct research regarding traditional healers and ethnographic aspects of STDs and HIV/AIDS.^[14]

For the first time, care and support for people living with AIDS is part of a comprehensive national plan. In this plan, NGOs are recognized as having an important role in reaching specific priority populations, mobilizing community support and involvement, and piloting innovative models in collaboration with government services at the provincial and sub-provincial level.

The strategic plan is also ambitious, involving many activities, priorities and provinces. Its implementation therefore requires well functioning planning and coordinating bodies at both national and provincial levels.

3.4 1998 – NCHADS

In 1998 the NAP and the National STD Center merged together into the National Centre for HIV/AIDS, Dermatology and STD (NCHADS). NCHADS has the status of a separate department for HIV/AIDS within the MoH. The aim is to oversee the response of MoH and provide technical support to other government agencies and national partners.^[15] NCHADS has six different units:

- Program Management, Evaluation and Research
- Multisectoral Unit
- STD Control
- STD & Dermatology Clinic
- AIDS Care, Testing and Counseling
- IEC

The six units were established just before the strategic plan 1998-2000 was developed, and the priorities set in this plan were spread out over the six units.

At present, NCHADS is preparing a strategic plan for the years 2001-2003, which will entirely be a MoH/NCHADS plan. This means that some priorities of the 1998-2000 plan, which primarily are being carried out by other ministries, will not return in the 2001-2003 plan.

The AIDS Care, Testing and Counseling Unit collects data from the main hospitals, organizes/facilitates training in clinical management, and develops guidelines for adult, pediatric and home based care. The National Home Care Program is managed and supervised by the AIDS Care Unit of NCHADS, in close cooperation with KHANA and International NGOs. The unit does however not have a clear picture of all care and support activities, due to a lack of reporting of several international organizations to NCHADS. With regard to blood testing and blood banks, NCHADS initiates plans and sets priorities for expansion of primary voluntary testing centers (ELEISA available) or secondary testing centers (no ELEISA available) to the provinces, in close cooperation with the French Cooperation. NCHADS is also facilitating a working group on prevention of mother to child transmission, and a sub committee on AIDS and TB (with a possible link between DOT and home based care).

NCHADS provides direct technical support to the Provincial AIDS Offices. One of its main functions is to establish policy and appropriate guidelines that can be implemented at the provincial level. NCHADS, and the AIDS Care Unit in particular, still need capacity building in carrying out this task, since its strategic planning capacities are still weak. NCHADS is flooded by requests from the provincial authorities to make budgets available to start activities, whereas it currently does not have the capacity to answer even part of the requests.

3.5 1999 – National AIDS Authority

In January 1999 the National AIDS Authority was established, replacing the old National AIDS Committee and Secretariat. The functions of the NAA are: to improve coordination between different actors and activities; to develop policy and strategies; to mobilize the resources needed; and to monitor and evaluate the implementation of activities. Implementation however is not the role of NAA. NAA consists of a Policy Board with Secretaries of State from 12 Ministries and provincial governors as members, and a Technical Board. The Secretaries of State are directly responsible for the implementation of activities of their Ministry in relation to HIV/AIDS prevention and control. The Technical Board reviews the policy developed by NAA, recommends national action, reviews reports on the progress of the epidemic and the national response, reports to NAA on the progress made by individual Ministries, and reviews efforts to improve information exchange.

Most ministries are involved in awareness raising and education, in order to prevent the epidemic from spreading further. The most active ministries, besides the Ministry of Health, are: Ministry of Education (school curriculums), Ministry of SALVY (education for women in factories), Ministry of National Defense (military and police), Ministry of Women • fs and Veteran • fs Affairs (women and communities), and Ministry of Rural

Development (communities through village health volunteers) (see Annex 3 for structure and policy of NAA)

Ever since its implementation however, the NAA seems to face problems of coordination and cooperation. Not many activities seem to have taken place yet. Its roles and functions with regard to management and policy issues, in particular vis-a-vis NCHADS, are still unclear.

4. The Provincial Response

At the provincial level, Provincial AIDS Offices (PAO) were established under the Provincial Departments of Health. The PAOs were meant to carry out the National AIDS Plan at the provincial level, through which training, education and outreach to sex workers, schools, the military and police are to be provided. However, the activities carried out in reality are limited due to a lack of resources (human as well as technical and financial).

The PAOs fall directly under the Provincial Health Departments. Due to this set up, HIV/AIDS was being approached as merely a health problem. In order to approach the epidemic in a more multi sectoral way, a pilot program was started in four provinces, involving the establishment of multi sectoral Provincial AIDS Committees (PAC) and Provincial AIDS Secretariats (PAS). UNICEF, UNAIDS and UNDP/CARERE support these structures. Similar to the NAA, the members of the PAC and PAS are representatives from the different provincial departments. PAC sets the policy (comparable to the Policy Board of NAA); PAS is the implementing/coordinating body, reflecting the Technical Board of NAA at the provincial level. In the past, NAP/NCHADS was directly involved in the implementation of activities at the provincial level. Meanwhile, decentralization has become the key priority, although access to financial resources at the provincial level is still a problem. At present, a budget is made available for 11 provinces. Budgets are made available on the basis of annual and quarterly work plans, to be developed by the PAO. The planning and managing capacity of many PAOs is however still very weak.

The functions of the PAS are: coordination/facilitation of activities at the provincial level between the local government, NGOs and international partners; reducing the impact of the epidemic in the province; designing, implementing and reviewing the Provincial Strategic Plan on HIV prevention and control; and improving the flow of information and communication between the commune, district, provincial and national levels.

The examples of Battambang and Banteay Meanchey (see chapter 7 and 8) show that the planning and coordinating capacities of the PAS in both provinces is still fairly weak, and that in reality the PACs are non-existent. The roles and functions of the PACs still remain unclear, and may have to be reconsidered. Apparently, there are no official strategic organizational and operational guidelines, resulting in different organizational and operational strategies per province.^[16] Another problem is the difficult accessibility of funds from the national level.

5. Bilateral and Multi-lateral support

5.1 Bilateral Support

The French Cooperation (FAC) was the main bilateral supporter of the AIDS program from 1995 to 1997. It is still the only bilateral organization involved in blood testing and medical care for AIDS patients. FAC has been involved in the following activities:

- Blood testing: set up and operational (financial and technical) support of two testing centers in Phnom Penh and four in the provinces.
- Operational support for the construction or rehabilitation and equipment of STD centers throughout the country.
- Provision of ELEISA testing to the National Blood Transfusion Center and the blood bank in Battambang
- Support to the surveillance system through training and technical supplies for testing.
- Support to hospital care (financial support to MSF-France in Phnom Penh and Battambang)
- Support to NCHADS and the Provincial AIDS Offices (logistics, equipment, etc).
- Training of Cambodian health staff in France and curriculum development for training activities with regard to HIV/AIDS at the Faculty of Medicine.

FAC provided support from 1995 to 1999 for a total of 1.5 million US\$. A new focal point for the next few years will be the prevention of mother to child transmission (see paragraph 6.5).

Ausaid funds some international and local NGOs to carry out activities, primarily in the field of prevention and awareness raising. Among the local NGOs funded by Ausaid will soon also be a local NGO in Banteay Meanchey, which may possibly start home care activities in the future.

USAID funds PSI (distribution of condoms) and FHI/IMPACT. The organization focuses on prevention and behavioral change. One of their aims is the empowerment of commercial sex workers.

5.2 Multilateral support

There are seven multilateral agencies involved in HIV/AIDS activities. Those agencies, WHO, UNICEF, UNFPA, UNDP, UNESCO, and the World Bank are brought together by UNAIDS, which opened an office in Cambodia in 1996. The main roles of UNAIDS are to coordinate the programs of the multilateral agencies, provide them with technical back up and help them with resource mobilization. Besides, it is one of the main bodies to assist the national program in coordinating and mobilizing international support. The technical staff of multilateral agencies, some bilateral organizations and major NGOs hold regular meetings.

Most multilateral agencies are mainly involved in prevention of HIV/AIDS, such as education and awareness raising. UNICEF and WHO are also involved in activities of care and support for people with AIDS.

The general objective of UNICEF is to reduce HIV transmission and to reduce the impact of the epidemic on children, youth and families, through preventive interventions, services and initiatives for people living with HIV/AIDS. Its plans are very ambitious.

Besides awareness raising and education, UNICEF wants to contribute to the national capacity to respond to the epidemic by:

- involving Buddhist institutions, monks and pagodas in providing assistance and support to people with AIDS
- developing voluntary and confidential testing and counseling facilities in the public health services
- expanding practical support for children and women living with HIV/AIDS, through advocacy at the national level and practical support at the community level through full participation of people affected.

UNICEF wants to contribute to reducing HIV transmission from HIV positive mothers to their newborn children through the development of Prevention of Mother to Child programs (see paragraph 6.5). UNICEF also plans activities to ensure the safety of blood transfusion in provinces, knowing that blood transfusion is often mainly used for children and women.

At the village level, UNICEF is planning to start a combination of community education and community care and peer support groups for families and children living with HIV/AIDS. The agency wants to work through existing forms of cooperation, such as Village Development Committees, Feedback committees, parent teacher organizations, and Buddhist monks (the latter in cooperation with the Ministry of Religious Affairs). UNICEF stresses the need for strengthening the existing structures, such as health centers, rather than creating new ones. The organization has doubts about the home care program.

Besides, UNICEF has been, and will stay involved in the strengthening of national and local institutions in both the public (e.g. PACs) and civil society sector.

WHO has been involved in prevention and care and support from the very beginning, through technical and financial support of the National AIDS Committee, the National AIDS Plan and NCHADS. In coordination with NCHADS and other organizations, a pilot project was developed on home based care. WHO provides technical assistance to NCHADS for developing guidelines for adult care, childcare, and home care (only Khmer versions available; English versions soon to be finished), which serve as training documents for doctors. WHO provided training for blood testing, but stopped this activity. It still provides technical assistance to the National Blood Transfusion Center.

The World Bank provided a loan of 6 million US\$ for prevention of HIV/AIDS and care and support for people with HIV/AIDS over a period of five years, starting from 1997. NCHADS is financed through this World Bank loan.

6. Programs and Facilities in Phnom Penh

6.1 Sentinel Surveillance Data

Table 4: HIV prevalence in Phnom Penh 1998

Sentinel Group	1998
Direct Sex Workers	61.3%
Indirect Sex Workers	7.0%
Police	8.7%
Hospital in-patients	11.3%
Married women of reproductive age	3.8%

Source: Report on Sentinel Surveillance in Cambodia 1998

The prevalence rate among direct sex workers in Phnom Penh is the second highest among 18 provinces (the highest being Pursat). The prevalence rate among the police is the fourth highest, and the prevalence among married women is fifth highest.^[17]

6.2 Safety Blood Donation

The National Blood Transfusion Center (NBTC) in Phnom Penh was set up by the Cambodian and International Red Cross (ICRC). The ICRC started rebuilding and rehabilitating the NBTC and supported it from 1991 to 1997. It provided all funding, technical and material support.

When the ICRC left in 1997, the Center was handed over to the MoH and was supported in 1998/1999 by an Italian NGO. At present, WHO provides technical assistance in order to assess the situation and prioritize problems. The ICRC left the NBTC behind in a good state, and at present the NBTC has been able to maintain at least the same level as before. MoH provides the budget. Nevertheless, international support is needed to improve existing systems and develop new ones. The World Bank currently provides loans for HIV-testing, as well as for the establishment of new blood banks throughout the country.

At present, there is one blood bank in Phnom Penh and there are 14 provincial transfusion centers. Seven or eight more provincial blood banks will be built in the near future. Besides the NBTC, there is also a blood transfusion center in the Swiss supported pediatric Kantha Bopha hospital in Phnom Penh. There is no exchange of information or coordination between the national centers and Kantha Bopha, except for the exchange of statistics. In 1998 almost 23,500 blood units were collected all over the country.^[18] This blood is systematically being tested on HIV, Hepatitis B and C, Syphilis, and in the endemic areas also on Malaria.

For detection of HIV the NBTC uses a rapid test (partial agglutination) and the ELEISA test. It follows the protocols set by WHO. If the two tests show different results, both

tests have to be repeated. If after repetition the test results still differ from each other, the blood unit is sent to Pasteur Institute for further analysis. This system ensures almost 100% accuracy, but problems with the window period still persist. The tests have an accuracy of 99% after 21 days, almost 100% after three months. The residual risk is 1%, meaning a possible contamination of 230 among a total of 23,500 units. In Western countries other tests are used, measuring the presence of the virus, which reduces the window period to about one week. The tests that are used in Cambodia detect for antibodies, which develop about three weeks after transmission of the virus.

The only way to really reduce the risk, is to screen the donors themselves, and to encourage self-deferral. Here lies the heart of the problem. All blood banks in Cambodia are faced with the serious problem of finding good blood donors. There are three main types of blood donors:

- 1) Internal Replacement donors (family and • eprofessional donors • f)
- 2) External Voluntary donors, found through a mobile blood collection (low risk groups, such as students from high school and colleges, monks, etc)
- 3) Internal and Spontaneous donors

Among the first group, the Internal Replacement donors, are • eProfessional • f donors as well. Illegally paid (up to US\$ 60 per unit), professional donors are brought in by family of a patient in need of blood. Cambodian people are often reluctant to donate blood: selling blood seems to be one of the last things to resort to. Those who do, are mostly people in need of money, and chances are high that they are involved in risky behavior like engaging in sex work as well. It is however not possible to refuse a donor brought in by family of the patient, especially in case of a serious shortage of blood units. The NBTC states that further qualitative research on the reasons behind the reluctance to donate blood is of utmost importance.

Table 5: blood donor groups and the infection rates at NBTC per 1998 and 1999

Donor	% of total in 1998	% HIV+ in 1998	% of total in 1999	% HIV+ in 1999
Int. Replacement*	89.0%	6.0%	79.0%	5.0%
External Voluntary	6.0%	4.2%	17.4%	0.9%
Internal and spontaneous	5.0%	1.8%	3.6%	0.5%
Total	100%	5.6%	100%	4.1%

Source: National Blood Transfusion Center

In approximately 5.6% of all blood units collected in 1998, antibodies to HIV were found; in Kantha Bopha this figure was 5.1%. The percentage of infected donated blood in the provinces is around 2.9%. Those percentages are extremely high compared to other countries. Thailand has the second highest infection rate of donated blood in Asia, 0.5% of all blood units in Thailand are infected with the HIV virus.

One of the reasons for the high infection rates in Cambodia was the practice until 1998 of collecting blood from the military. However, the military is among the highest risk groups, and the NBTC stopped this practice from 1999 onwards. The infection rate

among External Voluntary blood donors decreased from 4.2% in 1998 (including military as donors) to 0.5% in 1999. The NBTC tried to increase its stock in 1999 and solve its problems with blood donors. It managed to reduce the percentage of HIV+ units to 4.1% in 1999.

Another challenge is to increase voluntary blood collection: the NBTC started to focus more specifically on this group since the last quarter of 1999. Students are the main focus for voluntary blood collection. However, especially among these donors a high percentage of hepatitis is found (12.4%). All together, still almost 20% of all blood units have to be discarded. Note: the NBTC considers students as a low-risk group, whereas several other informants consider them as a group whose behavior is soon getting more and more risky.

6.3 Blood Testing

6.3.1 Pasteur Institute

The first voluntary testing center opened in Cambodia was Institut Pasteur, funded by the French Cooperation. Testing in this center is, like the later established national testing centers, free and anonymous. The French Cooperation provides the funding, equipment, and training. Pasteur conducts approximately 10,000 to 12,000 tests per year: 18% of the tested persons are found HIV+. Those who test positive for HIV, are referred to either Calmette or Sihanouk hospital.

According to Pasteur, the objective of testing is not only to detect HIV, but also to raise awareness among people who are still HIV negative. However, whether the testing facility is successful in reaching this objective, remains to be seen. Many people who were tested negative once, return several times: 15% in 1998 came for the second time, and this figure is increasing. So far, there is no evidence for improvement of their behavior. Pasteur provides, like the national testing centers, pre and post test counseling.

Most people belong to groups that are well defined. Besides known groups such as sex workers and military, Pasteur also mentions students. In the beginning Pasteur received only 50 persons a day. Since then, this figure increased by 10% each month. In 1995, Pasteur tested 1,500 persons, in 1996 6,000, and in 1997 9,000. From 1998 onwards, a total of 10,000 to 12,000 tests per year are conducted.

6.3.2 National testing centers

The percentage of 16-20% of people tested HIV+ is fairly stable, and is approximately the same in all voluntary testing centers in Cambodia. There are five national blood testing centers in Cambodia, all supported by the French Cooperation (FAC), of which two are located in Phnom Penh. The other provinces with national testing centers are Battambang, Siem Reap and Kampong Cham. There will soon be a national testing center in Sihanoukville. FAC provides training, technical installation and finances the running costs of the centers. Institut Pasteur operates independently from the national centers, but follows the same protocol and is in charge of the quality control of all national testing centers, including the National Blood Transfusion Center and Kantha Bopha.

All national testing centers are voluntary and anonymous, and free of charge. In August 1996 a policy document for testing was developed, stating that in order to be recognized

by the NAP/NCHADS, one has to follow the national testing protocol, and enter into the quality control system of Pasteur.

6.3.3 Private testing

There are many private-testing facilities throughout Cambodia. They are not recognized by the NAP/NCHADS, and there is no control on them. Private testers charge money for testing, do not provide counseling, and often use only rapid tests: tests that are sensitive for detecting various viruses, but not specifically for HIV. In other words, the tests only indicate the presence of viruses. As a result, those who are tested at private testing facilities may get false results. According to the NBTC, around 30% of the positive results will be false results.

There are many rumors about private testing. Some people who work in private facilities do not seem to tell the true test result (i.e. a HIV+ status) out of fear of losing a customer. There is another downside to private testing. There are cases in which the private tester shared the results with other people in the neighborhood of the customer. Another problem reported is the use of different methods for testing so as to make it cheaper, and at the same time even less reliable.

6.4 Counseling and Social Work

The national guidelines for blood testing state that people whose blood is being tested on HIV/AIDS, have to receive proper counseling before and after the test (pre –and post test counseling). Without counseling, testing should not be done.

WHO defines HIV/AIDS counseling as • ga confidential dialogue between a client and a care provider, aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. The counseling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour • h.^[19]

The counseling, received before and after testing, is to a large extent limited to providing information on HIV/AIDS and its transmission, and to explaining to people how to avoid infections through hygienic practices and a nutritious food intake. The tested person, if HIV+, will be referred to either a hospital, or to a NGO/home care team. Although there are counseling centers that also provide some • e follow up • f counseling, in practice very few people ever return for more counseling.

In principle, everybody can become a • e counselor • f. Quaker Services Australia provides a ten-day course, for which no special educational background or working experience is required. After ten days, people are counselors and can either provide pre- and post-test counseling, or become a counselor as a member of a home care team. The QSA training is to a large extent focused on trying to teach future counselors not to be too fast in • e advising • f people, but first to take the time to listen.

World Vision International (WVI) was the first organization to provide pre- and post-test counseling in Cambodia through the National STD Center (Ponleu Chivith I), and later also through its own center, Ponleu Chivit II. WVI has an AIDS telephone hotline for anonymous counseling. The organization is planning to provide training in counseling to government and NGO staff in the provinces.

Other NGOs work in a different way. Social Services Cambodia (SSC)^[20], for example, tries to work in a more holistic way and on a longer-term basis by utilizing local resources and knowledge. The aim is to help people come to terms with themselves and their situation, and to help them discover their problems and finding solutions. The counselor visits the patient at home on a regular basis, as long as is needed. The interaction is based on providing the patients the opportunity to express their own feelings. SSC has a program in Kampong Speu and works with all kinds of people in personal distress. Among the 240 clients in Kampong Speu, currently six have AIDS (with another ten family members suspected of having AIDS). Staff of SSC has no specific counseling for people with HIV/AIDS, although they visited several home care teams to learn more about the kind of problems related to HIV/AIDS. SSC also provides training in counseling to nuns and other NGO staff.

In November 1999 NCHADS, FHI and UNAIDS organized an HIV/AIDS Counseling Meeting to discuss the need for a coordination of counseling services and to identify existing training and support services. The meeting led to the formation of a Technical Working Group to look at issues of coordination, and the monitoring and evaluation of progress.^[21]

6.5 Prevention of Mother to Child Transmission, and children with AIDS

In a country where the AIDS epidemic is moving from being concentrated in certain well-identified risk groups to affecting the general population, more and more women are infected by their husbands, who in turn infect their yet unborn children. Cambodia is faced with the fastest growing number of children with AIDS in Asia. According to estimates, there will be a total of 15,637 cumulative cases of children with HIV in 2000. The cumulative number of children with AIDS may reach a total of 25,000 in the year 2005.^[22] Pregnant women who are HIV+ have an estimated chance of 30% to deliver an HIV+ baby, and 60% of those transmissions take place at the time of delivery. However, most children get infected at a later stage through breastfeeding.

A Technical Working Group, consisting of NCHADS, FAC, UNICEF, WHO, JICA and several NGOs, was set up last year to discuss the possibilities of starting a program on Prevention of Mother to Child Transmission (PMTCT). In 2000 a PMTCT program will be started in Calmette Hospital, the National Maternal and Child Health Center, and the provincial hospital of Battambang, aimed at reducing the transmission of mother-to-child at the time of delivery by providing anti retroviral therapy. The treatment is only needed at the time the delivery takes place. The problem however is that the HIV status of the woman needs to be known; one cannot test blood without providing counseling, and counseling cannot be given at the moment of delivery. Pregnant women often come to the hospital just for delivery, which is too late for testing and counseling. The protocol for PMTCT will soon be completed. Antiretrovirals are already available in the private sector, but will only be used in the public sector for PMTCT. The aim is to provide this treatment in all provincial hospitals in the long run.

The International organization Mith Samlanh/FRIENDS is working with children, mainly street children. It has a separate HIV/AIDS program, supported by UNAIDS and FHI/IMPACT. It tries to improve children's understanding of HIV/AIDS and tries to change their behavior. Many street children are involved in prostitution, and the program

tries to increase their skills to avoid risky behavior and protect themselves. Mith Samlanh also supports infected children and their families. Since there is an increasing number of AIDS-orphans (both parents died of AIDS) who end up in the streets of Phnom Penh, Mith Samlanh tries to reintegrate the children into the extended family.

6.6 Home Based Care

People who live in and around Phnom Penh and who are found HIV+ are quite likely to enter into a relatively new system of home based care. People who get their blood tested, often already show some minor signs of AIDS in its first stage. The typical illness pattern for an AIDS patient starts with minor infections, such as skin diseases: illnesses that can be managed at home as well as in a hospital. Minor infections will be followed by several episodes of more serious illness over the course of several years, although many patients in Cambodia do not live longer than six to eighteen months once they have developed full-blown AIDS.

Based on experiences with other poor countries with AIDS epidemics (Sub Sahara Africa, India and Thailand), NCHADS and several NGOs started a pilot project on home based care for AIDS patients in Phnom Penh in February 1998, with technical and financial assistance from WHO. The aim was to develop an alternative to institutional care, which will be unable to absorb the fast increasing number of AIDS patients in the immediate future. Moreover, staying at home was thought to be cheaper, more convenient, and would expose the patient less to other infections. Many patients would also prefer to stay and die at home rather than go to a hospital.

Although home care programs were being set up in many other countries before, their implementation varies per country, depending on the available resources and existing structures. The aim for Cambodia was to develop a structure that would fit in the public health system and the current Health Reforms. In December 1997 national guidelines for home and community care were developed.^[23] Eight home care teams were formed, visiting patients at their homes and supporting them and their families in their physical, social and mental needs. The teams consist of NGO and health center staff who, prior to starting the home visits, received training on health education, management of symptoms, palliative care, psychological support and working with families. The home care staff consists both of people with clinical skills and people with psychosocial skills. The teams not only visit AIDS patients, but also people with other serious and/or chronic diseases. This to avoid stigmatization of the team as •gthe AIDS-team•h, which can lead to further stigmatization and discrimination of the families visited. The teams, consisting of both government nurses from a health center and NGO community workers, are based in the state health center, from which outreach activities are taking place. They find sick people in need of help through local leaders, Wats, health centers and other people. The NGOs involved in forming home care teams were all to some extent already involved in HIV/AIDS activities in the past (often education and awareness raising).

The objectives of the teams are twofold: to care and to educate. The purpose of the visits are 1) teaching families about symptoms and basic treatment of easily manageable diseases, 2) to provide psychological support for the whole family, and 3) to educate the •ecomunity•f about care and prevention. The teams visit the patient and family once or several times a week (depending on the needs) and explain to them about prevention of

transmission, prevention of illnesses through hygiene and nutritious food intake, and how to take care of the patient. The teams provide some basic medicines for opportunistic infections, and if needed some welfare funds (food, material or money). Besides, the teams can refer the patient to the hospital if needed. After a while, the teams also started recruiting volunteers from the communities, who can serve as peer educators after they received training. The volunteers (some are HIV+) help identify other people whom they think are infected with the virus. They receive approximately US\$ 12 per month to cover their expenses.

The pilot project started in 1998 and lasted for 10 months, followed by an evaluation. All teams took on a different geographical location in Phnom Penh. By the end of the pilot period, the eight teams were visiting over 700 families, of whom approximately 60% were known to have members with HIV/AIDS. In general, the families visited were very positive about the teams. It seemed to reduce discrimination in the neighborhood and encourage positive thinking among patients as well as their families. Many stressed the importance of the social support function of the teams: helping to buy food and medicines. One of the other positive outcomes was the decreasing amount of money spent by the family on health care, although this was mentioned less often than the points mentioned previously. However, the hospitals saw an increase in AIDS patients in the period due to an increase in number of patients found and visited by the teams.

The overall results of the evaluation were positive, and it was decided to expand the program. However, it was also recommended to carry out a cost-benefit analysis, as well as a more in-depth analysis of the mechanisms of the model. After the evaluation, several improvements were made, such as an upgrading of medical skills of the team leaders, and monthly visits of a medical doctor.

At the time of the research, there were 10 home care teams in Phnom Penh. Six teams were organized by local NGOs, getting organizational, material and financial support from KHANA (see box for further information). Teams that are organized by International NGOs are financed by the international organization. The International NGOs involved in home based care in Phnom Penh are World Vision International, Mary knoll, and SERVANTS. The local NGOs involved in home based care are CUHCA, Hope, Indradevi Association, and WOMEN.

The number of patients per team varies roughly from 50 to 80. The percentage of

KHANA

The International HIV/AIDS Alliance in London channels funds to small-scale local initiatives working with HIV/AIDS. The aim is to build capacity among local NGOs to carry out community initiatives. Alliance supported the establishment of the Khmer HIV/AIDS NGO Alliance (KHANA) as the local counterpart in Phnom Penh. At present, KHANA provides 36 grants to local NGOs in 13 provinces. The financial support however is small: emphasis is on technical support and capacity building. In case an organization is strong and independent enough to apply for its own funding elsewhere, Khana stops its support.

AIDS patients among people visited was around 20 – 30% in the beginning: now this percentage is 60 – 80%. The costs to finance one team exceed US\$ 10,000 a year.

At present a second evaluation phase is underway. It has to provide more insight into the key components of the program, such as the level of a health center needed to support a home care team (important for eventual expansion of the program to other provinces), the importance of a good communication network between health centers and NGOs, and the NGO-government partnership. The evaluation will also provide more insight into the real costs per person per visit. A study from an African country showed that home based care is extremely expensive (total cost of more than US\$ 20 per visit). There are however indications that the Cambodian variant is cheaper. The results will be available by April 2000.

Local and International NGOs meet in the monthly HACC meeting (HIV/AIDS Coordinating Committee). HACC was established in 1993 to update and exchange information on NGO activities, discuss problems, promote cooperation and linkages, and to inform and coordinate with NCHADS. There are three working groups on Training and Counseling, Care and Support, and Mass Media respectively.

6.7 Other forms of community involvement

6.7.1 AIDS Support Groups

World Vision International set up the first AIDS support group in 1997: the Ponleu Chivit (light of life) Club of People Living with HIV/AIDS. The club provides people with AIDS the chance to meet and encourage each other with positive thinking. They can help each other by giving advice, share their experiences and fears. At present the club has 75-80 members. Some members are still healthy but do not want to reveal their status. Some members are sick, but do not want a home care team to visit them, out of fear that family and neighbors will find out about their status. The club is managed by the patients themselves, who also organize outings on a monthly basis.

The Center of Hope started an AIDS Support Group in 1997 as well. At first, the Center invited some of the most hopeless patients to talk about their feelings. They got to know each other and developed friendships. They meet every week to share a meal together and talk about their experiences and ideas. Meanwhile, small teams are formed that visit members at home who cannot join the weekly meetings because of illness. The group is very active, and sometimes organizes outings.

AIDS support groups can provide an important outlet to people living with AIDS. It provides a place and an opportunity to share experiences and meet people who are facing similar problems.

6.7.2 monks and nuns, and traditional healers

In 1997 Salvation Center Cambodia (SCC) started a project called Monks and HIV/AIDS.

It started with a study tour of ten monks to Thailand, organized by SCC in collaboration with COERR, and supported by UNICEF. The tour was to show some of the ways Thai Buddhist monks got involved in HIV/AIDS as educators, counselors and care

providers. Following the tour, SCC started a project to mobilize monks to take part in the HIV/AIDS prevention education campaign.

The aim is not only to educate the community, but also to make monks key agents on which people can rely and whom people can trust talking with about problems related to AIDS. Ten monks were trained in Phnom Penh to become core trainers for training other monks. The idea was that monks and nuns would start making use of pagodas as resource centers, centers where people can come to learn, ask questions about AIDS, and monks can provide answers, advice, mental and spiritual support, and create a more compassionate attitude among the community members towards people with HIV/AIDS. The underlying idea is that monks are considered as influential and trustworthy figures. People usually believe, respect and follow the advice of monks and nuns.

Some monks are collaborating with the home care teams. They try to encourage people to deal with AIDS in a spiritual way. SCC provides the training, as well as per diem and transportation reimbursement for travel to the villages.

Another organization working with monks is COERR. Its main working area is Takeo. The organization organizes two-day seminars for monks, abbots and *achaa*, to explain about HIV/AIDS and prevention and try to convince them to become health educators in the villages. COERR plans to start a hospice with approximately 20 beds in a Wat in Takeo.

The Ministry of Religious Affairs recently joined NAA. The aim is to explore possibilities of cooperation with monks and nuns in the future.

NCHADS tries to stop the practices of traditional healers (Kru Khmer) with regard to HIV/AIDS. MoH cannot prevent traditional healers from selling medicine to people with AIDS. However, MoH recently got a permission letter from the Ministry of the Interior to inform local authorities about the activities of traditional healers related to HIV/AIDS treatment. The general feeling is that many traditional healers are cheating people with HIV/AIDS, taking advantage of their desperation, claiming that they can cure people with AIDS and selling expensive traditional medicines. However, there are several cases known of traditional healers who really seem to be able to improve the general health condition of people with AIDS, and manage to stop them from losing weight. Some of them do indeed ask very high prices. At present, the ingredients of the traditional medicine of one healer who has very positive results with his patients, are being analyzed at a university in Amsterdam.

6.8 Hospital Care

6.8.1 Sihanouk Hospital

The Preah Norodom Sihanouk Infectious Diseases Ward in the former Russian Hospital is set up and supported by MSF-France (financially supported by FAC as well). MSF has been working in this ward since 1997: it provides technical support to the national staff and supplies specific drugs for opportunistic infections. Initially there were only 26 beds (three beds with oxygen therapy). Since June 1999 the Ward has 59 beds (five beds with oxygen therapy).

Although the Ward was not specifically set up for AIDS patients, around 90% of its patients are HIV+: there are fifty to sixty admissions to the IPD on a monthly basis with an average length of stay of two weeks. The most frequent diseases are chronic diarrhea, mycosis, tuberculosis, lower respiratory infections (including pneumocystosis), cryptococcal meningitis, and skin infections.^[24] The crude mortality rate is 20-30% per month. However, many patients decide to return home to die.

The Ward has one volunteer who takes care of the patients without family. Sometimes Maryknoll also comes to the Ward to help nurse those patients, such as bathing, feeding, washing cloths and dishes, etc. There are two counselors, a man and a woman, who visit the patients on a regular basis. In general it takes several visits before patients open up and are willing to share their thought and feelings. The counselors meet regularly with Maryknoll. Sometimes, staff members from Mith Samlanh/Friends come to the hospital to take care of the children whose parents are in the hospital. They play games and supplement their diet.

The Ward opened an outpatient consultation in 1998 on an every morning basis for HIV+ patients. There are approximately 300 consultations on a monthly basis, with 25% of the patients coming for the first time.

There are frequently contacts with KHANA and other NGOs that work with people with HIV/AIDS, such as Maryknoll, World Vision and WOMEN.

6.8.2 Calmette Hospital

Calmette hospital has two Wards: Ward A for patients who can afford to pay for hospitalization and Ward B for the poor who are unable to pay for their treatment. Ward A is supported by FAC, Ward B by MDM. Most AIDS-patients in Calmette hospital are in Ward B.

Ward B had 61 beds until December 1999. Around 40% of the patients were coming from Phnom Penh; 60% from the provinces. In 1996 15% of the beds were occupied by AIDS patients: in December 1999 this was 30-40%. It is expected that in the year 2000 50-60% of the beds will be occupied by AIDS-patients. However, there is a shortage of beds and patients often have to wait. Sometimes people are discharged without having a home to return to. This shortage of beds became even worse after January, when Calmette started renovating part of the building. Ward B had to move to another part of the hospital with only 30-40 beds as a result of the temporary relocation.

The most common opportunistic infections are the same as for Sihanouk Hospital. There are about 5 meningitis cases per month. There is a shortage of oxygen machines and moveable oxygen bottles, as well as anti fungus medicine. Ward B spends 10,000 US\$ on medicines on a monthly basis.

There is an OPD four days a week. When people get discharged from the IPD, they usually get follow up treatment through the OPD. Calmette has regular contact with NGOs providing home based care, such as Mary knoll, and other hospitals.

Testing of blood used to be done by Pasteur in the past, but the hospital recently set up its own testing facility with material support from FAC, and follows the national protocol for

testing. However, only the rapid test is used (partial agglutination) and not the ELISA test. It is not a free voluntary testing center where people can get their blood tested: blood is only tested for their own patients. Some medical doctors at Ward B attended a workshop on counseling and are now able to provide counseling in a room that is especially assigned for counseling purposes.

Calmette started a blood donation system in 1997, but stopped this activity in 1998 because the costs were too high and there were no donors. In case blood is needed, the hospital asks a relative of the patient to go to the blood center.

Calmette Ward B claims it needs more and well-trained doctors, especially trained in HIV/AIDS treatment, and more medicine. There are six doctors in Ward B (two studied in France and one in Bangkok) and 12 nurses. These medical staff still lack the medical knowledge on how to treat and take care of AIDS patients.

AIDS-patients and non-AIDS patients stay in the same room. There is only one special room for AIDS patients who are abandoned by their family. One third of the AIDS patients cannot count on any family member. There is one support staff member who provides nursing in that room. Mary Knoll also sometimes comes to help nursing.

6.8.3 Center of Hope

The management and administration of the Center of Hope is under Hope Worldwide. The hospital is funded through private donations by individuals, organizations and foundations. In 1998, in total 20 expatriate and 106 national medical staff members worked at the hospital.

The Center of Hope has only 22 beds: 11 on the surgical Ward and 11 on the medical Ward. About 10% of the Center's in-patients have AIDS. However, in-patient care is not the Hospital's main objective. The Center of Hope mainly provides palliative care at home (through a home care team) and outpatient services. The aim is to keep the patients at home. According to the Center of Hope, most patients prefer to die at home. Patients are only admitted to the IPD if the hospital is able to treat the disease (serious dehydration, pneumonia, TB).

There are on average 250 outpatients a day, more than 50% coming from outside Phnom Penh. The most serious patients are in general seen the same day, but for the others a lottery system is in place. There is no information available on the number of AIDS patients among the outpatients. However, there is a separate STD clinic once a week with approximately 12 patients of whom most have AIDS. On another day there is a special TB clinic: many of the patients attending this clinic have AIDS. Like Calmette, the Center does some blood testing for its own patients on the basis of symptoms. People cannot walk in freely to get their blood tested. Of the 90 patients tested per month on HIV, 70% is found HIV+. The Center also has its own system of blood donation with a list of volunteers and encouragement of relatives to donate blood. There is close cooperation with the national blood bank.

There are two volunteers who provide pre- and post-test counseling, as well as follow up counseling. As for counseling for AIDS patients the Center of Hope feels expatriate social workers are needed to train local counselors in a culturally sensitive and appropriate

way. Counseling for AIDS patients often begins and ends with the pre- and post-test counseling sessions respectively.

One of the main problems at this moment seems to be the lack of beds. The hospital only admits patients if they are seriously ill and can be cured. However, the hospital does not have the means to treat meningitis (a common opportunistic infection among AIDS patients) and refers those patients to the MSF hospital. At the time of interviewing, the Center of Hope mentioned the need for a health center to offload the hospital. The Center of Hope is built in the middle of the compound of the Municipal Hospital that has too many empty beds. Unfortunately, there is a lack of cooperation between the two hospitals.

According to the Center of Hope, more community mobilization and use of community resources is needed. Many health centers are not being used and could be turned into hostels for the • e not so sick • f and hospices for the people in their last stage of life.

6.8.4 Other Hospitals

There are other hospitals in Phnom Penh that are dealing with AIDS patients on a regular basis. Kantha Bopha is the Swiss pediatric hospital, with 10-15% of the children having AIDS. Other hospitals in Phnom Penh with AIDS patients are the Municipal Hospital, the military hospital, and the National Maternal and Child Health Center. The Municipal hospital has an STD clinic, and an Infectious Disease Ward where an American monk takes care of the AIDS patients. The Infectious Disease Ward is rehabilitated by QSA, but is still lacking basic medicines. Most people go to the Center of Hope, which is built on the compound of the Municipal Hospital, because of better (there are many expatriate doctors) and cheaper care. The Municipal Hospital would like to concentrate more on special care for AIDS patients, but is lacking the means to do so. Many beds are empty.

6.9 Hostels and Hospices

Home based care is in principal based on the idea that people with AIDS have a home and relatives to turn to. This is however not always the case. A large number of persons with AIDS have no home, either because of distress sale of home and land (due to expensive treatment from private practitioners, hospitals or traditional healers), or because the person was abandoned by the family when they found out about his/her HIV status. Many families leave their family member with AIDS behind in the hospital, in the pagoda, or simply in the streets. There are also people with AIDS who do not want to put an even bigger burden on their families, and prefer to leave. Many people with AIDS express the wish to stay among peers in a hostel, which they can manage themselves.

There is a rapidly growing need for hostels and hospices for abandoned homeless people with AIDS, or people who choose themselves to stay among peers. In Phnom Penh there are at present only two such places, with in total 22 to 24 beds.

Missionaries of Charity opened a hospice in Phnom Penh in 1993. Then, there were still no AIDS patients. Quite soon however, the hospice received the first persons with AIDS, although they were not officially known as such. The other patients were often scared of the AIDS patients and tended to look down on them. Finally, the patients had to be separated from each other. In 1997, Missionaries of Charity bought an attached piece of

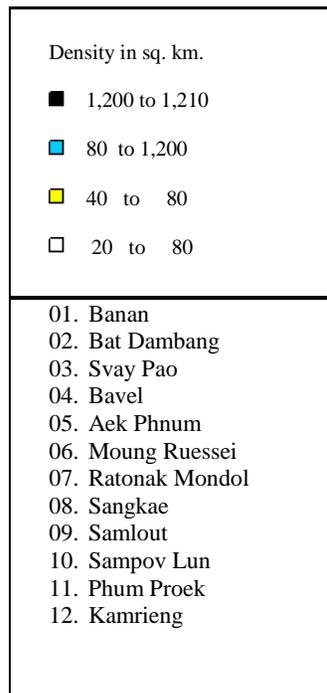
land and built a separate home for AIDS patients with 10-12 beds. The stronger ones have to help wash cloths and dishes and clean the compound. The patients can walk around, pick fruit from the garden, play games and do some cooking if they want. The hospice has a dispensary with basic medicines. A medical doctor from Calmette hospital visits the hospice once a week. However, not all patients in the hospice are abandoned patients. If they regain strength, they can return home. The hospice does not admit children. There is always a long waiting list for the hospice.

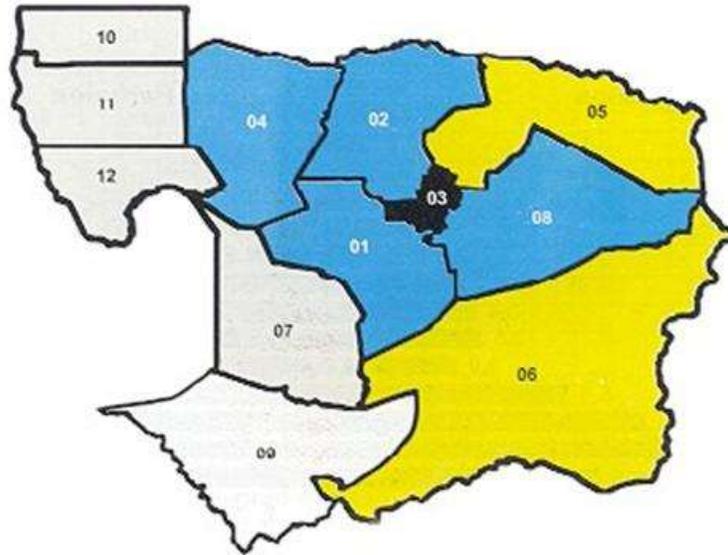
Mary knoll just opened a hostel/hospice (February 2000). It has approximately 12 beds. The organization is also trying to find other solutions for the problem of abandoned, homeless people with HIV/AIDS.

7. Battambang

Battambang province has a population of 793,129, with a female population of 51%. The province consists of 12 districts, 89 communes and 611 villages. 17.6% of the population lives in the urban area (the national average is 15.7%). The most densely populated districts are Svay Pao (the urban population), Battambang, Banan, Bavel, and Sangkae.

Figure 1: Population density by district, Battambang Province





The average household size is 5.3 persons, and 29% of the households are female headed. Children (age 0-14) form 44.4% of the population; the economically productive age group (15-64) forms 52.5%.^[25]

Battambang is known to be one of the best organized provinces with regard to HIV/AIDS. Many organizations are active in HIV/AIDS awareness raising and education and there are even several organizations that have started home care teams. NCHADS has Battambang in mind to start the first ten home care teams in the province. Battambang has a high HIV prevalence rate:

Table 6: HIV prevalence in Battambang 1998

Sentinel Group	1998
Direct Sex Workers	53.3%
Indirect Sex Workers	20.4%
Police	5.3%
Hospital in-patients	18.4%
Married women of reproductive age	3.3%

Source: Report on Sentinel Surveillance in Cambodia 1998

The prevalence of HIV among married women of reproductive age in Battambang is the fourth highest among 18 provinces. The prevalence among direct sex workers is the sixth highest.^[26]

7.2 Provincial structure

Battambang has a Provincial AIDS Office under the Provincial Department of Health. Last year, it was decided to work more along department lines (women • fs affairs, social affairs, education, military and police, etc.). Therefore a Provincial AIDS

Secretariat was created, with representation from all departments involved in HIV/AIDS activities. A Provincial AIDS Committee was created as the coordinating, policy developing committee, and the PAS as the implementing body. The roles of the PAC however are unclear, and the committee is in reality practically non-existent. CARERE supports the PAO and PAS/PAC structures. CARERE encouraged the PAO/PAS to develop a provincial development plan (PDP). A PDP 1999-2000 exists, but is limited to activities in education and awareness raising.

A year ago, District AIDS Secretariats (DAS) were set up in 10 of the 12 districts in Battambang. The PAS is the coordinator of the DAS.

Although Battambang is one of the most organized provinces when it comes to HIV/AIDS, the coordination between the PAO/PAS and NGOs does not seem optimal. The PAO seems largely unaware of future planning of NGOs with regard to HIV/AIDS activities.

There will probably soon be a volunteer from Australia who will assist the PAO and PAS with the coordination of activities in both Battambang and Banteay Meanchey.

7.3 Blood transfusion, blood testing and counseling

There is a blood bank in the provincial hospital in Battambang. Before 1996, the blood and the testing of blood were of poor quality. The military were the main blood donors. MSF-France improved the quality by focussing on better donors and teaching doctors only to use blood transfusion when it is really needed. The blood bank tries to find donors among low risk groups, such as students in high school and young monks who stay only for a short time in the pagodas. The blood bank tries to discourage professional and spontaneous donors. In theory, donors should not be given money, but in practice it often happens. Most donors are still professional donors. The blood bank wanted to set up a committee for blood donation promotion in the community, but according to MSF-France this was never materialized.

According to MSF the quality of the blood bank improved a lot; the main problem however is to find low risk donors. 70% of the donors are replacement donors, 20-30% comes from external collection. 1% is spontaneous. According to the NBTC in Phnom Penh, the blood bank in Battambang is one of the best provincial blood banks. It is the largest national blood bank after the NBTC.

There is an HIV testing center in Battambang, supported by the World Bank. The testing center used to be known as the Provincial Hygienic Department, and is now known as the Provincial Department of Infectious Diseases, dealing with TB, Malaria, and STDs and HIV/AIDS. The blood sample is taken in the center, after which it is brought to the Provincial Hospital (blood bank) for testing. On average, approximately 100 persons per month get their blood tested, and around 30-40% is HIV+. One of the problems is that people sometimes refuse to get tested out of fear that nobody will give them the result. This is probably related to the yearly surveillance research, for which people's blood is taken without providing the results of testing.

The center does basic pre- and post-test counseling. They are planning to set up a second counseling office in the hospital.

7.4 Hospital care

The Provincial Hospital of Battambang is located in Battambang. MSF-France has been working in the hospital the past nine years. MSF's first activities related to AIDS started in 1997: STD treatment, safe blood transfusion, infection control and TB control. In April 1999 the activities of MSF were evaluated, and MSF was found to be involved in too many activities. Most activities were recently handed over to the DoH, except the TB activities. STD treatment is still in the handing-over phase: NAP is now able to supply the drugs needed for STD treatment.

According to MSF, AIDS treatment is one of the main objectives of the hospital. MSF tries to support the hospital through improving the quality of care to AIDS patients by training doctors and nurses, and setting up a well functioning structure and network in the Ward. MSF also provides nutritional support for poor patients, to supplement their hospital nutritional diet. One other NGO is working in the hospital: Operation Enfants Battambang (OEB). OEB organizes recreational activities for children and other family members outside the hospital. OEB also helps abandoned AIDS patients, does some basic counseling, and can provide some material and financial support. OEB is supported by UNFPA and UNICEF.

According to the director of the hospital, the hospital is lacking the financial resources to provide proper care to AIDS patients. Many AIDS patients have chronic diarrhea, but the nurses are unwilling to provide proper nursing care, claiming their salaries are too low for the amount of work they have to do. In general, there is a lack of medical and nursing staff to care for the sick. Many AIDS patients are abandoned by their family members who do not want to care for them after they fell sick.

The hospital had around 140 AIDS patients up to May 1999, of which more than 30 died (many patients who have a home, would leave the hospital to die at home). Now the hospital gets on a monthly basis approximately 15 AIDS patients.

The provincial hospital wants to create an HIV/AIDS Center, but they have no financial support to pay for the medical staff and for the maintenance.

People reported discrimination against AIDS patients from the medical staff at health centers. There seems to be a serious lack of medical knowledge of HIV/AIDS and its transmission among those who work with AIDS patients.

The Military Hospital in Battambang had 39 HIV+ patients in 1999, and 30 patients died of AIDS in the same year. The hospital collaborates with the Provincial Hospital for STD services. MSF provided financial and technical support for STD management. There is no special care for AIDS patients in the hospital, but there are two counselors who are trained by World Vision (Ponleu Chivith) to provide some support. The director would like to improve services, but points at the lack of interest for HIV/AIDS within the military hierarchy. The medical staff needs training on transmission of HIV, symptoms of AIDS, and basic treatment of related opportunistic infections.

7.5 Home Based Care

Both NCHADS and NAA are very much in favor of expanding the home care program to other provinces. The general feeling in NCHADS and NAA seems to be that its application in the provinces will only need a little modification, but is fairly easy, since the guidelines and strategies are developed already. The aim of NCHADS is to have 10 teams in Battambang, but at present there are not enough funds to be able to create and sustain new teams

At the time of the research, there were two home care teams (organized by the local NGOs BWAP and KRDA), although one of them (BWAP) was temporarily closed due to internal problems. Both teams are supported by KHANA. KRDA started in November 1999, and visits 58 people with AIDS. KRDA created a Funeral Assistance Association, and encourages people with HIV/AIDS to become members. KRDA has seen 98 children with only one HIV+ parent left: those children will soon all be orphans. There is a problem in Battambang with orphans whose parents died of AIDS and who are not easily taken by orphanages. Again, the major problem has to do with AIDS and its transmission. Homeland has considered setting up a program to have a caretaker in the village, so that children can stay at home and continue school.

According to the PAO in Battambang, there will soon be more home care teams. The PAO wants to start a pilot project in Battambang with two teams, following the Phnom Penh structure. However, there seem to be problems related to the costs of salaries of both the NGO and government staff. The PAO does not consider the BWAP and KRDA teams as a pilot project, because they are entirely run by NGOs. The PAO wants to start its own government based home care pilot project.

Several local NGOs in Battambang are interested in starting home care teams, such as Chivith Thmey and Buddhism for Development (the latter submitted a proposal to KHANA). Both NGOs have tried to contact other home care teams to learn from their experiences. There seems to be some miscommunication in Battambang regarding home care teams. The PAO mentioned several national and international NGOs as future home care providers, whereas some of those organizations emphasized that they are not planning any home care activity in the near future.

There are also concerns expressed about home care. It is believed to be very expensive, especially because of the potential of finding too many sick people in the villages. Another concern is that the situation in Battambang province is entirely different from that of a big city like Phnom Penh, where many people with HIV/AIDS can be found and helped in a fairly small area. The distances in Battambang are much larger, and the health centers may not have enough capacity to deal with home care and serve as a link in the referral system.

There are alternative approaches to the HIV/AIDS epidemic, such as the approach of CRS. CRS wants to try to work more alongside the already existing services. CRS trains health center staff to identify symptoms of AIDS and provide basic care. The organization works in five districts with 15 health centers, and with Village Health Committees (VHC) in 29 villages. CRS wants to mobilize the VHCs to spread awareness about AIDS, support people with HIV/AIDS, and identify volunteers who can provide

basic care and refer people to the health center or the hospital. CRS hopes that this will be more sustainable on a long-term basis than home care teams, although the organization can imagine working together with home care teams. There are, however, doubts whether unpaid volunteers can take up such an intensive job as to care for people with AIDS.

It is unlikely that Battambang will benefit from blanket copies of the Phnom Penh system. The province may indeed need one or several different approaches, which probably only can be found out through trial and error. Whatever solution is found, the existing public health structures at lower levels need more strengthening.

7.6 Monks and nuns

SCC's project on Monks and HIV/AIDS also takes place in Battambang. SCC has trained monks from six neighboring pagodas, covering 4-7 villages each, to cooperate with each other, and go to villages to find people with HIV/AIDS. They provide AIDS education and discuss the issue of discrimination regarding HIV/AIDS in the villages. According to the monks, many families reject their family members with AIDS. The monks try to mediate between the person with HIV/AIDS and the family. The aim is that people with AIDS can stay within the own family. The monks visit patients whenever they have time, and try to explain to the family how to care of them. They also visit patients in the hospital. At one Wat a monk had built four small huts with money collected from the villagers, meant as temporary shelter for people with HIV/AIDS who are rejected by their families. They can be used for no longer than one week; in the meantime the monk tries to mediate, after which the patient can return to the own family. However, the huts have not been used yet.

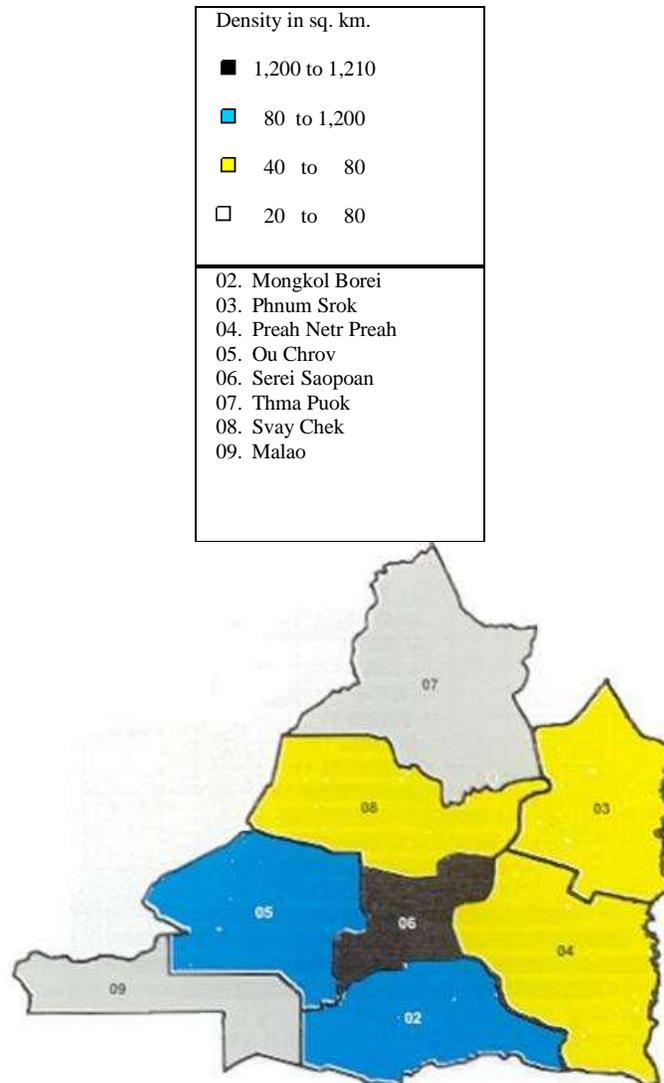
In Battambang nuns from several Wats are involved in care and support for AIDS patients. OEB provides health education training to nuns. Six nuns were trained by OEB/UNICEF to provide counseling to AIDS patients. This involves explaining to them how to deal with death as part of life, and following Buddhist precepts as a way to avoid suffering. They try to comfort the patients. According to the nuns, improving the mental state is half of the healing process. As nuns they cannot go into details, as that would be against Buddhist precepts. However, they can provide some general advice, such as the use of condoms, how to get help, etc. They raise money at religious events and rituals, to pay for transportation for patients to the hospital. Most nuns are involved in outreach activities, but there are only a few nuns who provide counseling for people with HIV/AIDS. Many nuns feel they are too busy already, too old to learn about health education and retain the information learned, or they feel that their place is at the Wat and not in the community. According to the nuns, many monks are afraid of engaging in community activities. One of the nuns, who has a medical background as a midwife, stated that she would like to start a hospice for abandoned patients in the Wat, if only the monks would cooperate.

Involvement of monks and nuns seems an interesting field to explore. However, one also has to keep in mind that pagodas, abbots, monks and nuns are different from one another. Many will not want to cooperate. Monks are often afraid of HIV/AIDS, and certainly not all monks are interested in community activities, let alone for HIV/AIDS. Nuns however might have more freedom and capacity to cooperate in this field.

8. Banteay Meanchey

The province Banteay Meanchey has a total population of 577,772, with a female population of 51%. The province consists of eight districts, 63 communes and 604 villages. The three most densely populated districts are Serei Sophon (with the provincial capital Sisophon), Mongkol Borei (with the provincial hospital) and Ou Chrov, with the border town Poipet.

Figure 2: Population Density by District, Banteay Meanchey province



The average household size in Banteay Meanchey is 5.1 persons, and 21.6% of all households are female headed. Children (age 0-14) form 44.3% of the population; the economically productive age group (15-64) forms 53.1%.^[27]

Battambang can be called one of the best-organized provinces regarding HIV/AIDS activities, with many active organizations; Banteay Meanchey is probably one of the least organized and most neglected provinces in this area. All activities so far have been

concentrated on prevention and awareness raising. There are still no programs or facilities for people with AIDS.

However, the province has a high prevalence rate, and a fast growing number of people with AIDS. The province borders Thailand, with Poipet as one of the main official points of exit/entry. Many trucks and businessmen pass the border every day, often staying overnight in Poipet, Sisophon or Battambang and making use of the brothel and karaoke facilities. As such, they are an important source for infection in the province.

8.1 Sentinel Surveillance Data

In December 1994, blood was taken from a sample of sex workers and their clients in Sisophon and Poipet for the HIV seroprevalence study (conducted by MoH/WHO/Pasteur). According to the initial outcome, 92.5% of the sex workers tested HIV+. Later, it became clear that important mistakes were made. However, the percentage of 92.5% was widely disseminated in the province in early 1995. Clients' visits to the brothels dropped dramatically and the majority of the sex workers went to other areas where people would not suspect them of being HIV+. It caused panic among the sex workers and their clients, and condom use suddenly went up to 80%. No official denial of the percentage afterwards was made.^[28]

The latest statistics for 1998 show a more realistic picture. However, the percentages of HIV among the sentinel groups is still very high, compared to other provinces.

Table 7: HIV prevalence in Banteay Meanchey 1998

Sentinel Group	1998
Direct Sex Workers	54.0%
Indirect Sex Workers	22.3%
Police	10.0%
Married women of reproductive age	0.2%

Source: Report on Sentinel Surveillance in Cambodia 1998

The prevalence of 10% among the police in Banteay Meanchey is the third highest rate among 18 provinces; 54% among direct sex workers is the fifth highest rate. The 0.2% among women of reproductive age however, is the lowest among the provinces.^[29]

8.2 The Provincial structure: cooperation with Thailand?

A PAS and PAC were set up in 1998. The PAC is, like in Battambang, practically non-existent. The PAS has 60 members, with the PAO as technical supervisor. However, none of its members had had experience with HIV/AIDS when it was set up. According to CARERE, the PAS still needs a lot of capacity building. The year 1998 was mainly used for setting up the PAS and making a work plan. Representatives from NAP Phnom Penh came to Sisophon to help set up a work plan for 1999. The departments started to implement activities only from 1999 onwards. The Departments of Women's Affairs,

Education and Military/Police are most active in HIV/AIDS awareness raising and education. The other departments are less active and do not have any experience in this field. According to CAREERE, the PAS should be the coordinating body of the HIV/AIDS activities carried out by all organizations in Banteay Meanchey. However, no NGOs were invited to the meetings so far, although first dialogues seem to have started.

In mid February 2000, a mission from Phnom Penh (NCHADS and UNDP/CAREERE) visited Banteay Meanchey province to discuss future priorities, and all health organizations active in the area were invited to attend the meeting. Banteay Meanchey has not received a budget from NAP yet, but probably will in the near future. The aim of the meeting was to discuss the situation of the provinces that were not included in the National Plan (12 other provinces do receive a budget). Banteay Meanchey never submitted a plan, but has started working on it. PAO and NAP presented the following priorities: 100% condom use; outreach for sex workers; a behavioral survey on sex workers; extension services to train health staff; establish a testing center, improve care and investigate the possibilities of starting home-based care; and develop special interventions for the mobile population as a special target group.

First steps are being taken to collaborate with the Thai government in the areas of Malaria, AIDS, EPI, Dengue, and severe diarrhea outbreaks along the border districts of Banteay Meanchey. The aim is to develop a close cooperation between bordering districts in both countries in the future. There have been several field visits to Thailand and Cambodia by both provincial and medical staff. The first priority will be Malaria; the second HIV/AIDS. ZOA Refugee Care in Poipet is one of the organizations that is taking the lead in this collaborative effort.

8.3 International NGOs

MSF-HBS is at present the only international NGO that might start activities in the area of AIDS. The organization mainly focuses on STD management, with two STD clinics: one in Sisophon (another STD-clinic is run by the government) and one in Poipet. However, MSF is planning to include some basic care activities for people with HIV/AIDS in the future. Especially Poipet is mentioned by MSF as a place with many HIV+ people. There is no national testing facility in Banteay Meanchey yet. There are, however, many places where people can get private tests. Those tests are known for not being reliable and often are not anonymous. As long as there is not a good testing facility, medical staff cannot tell patients that they probably have AIDS, even though they show all the symptoms of the disease. The STD clinic in Sisophon sometimes refers people to Battambang for testing.

ZOA Refugee Care is working in six villages in Poipet District, including Poipet town. ZOA's health program focuses on rehabilitation of health centers. The health center in Poipet has a complementary package of activities, which means that it also receives hospital drugs (the reason was an important cholera outbreak in 1998). The staff received training on STD treatment in Sisophon. ZOA wants to upgrade its medical staff on HIV/AIDS. According to ZOA, there is a lot of discrimination against people who show signs of AIDS. Since people are so scared of AIDS, they easily accuse someone of having the virus. Most people have heard about AIDS, but do not really know how it is transmitted, what it is and what the symptoms are. Establishing a testing center in the province would therefore be a good step toward providing care for people with AIDS.

Health Net International used to train medical staff in STD treatment. The Provincial Health Department has taken over this activity. HNI supports the PAO in Sisophon for special occasions. However, the organization is phasing out of Banteay Meanchey in April 2000. The reason mentioned is that the organization has to work too often with other international NGOs, whereas HNI has a preference for working alongside government structures.

The fact that many international organizations are phasing out of Banteay Meanchey, seems to be a serious problem. Many international organizations once came to the province as emergency and relief organizations. Banteay Meanchey does not have any real emergency problems anymore, and organizations are starting to reorient themselves: either they move towards structural development, or they phase out their activities. It is mainly the latter that is happening, leaving a gap behind in the area.^[30] However, almost every informant confirmed to some extent that another reason for phasing out is the lack of cooperation with the local authorities, especially with health care officials. The Provincial Health Department does not seem to be too concerned about the shortage of staff and motivation, and the Provincial Hospital in Mongkol Borei is facing serious problems with both losing qualified medical staff and medical supplies.

8.4 Local NGOs

When organizations or people in Banteay Meanchey find people with AIDS, they can refer them to several local NGOs providing basic social and economic support. MSF cooperates with CFDS in Sisophon and KBA in Thmar Puok. Both provide social support to poor families, and will probably link with TPO in the future for counseling. KBA wants to start home care activities in the near future. KBA currently cooperates with the Thmar Puok hospital, providing nursing care and some food and clothes to poor patients. Another local NGO providing basic socio-economic support to poor families is CAAFW. It has no specific HIV/AIDS activities, but provides support to several families living with AIDS, and assumes that approximately two to three patients per village have AIDS. CAAFW also works closely with MSF. The local organization SEADO, currently funded by KHANA, is planning to apply to USAID for funding to start home care teams in Poipet and Sisophon. They are now involved in providing socio-economic support to poor families and education and awareness raising activities.

The four organizations, KBA, CFDS, SEADO and CAAFW provide similar services in different areas, although some of them are more actively involved in HIV/AIDS awareness raising and health education in villages than others. They meet regularly to discuss their activities and the problems encountered, and to make sure that they do not work in the same areas. These local organizations seem to have a lot of potential, although capacity building and training is seriously needed. They need funding and technical support, which seems difficult considering that international organizations are phasing out from the area.

8.5 Hospital care

The Provincial Hospital of Banteay Meanchey in Mongkol Borei used to be a good hospital in the past, but its services seem to have deteriorated over the last few years. It was supported by the International Red Cross (ICRC) from 1991 to 1995, but since ICRC left, the hospital's services changed. The hospital has, according to almost all informants, a poor management, and medical staff with low motivation. According to our informants, the staff is often not paid, funds and equipment are misused, and poor patients are treated badly. As one informant puts it, "AIDS patients are left to die as dogs in the backyard." There is a lot of discrimination by the staff toward the poor patients, especially if they have AIDS. Rumors circulate that the hospital was recently reduced to being a district hospital, which means that Banteay Meanchey no longer has a provincial hospital.

The hospital reported having 52 patients in 1999 who were assumed to have AIDS, based on their symptoms. The hospital has no special support for AIDS patients, but would like to set up a special AIDS unit. However, good testing and counseling facilities will be needed, as well as training of the medical staff. The hospital recently submitted a proposal to the NAP, through the PAO, to work with AIDS patients. The hospital reports visits from Thai NGOs and government officials to start HIV/AIDS activities. However, so far nothing has materialized.

There is a blood bank in the hospital, which is – according to the NBTC – one of the worst examples in the country. It was set up by the ICRC, but the blood bank collapsed when ICRC withdrew. The main blood donors are replacement donors, military and students. When they have to collect blood from the military and students (only when there is no adequate supply) they have to discard many units. Once six out of ten units had to be discarded. According to ICRC, the hospital charges patients money for blood transfusions.

MSF supports, among others, one hospital in Thmar Puok. This hospital is especially worth mentioning because it receives many AIDS patients. For some reason rumors were spread that AIDS can be cured in this hospital. People from far away come to this hospital, although it has no special facilities for AIDS patients. These kinds of rumors probably came from someone who got a blood test from a private clinic and who was given a wrong positive result, or from someone who got cured from TB and thought he/she was cured from AIDS as well. The first AIDS patients were seen in May 1999. In the beginning, the medical staff was scared, talking about "the dangerous disease." MSF started to invest in education on HIV/AIDS among the medical staff. At present, the hospital has 10 to 15 patients per month who probably have AIDS (in total there are over 100 patients per month). Most of them remain in the hospital until they die. The hospital has inadequate staff to nurse abandoned patients. There are plans to start a cooperation of activities with CAAFW for providing support to AIDS patients.

9. Conclusions and Recommendations

In this study, we have reviewed and summarized our findings about existing programs and facilities for people with HIV/AIDS, the main problems and gaps, and needs for the immediate future. Care and support for people with HIV/AIDS is still a relatively new area in Cambodia, and is mainly limited to Phnom Penh and its immediate surroundings. An increasing number of international and local organizations, both governmental and non-governmental, are actively setting up programs and activities to improve and expand blood testing, counseling, hospital and home based care. Other organizations focus on children affected by the epidemic (both AIDS orphans and children with HIV/AIDS). Furthermore, some organizations have begun to find solutions to the problems of homelessness of people with HIV/AIDS.

The general feeling is that no ready-to-use models which can be copied are available for AIDS care and support: the country has to find ways to cope with the epidemic through trial and error. The success of this process will largely depend on the extent to which different activities and services can be linked to one another. Coordination and collaboration between the different partners involved, can therefore be considered as the key components.

9.1 Phnom Penh

All care and support activities in Cambodia are managed and supervised by a special department for HIV/AIDS within the MoH: NCHADS. This department has to provide the larger framework for all HIV/AIDS activities related to health in the country. The strategic planning capacity of this department, especially that of the AIDS Care Unit within NCHADS, is still very weak.

Phnom Penh at present has ten home care teams, at least three hospitals with services for AIDS patients, two testing centers, two counseling centers, two AIDS support groups, and two hospices. There are regular meetings between all organizations involved. The key to success is a well functioning system of referral, which entails a high degree of cooperation and coordination among the various partners involved. Coordination and collaboration regarding activities in care and support for people with HIV/AIDS seems, except for a few specific cases, to work relatively well in Phnom Penh.

Over the last few years, many improvements in care and support for people with HIV/AIDS have been made. However, the number of people with HIV/AIDS in Phnom Penh is growing very fast, and the improvements made are not sufficient to deal with the problem. According to our informants, almost everything still needs to be improved, e.g. an expansion of home based care to 15 teams, more hospital beds with good medical and nursing care, and, above all: hostels and hospices for homeless people with HIV/AIDS and those without a family to care for them.

An area that does not seem to have a well-established system yet, is counseling. At present, only a ten-day training is needed to qualify for providing counseling, which is to a large extent limited to pre- and post test counseling, through which very basic information about the virus and its transmission is provided. At present a working group is trying to

assess the different curriculums for counseling that are available and define needs for the future.

9.2 Battambang

Battambang is one of the best-organized provinces regarding the HIV/AIDS program, with a relatively well functioning provincial hospital, a voluntary testing center, and two home care teams. It is targeted as the next province for setting up a network of home care teams. However, the provincial AIDS structures, the PAO, PAS and PAC, seem fairly weak with little budget and knowledge about the activities and planning of NGOs in the area.

NCHADS/MoH and NAA are eager to start home care in Battambang, using the Phnom Penh model with a slight modification. The PAO and several local organizations are eager to have a home care team if financial and technical assistance is provided. However, questions are raised about the replicability of the Phnom Penh model in the provinces. The area is much bigger and the population is much more dispersed than that of Phnom Penh. Other questions raised relate to the current level of the health centers in the provinces, which have to be able to take part in the teams and serve as one important step in a referral system. KHANA seems to be well aware that home care in the provinces may need a different approach, and therefore prefers to expand the program step by step.

Another, more fundamental criticism is related to the question of whether a focus on home care may lead to decreasing attention for solving problems within the public health system at different levels. NCHADS and NAA indeed focus entirely on an expansion of home based care as the only solution. However, it is important to note that although home care may at this moment be the best way to respond to the epidemic, it should not lead to neglecting the public health services. Mobile home care teams lead to more referrals, which emphasize once again the need for a well-functioning public health care system.

9.3 Banteay Meanchey

Banteay Meanchey is among the three provinces studied, the most neglected in terms of programs and activities for people with HIV/AIDS. However, the HIV prevalence rate is high. The PAO, PAS and PAC appear to be weak, with a serious lack of coordination and collaboration between international NGOs and the provincial AIDS structures. Another problem is that many international NGOs are currently phasing out of the area. At the time of the research, there were no programs for support and care for people with AIDS. The provincial hospital in Mongkol Borei is in a deteriorating state, without proper medical facilities and services for people with HIV/AIDS. The blood bank in the hospital, that was once functioning quite well, is currently among the worst in the country. There are no home care teams in Banteay Meanchey, although there are several local NGOs that provide basic social and economic support for poor families. Some of them want to start a home care team if financial and technical support are provided. There is a good coordination network among the local NGOs, and they seem to have the potential to start up home care teams. However, these organizations need capacity building, as well as financial and technical support.

Many informants voiced the opinion that home based care is pointless without voluntary testing facilities. Others emphasized that voluntary testing centers are useless if there is no follow up in terms of care for people who test HIV+. It is a catch 22 situation, where providers of the one type of service are waiting for the other to start. At present, the only alternative to going to Battambang for a blood test, is to go to one of the widely available private testing places. However, these tests give very inaccurate results. We therefore think that setting up a voluntary testing and counseling center would be an important step forward to care and support for people with HIV/AIDS in Banteay Meanchey.

9.4 In general

People with HIV/AIDS are, in all provinces, faced with discrimination. Even medical staff of health facilities discriminate against AIDS patients. There is still a lack of knowledge about the disease and its transmission, especially in Banteay Meanchey. The majority of the people are afraid of the disease and know little about it. It is important to provide training to medical staff in health facilities at different levels (health centers, district and provincial hospitals), both on medical knowledge about HIV/AIDS and on nursing people with HIV/AIDS.

In all provinces blood banks are facing similar problems with finding blood donors among low risk groups. In general, people in Cambodia are not willing to donate blood, which forces the blood banks to accept blood from high risk groups (military, professional donors). An extremely high percentage of the blood units has to be discarded for being infected with HIV. There is a need to investigate the reasons why Cambodian people are reluctant to donate blood, and find out how people with a low risk could be approached for this matter.

9.5 Recommendations

- We recommend that JICA provide technical assistance to the strategic planning capacity of NCHADS, preferably that of the AIDS Care unit. JICA could provide a technical expert with experience in strategic planning for AIDS care and support in developing countries, preferably in South-East Asia. The expert will need excellent communication and English language skills.
- We recommend that JICA support home based care, in partnership with NCHADS and an experienced organization within the existing service system. This partnership could entail financial assistance to KHANA or other international NGOs, or technical assistance for capacity building among local inexperienced NGOs, especially in Battambang and Banteay Meanchey.
- We recommend that JICA rent and renovate small empty buildings in Phnom Penh, Battambang, and Banteay Meanchey, so that they can serve as hostels and hospices for people with AIDS who do not have a home or relatives to care for them. Hospices will need intensive care and require technical advisors to help manage. Hostels can eventually be managed by people with HIV/AIDS who prefer to stay among peers and help one another, with occasional assistance from health care providers.

- We recommend that JICA provide financial and technical support to the provincial hospital in Mongkol Borei, Banteay Meanchey. However, an initial assessment is needed to determine the problems of this hospital, since it was once well known for its quality medical care. Financial and technical support is needed for rehabilitation and upgrading of this hospital in general, and for AIDS-care and safety of blood transfusion in particular. This entails that a testing center should be set up in the province, possibly at the hospital as well. However, JICA may also consider supporting the PAO setting up a separate testing and counseling center, from which all care and support activities in the province regarding HIV/AIDS, could be coordinated. Although getting the cooperation from the provincial authorities may not be easy, it is not recommended that independent structures be set up separate from the PAO. This would weaken rather than strengthen the position of the PAO as the main coordinating body for care and support for people with HIV/AIDS in the area.
- We recommend that JICA provide technical support to the existing provincial structures, i.e. PAO, PAS and PAC, to actively coordinate all existing programs and activities in the respective provinces, and assist in the development and implementation a feasible plan of activities.
- We recommend that JICA support, in close cooperation with the AIDS Care Unit of NCHADS, the development of training for medical and nursing staff at different levels of the public health system, especially in Battambang and Banteay Meanchey.
- We recommend that JICA take part in the working group on counseling, and provide the financial and technical means to improve the existing curriculums and extend the training program to a more comprehensive program for responding to the mental health needs of people with HIV/AIDS.
- We recommend that JICA support further research on the reluctance of Cambodian people to donate blood, and ways to approach potential blood donors among low risk groups.
- Prior to starting any activity, we recommend that JICA consult all organizations involved in that particular activity (see the contents of this report).

Bibliography

Chin, J., *HIV Prevalence estimates for Cambodia: Recommendations for Future HIV Surveillance*, Cambodia Trip Report – September 30-October 12, 1996, October 21, 1996, Berkeley, California

Chun, B., Arnaud, D., Manthey, G., PAC Project, *Strengthening multi-sectoral Provincial AIDS Committees and Secretaries*, Final Report, August 1999

Crochet, S., *Activitees et ideologies des Agences Internationales en Charge de programmes SIDA au Cambodge*, Octobre 1997 – Janvier 1998

Edstrom, J., Janssen, P.L., International HIV/AIDS Alliance, *Visit to Cambodia and Bangkok, 12 March – 1 April, 1996*

Eisenbruch, M., *Doctor Hansen and the crouching Mango: STD and HIV-AIDS*, UNESCO, Technical discussion document for National AIDS Review, Phnom Penh, May-June 1997, Draft

Escoffier, C., *Sexually Transmitted Diseases in Banteay Meanchey*, A report for Medecins sans Frontieres, April 1995

Fabre-Teste, B., *Appui a la lutte contre le SIDA et les MST au Cambodge*, Projet FAC MST/SIDA No 97001400, Rapport d'Activite 1999

FHI/IMPACT and UNAIDS, *Report on HIV/AIDS Counseling Meeting*, 3rd November 1999, Cambodia

Gorbach et al., *Bridging between high and low risk groups in Cambodia: potential importance in the spread of STD/HIV*

Goulburn, L., *Report on Counseling and Community-Based Care For UNICEF Cambodia*, Australia, September 1997

International HIV/AIDS Alliance, *Local NGOs Responding to AIDS: Issues emerging from a strategic planning workshop, Phnom Penh, Cambodia, 25-27 March 1997*, Summary report by the international HIV/AIDS Alliance and an observer • fs account by Alan Greig, Associate Consultant

Joint Ministry of Health/NGO, *Pilot Project on Home and Community Care for People with HIV/AIDS, February 1998-February 1999*, Phnom Penh

Maryknoll, *HIV/AIDS Project*

Mith Samlanh/Friends, *Quarterly Activity Report, July 1999 – September 1999*

MoH/NAC, *Comprehensive national Plan for AIDS Prevention and Control in Cambodia, 1993-1998*

National Guidelines on HIV/AIDS Home and Community Care, Cambodia, December 1997

National Institute of Statistics, *General Population Census of Cambodia 1998, Final Census Results*, Ministry of Planning, Phnom Penh, July 1999

NCHADS, *National Strategic Plan STD/HIV/AIDS Prevention and Care in Cambodia 1998-2000*

NCHADS, *Report on Sentinel Surveillance in Cambodia 1998*

NCHADS, *Consensus Workshop on HIV/AIDS in Cambodia*, Phnom Penh, March 1999.

NCHADS, *Cambodia National Strategy for the Surveillance of HIV/AIDS/STDs and Related Behaviour 1999-2000*, Phnom Penh, March 1999

NCHADS, *Consensus Workshop on HIV/AIDS in Cambodia*, Phnom Penh, March 24, 1999

NCHADS, *Draft Background paper RTI/STI/HIV in Cambodia*, January 2000

UNAIDS, *Country Profile • g The HIV/AIDS situation and the national response in the Kingdom of Cambodia*, 2nd Edition, October 1999

UNAIDS, *Country Profile • g The HIV/AIDS situation and the national response in the Kingdom of Cambodia*, 3rd Edition, February 2000

UNDP/CARERE, *Banteay Meanchey Year 2000 Workplan*, 22/12/99

Ryan, C.A. et. Al., *HIV and Sexually Transmitted Diseases in Cambodia: prevalence of infections, evaluation of treatment flowcharts and assessment of risk and health seeking behaviors*

Sangha Metta Newsletter, *Buddhist Monks Against Aids*, Volume 1, July/August/September, 1998

Sangha Metta Newsletter, *Buddhist Monks and HIV/AIDS Management*, Volume 2, October/November/December, 1998

SCC, *Monks and HIV/AIDS, Final Project Report*, September 1997

SCC, *Monks and HIV/AIDS*, project proposal 1997-1998 submitted to CARERE

Sihanouk Hospital Center of Hope, *Annual Report 1998*

Phalla, Tia et.al: *HIV and STD epidemiology, risk behaviors and prevention and care response in Cambodia*, in: AIDS 1998, 12 (suppl B): S11-S18.

WHO, *STD/HIV/AIDS Surveillance Report*, Issue No 13, May 1999

WHO, *STD/HIV/AIDS Surveillance Report*, Issue No 10, October 1997

WHO, *STD/HIV/AIDS Surveillance Report*, Issue No 14, October 1999

ANNEX 1: List of service providers interviewed

Interviews with service providers in Phnom Penh

Organization	Name	Title/Project
Calmette Hospital	Hak Chanroeun	Program Secr. HIV/AIDS
CARE Cambodia	Caroline Francis Ellie Brown	HIV/AIDS Coordinator HIV/AIDS Research Off.
COERR	Chalor Vannaprateeap	Country Representative
CWDA	Kan Yon	Coordinator
EU/Institute of Trop. Medicine	Francois Crabbe	Project Technical Advisor
FAC	Bernard Fabre-Teste	Manager STD-AIDS Proj.
FHI/Impact	Francesca Stuer Philippe Girault	Country Director BCI/Evaluation Officer
Hospital Center of Hope	Gillian Hall Kong Bun Navy	Head HIV/AIDS Departm. Comm. Projects Supervisor
Indradevi Association	Uysong Chhan Sothy Dy Ratha	HIV/AIDS/STD Proj.Coord President
Japanese hospital + MSI	Bun Leng Hor	Chief of AIDS Unit
JICA	Saito Katsuyoshi	Assistant Res. Represent.
KHANA	Henrietta Wells Chhim Sareth	Techn. Adv.Care / Support Progr. Off. Care / Support
Maryknoll	Father Jim Noonan	
Medicam	Stephane Rousseau	Executive Director
Ministry of Education	Chhay Kim Sopheavy	Chief Dep.of Health Educ.
Missionaries of Charity	Sister Leon	Head Sister
Mith Samlanh/Friends	Ouk Oeun Andree Magnaldi	HIV/AIDS Proj. Manager Program Manager
MoSALVY	Prak Chantha	Secretary of State
MSF-France/Sihanouk Hospital	Muriel Scarato Celine Soulier	Manager AIDS Project AIDS project
Municipal Hospital	Vira Avalokita	HIV/AIDS Ward
NAA	Tea Phalla	Secretary-General
NCHADS	Mean Chivun Nong Kanara	Director Chief of AIDS Care Unit
Pasteur Institute	Philippe Glaziou	Epidemiologist
Ponleu Chivit I/ WVI	Ul Ny	Counseling Coordinator
PSF	Meas Phally	Assistant to Director
QSA	Oeung Kim Ann	HIV/AIDS Chief Trainer
RHAC	Mao Vannak	Physician/Trainer
SCC	Oum Sokcham Roeun	
SERVANTS	Kristen Jack Or Hy	Counselor/Coordinator

SSC	Ellen Minotti	Adviser
SUPF	You Thol + 8 volunt.	
Team 1: Kilom. 9 / CUHCA	Mony Dara	Team leader
Team 2: Kilom. 6	Hou Samey	Team leader
Team 3: Stoeng Mean Chey	Ly Tra	Team leader
Team 4: Psar Deum Tkov	Kim Saroeun	Team leader
Team 5: •gA•h/Women	Loeng Chanthol	Team leader
Team 6: •gB•h/IDA	Sun Seda	Team leader
Team 7: Wat Moha Montrey / Hope	Benthy	Team leader
Team 8: Toul Kork/ WVI	Chea Mongkol	Counselor
UNAIDS	Jan W. de Lind van Wijngaarden	Programme Officer
UNICEF	Etienne Poirot	HIV/AIDS Focal Point
USAID	Jeffrey Ashley Chak Chantha	Chief Health and Hum.Ass. Project Management Spec.
WHO	Annie Macarrie	HIV/AIDS Focal Point
WHO/NBTC	Oscar Barreneche	Medical Off. Blood Safety
WOMEN	Loung Chanthol	Home care Team leader
Women • fs Room	Kim Phalla	
World Bank/NCHADS	Peter Godwin	Technical Advisor
WVI	Oum Sopheap	Project Man. AIDS Prev. and Care/Chair HACC

Interviews with service providers in Battambang

CARERE Battambang	Joanne Morrison Choup Loeur	Prov. Programme Manager Health NPPP
CFDS	Mong Sareth	Program Manager
Chivith Thmey	Son Sokhom	Director
CRS	Lori Dostal	Adviser
Homeland	Mao Lang	Executive Director
Huripruda	Im Loum	Director
Hygenic station	Lay Vichea	Vice-chief
Hygenic station	Sin Wattana	Counselor
Khmer Buddhist Association/Wat Norea	Mony Van Saret	Monk
KRDA	Dim Samedy	Director
Military Hospital BTB	Men Sokhum	Director
MSF-France BTB	Ahmed Berzig	Physician Battambang Project
Operations Enfants de	Tith Davy	Executive Directrice

Battambang		
PAO BTB	Chum Sopheak	Chief of PAO
Provincial Department of Women • fs and Veteran • fs Affairs	Chuonh Sochhay Sin Mari	Director PDWVA BTB Vice Director (in charge of health)
Provincial hospital BTB	Phuoy Sovannarath	Medical Doctor
UNICEF BTB	Pha Rin	
Wat Kampheng	Vimean Chan	Nun
WVI	Ouk Samoeun	Svay Por ADP Project Manager

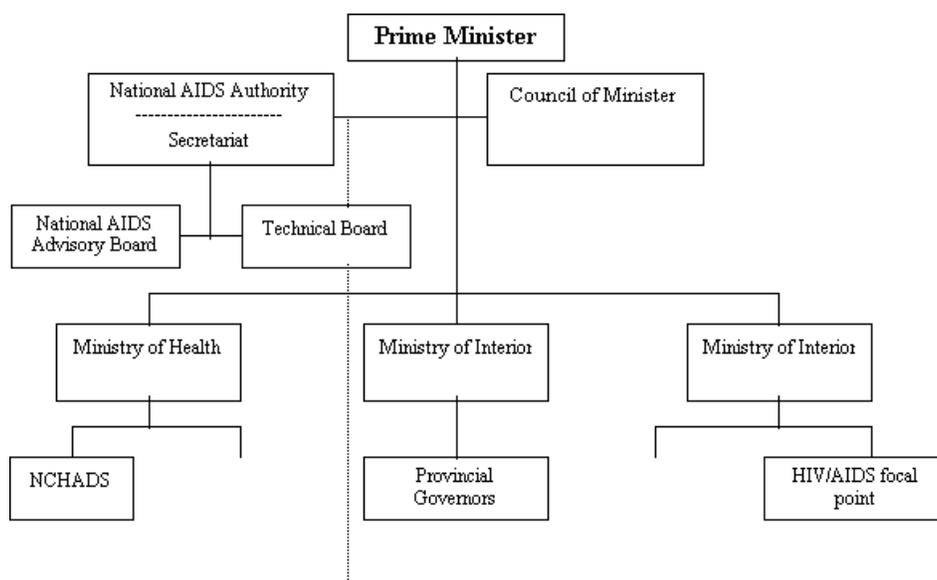
Interviews with Service Providers in Banteay Meanchey

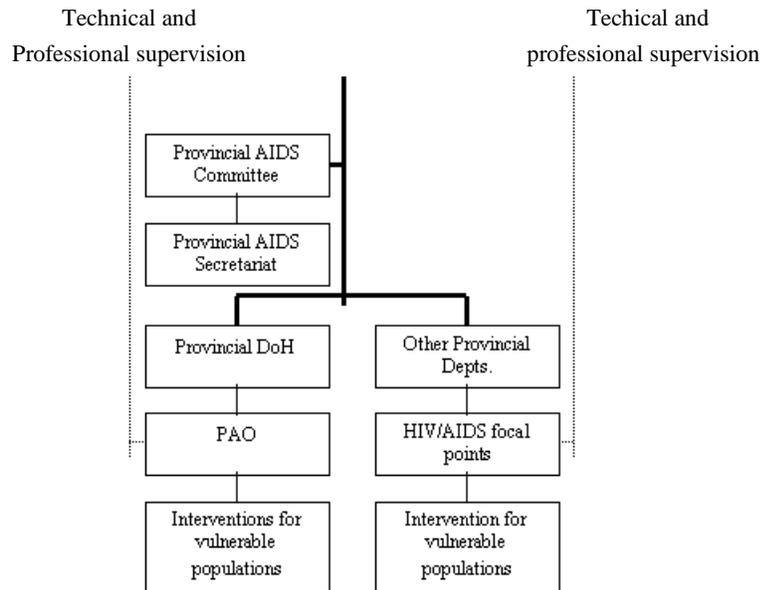
Action Against Hunger	Uk Sary	
CAAWF	Vath Chourn	
Camb. Children and Handicap Development Organization	Proeun Sarun	
CARE	Muong Sopha	Manager MCH Project
CARERE BMC	Lath Ponlok	Health Assistant
CFDS	John Phay	Director
CFWD		Director
Goutte d • fEau	Soun Malie	
Health Center Poipet	Klok Vong Sareth	
Health Net International	Bert Bosch	Programme Manager
ICRC	Sopha Sovannareth	Liaison Officer
Khmer Buddhism for Development	Tuy Sakoeun	Programme Coordinator
Khmer Buddhist Association	Thy Sokoun Neu Sophon	Director
Mongkol Borei Hospital	Yith Saream	
MSF-H/B/S	Savet Sovanna Luc van Leemput	STD Coordinator STD Poject Project Coordinator
Norwegian Aid	Muong Chhavy	Health Training Officer
PAC	Por Kimoeung	Third Provincial Governor
PAO	In Sophirum	Chief of the AIDS Program

Police	Sok Saret	Commissioner
SEADO	Koy Van Lyn	Field Coordinator
STD-clinic Sisophon	Several staff members	
Thmar Puok hospital	Chav Dary Jannie Gielen	Director Physician
WHO	Andre Reiffer	Provincial Health Advisor
ZOA-vluchtelingen zorg Poipet	Tess Prombuth	

ANNEX 2: Structure of the National AIDS Authority

(from UNAIDS Country Profile, 3rd Edition February 2000)





ANNEX3 : National Policy and priority Strategies for HIV/AIDS Prevention and control (NAA, 1999)

(from UNAIDS country profile 3rd Edition February 2000)

General Policy

To ensure the prevention and control of HIV/AIDS in the Kingdom of Cambodia .the NAA has established the National policy and Main Strategies for 5 years, from 1999 to 2004.

The NAA endeavours to ensure that:

- HIV transmission into the general population is prevented by creating a social environment which is conducive to the prevention and control of HIV/AIDS, and supportive to activities aimed at systematic relief of the problem.
- the potential of the individual, the family and the community .as well as the country • fs economic system for managing and reducing the scope the problem, is strengthened.

Policy 1-AIDS Response Structure

The NAA considers that the HIV/AIDS problem is a relevant issue for many fields of society. Programme management to deal with the problems of HIV/AIDS must therefore be organization and implemented in a multisectoral structure at each level, to deal with the situation and evolution of the epidemic.

MAIN STRATEGIES

- HIV/AIDS prevention is the most urgent priority to be fully supported by the Government with regard to policy, and by various technical institutions with regard to

technical issues of implementation.

- Preventive services to control the spread of HIV/AIDS require cooperation between governmental institutions, international and non-governmental organisations, religious institutions, private organisations and the community.
- The management structure to fight against HIV/AIDS must have a multisectoral and decentralised character.
- The NAA plays a key role:
- in elaborating National Plans and Main Strategies for Prevention and Alleviation of HIV/AIDS,
- as coordinator leader between public or private and national or international institutions that implement HIV/AIDS programmes.

Policy 2- HIV/AIDS Response Structure

The NAA has responsibility for:

- resource mobilisation for HIV/AIDS activities throughout the country by motivating and encouraging the support and active cooperation from national and international communities,
- developing, upgrading the knowledge, and improving the understanding of all government personnel working in the HIV/AIDS programme.

MAIN STRATEGIES

- Allocate adequate financial support by the Government for HIV/AIDS activities throughout the whole country.
- Endeavour to find support from friendly nations, national and international organizations public and private enterprises.
- Encourage all concerned public and private sectors in the country to make contributions as donations, or voluntary cooperation.
- Increase the potential of provincial and district authorities for initiating their own efforts to find financial support to deal with HIV/AIDS.
- Promote and strengthen the understanding of government personnel to increase their capacity for implementing the national policy.
- Promote collaboration and synergy of concerned agencies, i.e. associations, NGOs. community organizations and persons living with HIV/AIDS, in managing HIV/AIDS problems.

Policy 3-Health Information and education

The NAA cooperates with the relevant national and international institutions to promote knowledge and understanding on HIV/AIDS for the general population, focusing on vulnerable populations.

MAIN STRATEGIES

- Produce documents for advocacy and awareness on HIV/AIDS to be included in the other education programmes of concerned ministries, in particular in the curriculum of schools at all level.

- Produce education materials to promote education on HIV/AIDS through the media for:
 - a good understanding on HIV/AIDS,
 - a good understanding of the links between HIV and STDs,
 - a good understanding about sexual behaviours,
 - safe sexual practices.
 - Establish :
 - an education programme on HIV/AIDS prevention to be broadcast by public or private authorities, in particular in educational establishments,
 - direct education for groups in vulnerable situations, such as youth, women, sex workers, migrant workers, refugees, displaced persons, drug users, gays and their sexual partners.
 - Establish the policy of 100% condom use throughout the whole country, focusing on situations of high risk of transmission of HIV, and create conditions so that condom supply is sufficient, easily found and very cheap.
 - Promote mobilization of public and private authorities to assure that their personnel have access to information and education related to HIV/AIDS.
 - Encourage media in the public and private sectors to cooperate in diffusing information or documentation related to HIV/AIDS.

Policy 4-HIV/AIDS Prevention and Care Services

The NAA seeks to find ways to:

- Ensure the population has access to efficient and effective prevention services,
- Ensure that persons living with HIV/AIDS have access to cure and care services in an atmosphere of tolerance and respect to human rights.

MAIN STRATEGIES

- Ensure equitable access to health care for all individuals without consideration of gender, location, socio-economic or legal situation, or HIV status.
- Institute a tolerant atmosphere, and avoid discrimination and isolation of people living with HIV/AIDS.
- Establish directives that HIV antibody testing must occur only with free and informed consent, and with pre-and post-test counseling.
- Ensure that complete guidelines for the case management of persons living with HIV/AIDS are established. These should operate within the continuum of care, including home care, community care and care in health establishments. This case management must be complete and include clinical care management, nursing care and counseling.
- Distribute technical directives about prevention and case management of people living with HIV/AIDS.
- Establish appropriate strategies for prevention, and care of people living with HIV/AIDS, such as blood safety, prevention of mother-to-child transmission, and prevention and cure of opportunistic diseases with particular attention to Tuberculosis.

Policy 5- HIV/AIDS Research

The NAA will make every effort to increase and strengthen the national capacity for undertaking epidemiological, clinical, and socioeconomic research to collect information:

- on the situation and trends of the HIV/AIDS epidemic in Cambodia.
- to be used for a database to define appropriate approaches in HIV/AIDS prevention and alleviation.

MAIN STRATEGIES

- Strengthen health information systems for HIV/AIDS, including routine reporting of HIV/AIDS.
- Promote and set up programmes of research :
- to evaluate the number and of the persons living with HIV/AIDS in the population according to sex, age and area, and rate of spread of infection
- to determine the type of HIV in Cambodia,
- to study the clinical form of HIV/AIDS in Cambodia and appropriate therapeutic responses,
- to study the sexual behavior of the Cambodian population,
- to study the socioeconomic impact of the HIV/AIDS epidemic.

-
- [1] See Tia Phalla, 1998
- [2] See Gorbach et al
- [3] STDs and HIV are closely linked: STDs cause genital inflammation, thereby increasing the transmission of the HIV virus approximately 5-fold.
- [4] NCHADS, Consensus Workshop on HIV/AIDS in Cambodia, NCHADS, Phnom Penh, March 1999.
- [5] Ibid.
- [6] See Joint Ministry of Health/NGO Pilot Project on Home and Community Care for People with HIV/AIDS, February 1998-February 1999, Phnom Penh, p. 6
- [7] See WHO 1997
- [8] See WHO 1999, p.6
- [9] See Tia Phalla et. al, p. 1
- [10] See NCHADS, Cambodia National Strategy for the Surveillance of HIV/AIDS/STDs and Related Behavior 1999-2000, Phnom Penh, March 1999.
- [11] NCHADS, Consensus Workshop 1999
- [12] See Tia Phalla 1998
- [13] NCHADS, National Strategic Plan STD/HIV/AIDS Prevention and care in Cambodia 1998-2000, p. 11
- [14] The only existing study on the beliefs and illness etiology of Cambodian people is a technical discussion document by Maurice Eisenbruch. See Bibliography.
- [15] See UNAIDS Country profile February 2000, p.16
- [16] See Chun Bora et.al, PAC Project, 1999
- [17] See NCHADS, Report on Sentinel Surveillance in Cambodia 1998
- [18] National Blood Transfusion Center
- [19] See FHI/IMPACT/UNAIDS, 1999, p.6
- [20] Another organization that approaches counseling in a more holistic way is Transcultural Psychosocial Organization (TPO)
- [21] See FHI/IMPACT/UNAIDS, 1999, p.6
- [22] NCHADS, Consensus Workshop on HIV/AIDS in Cambodia, MoH/NCHADS, Phnom Penh, March 24, 1999
- [23] Only the Khmer version is finalized; the English version still remains in draft form.
- [24] Drugs for opportunistic infections available are: amphotericine B, Pyrimetamine, Sulfidiazine, A part of Cotrimoxazole, Acyclovir, Ketaconazole, and Miconazole.
- [25] National Institute of Statistics 1999
- [26] Report on Sentinel Surveillance in Cambodia 1998
- [27] National Institute of Statistics 1999
- [28] See Escoffier, 1995
- [29] See NCHADS, Report on Sentinel Surveillance in Cambodia 1998
- [30] Other organizations that phased out in the past few years are: Norwegian Red Cross, International Red Cross, Action Contre la Faim.