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USAID/CAMBODIA

**CAMBODIA HIV/AIDS MITIGATION
AND PREVENTION**

STRATEGY AND SPECIAL OBJECTIVE

PHNOM PENH

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EXECUTIVE SUMMARY

According to the most recent epidemiologic findings, Cambodia may rival the worst-hit countries of the world in terms of human immune deficiency virus (HIV) infection and future acquired immune deficiency syndrome (AIDS) deaths. With the first cases recorded in 1991, the epidemic has been growing faster than other countries that exhibit similar factors which contribute to the spread of the disease. Currently some 1.7 percent of women surveyed in antenatal clinics are HIV positive, with rates in urban and border areas even higher. Over 40% of commercial sex workers (CSW) now test positive. A vigorous and growing commercial sex industry, fuelled by low prices, a strong demand on the part of Cambodian men and an unregulated and permissive environment, are the "engines" that are driving the epidemic into the general population.

The Royal Government of Cambodia (RGC) recognizes the problem and is attempting to respond. A National AIDS Committee (NAC) has been formed, chaired by the Minister of Health with the First Prime Minister as honorary Chairperson. The NAC includes representation from multiple sectors across the government. The National AIDS Program (NAP), located in the Ministry of Health (MOH), is most active in attempting to stanch the epidemic. Like other national priorities, however, efforts are plagued by lack of infrastructure, funds, and human resource capacity. Multiple international and local Private Voluntary Organizations (PVOs) and Non-Governmental Organizations (NGOs) also contribute substantially to efforts in the battle against AIDS. Most, however, are geographically limited or focused on one aspect of the epidemic, such as information, education, and communication (IEC) or HIV testing and counselling.

The United States Agency for International Development (USAID) began assistance to Cambodia in HIV/AIDS prevention in 1993 with funding from the PVO (Private Voluntary Organization) Co-Financing Project, (442-0112) through grants to Population Services International (PSI) to socially market condoms and to Family Planning International Assistance (FPIA) to introduce integrated reproductive health services, including Sexually Transmitted Infection (STI) management. In addition, a number of Cambodians were sent to a variety of workshops and training under the auspices of the AIDS Control and Prevention Project (AIDSCAP) Regional Office in Bangkok. In 1995, an HIV/AIDS Sector Assessment resulted in an interim course of action using Asia and the Near East (ANE) Bureau regional funding through AIDSCAP for a number of critical baseline activities. These include the institutionalization of sentinel surveillance systems for HIV, syphilis and behavioral surveillance, a major study on STI prevalence, antibiotic resistance and associated behaviors and the development of HIV counselling and testing policy guidelines. In early 1996 USAID/Cambodia elaborated a Maternal Child Health Strategic Objective (MCH SO) which provided strong support for integrated reproductive health including sexually transmitted infections (STI) management in the public and private sectors and social marketing of condoms. Although the MCH SO received strong support during its review in Washington, USAID/Cambodia was required to further analyze the HIV/AIDS situation and make recommendations for ongoing assistance. This mandate has resulted in this strategy document.

Other donors, including the United Nations (UN) family, the European Union (EU), The British Overseas Development Administration (ODA), the German Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), and the French Cooperation have also been active in providing funds and technical assistance to the Government of Cambodia and NGO's to help stanch the epidemic. The World Bank is in the initial implementation phase of a major health sector loan which will provide significant support to HIV/AIDS programs, with a particular focus on the National AIDS Program in the Ministry of Health.

Based on analysis of the situation in Cambodia, the team recommended that a dual approach on the part of the Mission would be the most effective in responding to the epidemic and in keeping with USAID strategic priorities. Antenatal clinic surveillance clearly indicates that HIV is moving into the general population. Relatively high prevalence of STIs, particularly syphilis, were also found in this population. These findings confirm that the emphasis the Mission MCH SO has placed on improving integrated reproductive health services and the interventions proposed is appropriate. In this area the team recommended only that the Mission consider adding an implementing partner for proposed pharmacist interventions in STIs and that additional funding be allocated to the MCH SO to assure sufficient efforts be made in STI interventions and social marketing of condoms.

Though important, however, these interventions are unlikely to have significant impact on the spread of the epidemic. This is largely because the target population for these reproductive health interventions primarily represent women at the end of the HIV transmission line. In Cambodia all evidence clearly demonstrates that the epidemic is fueled by a dynamic sex industry where commercial sex workers (CSW) and their clients sustain and increase the epidemic. Focusing intensive, effective interventions on high risk populations, particularly within the commercial sex industry, ultimately will have the most powerful impact on slowing the rapid increase of this epidemic and diminishing the "engines" that sustain its spread over the long term.

Consequently, a Special Objective (SpO) is mandated to reduce transmission among high-risk populations. The primary beneficiaries are both direct and indirect CSWs and their clients. An important secondary audience and key intermediary group are the economic beneficiaries of the sex trade including, for example, brothel owners, restaurant and hotel workers etc. Activities to achieve the objective will be supported over a five year time frame, through the year 2002 and will require achievement of three intermediate results (IRs).

Special Objective Reduced transmission of STI/HIV among high risk populations - direct and indirect CSWs and their clients

Indicators

It should be noted that although the SpO will reduce STI/HIV prevalence, the measurement of HIV prevalence is beyond the scope of this activity and Cambodian capacity. Thus a series of proxy indicators have been selected which are well documented to correlate with reduced HIV prevalence. These are

- 1 Reduced number of high-risk behaviors
- 2 Reduced prevalence of selected STIs
- 3 Improved Policy Environment Score

IR 1 Policy Makers are informed about the HIV/AIDS epidemic in Cambodia

Policy makers, including high level officials of the RCG at the national and provincial levels are the target of this intermediate result. This is based on the premise that the increasing dimensions of the sex industry can be contained with the support of key individuals. Activities will be targeted to provide accurate information and options for strategies based on effective models. This will include support to study tours, workshops and information dissemination events and materials.

IR 2 Reduced high risk behaviors in target populations

Behavior change amongst the target population will be effected through the use of quality information, education and communication (IEC) strategies and tools. Information indicates that, for commercial sex, Cambodians are beginning to adopt condoms, although without consistency. Other approaches, such as partner reduction, have not really been piloted. Support will be provided to develop and disseminate information using high-quality techniques to reduce high risk behaviors.

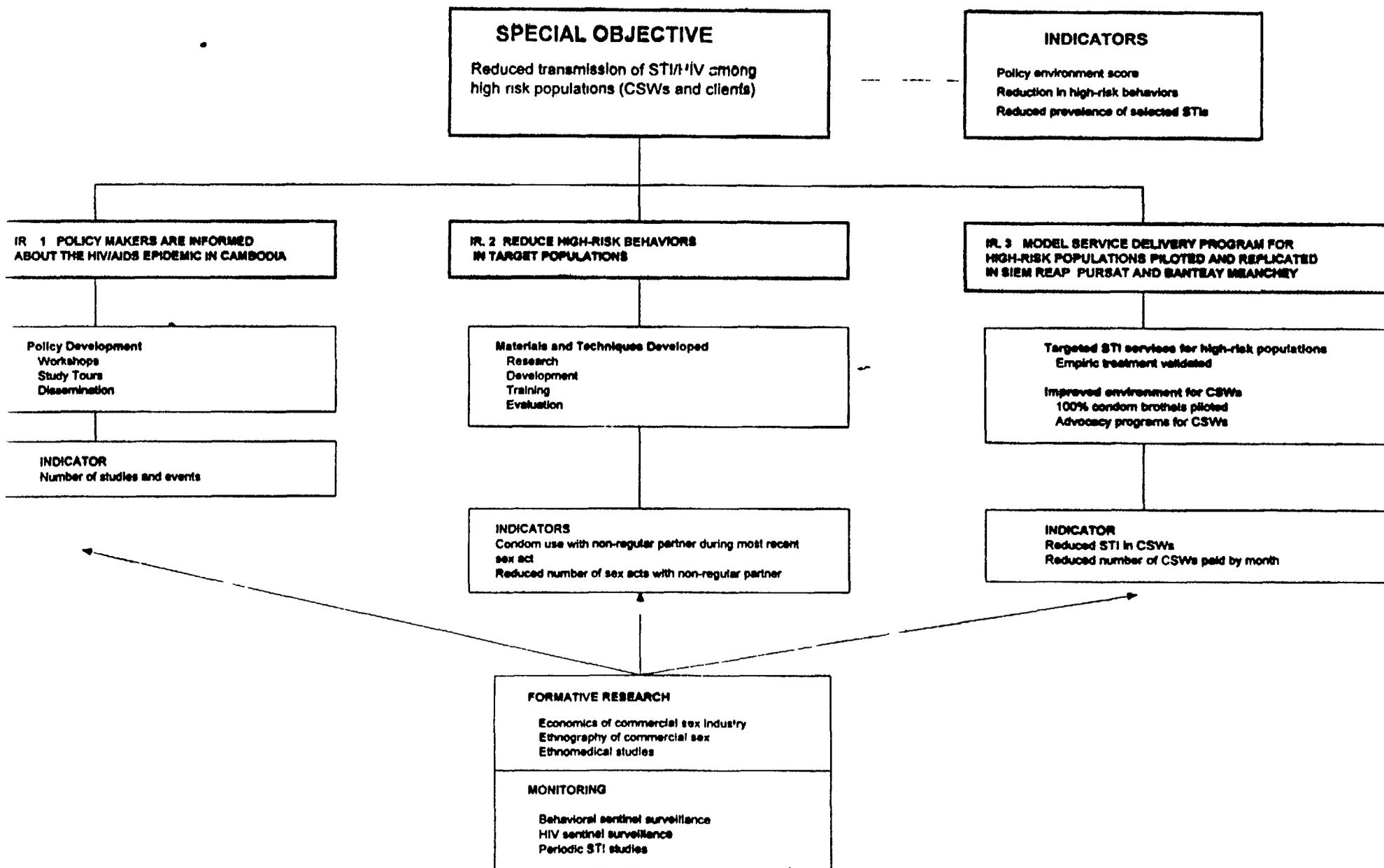
IR 3 Model service delivery program for high risk populations piloted and replicated in selected provinces

The nature of the epidemic in Cambodia mandates direct intervention at the level of high-risk sex, particularly for direct and indirect CSWs. Pilot interventions will include support to outreach programs and other models of STI service delivery - including empiric treatment models. Advocacy programs for CSWs also will be pilot tested.

Achievement of these intermediate results, particularly given the ongoing state of flux of the Cambodian environment, will require substantial attention to formative research and ongoing monitoring. This will not only serve to inform program interventions but also for ongoing monitoring of the epidemic as a whole in Cambodia. Funding will be provided to support

monitoring and research activities

The recommended mechanism for implementation of this SpO is through a competed contract or cooperative agreement with an internationally-experienced organization. Planned bilateral resource requirements over five years would be \$7.5 million in new funding. In addition, complementary support and funding is requested from ANE Regional Bureau HIV/AIDS funds. This support would be used to assure ongoing assistance to grass roots responses through the AIDS Alliance and to fund selected monitoring and research activities.



ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
AIDSCAP/ARO	Central Assistance Project/Area Regional Office (Bangkok)
ANC	Antenatal care
ANE	Asia/Near East Bureau
BSS	Behavioral sentinel surveillance
CAPE	Cambodian Assistance to Primary Education
CRC	Cambodian Red Cross
CBD	Community Based Distribution
CRS	Catholic Relief Services
CSW	Commercial sex worker
FHI	Family Health International
FPIA	Family Planning International Assistance
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
G/WID	USAID Office of Women in Development
GPA	Global Program for AIDS
HACC	HIV/AIDS Coordinating Committee
HIV	Human immunodeficiency virus
HSS	HIV sentinel surveillance
ICRC	International Committee of the Red Cross
IEC	Information, education, and communication
IPC/E	Interpersonal communication and education
IR	Intermediate result
KAP	Knowledge, attitude, and practice
MCH	Maternal and child health
MOH	Ministry of Health
NAP	National AIDS Program

ABBREVIATIONS, cont

NGO	Non-governmental organization
ODA	[British] Overseas Development Administration
PRA	Participatory Rural Appraisal
PSI	Population Services International
PVO	Private voluntary organization
RAPID	Resources for Awareness of Population Impacts on Development
RGC	Royal Government of Cambodia
RHAC	Reproductive Health Association of Cambodia
RSM/EA	Regional Support Mission/East Asia
RTI	Reproductive tract infection
SO	Strategic objective
SpO	Special Objective
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TA	Technical Assistance
TB	Tuberculosis
TCN	Third Country National
TIR	Targetted Intervention Research
UN	United Nations
UNAIDS	United Nations AIDS Programme
UNFPA	United Nations Population Fund
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

At the request of USAID/Cambodia, a five-person team visited Cambodia for three weeks in January of 1997. The team comprised Paul DeLay, HIV-AIDS Division, Office of Health and Nutrition, Global Bureau, Edward Green, an independent consultant in social science research, behavior change and social marketing, Laurie Krieger, Women in Development (WID) Office, Global Bureau, Michele Moloney-Kitts, Health Population and Nutrition (HPN) Officer, USAID/Phnom Penh, and Jack Thomas, Office of Strategic and Economic Analysis, Bureau for Asia and the Near East, Team Leader.

The team was charged with analyzing the current HIV/AIDS epidemic in Cambodia, the response to the epidemic by the RGC, other donors, international NGO's and local NGO's, reviewing the current epidemiological situation, relevant components of the current USAID MCH Project and the regional HIV/AIDS activities, and then developing a USAID strategy for the next three to five years. A management and implementation plan also was requested. The team reviewed key documents, visited officials of the MOH and the NAP, eight international donors agencies, 20 international and local NGO's, as well as visiting pharmacies and drug sellers, provincial and district clinics, and brothels and dance halls in the Phnom Penh area, Siem Reap and Sihanoukville (See Annex 4).

Based on their analysis, the Team presented a recommended course of action to the NAP, USAID/Cambodia and the U S Ambassador for targeted USAID interventions over the next five years which will complement the Government's, other donors' and the NGO community's activities to stanch the AIDS outbreak in Cambodia. Strong Mission and Embassy support were clearly stated. A SpO for HIV/AIDS Prevention has been articulated that will supplement ongoing activities under the MCH Project, as well as efforts of the Government and other agencies working in the sector.

The team expresses its gratitude to Dr. Hor Bun Leng, Director of the National AIDS Program, Ministry of Health, for his insights, his frankness and his dedication to addressing the AIDS epidemic in Cambodia. In addition, the team wishes to thank Team member Michele Moloney-Kitts for her knowledge, guidance and leadership in the development of this SpO. The Team also appreciates greatly the considerable time and insights provided by the representatives of international and local organizations which are working diligently to stanch the epidemic in Cambodia. Lastly, the Team is especially grateful to USAID/Cambodia, which provided strong logistical support for our efforts.

1. CONTEXT

A. Epidemiological Setting

BACKGROUND

HIV infection was first detected in Cambodia during selected serologic screening in 1991. In late 1993 and early 1994, the first cases of AIDS were diagnosed. As of September 1996, a total of 6,835 HIV infections have been officially reported to the MOH NAP. However, due to under reporting and lack of access to HIV testing this number does not represent the reality of the epidemic. The actual cumulative number of HIV infections in Cambodia as of 1996 is estimated to be between 70,000 and 120,000. As of November 1996, 245 cases of AIDS have been officially reported, though the actual number is more likely between 2,000 and 3,000.

Nearly 40% of all HIV infections are occurring in the 20-29 age group and over 80% in the 13-39 age group. For the reported HIV infections the male female sex ratio is 3:1. However, due to sampling bias the actual ratio for the country is closer to 1:1. The primary mode (greater than 90%) of transmission is through heterosexual sex.

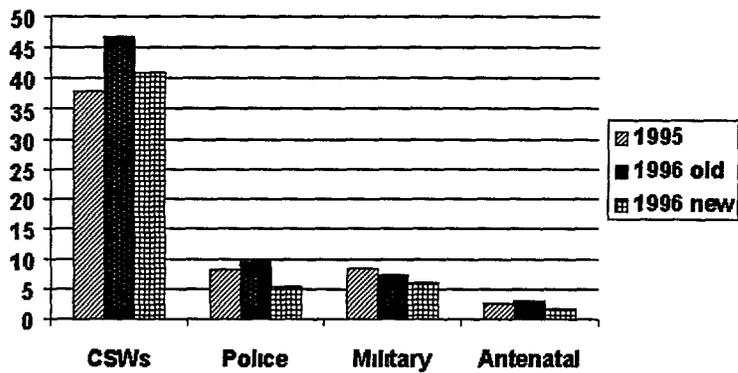
THE 1996 SURVEY RESULTS

Because of the critical need to better understand the dynamics of the HIV/AIDS epidemic in Cambodia and the imminent loss of further funding from World Health Organization (WHO)/Global Program for AIDS (GPA), USAID supported sentinel surveillance activities for a 1996 round of testing. For this set of surveys, it was recommended that the testing be expanded from 9 to 18 of the 21 provinces, high risk groups be limited to CSWs, military and police, and that there be larger samples of antenatal clinic attenders from both rural and urban settings. The number of provinces was increased from the original nine, which mainly were located along the Cambodia/Thailand border, to 18, in order to better assess nationwide average prevalence rates.

The first graph below (Figure 1) shows the 1996 HIV sero-prevalence rates for each of the high risk and general adult populations that were tested in the originally surveyed nine provinces and compares this data with the 1995 rates. It should be noted that the rates in CSWs in these original nine provinces increased from 37% to almost 48% and antenatal clinic rates increased from 2.5% to almost 3%.

HIV Sentinel Surveillance- Comparing 1995 and 1996 data

The latest round of HIV testing performed in 1996 reconfirmed the data from the nine original provinces surveyed in 1995, and permitted a better understanding of the scale and scope of the epidemic throughout the country. Annex 8 shows a map of the 21 provinces of Cambodia and HIV prevalence rates by population group. The western provinces along the Thai border and Rattanakari Province (sharing borders with Laos and Vietnam) demonstrate the highest HIV prevalence for both high risk and general adult populations.



The national 1996 HIV results are shown below

1996 HIV RESULTS

Category of Population	Average HIV Seroprevalence	Range of Prevalence Values
CSWs	40.88%	range of 13.3 - 58.33%
Police	5.46%	range of 0 - 14.86%
Military	5.95%	range of 1.27 - 17.31%
Tuberculosis patients	3.9%	range of 0 - 9.4%
Pregnant women	1.73%	range of 0.29 - 6.19%

There are three important conclusions that can be made after reviewing this information and comparing it with previous year reports and data from neighboring countries

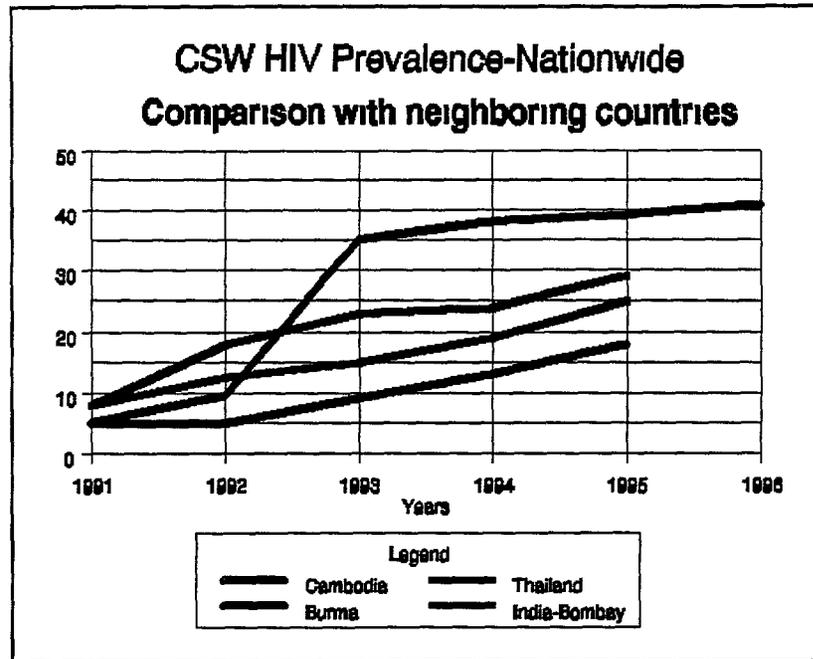
1 *The nationwide HIV prevalence in pregnant women in Cambodia is nearly the highest in the Asia region*

The graph and table below compare the 1996 rates in Cambodia with the three other most severely affected countries in the region (Thailand, Burma, and India) and give the antenatal clinic attender figures for seven other Asian countries with HIV epidemics

	NATIONAL HIV PREVALENCE IN PREGNANT WOMEN IN 1996
Indonesia	0%
Vietnam	0%
Philippines	0%
China	1%
Nepal	1%
Laos	8%
India	8%
Burma	13%
Cambodia	17%
Thailand	18%

2 *The nationwide HIV prevalence in brothel-based CSW is the highest in Asia*

Clearly, the widespread utilization of the commercial sex industry was a significant factor during the early explosive increases of HIV in Cambodia and continues to contribute to the general population epidemic

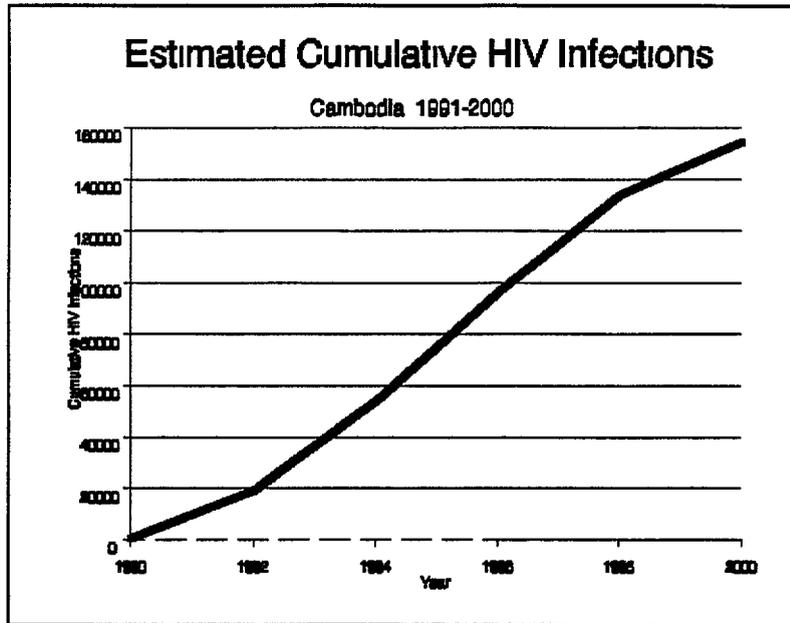


- 3 *The "pattern" of increasing HIV prevalence in both the high risk and general population groups in Cambodia is much more rapid than in surrounding countries - representing an explosive "outbreak" configuration*

Between 1991 and 1994, HIV prevalence rates in CSWs increased from 5% to nearly 40%. Between 1991 and 1994, HIV rates in pregnant women rose from 0% to nearly 2%. This represents an extremely rapid progression of the epidemic beyond the "standard" high risk populations into the general adult population.

FUTURE PROJECTIONS OF HIV INFECTIONS AND AIDS CASES

Using the international HIV/AIDS modelling tool, EPIMODEL, and a "low" to a "high" scenario, in the year 2000 it is estimated that there will be between 6,000 to over 12,000 new AIDS cases occurring per year. (See "HIV Sentinel Surveillance and Estimation and Projection of HIV/AIDS in Cambodia," December 1995, by Dr. James Chin). The chart below gives estimated cumulative HIV infections until the year 2000 (from "Sexually Transmitted Diseases (STD) HIV/AIDS Surveillance Report" World Health Organization, Western Pacific Region, No. 8, November 1996).



THE EPIDEMIOLOGY OF SEXUALLY TRANSMITTED INFECTIONS (STIs)

It is now well documented that the presence of a STIs, such as syphilis or gonorrhea, can increase the efficiency of acquisition or transmission of HIV five to ten times. Data from Mwanza, Tanzania, has demonstrated that providing simple, realistic syndromic management of STDs to symptomatic persons at village level resulted in a 42% decrease in HIV transmission. This effect was seen without concomitant changes in sexual behavior or condom use. More recent data (to be published) has provided part of the biologic rationale for the dramatic impact derived from STI interventions on HIV transmission, demonstrating dramatically increased "viral load" of HIV in semen in the presence of a STI. Data from Malawi shows that the viral load of HIV in men's semen increases almost a hundred times in the presence of a gonorrhea infection. When the gonorrhea is treated, the viral load in the semen decreases to the levels prior to the gonorrhea infection. Treating STIs, in this case one causing urethritis, will have a profound impact on HIV transmission.

Given the impact of STIs on HIV transmission, USAID also supported specific studies to determine the prevalence of selected STDs in "high" and "general" risk populations. This data serves three important functions:

- it provides further information on the scope of "high risk" sexual behavior,
- it provides invaluable baseline and trend data that can be used to monitor the success of behavior change and improved STI management interventions, and
- it is critical for the development of rational STD syndromic management guidelines

The findings are startling 44% of the CSWs examined had at least one STI (not including HIV) Over 50% of these were asymptomatic, meaning that despite the presence of infection, they felt essentially well and did not necessarily have clinical signs of infection These same CSWs had HIV infection rates of 46%, meaning that as a group they are very efficient transmitters of HIV In addition, over 12% of the men examined had an STI and almost 12% were HIV infected - again making them efficient transmitters, not only to CSWs but also to their wives and sweethearts normally considered lower-risk populations

Specific prevalence for syphilis and gonorrhoea, determined to be the most prevalent STIs are noted below

SYPHILIS

Category of Population	Average Syphilis Prevalence	Range of Prevalence
CSWs	16.1%	4 - 24%
Police	7.1%	1.4 - 20.8%
Military	8.8%	4.3 - 14.3%
Pregnant women	3.4%	0 - 13.3%

GONORRHEA

Category of Population	Average Prevalence of Gonorrhoea	Range of Prevalence
CSWs	23%	20 - 30%
Pregnant Women	3.7%	2 - 5%

CONTRIBUTING FACTORS FOR THE EXPLOSIVE HIV/STI EPIDEMIC IN CAMBODIA

Peter Piot (UNAIDS) has delineated the full range of factors known to influence the spread of HIV, even if causal mechanisms are still not well-understood in some cases These factors include a range of biological, behavioral and societal factors, ranging from HIV-1 sub-type variation, a newly discovered possible factor, to presence of other STDs, a well-established factor, and several macro-economic and societal conditions such as poverty and social disruption

Cambodia exhibits a disturbing constellation of these HIV/AIDS risk factors which helps explain the explosive take-off of HIV infection in this country The first case of AIDS in

Cambodia was diagnosed only in 1993 (which does not mean there were no cases earlier, rather that surveillance could not find any), 3 years later HIV was found in about 40% of CSWs and nearly 2% of women at ante-natal clinics in border and urban areas, an infection rate placing Cambodia among the hardest-hit countries in Asia. Indeed, Cambodia has all the risk factors of a country like Uganda, which has the highest current HIV infection rate in the world.

Factors specific to the thriving, widespread Cambodian sex trade that lead to a high risk of STI and HIV infection in the country include

- The large proportion of men who visit CSWs (over 40% of men in Phnom Penh between 18 and 30 years and 30% of men between 31 and 40 years in rural areas surveyed by the Cambodian Red Cross had commercial sex sometimes, over 50% of military had commercial sex in the last month according to the AIDSCAP survey)
- High CSW client turnover rate (average of 4.2 according to AIDSCAP survey-- compared to 2.6 per night for Thailand)
- Preference for young CSWs (immature vaginal epithelia facilitates entry of HIV and once infected, a person remains highly infective for some three weeks)
- High levels of STIs among CSWs (44% any STI in the AIDSCAP study)
- Highest rates in Asia of HIV infection among CSWs (about 40%)
- Very high rates of reproductive tract infections (RTIs)
- High rates of STIs in the general population--2-5% of surveyed women attending antenatal care (ANC) were found to have gonorrhea (AIDSCAP), 3.4% tested positive for syphilis (national surveillance)
- Lack of male circumcision
- Circulation of CSWs throughout the country
- Relatively large numbers of men working away from home, but returning periodically (soldiers, police, transport workers, loggers, traders, de-miners, fishermen, etc.)
- Cross-border sex industry with CSW's from high prevalence countries working in Cambodia

Enough is now known about HIV transmission factors in general and in Cambodia to (1) predict in a general way the nature and rate of transmission among different populations, and (2) prioritize interventions in order to ensure limited resources have maximum impact.

B CURRENT ENVIRONMENT/RESPONSE

1 Policy

The Royal Government of Cambodia (RCG) recognizes the significance of the STI/HIV problem and is attempting to respond. A National AIDS Committee (NAC) has been formed, chaired by the Minister of Health with the First Prime Minister as Honorary Chairperson. The NAC includes representation from multiple sectors across the government, reflective of recognition of the need for a multisectoral response to the epidemic involving other key government ministries and the private sector. Like other national priorities, however, efforts are plagued by the lack of infrastructure, funds, and human resource capacity common to the Cambodia environment.

The National AIDS Program (NAP), located in the MOH, is most active in attempting to staunch the epidemic. The NAP program is broadly oriented towards biomedical and behavior change interventions but has been extremely under-funded. A World Bank loan that will further bolster the NAP's budget and technical capacity is, however, just getting underway. Other international and local Private Voluntary Organizations (PVOs) and Non-Governmental Organizations (NGOs) also contribute substantially to efforts in the battle against AIDS. NGO activities are coordinated through an HIV/AIDS Coordinating Committee (HACC). UNAIDS is also beginning to take shape and contribute.

Because of less than adequate government revenue, RCG policies that provide sufficient budgetary support for condom and drug supplies, as well as adequate anonymous testing, counselling and care (especially home care) are not likely at present and, instead the RCG relies heavily on donor support in combating the AIDS epidemic. The future explosion of frank AIDS cases is likely to further exacerbate the budgetary shortage. "Moral" support from the highest levels is, none-the-less, apparent as evidenced by the HIV/AIDS education "garden party" hosted by King Sihanouk at the royal palace.

Another significant policy issue is the booming sex industry. Indeed, there have been allegations that certain "regulatory officials" including the military and police are involved both actively and passively. Likewise, there is reported luring and kidnapping of young Cambodian girls for the sex industry from rural areas. These issues are compounded by the fact that, across all sectors in Cambodia, the establishment of legal frameworks and efforts to enforce resultant laws are at a nascent stage. Decision makers also lack the necessary information, experience and relevant models to make appropriate decisions concerning the sex trade in their areas.

There are multiple examples of difficulties relative to enforcing laws which do exist relative to the sex industry. Although articles 45 and 48 of the Cambodian constitution explicitly prohibit trafficking in humans, particularly women and children, and support the rights of children as stipulated in the Convention on Children, there are loopholes in these articles and

enforcement is extremely problematic. A specific trafficking law targeting brothel owners and those who traffic in humans was passed in 1996. It places the legal age of consent at 15. Even this, however, is not uniformly applied in the courts and, in some instances, courts are not even aware of the law's existence. As in other countries, local police respond by sporadically raiding brothels. However, their reaction has been to criminalize prostitution and CSWs, rather than criminalizing their clients or viewing most of the CSWs as victims.

2 Condom Supply

Prior to the initiation of the social marketing project through Population Services International (PSI) funded by USAID, only an estimated 2-3 million condoms were sold nationally in Cambodia, augmented by sporadic and small supplies from international donors which are distributed free through the essential drug network to MOH hospital and clinical facilities. UNFPA, for example, provides condoms for the Birth Spacing Program of the MOH. The PSI project has succeeded in quadrupling condom sales, mainly in urban areas, through aggressive promotion and distribution through Government and NGO infrastructures, as well as the commercial network. 9.5 million condoms were sold by PSI in 1996, with over 30% targeted directly to the sex industry. Free condoms through NGO's and MOH static facilities are spotty, with most organizations relying on the social marketing project as the primary (and seemingly only) national supplier. Anecdotal reports indicate that other commercial brands have also increased sales.

Despite these successes several questions remain about condom availability, promotion and use in Cambodia. In terms of the social marketing program there are concerns as to whether PSI has penetrated sufficiently into retail sales points which serve the general population, especially in rural areas. Their current strategy focusing on governmental and NGO distribution agents in some ways more closely resembles a community-based distribution system than a well-planned social marketing endeavor. There also is some question whether the supply of condoms to PSI has been sufficient and assured. The British Overseas Development Administration (ODA) has provided the last several tranches of condoms, but guaranteed supplies of 49 mm condoms are only sufficient through 1997. Given that a six-month supply should always be available in country, and sales that are increasing monthly, PSI cannot endeavor to maximize sales nationally until funding for such supplies are assured in the long term. There are also issues concerning the availability of free condoms through the public sector. Although the MOH feels it has sufficient supplies of free condoms, there are questions as to whether the current policy of free condoms only for certain programs is adequate.

Thus although there is general consensus on the success of increasing access to condoms dramatically over the last several years, additional work remains to be done to assure continued appropriate supplies and marketing in the public and private sector.

3 Research

For a country with such a serious outbreak of HIV/AIDS and with so much, albeit relatively small scale, preventive activity underway by donors, governmental and non-governmental organizations, there has been surprisingly little rigorous research, including IEC-related formative research, standard marketing research for contraceptive social marketing, and anthropological research to form the basis for culturally appropriate interventions (service delivery, preventive education and other communication) This is reflective of the crisis atmosphere which has prevailed in HIV/AIDS in these first few years of assistance Also because of the very short time-frame in which activities have been launched, there have been few pilot service delivery models established and little opportunity for evaluation

There are some recent research efforts, however, which are facilitating understanding of the epidemic The development of an ongoing sentinel surveillance system through the NAP has been of critical importance Likewise, the establishment of a behavioral sentinel surveillance (BSS) system, now beginning, will provide very useful behavior data to link with HIV and syphilis status In addition NAP program reviews, including an evaluation of the NAP outreach worker program supported by GTZ will provide valuable information for program direction Three key behavioral data sources are mentioned below

Cambodian Red Cross (CRC) KAP Survey

This recent KAP survey combined qualitative methods (22 focus groups) with survey methods, in 4 provinces in addition to the capital The study surveyed 572 respondents in Phnom Penh and 794 respondents in provinces (including the city of Sihanoukville) 885 of respondents in Phnom Penh and 77% of respondents in rural areas knew that HIV/AIDS is transmitted sexually Less were aware that it can be transmitted by blood and many thought it could be transmitted through other places, such as public toilets etc Importantly, although 79% of respondents identified condoms as a means of prevention in Phnom Penh, only 54% of rural respondents did so Three out of four of all respondents said they would not care even for family members who had AIDS at home - the main reason being fear of themselves becoming infected Sources of knowledge were magazines for more in-depth information (there appears to be only one commercial magazine in Cambodia), and radio or TV for more general awareness-concern-fear Posters and other print materials from IEC campaigns were found to have little apparent impact or recall

The study also provided important information about commercial sex, with high rates of "sometimes" visits to CSWs among men between 18-30 years in Phnom Penh (average 42.5%) and among men between 31 - 40 in rural areas These findings are consistent with other studies Interestingly 38% of men in Phnom Penh who visited CSWs were also married Reported condom use is moderate with CSWs and almost non-existent with wives The study showed that one general and very real constraint to condom use and behavior change in general is that HIV/AIDS is new, and not real for most Cambodians A doctor in Sihanoukville was quoted in this study as saying he has never seen a person with AIDS, it's

all "just word of mouth" as far as he is concerned

Behavioral STD Study

Behavioral data from the USAID-supported STI Prevalence, Antibiotic Resistance and Behavioral Study also provide a wealth of information. This study confirmed that, in general, reported condom use is unreliable, as researchers were able to correlate reported condom use with the presence or absence of an STI. Indeed, there was no correlation between either "always" use and "never" use, but rather those who stated sometimes use had somewhat fewer STIs. The overall conclusion of this study is that Cambodian men are moving toward condom use, but that it is inconsistent. CSWs consistently reported approximately one less condom used than number of clients on the previous day. This study also provides information concerning average number of clients, debt, movement and payment related to CSW as well as information from clients.

"People in Cambodia Don't Talk About Sex, They Simply Do It!"

This study of high school students in the Phnom Penh area by a Cambodian anthropologist found that there is a considerable amount of sexual activity on the part of both male and female students, previously thought to be negligible, and suggesting further studies, perhaps quantitatively-based.

There have been a number of other HIV/AIDS-related knowledge, attitude and practice (KAP) surveys in Cambodia and another KAP by Save the Children/UK concerning children's knowledge of HIV/AIDS will also be released soon. These mentioned, above, however, seem to have the most up-to-date information on a larger scale.

4 Information, Education and Communication (IEC)

There has been a plethora of activity in producing print and electronic materials targeted at a variety of high risk and general population groups. Most, however, has not been based in the necessary formative research that is culturally appropriate for theme and message development in concert with IEC principles. Many of the NGO's recognize this problem and are solicitous of training and technical assistance in this discipline. Some of the problems include 1) print materials that rely on Khmer literacy, 2) pictorial representations not based in research or pretested that may give the wrong message or a message not understandable by the target audience(s), and 3) lack of understanding of the indigenous belief systems associated with disease causation or prevention.

Many NGO's are each developing their own materials, often for the same target audiences, at considerable expense of time and scarce resources. While print materials and posters are most often chosen as the IEC medium, existing research suggests that radio and one national magazine are the most effective in reaching target populations. There is also a recognition of the need for better coordination on messages to be disseminated and that this is an area in

which the NAP has an important role to play. The World Bank has included technical assistance to the NAP in this area in their upcoming project.

5 Blood Safety

The International Committee of the Red Cross and the CRC have worked over the past several years in screening blood supplies in Phnom Penh so that the blood supply is now estimated to be 98% safe, but outlying cities and rural areas are still without services. The ICRC and CRC are continuing to work in this area with technical assistance and funding from the World Bank.

6 STIs

Systematic appropriate treatment of STIs is currently unavailable on a wide scale in Cambodia. A few organizations including Medecins Sans Frontieres (MSF) and Family Planning International Assistance (FPIA) have integrated services and the NAP with assistance from the WHO and the French Cooperation is attempting to establish STI clinics in the provinces. There is a National Center for Dermatology and Venereology which serves as a training site, but sees few clients. Most studies suggest, as in other countries, the first contact for, in particular, men with an STI is either the pharmacy or traditional healer. Efforts to improve STI care have been impeded by the lack of substantial data concerning STI prevalence and antibiotic resistance patterns. The USAID funded study to determine these issues is now complete (see Epidemiology for data summary) and the technical working group on STIs has developed treatment guidelines, which have been approved. Plans are now underway to translate these drug protocols into bona-fide case management guidelines and develop training curricula and programs. The NAP has assumed leadership in this area effectively and multiple donors and the UN agencies, with United Nations Population Fund (UNFPA) and WHO in the lead, are involved in these efforts. Outstanding issues remain about the procurement and availability of STI drugs and certain types of lab reagents in public facilities.

7 Peer Education

The NAP, particularly at the provincial level and several NGO's, are working to train and inform both direct and indirect sex workers of the danger of HIV infection, largely through peer counseling programs. The PSI condom project, through its sales force, helps to augment these efforts through direct sales to brothel, dance halls and bars and regular contacts with its sales force. Efforts are largely focused on condom promotion with CSWs. There has also been an absence of rigorous formative research and qualitative monitoring to gauge attitude or behavior change among CSW's, brothel owners and clients. The NAP, however, is currently undertaking an evaluation of their peer educator program with CSWs including a mystery client component with funding from GTZ. This should provide valuable information to further refine and expand these programs, as appropriate.

8 Testing and Counselling

Support to the MOH by USAID through AIDSCAP resulted in the elaboration of a national HIV testing and counselling policy. Dissemination of these guidelines is underway, although enforcement is a recognized problem. Anonymous testing is not widely available, although plans are in place to widen access. The Institute Pasteur and World Vision are both involved with this effort, each supporting one center in Phnom Penh. Even attenders at one MOH testing center in Phnom Penh who request a test and receive counseling are referred to the Institute Pasteur for the blood test itself and then report back to the MOH facility for the results - a rather daunting process. Plans are in process to expand the number of testing centers to nine including several in the provinces, supported by the French Cooperation. The Family Planning International Assistance/Reproductive Health Association of Cambodia (FPIA/RHAC) clinics in both Phnom Penh and Sihanoukville are also considering offering testing and counselling. A widely expressed concern is expressed related to the availability of trained pre - and post - test counselors.

9 Care

Due to the "outbreak" nature of the HIV epidemic in Cambodia, relatively few deaths have been reported or witnessed by MOH personnel nor by the general Cambodian citizenry. With HIV infection so new (first cases reported in 1991) the disease is just not widely evident. Anecdotal reports suggest that the relatively few individuals who have tested positive or who have exhibited symptoms of frank AIDS are rejected by their families for fear of contagion. Hence, many people living with HIV are without familial or financial support and are left to fend for themselves.

At least one ward of an MOH Hospital in Phnom Penh has dedicated space for treating AIDS patients but already is overtaxed. The NAP Director has obtained RGC approval to use a district hospital 70 km north of Phnom Penh as a hospital and hospice, but this will only help in the short term. These programs are largely supported with funding from the French Cooperation and support from Medecins Sans Frontiers (MSF).

At present, many Cambodians shun infected relatives and friends and are not comfortable with the idea of caring for them at home. Basic Home Care methodologies will need to be introduced as the epidemic progresses. In recognition of this approaching crisis, UNAIDS in collaboration with the MOH has created an AIDS Care forum which brings together all interested organizations to participate on strategies in this sector. WHO has also placed an advisor who is focused on AIDS care and particularly interested in psycho-social issues.

10 Grassroots Response

Local organizations are increasingly interested in contributing to the response to HIV/AIDS in Cambodia. They generally participate in HIV/AIDS Coordinating Committee (HACC) meetings and focus activities primarily on condom promotion. With USAID funding, the

AIDS Alliance works in Cambodia to improve the technical capacity for local NGOs in HIV, while improving their organizational abilities. The Alliance has held a series of workshops reaching over 20 local NGOs and has awarded funding to 8 organizations in their first year of operation. The general consensus is that local NGOs could play a very important role in the future. At the present however, again somewhat due to the lack of visibility of the epidemic, activities remain fairly limited to awareness raising.

11 Other Donors

Cambodia has numerous international and bilateral donors which are involved in slowing the epidemic. WHO has been working with the Government in addressing the epidemic ever since the first cases were discovered. The United Nations Development Programme (UNDP), UNFPA, and the United Nations Children's Emergency Fund (UNICEF) all are involved in various aspects of the epidemic and have been strong partners in providing support to various components of HIV prevention efforts. UN agency efforts are now coordinated through UNAIDS which has a representative in Phnom Penh. The major donors to date have been USAID, the British ODA, UNAIDS and other members of the UN family, and the French Cooperation. Some assistance has also been provided by GTZ and the Japanese. The European Union (EU) is planning on providing support specifically the STI program. The World Bank is in the process of launching their major health sector loan one component of which focuses specifically on HIV/AIDS. A list of specific activities appears in Annex 6.

12 Cross-Border Issues

A USAID Lessons Learned Seminar showed that in SE Asia, border areas have the following HIV/AIDS-relevant characteristics: Multilingual, multi-cultural environment, widespread alcohol consumption, easy-to-access commercial sex, free-lance and casual commercial sex, remoteness from government health services, a young working population (with available cash), frontier atmosphere of crime and lawlessness, instability, insecurity (adding to lack of government services), infrastructure for commercial sex and injection drug behavior.

At present there is little or no intervention specifically targeting cross-border populations and issues. However, there appears to be some interest in attempting creative approaches. The NAP with assistance from UNAIDS has begun dialogue with Thai counterparts across the border from Koh Kong. Certain donors and agencies also support a "cross border" or regional concept, including the UNICEF Mekong project, regional efforts from GTZ and a CARE project proposal. It is unclear at this time, however, whether these efforts will be able to transcend difficulties inherent in this approach, or whether they will essentially result in a series of country programs. Should a cross-border approach be deemed appropriate, special ANE Bureau support and probably technical assistance (TA) will be needed.

13 Gender Issues

The HIV/AIDS epidemic is intimately and inextricably connected to gender and sex roles and status. Cambodia is a strongly patriarchal society where females traditionally have been subordinate to and have occupied a much lower status than males. Children are viewed as parental property. Although families are expected to protect their members, family and economic structures have broken down due to the loss of many family members, traumatization of remaining members, and destruction, through conflict and past governments' actions, of much economic infrastructure and relations. This has meant that aspects of Khmer culture that might have been de-emphasized or compensated for through other cultural mechanisms have become distorted. For example, a husband's hegemony over his wife was probably kept in check traditionally by the practice of uxorilocality (i.e., a couple went to live with the wife's family after marriage--at least for several years). Similarly, the presence of grandparents and other relatives could provide children with a recourse if their relationships with parents were strained, as is the case in many other patriarchal societies.

The current reality is that an estimated 25.8% of households are headed by women, who are markedly poorer than other households. Uxorilocality is impossible when parents are dead. Polygyny (one man with multiple wives), a traditional Khmer custom, has been revived in a country where 55.8% of the population are women over the age of 20. About 85% of the population lives in rural areas. Low agricultural productivity, due to poor water control and limited access to markets and agricultural inputs, sustains impoverishment.

The rates of female illiteracy are much higher than for males. According to the National Institute of Statistics 1996 survey, 81.8% of males and 58% of females are literate. Among the poorest families it may be that virtually all females are illiterate. In the AIDSCAP study over 60 percent of CSWs had no formal education at all. Studies of domestic violence indicate that women in households that do not live uxori-locally experience a much greater amount of physical and verbal abuse. Research also indicates that adults may be more violent than before 1970 due to the experience, as participants or survivors, of decades of armed conflict and the horrors of the Pol Pot era.

Traditionally, females were expected to be virgins before marriage and chaste after marriage. Buddhism requires that males follow the same sexual precepts. However, behavioral norms in much of Southeast Asia favor pre-marital and extra-marital sexual unions for men, both fleeting and longer-term. Research by Dr. Chou Meng Tarr suggests that some Cambodian unmarried teenaged girls now have boyfriends and may engage in sexual intercourse. For males, the result of this combination of factors is that males feel free, and perhaps encouraged, to have sexual liaisons with girlfriends and CSWs. Among low risk women interviewed during the AIDSCAP sexual behavior study, approximately half responded that their husband had sex with other women or that they didn't know whether he did or not.

Women may have more power economically than in the past, as they are now responsible for earning or producing more of the family's livelihood, but appear to have less power within the family. Research suggests that a woman may be abused for raising the issue of her

husband's other sexual unions (including other wives) Wives who are poor and uneducated do not seem to be at a point right now where they can negotiate condom use Girl children in poor families--who are, of course, the property of parents--may be sold into the sex trade Other girls are duped into leaving their villages and then forced into the sex trade Still others may willingly leave harsh domestic conditions and grinding poverty to earn money as a CSW Data are problematic, but suggest that 50% or more of CSWs were recruited through involuntary means During participatory rural appraisal (PRA) interviews in one province, women stated that they needed more income so they would not have to sell their daughters

NGOs working with abused children and CSWs, as well as research, carried out by other groups, point out that once a girl has entered the sex trade--for whatever reason -- or has been raped, she perceives herself as culpable, shameful, and vulnerable As word of the HIV epidemic spreads, men in Cambodia demand increasingly younger sexual partners because they believe (erroneously) that young girls cannot transmit HIV Therefore, younger girls are forced into the sex trade, where their immature anatomy makes them particularly susceptible to STI's and HIV This context of unequal gender and age relations, double sexual standard, and CSW illiteracy and poverty, is the background in which USAID interventions operates

14 The Sex Trade

By all estimates, the sex industry in Cambodia is widespread and widely patronized by a clientele covering the spectrum of Cambodian males Brothels are found in towns and cities throughout Cambodia Sex with an "experienced" CSW (who may be under age 15) can be very cheap In the AIDSCAP study the mean cost was \$4.1, however the median was significant lower at \$2 This means that commercial sex is available to most Cambodian men Young girls who are sold or abducted are kept prisoner until they have their first client Young virgins are reportedly rented to their first client by the week for a charge of \$300-\$800 This first encounter usually takes place in a hotel After the first encounter, the girl's market value declines rapidly, since she is no longer a virgin The CSW interviewed in the AIDSCAP study saw on the average over 4 clients a day This volume of customers is high compared to CSWs in Thailand, who reportedly see 1-3 customers per day CSWs who have been sold (including those who have been abducted) are required to "work off their debt" in order to gain their freedom This may take years NGOs report that many CSWs wish to return home, but fear that they will be sold again if they go home Some young CSWs whom NGOs have "rescued" report beatings, threats of beatings or even death threats and/or being kept prisoner by brothel owners to prevent their leaving Other CSWs are reportedly so demoralized and filled with shame, that they can envision no other life than that of a CSW Difficulties leaving the brothel are also compounded by the fact that a large number of brothel-based CSWs are paid by the month In the AIDSCAP study this was true for almost 50% of women interviewed It is very unusual for CSWs to be paid for their work so infrequently and reinforces the impression that the relationship with the brothel owners is closer to bondage

CSWs seldom stay at one brothel for longer than 4-5 months without being sold or moving on to another location, often in another town or province - although some data suggests that they may spend longer in Phnom Penh. Movement of CSWs is largely because "newer" CSWs command higher prices. Reportedly, CSWs are instructed by brothel owners to lie about their names, ages, and place of origin. Although some of their inmates come from cities, the majority seem to come from poor rural areas.

Not all CSWs are Khmer. A significant number are Vietnamese and there are also Thai and other Southeast Asian women in the sex trade in Cambodia. In one district of Sihanoukville visited by the team, the MOH was aware of 447 CSWs, of whom 153 were Vietnamese. The remainder were Cambodian.

In addition to the "direct" female CSWs, who work out of brothels, there are also "indirect" female CSWs throughout the country. These women work in establishments whose primary purpose ostensibly is not to sell sex, e.g., hotels, restaurants, bars. However, customers may approach these women with offers of sex for money, which the indirect CSW accepts out of economic necessity or coercion by her employer.

In sum, The widespread commercial sex industry that feeds the fast-growing HIV epidemic can be traced to a variety of reasons:

- Availability, even in provincial towns,
- Low cost,
- Constant demand for younger girls as knowledge and fear of HIV and STDs spread,
- Norms encouraging males to have multiple sexual partners,
- Norms encouraging unchaste women (even those who have been raped) to blame themselves and feel shame,
- Circulation of CSWs through many areas of the country to maintain their value, and consequently,
- The large amount of money to be made in the industry.

C USAID Interventions to Date

USAID has been active in the area of reproductive health (including STI/HIV) in Cambodia since 1993. The first interventions USAID supported were funded through the PVO Co-Financing project, with grants to PSI to undertake condom social marketing and to FPIA to introduce integrated reproductive health services, including STI services. In addition, select Cambodian candidates were invited to participate in a variety of workshops and trainings supported by AIDSCAP in Thailand.

In 1995, however, with early sentinel surveillance data suggesting that the epidemic may be growing particularly rapidly in Cambodia, the ANE Regional Bureau funded a sector assessment to examine the epidemiology of the epidemic, the response of the RCG and the

donor community, and to make recommendations for USAID assistance for a 15 to 18 month period. This time frame was determined based on the life of the AIDSCAP project and as ideal to initiate pilot programs which had potential for further support. As a result of this assessment, USAID, using ANE regional funds channeled through AIDSCAP, launched a number of activities widely acknowledged to have been among the most important interventions to date in Cambodia. These include

- **HIV Sentinel Surveillance**

USAID funded technical assistance and local cost support to the MOH for the 1996 and 1997 rounds of national HIV surveillance. The data provided have been critical in achieving a better understanding of the epidemic in Cambodia, particularly as the methodology was adapted to assure representation of rural, low risk areas as well as high risk urban and border regions. USAID technical assistance also helped the MOH use the data for presentations directed towards high level policy leaders and develop projections of the impact of the epidemic through the year 2000. In addition, the 1996 round of surveillance has provided essential information concerning the prevalence of syphilis, which is also extremely high.

- **Behavioral Sentinel Surveillance (BSS)**

USAID is providing technical assistance and local cost support to the MOH to initiate a Behavioral Sentinel Surveillance (BSS) system in Cambodia. This technique, also to be used in other countries, will provide essential information concerning reported behaviors of sentinel groups relative to sexual practices. Not only will it allow for better targeting of interventions, but will serve as a powerful evaluation tool concerning program effectiveness, particularly as concerns IEC. (See Research, Monitoring and Evaluation)

- **STI programs**

USAID, through a number of NGOs and the MOH, has funded the formative research concerning the prevalence of STI's in a number of populations in different geographic areas of Cambodia. This study also identified crucial drug resistance patterns which have been incorporated into new protocols for use nationwide and served as the basis for revision of the essential drug list. Study data provides the information necessary to develop comprehensive STI case management guidelines based on sensitivity and specificity of the syndromic approach in Cambodia. In addition, the behavioral component of the study has provided some of the first substantive data concerning reported sexual practices and condom use in a variety of groups, including commercial sex workers.

- **Counseling and Testing Policy and Guidelines**

Support to the MOH resulted in the elaboration of a national policy concerning HIV testing and counseling. This policy has been adopted by the National AIDS Secretariat and additional support is now being provided to disseminate these guidelines and train personnel in their application.

With the closure of the RSM, funding through the ANE Bureau also became available to support activities of the AIDS Alliance in Cambodia. The Alliance, active since the summer of 1996, supports the introduction of HIV/AIDS activities in local NGOs. Approximately 20 local NGOs have benefited from some type of assistance and 8 have had proposals funded.

In addition to activities designed to directly support HIV programs using primarily ANE regional funds, USAID/Cambodia also refocused health activities supported through the PVO Co-financing project and a newly designed Family Health and Birth Spacing Plan, completed in early 1996. Using reengineering principles, the Mission consolidated the health portfolio into a Strategic Objective (SO), "Improved Maternal Child Health." With an integrated approach, the SO targets reproductive health and child survival interventions, focusing on family planning, STI/HIV and safe motherhood interventions for women of reproductive age. Under the MCH strategy a number of existing PVO programs which were/are particularly strong in STI/HIV activities were designated to receive ongoing support. Specifically these include

- **PSI - condom social marketing program**

With an initial grant of \$2.5 million and an additional \$1.7 million awarded in January of 1997, PSI has dramatically increased condom sales in Cambodia in two years. In 1993 the total condom market was estimated at approximately 2 to 3 million. In 1996, PSI alone has sold 9.5 million. A particular highlight of the program has been direct sales to brothels and other establishments associated with the sex trade.

- **FPIA - Reproductive Health**

FPIA started the first private reproductive health center in Cambodia on a Planned Parenthood model. As a result, almost 50 percent of the Phnom Penh and Sihanoukville clinics are STI/RTI clients. Most importantly, however, these centers represent the only models of quality STI services in Cambodia, offering comprehensive care which includes counseling, treatment, laboratory support, condom promotion and partner treatment.

The MCH strategy directly addresses full integration of STI services into reproductive health services and provides mechanisms for support to this integration in the public and the private sector. In the private sector, USAID is also designated as the lead

agency to introduce syndromic management of STIs into pharmacies

II. PROPOSED USAID/CAMBODIA STRATEGY. A DUAL APPROACH

There is now sufficient information concerning the epidemiology of the HIV epidemic in Cambodia to understand the dynamics and develop an effective response. The epidemiologic data presented in Section I A dramatically demonstrates that infections with HIV and other STIs have sharply increased. Information also indicates that commercial sex is wide-spread, condom use is inconsistent and quality STI care virtually unavailable.

Two primary issues are evident. First is the dramatic increase and the firm entrenchment of the epidemic in high risk populations, particularly among CSWs. The nationwide prevalence rates for CSWs in Cambodia, at 40 %, now exceed all other Asian countries. Second is the progression of the epidemic into the general population. Antenatal care attenders have prevalence rates of 1.7%, placing Cambodia second only to Thailand in Asia in terms of infection among the general population. Given the widespread utilization of the commercial sex industry by both single and married men, it was inevitable that the HIV epidemic would "spill over" into the general adult population, as infected men return to their wives and girlfriends. This "generalization" of the HIV epidemic in Cambodia has occurred more rapidly than in any other country in Asia, resembling early "outbreak" epidemic patterns encountered in east Africa in the early 1980's.

Given these dynamics a dual approach is required in any effective response. Interventions targeted towards high-risk populations which drive the epidemic and fuel its spread into the general population, are essential and will likely have the greatest impact in reducing transmission of disease into the general population. Efforts to stem the epidemic in the general population are also required.

■ The Rationale for continued attention to the general population

A married woman who has contracted HIV from her husband who has frequented an infected sex worker probably represents the "end of the transmission line." It is unlikely that she will transmit the infection to another individual outside the conjugal relationship. However, interventions to prevent HIV and prevent and manage STIs in these general populations are justified for multiple reasons.

- ***Reduce the morbidity and mortality of STIs*** The STI data presented in Section I A demonstrate that there is a severe STI disease burden among the general adult population leading to infertility and significant morbidity and mortality for both women and newborns. Estimates based on the preliminary surveillance data, and the 14 to 39 year old population in three provinces where USAID RTI/STI interventions may be implemented as part of the MCH strategy (Siem Reap, Pursat, and Banteay Meanchey) indicate that, at the time of the survey, there were nearly 26,000 cases of active syphilis and nearly 30,000 cases of gonorrhea in these three provinces. To

determine the number of cases over a twelve month time period, these numbers can be multiplied by two to three times based on incidence of new infections

- ***HIV prevention and STI services improve the quality of Birth Spacing and Maternal Child Health Interventions*** The quality of birth spacing interventions, particularly when IUDs are utilized, requires minimal standards of reproductive tract infection assessment and management. Decreasing the prevalence of HIV and other STIs may have profound impact on maternal and neonatal outcomes, particularly when syphilis and gonorrhea are so widely prevalent. Finally, women utilizing birth spacing and MCH services often seek information and request services for reproductive tract infections. Their satisfaction, and ultimately their utilization of these services, can be enhanced by providing basic HIV prevention information and realistic RTI management interventions.
- ***Decrease in urban to rural spread of HIV infection*** Because most commercial sex establishments are based in urban and semi-urban settings, this is where most initial infections are occurring and where the epidemic is being sustained. However, as men bring these infections home to their villages and families, the epidemic takes on a more rural focus. Nearly 85% of the population lives in rural settings, but the logistics of program implementation are often more of an obstacle and thus, the cost effectiveness of interventions may be less. Access to basic care and palliative services for HIV-related diseases, including tuberculosis, will be more difficult in rural locations.
- ***Impact on total infections in general population*** As the HIV epidemic matures in a country, the cumulative total number of HIV infections is composed of a larger and larger proportion of "end of line low transmitter" individuals. Because HIV cannot presently be cured and each infection becomes part of the total longstanding epidemic, decreasing HIV infection in the larger general population will have considerable impact on the total numbers of infected persons.

This rationale fully supports the strategy already adopted by USAID to incorporate activities in STI/HIV targeted to the general population through the MCH SO. The reproductive health aspects of the strategy provide for full incorporation of essential STI care in reproductive health service delivery. This is fully justified and offers good opportunities for the introduction of such standard public health interventions as antenatal syphilis screening and routine eye prophylaxis of newborns. Another strength of the MCH SO is its emphasis on the private sector, particularly pharmacists. The planned training pharmacist training in syndromic management for STIs has significant potential for impact as anecdotal information supports the fact that pharmacies and drug sellers are frequently the first point of contact for clients with STIs. Ongoing support to the PSI social marketing program will assure condom availability. Thus there is a high level of confidence in the current program in terms of responding to the needs of the lower prevalence general population.

■ The Rationale for a focus on "high risk" populations"

Extensive experience in other countries and epidemiologic modeling both confirm that even when an HIV epidemic has spread into the general population, high risk populations such as CSWs and their repeat clients continue to increase and sustain the epidemic. Any individual (sex worker or client) who has frequent unprotected sex with casual partners is likely to be what is termed a "multiple transmitter," an individual who can transmit the virus to one or more partners. Reducing the prevalence of other STIs and reducing the prevalence of HIV in these "multiple transmitters" has five to ten times more impact on both the HIV and STI epidemic than interventions for the general population. Prevention and STI management programs which target these high risk populations do work, with neighboring Thailand proving to be an excellent example of the success of these focused activities.

At this point in time USAID/Cambodia does not fund interventions which are likely to have an impact on these groups, and, in general, activities targeted specifically towards high risk groups in Cambodia are relatively limited. It is here, however, where the most dramatic impact on the epidemic within a three to five year time frame is likely to be achieved.

Thus the team recommends a new Special Objective (SpO) for USAID/Cambodia. This SpO will augment and further target activities begun under regional funding and be directed at the large high risk groups that will continue to be the "engine" that drives HIV transmission and its rapid spread into the general population. When considering the design of the SpO, a series of criteria were reviewed. These include:

■ Criteria for Selection of Interventions

1. *Alignment with global USAID objectives* The Global Bureau's Strategic Objective 4, "Increased use of key interventions to reduce HIV/STD transmission," and its four performance indicators, the interventions selected below are well within USAID's overall strategy.
2. *Government and NGO Priorities* The interventions selected both complement and supplement RGC policy and programs, as well as those of other donors and international organizations.
3. *Capacity to implement* The interventions selected are well within the capacity of the Mission to fund and implement, and in fact are thought to be the most focused allocation of the resources available, filling gaps in the national program that are best addressed by a donor, yet will not add greatly to the Mission's management burden.
4. *Comparative advantage* These interventions, i.e. policy work, IEC and service delivery, are recognized internationally as the strengths of AID's Global and Mission programs, with experience and success in multiple country settings. Activities to date reflect these advantages and this SpO carries and refines these efforts.

- 5 *Epidemiology* The scenario described above, wherein the commercial sex trade is driving the expansion of the epidemic, clearly justifies this Objective's focus on high risk groups and is complemented by the activities directed at the general population by the MCH Project

II SPECIAL OBJECTIVE REDUCED STI/HIV TRANSMISSION AMONG HIGH RISK POPULATIONS (CSWs and their clients)

As state above, epidemiologic factors clearly demonstrate that to reduce STI/HIV transmission in Cambodia special efforts must be targeted towards the commercial sex industr Work of this nature also requires very selective interventions which are not always appropriate for the population at large, thus the need for a "special objective" The primary beneficiaries of the SpO are CSWs, both direct and indirect and their clients An important secondary audience, however, are those people who benefit economically from the sex trade, and tend to be an important intermediate group into the commercial sex industry, for example brothel owners, certain restaurant and hotel owners/managers, select police etc

The intention of the objective is that, through work at the policy level, communication efforts directed specifically towards commercial sex and service delivery activities in select provinces, again oriented toward high risk populations, HIV transmission will be reduced These interventions are elaborated below as intermediate results In addition substantial support will be provided for research and monitoring efforts, to include formative research to inform interventions, pilot studies to test service delivery models and to ongoing national surveillance systems to monitor the epidemic and trends Although the research elements of the work are not identified specifically as intermediate results, they are critical to the success of the SpO, and feed directly into each IR The SpO is intended to have a 5 year time-frame

Given the difficulties in measuring reduced HIV prevalence and the need to maintain a certain degree of flexibility given the rapidly evolving nature of the epidemic in Cambodia three proxy indicators have been selected for this IR These indicators will enable USAID to monitor achievement toward objectives and also track the impact of interventions beyond the target population itself and into the general population as well

The indicators will be	Improved Policy Environment Score
	Reduction in high risk behaviors
	Reduced prevalence of selected STI

Further elaboration of these indicators can be found in the performance monitoring plan

INTERMEDIATE RESULT 1 Policy Makers are informed about the HIV/AIDS epidemic
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USAID has been providing support to provide accurate information to decision-makers through work with the NAP in the establishment of national surveillance systems and the dissemination of information concerning such issues as the potential impact of the epidemic. In addition national counseling and testing guidelines have been adopted with support from USAID. This work has made an important contribution, and one in which partners agree that continued USAID support is desirable. Considerable additional work is required, however, to translate this information for decision-makers across sectors and at the national and provincial level about the causes of the epidemic, the impact and potential responses.

Specific effort is also required to help policy makers take appropriate actions relative to commercial sex and the commercial sex industry - and it is in this area that USAID policy work will be particularly focused. Although decision makers are beginning to be cognizant of the role of commercial sex in spreading the epidemic, there is little understanding as to how to react. Because of the decentralized nature of Cambodia, provincial officials are adopting individual responses without real technical knowledge or specific central level guidance. It is also difficult to know how involved select authorities may be in the sex industry.

The target audience to achieve results under this IR are key decision-makers at the national and local levels. This is likely to include municipal and provincial authorities, key legislators, authorities in the police and military and others as identified. A number of research activities will be used to inform activities under this IR (see Monitoring and Research). Of particular importance will be an analysis of the economics and functioning of the commercial sex industry in Cambodia which will take a more industry/business approach to identify key players and practices. This and other information gathered in implementation of the SpO will be disseminated using a variety of forums and media and possibly RAPID (Resources for Awareness of Population Impacts on Development)-like presentations to influence RCG policies and programs. In addition, it is anticipated that there will be regional study tours of key players in HIV/AIDS. Fortunately there are excellent resources in the region, including in Thailand, which has one of the best HIV/AIDS programs in the world. Pilot approaches adopted through the service delivery component of this program may also be used to influence policy makers.

USAID Inputs

To achieve these results, USAID will provide technical assistance, funding to support study tours, produce reports, presentations and other dissemination activities such as workshops.

Indicators

Ideally this intermediate result would be more clearly defined with the indicator specifically identifying policies to be implemented. Unfortunately, when dealing with HIV the result cannot be so specifically stated, especially at this point when it is unclear what will be appropriate policies for Cambodia relative to high risk HIV transmission and the commercial sex industry. Clearly defined policies require enforcement and in the area of HIV there needs to be an extremely careful balance to assure that policies, particularly those related to commercial sex, are appropriate and do not simply force activities further underground, impede access to direct sex workers and create a more amorphous and difficult-to-reach indirect sex industry. Here, it might well be better to have no policy, or a policy of "benign neglect," than a policy that restricts effective HIV/AIDS prevention programs--or one that tries to regulate in areas that governments cannot, in fact, control.

Given this, the indicator for this IR is currently loosely defined at the output level as

- Numbers of studies and events

As implementation proceeds, this will be refined as appropriate.

Intermediate Result II Reduced high risk behaviors in target populations
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This IR will be achieved through the development of a model IEC program targeted specifically towards high risk behaviors. Where appropriate interventions will be fully implemented in selected provinces that can be replicated elsewhere. The key assumption is that IEC will help people to change their high risk behavior through

- 1 Creating a milieu in which CSWs and clients can feel comfortable insisting on condom use,
- 2 Creating a climate in which there is a decreased positive value in visiting brothels or frequenting indirect CSWs,
- 3 Encouraging people to seek appropriate treatment for STIs

The primary target audiences are female CSWs--both direct and indirect--and clients of CSWs. A direct CSW works at an establishment that specializes in selling sex, i.e., a brothel. An indirect CSW works at an establishment that ostensibly has a primary function other than selling sex (e.g., a bar or restaurant). The secondary target audience is composed of those who derive financial gain from the CSWs (whether brothel owners, restaurant owners, police, taxi drivers, etc.). It is unusual to have two primary target audiences, however, both CSWs and their clients engage in risky sexual practices and are key to the epidemic.

Materials that address the interests of the secondary audience of key intermediaries of the sex industry to promote more healthful and/or less exploitative behavior have not been developed, yet, for example, the Thai experience suggests that brothel owners may be a powerful force for promoting condom use in their establishments. Currently there is little or no information on people who benefit economically from the sex trade and little information on backgrounds of CSWs (e.g., literacy levels, ages) that would assist in preparing IEC programs and materials.

High quality IEC materials and outreach activities to reach the primary and secondary audiences are sorely needed. Generic IEC materials on HIV/AIDS have been developed by the MOH as well as by a number of non-governmental organizations (NGOs), and recent research has shown that these materials have been relatively successful, given knowledge levels of HIV particularly among urban Cambodians. Clearly, though, this knowledge has not necessarily been translated into behavior change. Communication strategies with accompanying quality materials that address the specific needs of the SO target audiences are required.

It is also important to foster cooperation among all agencies and organizations working in HIV/AIDS so IEC messages, materials, and programs are coordinated to avoid contradictory information and duplication of efforts. Plans are in place for the MOH/NAP to assume this role with technical assistance from The World Bank. USAID funded IEC activities will collaborate directly with MOH in this effort, and ideally serve as a model for other organizations.

In order to achieve the IR, four activities will be implemented. They include:

- 1 *Research is conducted for segmentation of target audiences, message development, channel selection, and strategy development*

All materials and techniques supported under this IR will be informed by research. Formative research such as ethnographies of the sex trade and component studies of the culture of sex in the military and police, will provide much of the information necessary to segment target audiences and develop messages (see Research, Monitoring and Evaluation). Media surveys will help determine appropriate channels. Those already conducted indicate that radio is an important medium that can reach most of the country and that television is gaining in importance. McCann-Erickson market research shows that 70% of country can be covered by TV in 1997. Commercial marketing research will also contribute to development of new materials. A limited amount of new research targeted specifically to preparation of IEC materials or techniques (e.g., focus group research or in-depth interviews) may be conducted under this IR.

- 2 *High quality IEC materials and programs for each target audience segment are developed*

Examples of IEC materials to be developed may include TV and radio spots--to create awareness and an enabling environment for changes in sexual behavior, novelty items for CSWs or their clients that instruct and reinforce good condom use, list of STI symptoms and where to go for treatment, pictorial print materials for non-literate CSWs and clients, magazine ads, traditional media (e.g., shadow plays), etc. All materials produced would adhere to internationally accepted materials development standards. In addition, effective use of materials would be included in program design and implementation.

3 *Local capacity to plan, manage, and implement HIV IEC programs enhanced*

There appears to be significant lack of capacity, particularly at the provincial level, in planning, managing, and implementing IEC programs. This impacts on the quality of every aspect of a health communication program, including materials development and use, outreach activities, and counseling programs.

It is imperative to train Cambodians in these skills. USAID will train those responsible for HIV IEC programs in the USAID target provinces, including MOH provincial AIDS managers and, potentially, NGO IEC managers. Training may include hands-on training in materials development to build capacity and insure that HIV/AIDS materials are high quality and that messages are standardized.

Training in interpersonal communication and education (IPC/E) is also important for peer educators and outreach workers and those who manage such programs (so that they can monitor the performance of those they supervise). In order to guarantee the effectiveness and appropriateness of outreach programs in USAID-assisted provinces, IPC/E training will be carried out in the context of a program which assures ongoing support and follow-up for trainees.

4 *Evaluation of materials and programs*

The overall success of IEC programs is measured by falling rates of new HIV infections and declining prevalence of STIs. Inappropriate materials will be revised and retested. The reach and effectiveness of mass media pieces may be evaluated through recall studies, possibly by training NGO staff or hiring a commercial ad agency. Annual BSS surveys will also provide valuable information to monitor and adjust IEC program effectiveness.

USAID Inputs

To achieve these results, USAID will need to provide technical assistance, funding to produce materials and to hold workshops, and disseminate research results.

Indicators

- 1 Condom use with non-regular partner, most recent sex act

2 Reduced number of sex acts with non-regular partner

INTERMEDIATE RESULT 3· Model service delivery programs for high-risk populations piloted and replicated in selected provinces
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This intermediate result constitutes the actual delivery of services to high risk populations, particularly CSWs and their clients, in selected provinces. Work under this IR will provide valuable opportunities to pilot and replicate initiatives directly with the three key groups' target populations: CSWs themselves, their clients (particularly recurrent use clients), and the economic beneficiaries of the sex trade, including not only brothel owners, but also intermediaries previously mentioned, and others to be identified.

Given resource constraints and the fact that other donors and NGO's are concentrating their efforts in selected provinces, this SO will target service delivery interventions in specific provinces. Those currently identified include Siem Reap, Pursat and Banteay Meanchey. Kampot and Sihanoukville may also be included. Interventions will include IEC, STI prevention and treatment and efforts to improve conditions for CSWs, including potentially those which might deter young females from being lured to the commercial sex industry. It should be noted that the female sex worker in brothel-based settings is very likely to be the least empowered of all of these groups to influence safer sexual activity in these settings. Indeed, she may be both a young girl and a slave, disempowered in virtually all aspects of her life. Thus, working with all three groups will be essential to improve the environment of the sex trade, ensuring that sex workers are not involuntary workers, and that sex is safe for both client and sex worker.

There are three primary interventions under IR 3.

IR 3.1 *Effective prevention services to decrease HIV/STI transmission in the commercial sex industry will be piloted and replicated in selected provinces*

These interventions are closely linked with behavior change activities to be developed under IR2, and in many cases will provide the forum for the use of strategies and materials developed under that IR. The table below presents illustrative activities with each of these three target audiences.

AUDIENCE	ILLUSTRATIVE ACTIVITIES
Sex workers	<ul style="list-style-type: none"> - Peer education and group activities to increase skills for negotiating and using condoms during commercial sex - Personal counselling and consideration of offering confidential HIV testing - Symptoms of STI s and where to go for treatment - Organization of sex workers similar to the Brazilian model - Piloting of female condoms
Clients of sex workers (particularly recurrent clients)	<ul style="list-style-type: none"> - Awareness-raising activities focused on the risks of engaging in commercial sex or sex with multiple casual partners and how to lessen the risks through decreased utilization of commercial sex and use of condoms - Personal counselling and consideration of offering confidential HIV testing - Education on symptoms of STI's and what to do about them
Economic beneficiaries of the sex industry	<ul style="list-style-type: none"> - Awareness raising as to the economic and public service benefits of managing a "clean healthy, happy' sex establishment, particularly later in the epidemic as more of the client population become personally aware of AIDS - Messages for poor families in the 3 provinces especially families identified as at risk for selling the daughters about the realities of the sex trade and alternate sources of income (especially as these become available through USAID's rural economic growth activity

IR 3 2 *Improved, effective STI management services will be delivered to high risk populations in selected provinces*

As presented in the Epidemiology section of this paper, it is now well documented that the presence of an STI, such as syphilis or gonorrhoea, can increase the efficiency of acquisition or transmission of HIV five to ten times. As the recently completed STI study discovered, prevalence of STIs amongst CSWs is very high, and amongst their clients, only somewhat less so.

STI treatment amongst this population is extremely challenging, however. The majority of people with an STI were asymptomatic, meaning that despite the presence of infection, they felt essentially well and did not necessarily have clinical signs of infection. These issues, combined with lack of knowledge on the part of providers (and CSW intermediaries), and the transient nature of both CSWs and their clients, require very creative solutions. Work with providers, CSWs, their clients to improve access and quality of STI treatment, combined with awareness raising for intermediaries, will be piloted in the provinces. Empiric treatment of CSW's for STD's, highly successful in other countries, will be also be

validated in a pilot effort

IR 3.3 *Improving the "environment" of commercial sex by limiting involuntary sex work, enslavement, and trafficking within the sex trade*

One of the key ingredients that drives the sex industry in Cambodia is the luring or enslavement of young Cambodian women into the brothels, where their services are sold for degradingly low prices, and using their "indebtedness" (money paid to parents or others who may have kidnapped them) to ensure that they remain. Gross estimates from UNICEF suggest that as many as 50% of CSWs may be involved in the profession against their will. Evidence is also mounting concerning the appalling conditions that CSWs may be subject to. The low prices attract a high volume, meaning that Cambodian CSWs have a very high average number of clients a day, which, combined with relatively low condom use makes them far more vulnerable to STI's and HIV transmission. One startling piece of information from the STI study is that almost 50 % are paid on a monthly basis, implying that their conditions truly approximate bondage.

Using information gained through research activities in the SpO, efforts will be made in the pilot provinces to improve the conditions for the CSWs. It is likely that these efforts will be combined with policy work with local decision-makers and other outreach and advocacy efforts, either through local NGOs or through the provincial AIDS programs.

In addition advocacy efforts will be closely linked and rely on, wherever feasible, other USAID supported target interventions. Specifically, activities planned through the Rural Economic Growth (REG) strategy, and within that, the microcredit program, the Cambodian Assistance to Primary Education (CAPE) activity and targeting teachers, Democracy and Governance activities working with human rights organizations, and the AIDS Alliance, supporting grassroots NGOs may provide ideal opportunities. Examples of potential efforts include 1) informing parents and young women of the danger of being kidnapped or lured into the sex trade, and how it will expose them to very high risk of acquiring HIV, 2) programs that provide more income to rural areas, especially those known to primary sources of CSW's, 3) working with school teachers, opinion leaders and religious figures to enlist their support in getting the message to young women.

USAID Inputs

To achieve these results, USAID will provide technical assistance, local cost support training and outreach activities, select equipment and commodities, and, if essential, STI drugs.

Indicators

- 1 Reduced STI in CSWs
- 2 Reduced number of CSWs paid by the month

IV MONITORING, RESEARCH AND EVALUATION

This SpO has been designed linking three integral components - intermediate results - with a mutually supporting and reinforcing research and monitoring base. Each IR has formative and operational research requirements which will provide a range of information to inform the SpO as a whole. Ongoing national monitoring systems will also provide up-to-date information to inform and adjust program activities. A quality information base is particularly essential given the rapidly evolving situation in Cambodia, both in terms of the epidemic itself, as well as the overall country situation.

It is imperative, however, that all USAID support for research and monitoring be considered within the context of a national HIV/AIDS research agenda. Existing information will be consulted and every effort will be made to coordinate and consolidate to avoid duplication. Indeed, in terms of ongoing monitoring, the systems are squarely placed in the MOH, National AIDS Program to serve the national program. Likewise any research-associated ethical issues will be directly addressed through appropriate channels.

It is also assumed that information gathered will contribute to the SpO performance monitoring plan which provides a series of "lead" or proxy indicators to demonstrate progress towards the achievement of results.

A Research

A number of formative and operational research studies are needed to inform policy work, develop behavior change communication strategies and design service delivery models. Below is found an illustrative list including those deemed priority in the near term.

Economics of the sex industry and how it functions -- There is the lack of any substantive information on how the sex industry functions and its complex and hidden economics. Highly-flexible and adaptable qualitative methods including participant-observation are needed for this investigation. This study will provide better information to inform policy makers concerning the actual functioning of the sex industry. Issues to be examined include questions such as where do girls come from, how is money handled, are there major intermediaries, who profits from the sex industry, and by how much and in which ways? It is anticipated that information from this study may particularly contribute to the design of interventions directed towards the "supply" side of the industry.

Ethnography of commercial sex -- Survey research can only hope to measure some of the more superficial aspects of the lives and working conditions of CSWs, such as whether clients report using condoms. An ethnographic study using a mix of qualitative methods is needed to complement and supplement survey research findings, and to go more deeply and broadly into the overall commercial sex industry.

Health beliefs and therapy-seeking behavior -- There have been many knowledge, attitude and practice (KAP) surveys that have measured how well Cambodians can explain the Western, biomedical model of STDs ("HIV is a virus that destroys the human immune system ") What is not well understood is the indigenous model of contagious illnesses in general, and of STIs in particular This model contributes to beliefs and motivates health-related behavior Such information is needed in order to understand how to develop culturally meaningful ways to communicate information about STIs, HIV and AIDS A better understanding of what motivates therapy seeking behavior is also needed Recent evidence is fairly compelling, indicating that few Cambodian's use "health facilities" preferring to go directly to pharmacists or perhaps to a *kru kmae* traditional healer

Pilot STI prevention programs with CSWs -- This work, tightly linked to the service delivery IR, will include operational research to examine models of empiric treatment of STIs and other potential innovative approaches, for example use of female condoms, outreach programs and support networks

Materials development research -- All materials and training tools designed through this SpO will benefit from focus group research, including pre- and post-testing

B MONITORING

The NAP, with assistance from USAID and in collaboration with other partners, has initiated a series of activities which will be fully incorporated into national surveillance systems Ongoing support to these activities will be provided through this SpO and will not only substantially contribute to the national information base for program monitoring and design, but also be useful in tracking the success of interventions, included those funded under this SpO It should be noted that assistance for these efforts also substantially contributes to institution building at the national and provincial level

HIV Sentinel Surveillance (HSS) The MOH/NAP has instituted a national HIV sentinel surveillance (HSS) with surveys completed in 1995 with support from WHO/GPA and in 1996 from USAID The HSS measures HIV seroprevalence in selected epidemiological categories The 1995 HSS surveyed seven population groups in nine provinces The 1996 HSS surveyed four sentinel groups in 18 of Cambodia's 21 provinces including

- Direct CSWs (i e , those CSWs working in brothels)
- Members of the police
- Members of the military
- Women attending antenatal clinics (ANC)

These groups were selected because the first three represent "core transmitters " Women coming for ANC are conventionally used as a proxy for seroprevalence rates in the general population

As part of the national HIV program, annual HSS is planned. It should be noted that the sampling may not be identical each year, and the system is flexible enough to respond to annual data needs. In 1996 syphilis testing was included. In 1997 it is anticipated that serological surveillance will take place with tuberculosis patients and hospital in-patients. USAID will support the HSS in 1997 and is in discussion now with the World Bank and the MOH as to support through the life of this strategy. Support for this activity largely consists of local cost support and some short-term technical assistance. In the past Serodia test kits have been provided by the Japanese.

STI prevalence surveys In 1996, the first STD prevalence study in Cambodia was undertaken, funded by USAID and implemented with the NAP, MSF and the Reproductive Health Association of Cambodia (RHAC) with assistance from the University of Washington and the Institute Pasteur. Periodic STD prevalence studies should be institutionalized and USAID will continue to fund them as necessary under this SpO. The dual focus on prevalence of STDs and reports of behavior will continue to allow for comparisons between self-reports and biologic evidence of behavior.

STI drug resistance Surveys of STI drug resistance should be conducted periodically in order to revise treatment protocols as necessary. Ideally this activity would fall under the auspices of the NAP and also be carried out in collaboration with WHO regional efforts to monitor antibiotic resistance patterns.

Behavioral Sentinel Surveillance (BSS) The BSS will focus on selected respondents, based on vulnerability to HIV and ease of access to sexual encounters. These will include moto and cyclo drivers, vocational school students, beer promotion "girls," a sample of women from the general population, and one rural male group in 4 provinces. The survey will be repeated annually to gauge behavior change. The findings of the BSS, in conjunction with annual sentinel surveillance of HIV seroprevalence, will be very important from an HIV/AIDS program and policy viewpoint. It is hoped that this information can be used not only in evaluating and adapting behavior change and IEC strategies, but that it will provide invaluable information concerning "bridge groups," i.e. those persons who are moving the epidemic from the high risk groups into the general population. A potential limitation of the BSS may be its ability to obtain accurate information on behaviors like anal, homosexual and extramarital sex (including for married women) in an interview context. The accuracy of reported condom use is also a problem. It is hoped, however, that experience with administering the questionnaire may, however, improve the validity of the responses.

C EVALUATION

The research and monitoring pieces described above, in conjunction with the performance monitoring plan will provide a fairly accurate portrayal of progress towards achievement of the SpO. The program should be evaluated at the end of five years to determine issues such as customer satisfaction, management efficiencies and overall effectiveness of the strategy.

IV. CUSTOMER SERVICE PLAN

The USAID/Cambodia HIV/AIDS Prevention strategy seeks to reduce the transmission of HIV, especially among high risk groups, by strengthening the capacity of Governmental and private sector groups to plan and conduct rigorous formative and ongoing social and demographic research, to plan and implement targeting information, communication and education campaigns, and by pilot testing service delivery interventions in selected provinces. This customer service plan is a preliminary description of on-going and proposed actions for identifying and engaging the participation of customer groups and partners in planning, implementing, monitoring and evaluating the SpO program area.

A THE CUSTOMERS

1 The Ultimate Customers

- a **Commercial Sex Workers** The booming sex industry in Cambodia which is fuelling the HIV epidemic badly misuses young women, mainly from Cambodia but many from Thailand and Vietnam, through luring of young rural women into urban and border areas, or through outright kidnapping. The younger the girl, the more valuable she is to brothel owners. While there has been no census or survey to determine the actual number of CSW's, there are clearly thousands. In addition to the abominable conditions in which they are held, over 40% in urban areas currently are HIV positive.
- b **Indirect Commercial Sex Workers** There also are thousands of indirect CSW's, described as dance hall girls, beer girls or whiskey or cigarette girls, many of whom engage in commercial sex, and whose seroprevalence approaches that of direct CSW's who work in brothels. While they usually work of their own volition, they may be forced into the trade in order to care for families or because the income is far better than that of any other occupation.
- c **The Military and Police** HIV positive prevalence among the police and military is extremely high, some 4 to 14% of those tested (check data), and they are chief among the male population in spreading the infection. While there are allegations that they are involved both actively and passively in the sex industry, their prevalence rate will continue to rise unless there is substantial behavior change.
- d **The General Public** The most recent sentinel surveillance data indicates a prevalence rate of 1.7 percent for women visiting antenatal clinics, a proxy for rates in the general population. Most often, these are women whose husbands have brought home the disease.

2 Secondary Customers

Brothel Owners Brothel owners will be a secondary target in that they are central to the problems of CSW's, both in terms of their welfare and of their vulnerability to the HIV virus. Learning how they might be convinced to join a 100%-condom use concord will be key to interrupting the spread of the epidemic, if not the welfare of their CSW's. Other secondary customers are dance hall owners, taxi drivers, restaurant owners, cyclo and motorcycle drivers who benefit from the sex industry and whose support is needed for 100% condom use.

3 The Intermediate Customers

This SpO's intermediate customers are in both the public and private sectors. In the public sector, this includes commune, district and provincial health workers of the MOH in the selected provinces, the National AIDS Secretariat and employee of other Government ministries such as Finance. In the private sector, intermediate customers include pharmacy owners and workers, drug depot workers, women's associations and professional health associations, as well as health professionals such as doctors, nurses, traditional healers and midwives, and community opinion leaders.

4 Public Sector

Ministry of Health Policy and Operational -- At the policy level, the SpO will provide rigorous research to help policy makers write and enact policies that will produce plans and protocols for stemming the epidemic, including STI management protocols, further refinement of anonymous testing and counselling guidelines, as well as guide them in resource allocation. MOH workers will be trained at the national, provincial, district and commune level, especially in the selected provinces. MOH staff in other divisions, such as Family Planning and Maternal and Child Health, will also be trained in integrating STI/HIV prevention in their efforts.

5 Private Sector

- a Health Practitioners** Private health practitioners in Cambodia include trained medical practitioners, off-duty government health workers, traditional health practitioners, and traditional birth attendants (TBA's). In USAID's targeted provinces, these cadres will receive training and deliver (or refer) services in STI prevention and treatment, HIV prevention and encourage condom use. Some will be recruited for the community-based distribution of condoms and information.
- c Pharmacists and Drug Sellers** Cambodians have a strong tendency for self-treatment, often seeking the advice and products of the local pharmacist or drug seller. These service points are unregulated, lack adequate training and supervision, and are not reliable as a source of counsel for health-seeking clients. Pilot training

both in the targeted provinces and through the PSI Social Marketing Project, will upgrade these service delivery points to be more qualified to give advice and sell products to health-seeking clients

- d Researchers** Social science researchers are key to understanding the beliefs and motivations of high risk groups and beneficiaries of the sex industry. Cambodians will be trained as sources of formative and monitoring research to help staunch the epidemic

B The Partners

USAID's partners will be those organizations, institutions and individuals which already are working to stem the burgeoning epidemic and provide information and services to the ultimate customers

- 1 The Ministry of Health** The MOH will be the principal partner in the Government, in particular the National AIDS Program and its Secretariat, as well as the HIV/AIDS Coordinating Committee (HACC). MOH officials at the provincial, district and commune level in the selected provinces will be key information and service delivery providers
- 2 Secretariat for Women's Affairs** This Secretariat will be key in working in the selected provinces and with CSW's and indirect sex workers in organizing and empowering new and existing women's organizations to help mitigate the epidemic and the debasing treatment of young females in the sex industry
- 3 PVOs and NGOs** The SpO will rely heavily on an ongoing partnership with international and Cambodian NGOs, especially in strengthening their capacity to manage and deliver STI/HIV prevention and treatment services, as well as becoming even more vocal in their representation of customer needs. USAID will work closely with local NGOs in focusing on women's issues, reproductive health, IEC, community organization and economic opportunities. This SpO continues and builds upon results achieved by and with the following partners

- a Family Planning International Assistance
- b World Health Organization (WHO)
- c UNAIDS
- d UNICEF
- e CARE
- f World Bank
- g GTZ
- h European Economic Union (EU)
- i World Vision
- j Medecins Sans Frontieres (H,B,S)

k	International Committee of the Red Cross
l	Cambodian Red Cross
m	Population Services International
n	Cambodian Women's Development Association
o	Redd Barna (Norwegian)
p	Health Unlimited
q	Catholic Relief Services
r	AIDS Alliance

C Customer Services to be Delivered

In selected provinces and through other donor activities, the ultimate customers will receive information and services in STI prevention and treatment, HIV prevention, and general improved well-being

The intermediate customers will receive quality training in clinical STI management and HIV prevention, IEC material development, testing and counselling, and sentinel surveillance of HIV prevalence and behavior to gauge progress in stemming the epidemic

Key service delivery points that will verify quality information and service delivery will include MOH static facilities, especially in the selected provinces, pharmacies and drug sellers, providers of IEC media and materials, STI management facilities, women's organizations, and private providers of health services, both public and private

D Identification of Customer Needs

As delineated above, one of the key components of this SpO is the conduct of rigorous research into the beliefs and behavior of high risk target groups and beneficiaries of the sex industry in order to better design, implement and measure behavior change activities. Social-science based research studies will be carried out with CSW's, both direct and indirect, brothel owners, other beneficiaries of the sex trade and other key groups. This will include a variety of interview techniques, including in-depth interviews, consumer intercepts, focus groups and KAP studies. Sentinel surveillance of STI and HIV prevalence will provide the quantitative measure of progress. Informal feedback systems from both the public and private sector on customer needs, beliefs and reported behavior change will be documented

E Areas of Attention Identified

USAID/Cambodia's Customer Service Plan is based on epidemiological evidence that the HIV and STI epidemics are fuelled by the commercial sex industry, which is not receiving the information and services needed to protect sex workers from both infections. Especially lacking are quality services for the prevention and management of STI's, which exacerbate transmission of the HIV virus. Private health providers need training in order to better recognize, prescribe or refer for STI infections, as well as HIV prevention. The need for

national access to quality condoms is being addressed through the Social Marketing Project

The public sector lacks training and the drugs necessary to manage STI infections adequately, which will be bolstered in the selected provinces. There is little incentive for MOH staff to provide quality services, given the lack of drugs and medical supplies for treating most maladies, combined with wholly inadequate salaries.

Areas in the customer service plan which will require special attention include

- 1 Changing client perceptions of public health facilities so that they are seen as responsive to clients' needs, providing quality information and services,
- 2 Ensuring quality services for clients who cannot afford to pay,
- 3 Correcting pervasive traditional beliefs and practices related to high-risk sexual behavior, health-seeking patterns and management and treatment of STI's,
- 4 Creating a training environment in which sharing of service and information delivery is not considered a threat to professional cadres or the private sector,
- 5 Improving the accessibility of services for both urban and rural (in the selected provinces) health-seeking clients,
- 6 Attention to low client literacy levels,
- 7 Resistance to regulation or interference in the sex industry

F Customer Service Standards

The SpO's objectives will be driven by demand creation among the high-risk groups, as well as through programs aimed at the general population. While much of the demand-creation activities will be aimed at the high-risk target markets, there will be obvious spillover into the general public which should reinforce other IEC messages directed at them. USAID will measure customer satisfaction through both quantitative and qualitative means, including condom distribution reports, KAP surveys, focus groups and consumer intercepts. Numbers of clients attending clinics, both public and private, should also be a measure of clients' reaction to improved quality services.

USAID and its partners will work together to gauge customer satisfaction and where adjustments may be necessary. Continuous donor coordination will be paramount in reinforcing each others' programs, as well as avoidance of duplication and waste of resources. This SpO also is intent on developing Cambodian capacity to plan, implement, monitor, evaluate and adjust various program components in the interest of long-term institutional sustainability.

ANNEX I RESOURCE REQUEST

ELEMENT	FY 97	FY 98	FY 99	FY 2000	FY 2001	TOTAL
Long Term Advisor	150	325	275	270	270	1295
Short Term TA	30	85	40	40	20	215
Local Costs	75	200	140	145	140	700
IR I - Policy Development						
Local Cost	75	150	130	200	120	675
Study Tours	50	25	15	10	0	775
IR II - IEC						
Studies	50	50	25	25	40	190
Workshops	40	50	30	30	30	180
Materials Production	50	60	60	60	70	300
Media Placement	20	60	30	30	30	170
Training	30	60	30	20	30	170
IR III - Service Delivery						
STI Management	75	225	140	150	175	765
Advocacy Programs	50	75	75	60	60	500
Studies	75	175	100	90	95	535
Subtotal	770	1540	1090	1135	1080	5615
Overhead 30%	230	460	310	365	320	1685
Evaluations			100		100	200
Grand Total	1000	2000	1500	1500	1500	7500

ANNEX 2 MANAGEMENT & IMPLEMENTATION PLAN

This Special Objective will be managed in the Mission by one USDH professional and an FSN professional in an office which will have two USDH professionals and two FSN professionals and a Johns Hopkins Fellow. Since several important components of the overall HIV/AIDS Prevention Strategy are being implemented under the MCH Strategic Objective, there will be close coordination between the two teams. The larger SpO Team will comprise representatives of the National AIDS Prevention Office of the Ministry of Health, other donors including UNAIDS, the World Health Organization, the World Bank, the European Union, Cooperacion Francaise, and HIV/AIDS implementing agencies such as Population Services International, the International HIV/AIDS Alliance and Family Health International (Bangkok). The Team will conduct quarterly meetings to review progress and to address any problems or changes in assumptions.

The Mission's HIV/AIDS SpO Team will review Intermediate Results indicator data at least annually to help estimate progress towards the objectives. Based on changes in assumptions or in the nature of the epidemic, or as a result of recommendations from various evaluations, the Team may recommend changes in the Special Objective. Formal evaluations are scheduled for years three and five of the project.

The Design Team recommends that the project be competed through the normal acquisition process, and recommends that this result in a cooperative agreement with an experienced international organization that would propose a field project manager with the background and experience to manage, both technically and administratively, a program of this size. The entity winning the cooperative agreement would be required to open an office in Phnom Penh, obtain all necessary Governmental clearances and registrations, as well as hiring qualified local technical and administrative staff. It is envisioned that the field project manager reside in Phnom Penh until Year Five of the contract.

The winning entity will provide the services described in Section III above, and will be responsible for providing expert consultants in the technical areas indicated on a short-term basis. The entity will have the option of negotiating and contracting with local or international firms to provide the required deliverables, or may do so through subagreements proposed in its response to the Request for Proposals.

The contractor will establish strong and continuing contacts with other international, bilateral and non-governmental organizations working in Cambodia on HIV/AIDS prevention and may opt to consult them on mutual issues on a regular basis and will participate on the SpO Team.

The contractor will be required to work with and provide assistance to other USAID-funded activities working in HIV/AIDS prevention, i.e. the social marketing project, the full-service reproductive health clinics and other organizations that provide HIV prevention counselling and related services in conjunction with their community-based activities

The Regional Contract Officer will be responsible for negotiating, entering into a cooperative agreement and monitoring this program

Given confirmed staffing levels of the HPN Office, the Design Team feels that the management burden of two Objectives in the PHN Sector will not be a burden on the Mission, nor its support offices. The entity winning the cooperative agreement will be providing virtually all of its own logistical support and will rely on the Mission only for monitoring and policy guidance

ANNEX 3

PERFORMANCE MONITORING PLAN

OBJECTIVE S O 1 Reduced Transmission of STI/AIDS Among High-Risk Populations (CSWs & Clients)			
APPROVED DD/MMM/YYYY COUNTRY/ORGANIZATION Cambodia			
RESULT NAME S O 1 Reduced Transmission of STI/HIV Among High Risk Populations (CSWs and Clients)			
INDICATOR S O 1 3 Reported STI Prevalence Rate in High Risk Populations			
UNIT OF MEASURE Percent	YEAR	PLANNED	ACTUAL
	1997		
	1998		
	1999		
	2000		
	2001		
	2002		
SOURCE Survey of High Risk Populations/ frequency of reporting every two years			
INDICATOR DESCRIPTION The number of respondents in the target population who test positive for syphilis divided by the total number of respondents in the target population whose blood has been screened			
COMMENTS G/PHN recommends that data be desegregated by gender urban/rural residence and age group specifically by standard five year intervals (15 19 20 24 25 29 30 34 35 39 40 44 45 49) to enable monitoring of specific target groups Baseline data collected by AIDSCAP study, March 1997			

OBJECTIVE S O 1 Reduced Transmission of STI/AIDS Among High Risk Populations (CSWs & Clients)			
APPROVED DD/MMM/YYYY COUNTRY/ORGANIZATION Cambodia			
RESULT NAME I R 1 Policy Makers are informed about the HIV/AIDS Epidemic in Cambodia			
INDICATOR Number of policy level presentations			
UNIT OF MEASURE The number of events SOURCE contractor/grantee reports annual INDICATOR DESCRIPTION Meetings/presentations sponsored or co sponsored by USAID which present information on the HIV/AIDS epidemic and policy options to senior policy makers COMMENTS	YEAR	PLANNED	ACTUAL
	1997		
	1998		
	1999		
	2000		
	2001		
	2002		

OBJECTIVE S O 1 Reduced Transmission of STI/AIDS Among High Risk Populations (CSWs & Clients)

APPROVED DD/MMM/YYYY **COUNTRY/ORGANIZATION** Cambodia

RESULT NAME I R 2 Reduce High Risk Behaviors in Target Populations

INDICATOR I R 2 1 Condom use with non regular partner, most recent sex act

UNIT OF MEASURE Percent

SOURCE Survey of Target Populations/ frequency of reporting every 2 3 years

INDICATOR DESCRIPTION The number of respondents in the target population who report the use of a condom during the most recent act of sexual intercourse with a non regular partner divided by the total number of respondents in the target population who report sexual intercourse with a non-regular partner in the last 12 months

COMMENTS G/PHN recommends that data be desegregated by gender urban/rural residence and age group specifically by standard five year intervals (15 19 20-24 25 29 30 34, 35 39 40 44 45 49) to enable monitoring of specific target groups
Baseline data collected by AIDSCAP study March 1997

YEAR	PLANNED	ACTUAL
1997		
1998		
1999		
2000		
2001		
2002		

OBJECTIVE S O 1 Reduced Transmission of STI/AIDS Among High Risk Populations (CSWs & Clients)			
APPROVED DD/MMM/YYYY COUNTRY/ORGANIZATION Cambodia			
RESULT NAME I R 3 Model Service Delivery Program for High Risk Population Piloted and Replicated in Siem Reap Pursat and Banteay Meanchey			
INDICATOR I R 3 1 Reported STI Prevalence Rate in Target Populations			
UNIT OF MEASURE Percent SOURCE Survey of Target Populations/ frequency of reporting annual INDICATOR DESCRIPTION The number of respondents in the target population who test positive for syphilis divided by the total number of respondents in the target population whose blood has been screened COMMENTS Baseline data collected by AIDSCAP Survey March 1997	YEAR	PLANNED	ACTUAL
	1997		
	1998		
	1999		
	2000		
	2001		
	2002		

OBJECTIVE S O 1 Reduced Transmission of STI/AIDS Among High Risk Populations (CSWs & Clients)				
APPROVED DD/MMM/YYYY COUNTRY/ORGANIZATION Cambodia				
RESULT NAME I R 3 Model Service Delivery Program for High Risk Population Piloted and Replicated in Siem Reap Pursat and Banteay Meanchey				
INDICATOR I R 3 2 Proportion of Commerical Sex Workers (CSWs) in the Target Population who are paid by the month				
UNIT OF MEASURE Percent	YEAR	PLANNED	ACTUAL	
	1997			
	SOURCE Survey of Target Populations/ frequency of reporting annual	1998		
		1999		
		2000		
	INDICATOR DESCRIPTION The number of respondents in the target population who report they are paid by the month divided by the total number of respondents in the target population	2001		
		2002		
	COMMENTS Baseline data collected by AIDSCAP study March 1997			

ANNEX 4 CONTACTS

Royal Government of Cambodia

Dr Hor Bun Leng
Program Manager,
National AIDS Program, Ministry of Health

Dr Heng Sin
Centre National de Dermato-Venerologie, Ministry of Health
138 bd J Nehru
Phnom Penh
Tel 855 23 66206

Dr Kiev Bun Sany
Director, Health Department,
Provincial Health Department
Sihanoukville

Dr Neak Sokborom
STD Clinic Physician,
Provincial Health Department
Sihanoukville

Kim Sitha
Director of Ministry of Health,
Provincial AIDS Office
Sihanoukville

Ministry of Health - Siem Reap

Ms Lim Nary
Mr Sary Pen
Ms Chamnang Sok
Mr Tim Tra
Mr Yarann Tan
Mr Heng Lim

International Donor Community

Marieke Boot, First Secretary
Development Cooperation, Gender and Mekong Region Development
Royal Netherlands Embassy
Van Phuc Diplomatic Compound

Building D1
Hanoi, Vietnam
Tel 84-4-8430605

Michael Calabria
Programme Coordinator, HIV/AIDS, UNDP
164 Pasteur Street (51)
Boeung Keng Kang
Phnom Penh
Tel 855 23 42682
FAX 855 23 721153

Francoise Crabbe
European Economic Union (EU)
(email)

Andrew Morris, Health Officer
Jim Mielke, HIV/AIDS Coordinator
Margaret De Monchy, Project Officer
UNICEF
No 11 75th Street
Phnom Penh
Tel 855 23 426214
FAX 855 23 426284

Vincent Fauveau
UNFPA Representative
No 164, Rue Pasteur
Phnom Penh
Tel 855 23 426295
FAX 855 23 721 339

Liz Goodburn
MCH-BS Advisor, UNFPA
Maternal Child Health Centre (PMI)
Ministry of Health
Tel 855 23 362516
FAX 855 23 721339

Michael Porter (email)
Sandi Lwin
World Bank Operations Unit Chief, Project Coordination Unit, World Bank
Ministry of Health
Room 318, Nol 151-153

St Kampuchea Krom
Phnom Penh
Tel 855 23 366741
FAX 855 23 362435

Georg Petersen
Representative, World Health Organization
120, Street Pasteur
Phnom Penh
Tel 855 23 46610
FAX 855 23 426211

Dr Caroline Ryan
University of Washington
(email)

Dr Gertrud Schmidt-Ehry, Senior Advisor
Training of Health Personnel and Family Planning Project
GTZ
P O Box 1238
Phnom Penh
Tel/FAX 855 23 366205

Pawana Wienrawee
Country Programme Advisor, UNAIDS
3rd Floor
UNDP Service Center
164 Street Pasteur (51)
P O Box 877
Phnom Penh
Tel 855 23 426872
FAX 855 23 426863

PVOs/NGOs

Tony Bennett, Senior Program Officer
AIDSCAP AsiaRegional Office
Arwan Bulding, 7th Floor
1339 Pracharat 1 Road
Bangsue, Bangkok 10800
Thailand
Tel 587-4750
Fax (662) 587-4758

John M Deidrick, Director
Cynde Robinson, Vice Director
Om Chhen, Sales Manager
Population Services International
#47, Street 302
Boeung Keng Kang I
Phnom Penh
Tel 855 23 362518
FAX 855 23 362518

Eva Galabru, Director
LICADHO
Tel 364901
360965

Dr Zari John Gill, Project Manager
AIDS Prevention and Care Project, World Vision International
P O Box 479
Phnom Penh
Tel 855 23 426052
FAX 855 23 426220

Santiphong (Pik) Pimolsaengsuriya, General Manager
Veary Khaou, Account Director
McCann-Erickson Cambodia
Suite #12, Hotel Cambodianna
313, Sisowath Quay
Phnom Penh
Tel 855 23 426288
FAX 855 23 723656

Rand Robinson, Assistant Country Director
Chivariak Khus, Project Coordinator
CARE International
House 18A, Street 370, Quarter Boeung Keng Kang I
District Chamcar Morn, Phnom Penh
Tel/FAX 855 23 426233

Hou Hem Munnary
Clinic Physician, RHAC/FHSP
Group 16 Street Eikareachkahn Mittapheap
Sihanoukville
Tel 034 320064

Kassie Neou, Director
Cambodia Institute of Human Rights
#30 Rue 57
Sangkat Boeng Keng Kang 1
Kan Chamkar Morn
Phnom Penh
Tel 855 15 912607
FAX 855 23 36273

Phak Choo Phuah, Technical Advisor
International HIV/AIDS Alliance
c/o PACT
#11 Street 302
P O Box 149, Phnom Penh
Cambodia
Tel 855 23 427 820
FAX 855 23 426 746

Mark T Pierce, Country Representative
Catholic Relief Services
P O Box 493
Phnom Penh
Tel 855 23 26404

Guy Sautai, Deputy Medical Coordinator
MSF Holland-Belgium
P O Box 840
No 8, Street 211
Phnom Penh
Tel 855 23 462251
FAX 855 23 426243

Nop Sothera, Project Coordinator
Redd Barna
#9, Street 322
P O Box 34
Phnom Penh
Tel 855 3 62135
FAX 855 23 362523

King Udom,
Media Coordinator
Health Unlimited
No 2 Street 408

Toul Tom Pong 1
Phnom Penh
Tel/FAX 855 23 364583

Dr Ouk Vong Vathiny, Director
RHAC
House #6, Road 150
Sangkat Veal Vong
Khan 7 Makara
Phnom Penh
Tel 855 23 360217
FAX 855 23 366194

USAID

Gordon West, Mission Director

Ned Greeley, Chief
Office of Democracy and Governance

William A Collins, Senior Research Fellow
Center for Advanced Study
No 169, Mao Tse Toung Blvd
Phnom Penh

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ANNEX 4 SOURCE OF FUNDS FOR HIV/AIDS ACTIVITIES BY FUNDING AGENCY IN US\$

FUNDING AGENCY	BUDGET								REMARKS
	1992	1993	1994	1995	1996	1997	1998	TOTAL	
UN SYSTEM									
UNAIDS					100 000	200 000		300 000	
UNICEF					270 000	354 300	364 300	988 600	\$ from Netherlands
UNDP/OPS-HIV PROJECT					355 000	510 000		865 000	
UNDP/CARENE									
UNFSCO					12 500	12 500		25 000	
UNFPA			100 000	315 000	16 000	287 500	269 500	988 000	Integrated in MCH/FP pr 10% of total budget
WHO (all sources)				365 700	110 000	110 000		685 700	1996-1997 for STD Medical Officer Post
Sub Total									
WORLD BANK									
Sub Total									
BILATERALS									
USAID/AIDSCAP FPIA PSI Alliance				700 000	700 000	700 000		2 100 000	1997 PSI only
GTZ					65 000	65 000		130 000	
FRNCH COOPERATION					600 000	600 000		1 200 000	
INDONESIAN GOVT					70 000			70 000	1.4 MILLION CONDOMS/yr
ODA									
DUTCH EMBASSY					UNICEF	UNICEF	UNICEF		
Jap					3 000			3 000	
NORAD									
AUSAID					500 000	500 000			
<i>Add other if involved in HIV/STD prevention and care</i>									
Sub Total									
MULTILATERAL									
EU						600 000	600 000	1 200 000	
<i>Add other if involved in HIV/STD prevention and care</i>									
Sub Total									
NGOs									
Save the Children/UK					43 788	43 788		87 575	
Save the Children/USA									
CARE International									
PSI									
World Vision/Cambodia		100 000	100 000	120 000	120 000	150 000		690 000	Funded by World Vision International
Australian/Cambodian Red Cross									
CRS									
COFR					10 000			10 000	
MISF (French/Belgium)					30 000	26 000		56 000	
Australian Red Cross					68 500	68 500		137 000	
Maryknoll					30 000	30 000		60 000	
World Vision Cambodia					35 000	35 000		70 000	
Quek/Sue Lee Australia					110 989	110 989		221 978	
Cambodia Women's Development Association					20 000	20 000		40 000	
Sevens					2 500	2 500		5 000	
Redd Barna									
<i>Add other if involved in HIV/STD prevention and care</i>									
Sub Total									
NATIONAL									
Govt (Ministries/Departments)				None	10 000	None		10 000	
Sub Total									
OTHERS									
Private Sector									
<i>Add other if involved in HIV/STD prevention and care</i>									
Sub Total									
TOTAL		100 000	200 000	1 311 700	3 272 277	5 726 277	2 534 000	13 144 243	

N.B. Whenever possible please use the "reversed" of the funds i.e. NGOs, GOV, others. All make any problem or difficulty incurred in obtaining the data. If data are missing the SI user. A case of intermission and relevant implementing agency are available please include.

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