

CAMBODIA FINAL REPORT

June 1998–September 2007

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT



USAID
FROM THE AMERICAN PEOPLE





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**Cambodia Final Report
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for

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Submitted to USAID

By Family Health International

December 2007

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FOREWORD

It gives me great pleasure to present the following report, which chronicles ten years of FHI/IMPACT HIV programming in the Kingdom of Cambodia.

Cambodia has been heralded worldwide as an HIV/AIDS “success story.” Sentinel surveillance trends show a steady decrease in HIV prevalence, from a high of 3 percent in 1997 to the 2003 figure of 1.9 percent. Behavioral trends indicate that consistent condom use is increasing and risk-taking behaviors among most-at-risk populations are declining. A strong health system and improved service delivery and linkages have made it possible for more people living with HIV/AIDS to access life-prolonging care and treatment. While the results are encouraging, efforts must continue with the same vigor to ensure that these successes are maintained and enhanced. Approximately 123,000 people—many of whom are the poorest in the country—are currently living with the virus. Despite substantial declines, the incidence of new infections among entertainment workers and key client groups remains high. Anecdotal reports suggest that illicit drug use is increasing. Even more worrying, the virus has spread to the general population, particularly to married women and their children. Vulnerability reduction, impact mitigation and continued risk reduction interventions in HIV prevention, care, support and treatment are vital to stem the HIV/AIDS epidemic across Cambodia.

With the assistance of the US Agency for International Development (USAID), FHI/IMPACT has been working as part of the collective effort to bring down HIV transmission rates, reduce the spread of the virus, and provide care for those living with or affected by the disease.

Since 1998, FHI/IMPACT has worked in partnership with government and civil society to respond to the HIV/AIDS crisis. Through our collaborative effort, we have reached Cambodians in all of the country’s 24 provinces. We plan to scale up many of our interventions, and to continually assure the high quality of all programs. We strive to ensure that our programs remain relevant to local needs and realities, and are sustainable following the eventual end of our involvement.

This document illustrates the main activities and accomplishments of the FHI/IMPACT effort from 1998 to 2007. Special thanks to the Royal Government of Cambodia for its many years of support and partnership—particularly the Ministry of Health, the National Center for HIV/AIDS, Dermatology and STDs, the National AIDS Authority, the Ministry of National Defense and the Ministry of Interior. We extend our gratitude to USAID for its continuing commitment to addressing HIV/AIDS in the country. Special thanks to our implementing agency partners for their dedication and hard work, and to the people with whom we work closely in the field and who are most affected by the epidemic. FHI Cambodia looks forward to continuing collaboration with all of our partners and is committed to supporting the national comprehensive response to HIV in the years to come.

Dr. Song Ngak
Country Director
Family Health International, Cambodia

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ACRONYMS

ABC	Abstinence, Be faithful, Use condoms
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
BSS	Behavioral Surveillance Survey
CFDS	Cambodian Family Development Services
CoC	Continuum of Care
CRC	Cambodian Red Cross
CRS	Catholic Relief Services
CWC	Cambodia Women's Clinics
CWPD	Cambodian Women for Peace and Development
DOTS	Directly Observed Therapy Short Course
FHI	Family Health International
FSW	Female Sex Workers
HAI	HelpAge International
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
IA	Implementing Agency
IDU	Injection Drug User
IEC	Information/education/communication
ILDO	Islamic Local Development Organization
IMPACT	Implementing AIDS Prevention and Care Project
KRDA	Khmer Rural Development Association
KWCD	Khmer Women's Cooperation for Development
M&E	Monitoring and Evaluation
MEC	Médecine de l'Espoir Cambodge
MHC	Men's Health Cambodia
MSM	Men who have sex with men
MSW	Male Sex Workers
NCHADS	National Center for HIV/AIDS, Dermatology and STDs
NGO	Nongovernmental organization
OI	Opportunistic infection
OVC	Orphans and other vulnerable children
PATH	Program for Appropriate Technology in Health
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PSAD	Phnom Srey Association for Development
PSF	Pharmaciens Sans Frontières
PSI	Population Services International
QA/QI	Quality Assurance/Quality Improvement
SBC	Strategic Behavioral Communication
SSC	Social Services of Cambodia
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Emergency Fund
USAID	US Agency for International Development

USCDC
USG
VCT
WHO
WYA

US Centers for Disease Control and Prevention
Urban Sector Group
Voluntary Counseling and Testing
World Health Organization
Women and Youth Action

EXECUTIVE SUMMARY

Having completed a decade of work in Cambodia, FHI Cambodia has prepared this report to present accomplishments and lessons learned. We look forward to what we can do in the future.

Our mission is to strengthen the capacity of the country to prevent HIV/AIDS; provide care, support and treatment; and mitigate the impact of the epidemic. From 1998 onward, FHI—with generous assistance from USAID under the IMPACT project—has supported governmental and nongovernmental organizations (NGOs) and community partners across the country to implement a range of programs and activities. These include

- providing technical support to the National Center for HIV/AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS) to develop and use strategic information to generate a comprehensive response. This includes support for the design, implementation and data analysis of the National HIV Sentinel Surveillance, the Behavioral Surveillance Survey (BSS), and the Sexually Transmitted Infection (STI) Sentinel Surveillance Surveys
- developing, implementing and monitoring targeted behavior change interventions to reduce the risks and vulnerability of those who are most susceptible to STIs and HIV, including entertainment workers, uniformed services personnel and men who have sex with men. FHI also carries out STI/HIV prevention and vulnerability reduction interventions for the wives and family members of military personnel
- collaborating with the government and the NGO community to strengthen STI service delivery for high-risk populations in the civilian and military health systems
- reducing the vulnerabilities and impacts of HIV/AIDS on orphans and other vulnerable children
- providing technical support and systems for the rapid scale-up of HIV/AIDS care, support and treatment, using the Continuum of Care approach.

Achievements

Over the years, FHI Cambodia's programs have made a measurable impact. In collaboration with government, multilateral, NGO and community partners, FHI programs have yielded a variety of noteworthy results.

Nationwide coverage

FHI's sex worker interventions reach entertainment workers in 15 of Cambodia's 24 provinces—up to 80 percent of the total projected number of entertainment workers in the country. The uniformed services program provides national coverage of the military and police in collaboration with USAID, the Ministry of National Defense, the Ministry of Interior, Cambodian Red Cross and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Behavior change

The number of men visiting sex workers has declined—from 70 percent in 1997 to 37 percent in 2003. Approximately 89 percent of military personnel and 96 percent of direct sex workers in the 2003 BSS state that they consistently use condoms in high-risk sexual encounters—up from 57 percent and 42 percent in 1997.

High-quality strategic information

A strengthened surveillance system shows a pattern of changing behavior and decreasing HIV prevalence. Current research efforts highlight the needs of vulnerable hidden populations such as men who have sex with men (MSM) and examine trends in the quality of life of people living with HIV/AIDS (PLHA) on antiretroviral therapy.

Strengthened partner capacity

The National Defense and Interior ministries have emerged as leaders in HIV/AIDS planning and programming among the National AIDS Authority's multisectoral partners. Key implementing NGOs—such as Khemera, Homeland, Cambodian Women for Peace and Development and others—have developed vital and well-functioning HIV/AIDS programs.

Strengthened country plans, systems and structures

FHI Cambodia participates in and provides resources for the development of national frameworks, strategies, guidelines, strategic operating procedures, training curricula, and communications materials. We also sit on national and provincial technical working groups and coordination committees, assist in the development of national strategic plans (including the National AIDS Authority, NCHADS and the Ministry of National Defense) and work to improve the quality of STI and HIV/AIDS care and treatment services.

Leadership in new approaches

The Continuum of Care program supported by FHI at nine CoC sites across the country has produced learning areas for Cambodia and the Asia-Pacific region as a whole. FHI Cambodia's Strategic Behavioral Communication (SBC) messages and materials have been adapted by FHI country offices and partner agencies throughout Asia and beyond.

Emerging Themes to Guide the Next Decade

In the process of reviewing FHI Cambodia's overall contributions to the national response, a number of recurring themes consistently surfaced in discussions with staff, partners and other stakeholders. These themes will guide FHI as the organization enters its next decade of HIV/AIDS programming.

Strategic information highlights the best approach, identifies priority actions, and supports the national response.

FHI Cambodia's comprehensive program strategy is based on epidemiological evidence that shows higher HIV prevalence rates among specific population groups. Most-at-risk populations—such as sex workers, clients of sex workers and men who have sex with men—are the targeted key beneficiaries. FHI focuses its prevention efforts on most-at-risk populations as the most effective and cost-efficient way to stem the epidemic. While injection drug use remains low, FHI Cambodia is expanding drug use education and behavior change interventions to respond to increasing cases of illicit drug use (primarily methamphetamine use) among most-at-risk populations.

As in the past, FHI Cambodia will continue to emphasize evidence-based programming—especially its support of national surveillance research, systems and plans. The organization will continue to support NCHADS to gather epidemiological information so the national program will respond appropriately and well to the changing epidemic.

Technical assistance, innovation and leadership strengthen the effectiveness of the response.

FHI Cambodia has both developed innovative interventions and applied international best practices over the years, particularly in the areas of HIV prevention and care. One of the organization's unique strengths is its ability to offer technical assistance on issues ranging from treatment, epidemiological surveillance and STI case management to counseling and testing. To ensure high quality programming, FHI draws on the support and resources of FHI's Asia Pacific Regional Office and its global headquarters. The organization is also increasingly relying on the technical and programmatic expertise of a growing number of Cambodian professionals.

Partnerships create synergies, better meet beneficiaries' needs and maximize resources.

FHI's strength comes from its large network of implementing agency partners that are able to respond to local community needs and build community-based responses. FHI Cambodia also works with a variety of multilateral organizations, government departments, NGOs and donor agencies to ensure greater impact and eliminate gaps. Partnerships will continue to be central to FHI's work in the coming years, not only to maximize resources and synergies, but to assure that its activities are complementary and not duplicating other programs.

HIV initiatives are effective when they are situated within government structures and follow government strategic plans and priorities.

As the FHI program enters its second decade, the contribution it makes to HIV/AIDS prevention, care and impact mitigation is tied to the national HIV/AIDS support of the Royal Government of Cambodia. As in the past, all of FHI's work in Cambodia is in direct support of national priorities. FHI strategic frameworks and plans are developed in close consultation with national and provincial AIDS bodies. FHI also supports the strengthening of structures and systems and other capacity building measures to realize national targets, objectives and strategies.

Working at a variety of levels—from national to local—allows for a more comprehensive response.

As part of FHI's emphasis on strengthening country capacity for responding to HIV/AIDS, the organization is actively involved in and provides resources for the development of national frameworks, strategies, guidelines, strategic operating procedures, training curricula, and communications materials for all aspects of HIV prevention, care, support and treatment. FHI sits on relevant national technical working groups and task forces that shape Cambodia's priorities and actions, and provides capacity building and quality assurance/improvement at the national, provincial and community levels.

The active involvement of beneficiaries and marginalized groups ensures the effectiveness and sustainability of interventions.

Embracing the principle of greater involvement of people living with HIV/AIDS in not only assessment and research but also the development of communications tools, project implementation and monitoring has always produced better quality and more sustainable programs. FHI will continue to respond to the challenges of politics, economics, gender inequality, cultural constraints and finite systems to promote involvement of those who are most vulnerable and provide the highest quality HIV/AIDS services.

PROGRAM STRATEGIES, IMPLEMENTATION AND RESULTS

Introduction

Family Health International is one of the world's largest and most experienced international HIV/AIDS technical assistance organizations. It is dedicated to improving lives and increasing knowledge worldwide through research, education and services in HIV/AIDS prevention, care and treatment. FHI's culturally diverse staff of 1,700 provides expertise in such areas as strategic behavioral communication, voluntary counseling and testing (VCT), control of STIs, clinical management of HIV, care and support for people living with HIV/AIDS (PLHA), PMTCT, program management and evaluation.

For more than three decades, FHI's mission has been to work in partnership with government, multilateral agencies, NGOs and community groups to strengthen the capacity of resource-constrained countries, supporting lasting improvements in individual health and entire health systems. Worldwide, FHI operates programs in more than 70 countries and maintains field offices in 40, including Cambodia, China, India, Indonesia, Philippines and Thailand.

FHI has extensive experience managing large globally funded and bilateral HIV/AIDS projects. In the past 15 years, FHI managed the AIDS Technical Support Project (AIDSTECH), the AIDS Control and Prevention Project (AIDSCAP), and the Implementing AIDS Prevention and Care Project (IMPACT), among others.

Country Context

In 1991, as Cambodia emerged from decades of civil war and international isolation, HIV was first detected in serological screening of donated blood. Two years later, Cambodian authorities diagnosed the first AIDS case.

Following the systematic destruction of infrastructure under the Khmer Rouge regime, Cambodia's national health authorities lacked the human and financial capacity to stem the oncoming epidemic. The Royal Government of Cambodia established its National AIDS Program in 1993, but with limited resources its monitoring and response mechanisms were weak. Indeed, little was known about HIV transmission in Cambodia until the National AIDS Program initiated the first HIV Sentinel Surveillance (HSS) and Behavioral Sentinel Surveillance (BSS) surveys in 1995 and 1996, respectively.

Early data indicated a prevalence rate of 2 percent in the adult population and suggested that Cambodia's epidemic could eventually rival ones in the most affected countries of the world. The commercial sex business was—and remains—at the heart of the epidemic.

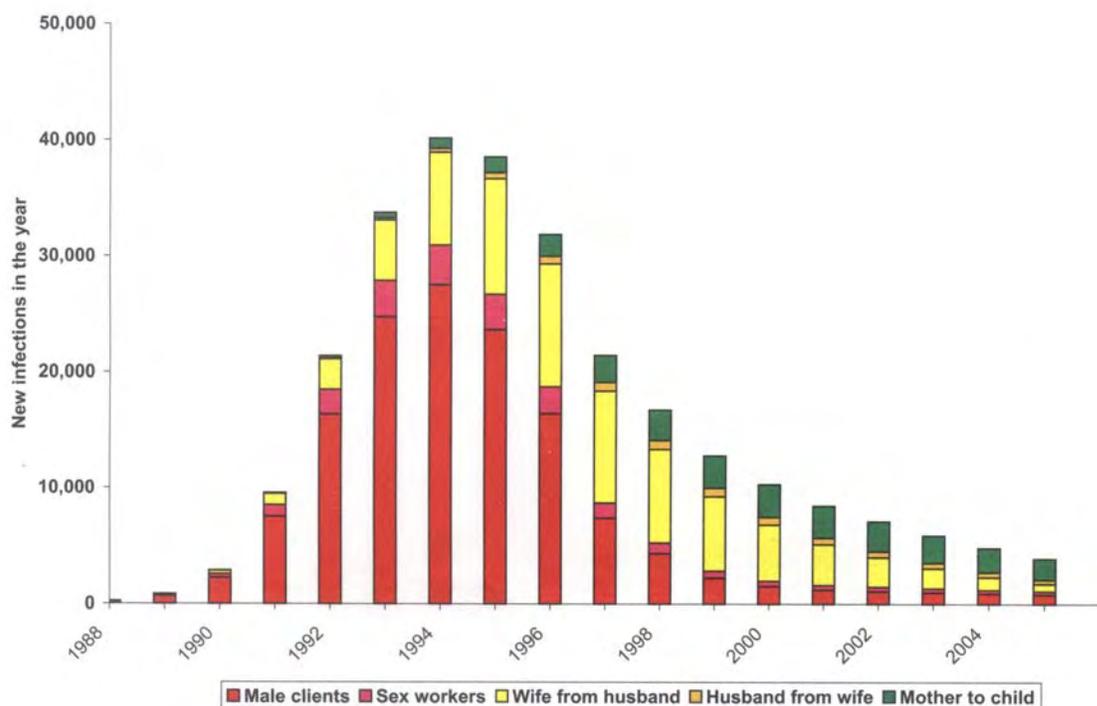
Throughout the 1990s, the epidemic stayed concentrated in groups most at risk, which included entertainment workers and their clients, particularly uniformed service personnel. The 1997 prevalence data showed that 42.6 percent of brothel-based sex workers and 4.4 percent of uniformed service personnel had contracted the virus.

During the same year, the HIV rate peaked at 3 percent in the adult population, making Cambodia's epidemic the most serious of those documented in Southeast Asia. For this reason Cambodia was selected to receive considerable financial support from USAID and in 1998 FHI used IMPACT funding to begin HIV/AIDS interventions.

The early efforts by NGOs and government agencies to control the epidemic focused on educating the most vulnerable people and groups about ways to decrease personal risks. Numerous NGOs responded in earnest, developing HIV prevention programs for populations deemed most vulnerable.

Despite various constraints, the Cambodian government response has been impressive. In 2001, it implemented the 100 percent Condom Use Program in all provinces, requiring brothel-based entertainment workers to be screened each month for sexually transmitted infections (STIs) and involving establishment owners in condom negotiation initiatives. The Interior and National Defense ministries have collaborated with FHI to spread peer education among police and armed forces personnel. In addition, the Ministry of Health works with NGOs, multilateral agencies and other partners to implement the Continuum of Care (CoC) model throughout the country. In 2002, the National Assembly promulgated the *Law on Prevention and Control of HIV/AIDS*. Though enforcement mechanisms are still weak, the law recognizes the human rights of infected persons, affected communities and vulnerable populations.

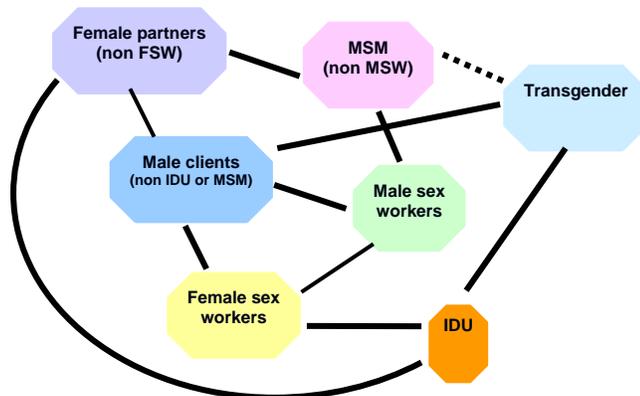
Prevalence rates among adults have significantly declined—from 3 percent in 1997 to 1.9 percent in 2003. Behavior change interventions lie at the heart of this success. The number of high-risk men who report visiting sex workers has declined—from 70 percent in 1997 to 37 percent in 2003. Approximately 89 percent of military personnel and 96 percent of brothel-based sex workers in the 2003 BSS state that they consistently use condoms in high-risk sexual encounters—up from 57 percent and 42 percent respectively in 1997.



HIV incidence has fallen among high risk populations like entertainment workers and clients, but an increasing proportion of new infections takes place between couples and from mothers to children.

—National AIDS Authority National Strategic Plan 2006–2010

Although Cambodia represents a “success story,” there is no room for complacency. Spousal transmission accounts for almost half of all new infections and another one-third of new infections are passed from mothers to children. Relatively small but significant groups such as men who have sex with men and injection drug users appear to be severely affected. The major risk behaviors for transmitting HIV in Cambodia—the buying and selling of sex, injection drug use and male-male sex—are by no means mutually exclusive. As long as the epidemic is generalized with adult prevalence just under 2 percent, the risk of a rapid HIV resurgence lingers.



A circle of interconnected risks: no time for complacency

Many avenues for action remain open. Access to prevention of mother-to-child transmission (PMTCT) programs is low, as is access to, and uptake of, STI treatment and counseling and testing services. In addition, HIV prevention interventions for sex workers, men who have sex with men, drug users and other most-at-risk populations must be scaled up and/or continued.

Approximately 123,000 people—often the poorest in the country—are currently living with the virus. Meeting the medical needs of an increasing number of these persons places a serious burden on the Cambodian health system. Innovative and holistic interventions must address the changing nature of the epidemic as well as the various social, health and economic factors contributing to the spread of the disease. Further cooperation between community, NGO and government bodies—as well as increased participation from the private sector—are essential in mitigating the impact of HIV/AIDS and curbing its spread.

Program Strategies and Activities

1997–2002

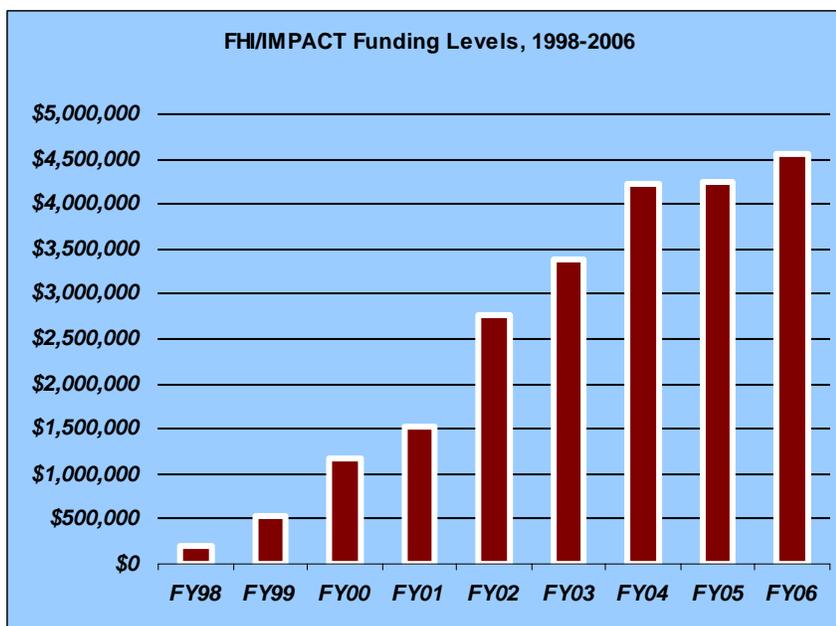
In 1997, USAID/Cambodia introduced a *Special Strategic Objective (SpO2) for the Mitigation and Prevention of HIV/AIDS in Cambodia*. The objective of “reduced STI/HIV transmission among high-risk populations” would initially be met by three intermediate results, to be achieved by 2002. The sought-after results were

- policy makers informed about the HIV/AIDS epidemic in Cambodia
- high-risk behaviors reduced in target populations
- model STI and reproductive health service delivery programs for high-risk populations piloted and replicated in selected areas.

In early 1998, USAID/Cambodia commissioned an action plan to achieve these intermediate results. The plan recommended that activities be focused on a cluster of highly populated central-south provinces, including the Phnom Penh municipality, and the provinces of Kampong Cham, Kampong Chhnang, Kampong Thom and Kampong Speu. These areas house the majority of Cambodia’s population, including significant numbers of persons identified as most vulnerable to HIV, such as sex workers and their clients.

Under the resulting program, USAID/Cambodia provided funds to FHI to open an office and implement activities in the action plan. Interventions in Phase 1 included

- providing technical support to NCHADS for the design, implementation and data analysis of the national HIV sentinel surveillance, the behavioral sentinel surveillance and the STI sentinel surveillance surveys
- developing, implementing and monitoring targeted behavior change interventions to reduce the risks and vulnerability of those identified as most susceptible to STIs and HIV/AIDS—entertainment workers and their clients, particularly men in the uniformed services
- collaborating with the government and NGO community to strengthen STI case management capacity and services in clinics serving entertainment workers and their clients
- implementing innovative projects for orphans and other vulnerable children
- creating model programs that address the TB/HIV interface.



Activities focused on the densely populated centers of Phnom Penh, Kampong Cham, and Kandal. From 2000–2001, the program expanded to cover the three remaining provinces, with the proviso that particular activities could take place outside the six targeted areas according to needs and available resources. In 2002, when USAID designated Cambodia as the “Rapid Scale Up” country for HIV/AIDS programs in Asia, FHI-supported programs expanded to 16 of Cambodia’s 24 provinces. Media campaigns and other initiatives—including the strengthening of disease surveillance systems—had a national reach.

2003–2007

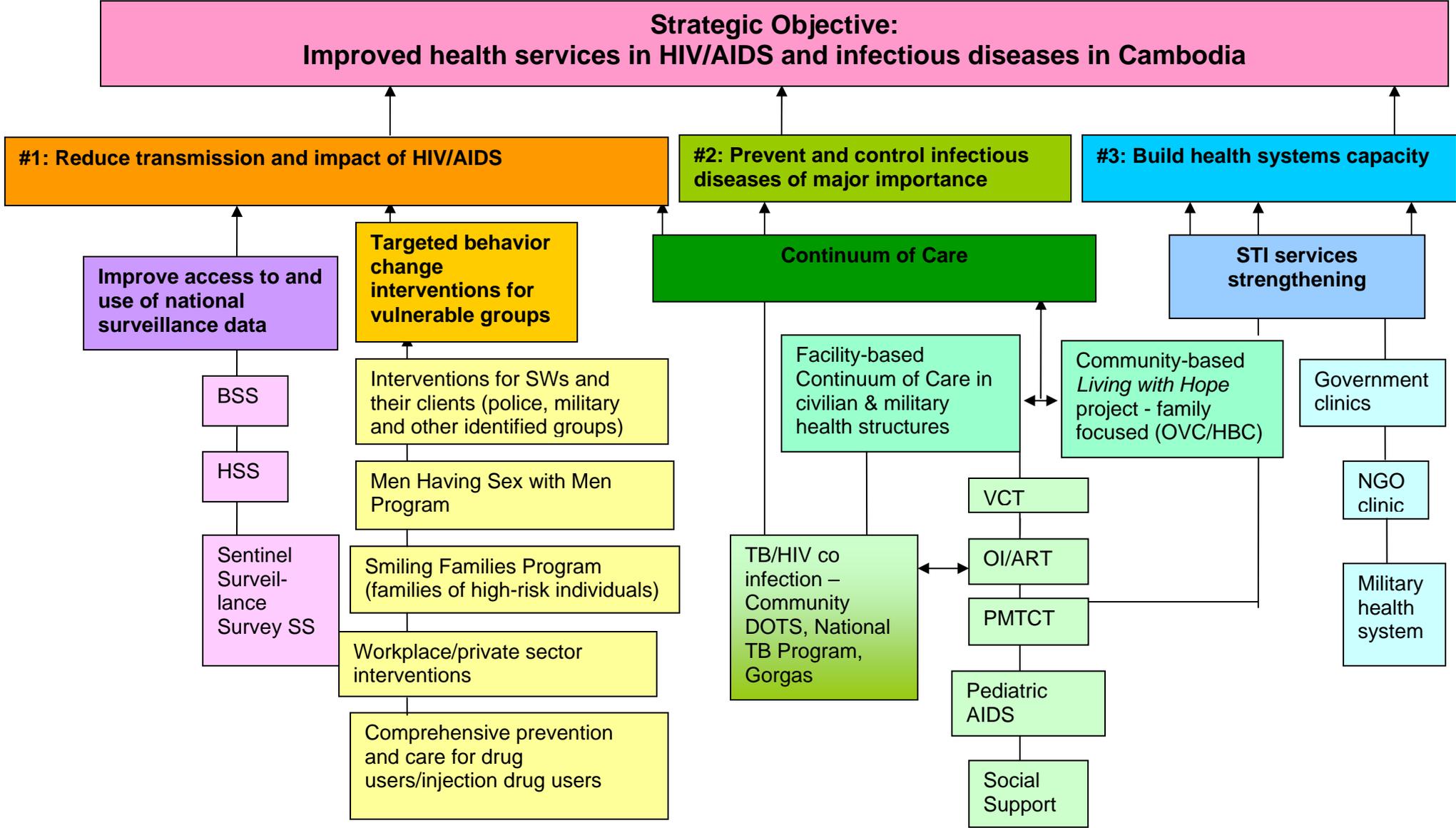
Building on earlier investments in public health, USAID’s health program continues to revolve around HIV/AIDS and other infectious diseases, mother and child health concerns and capacity building within the health sector. Emphasis is placed on a combination of improved quality, access and utilization.

From 2003–2007, FHI Cambodia expanded and diversified its portfolio. Funding levels increased from less than US\$500,000 in 1998 to US\$4-4.5 million annually during the fiscal years 2006 and 2007. In addition to activities carried out in Phase 1, FHI entered the domain of HIV/AIDS care and treatment in collaboration with NCHADS and other partners. Prevention programming expanded to include men who have sex with men, illicit drug users and family-based interventions in military settings. Connections between home-based care and initiatives for orphans and other vulnerable children (OVC) allowed for more integrated support for vulnerable households. To implement these interventions, FHI has partnered with more than 20 implementing agencies and a variety of collaborating organizations—including government ministries and departments, multilateral agencies and community-based organizations.

FHI’s portfolio now extends to all 24 provinces, directly reaching over 200,000 people with prevention, care and treatment services and indirectly, through programs, reaching approximately 3,943,850 people (see map below).



FHI Cambodia Program Strategy



FHI's Comprehensive Program Strategy

FHI Cambodia's comprehensive program strategy is based on epidemiological evidence that shows higher HIV prevalence rates among specific population groups. Most-at-risk populations—such as entertainment workers, clients of entertainment workers and men who have sex with men—are key target beneficiaries. While injection drug use remains low, FHI Cambodia is expanding illicit drug use prevention, risk reduction and behavior change interventions to respond to increasing cases of illicit drug use (primarily methamphetamine use) among most-at-risk populations.

In Cambodia, husband-to-wife and parent-to-child transmission are increasing. Husband-to-wife and parent-to-child transmission now constitute nearly half of all new HIV infections in the country. FHI Cambodia is building upon its current programs to ensure that family-based programming and prevention of mother-to-child transmission are strong components of its overall strategy.

Risk, vulnerability and impact reduction

FHI Cambodia strives to reduce risks, ameliorate vulnerabilities and mitigate the impact of HIV/AIDS on people's lives. Risk reduction activities emphasize comprehensive ABC education; condom promotion and social marketing; and increasing access and uptake of essential STI/HIV/AIDS services. Alcohol and drug use education, income generation, access to basic education, vocational training and savings schemes reduce the vulnerability of people to HIV/AIDS and mitigate the impact of the disease. In addition, care, support and treatment services help people infected with and affected by HIV/AIDS lead happy, healthy, productive lives.

Integrated approaches

Over the past few years, FHI Cambodia has increasingly moved into the domain of care, support and treatment for people living with and affected by HIV/AIDS. FHI and its partners strive to build upon and integrate HIV/AIDS programming so that Cambodians have access to a range of services. Nowhere is this more true than in Battambang province, where government and NGO partners have contributed to a comprehensive provincial package of services along the Continuum of Care. In all of its programming, FHI Cambodia is committed to building upon its successes, responding to gaps and ensuring synergies between organizations and projects so that initiatives better respond to the needs of the people.

Working in partnership

FHI strives to strengthen the capacity of Cambodian government offices, nongovernmental organizations and community groups to respond to the HIV/AIDS epidemic in the country. FHI works with and through key governmental, NGO and community bodies to implement comprehensive responses. As a result, FHI is both a direct implementer of programs and a source of funding, technical assistance and overall support for our implementing agency partners.

Using Strategic Information to Generate a Comprehensive Response

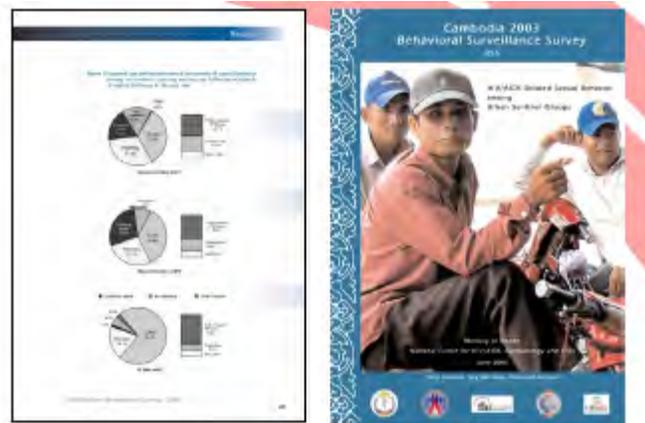
Reliable surveillance systems for tracking information about HIV/AIDS are vital for targeting resources and developing comprehensive responses to halt the epidemic. Surveillance can tell us who is infected with HIV, where infections occur, and perhaps more important, the underlying behavioral and socio-demographic factors contributing to the spread of the virus. Because behaviors precede infection, behavioral data acts as an early warning sign—identifying not only who is vulnerable to HIV, but also what risk behaviors threaten to drive the epidemic. When collected in conjunction with HIV sentinel surveillance data, policymakers can identify the stage of the epidemic and tailor interventions for greatest impact.

In the area of strategic information, FHI and its partners

- strengthen the capacity of the HIV surveillance/monitoring system and its personnel
- provide information to explain changes in HIV prevalence, including the impact of US government-funded prevention programming
- provide information for advocacy and policy
- assess effectiveness of programs that provide care and treatment to ART patients
- assess costs of programs, recurrent costs and implications of costs in the context of scale up
- strengthen program monitoring and quality assurance systems of implementing agencies
- develop a clear understanding of the HIV/AIDS epidemic in the country so that effective national policies and appropriately targeted programs can be developed.

Strengthening national surveillance systems

Cambodia has one of the most advanced surveillance systems in Asia. Based on the principles of “second generation surveillance” outlined by UNAIDS and the World Health Organization (WHO), this system uses several different sources of data to decipher trends in the prevalence of HIV and other STIs and in the behaviors that put people at risk for infection. NCHADS regularly conducts a national HSS survey in which people in selected groups are tested anonymously. Levels of risk behaviors for many of the same



groups are assessed by analyzing interview data from the BSS. Data on the prevalence of STI and related risk behaviors have been recently collected in USAID/Cambodia priority provinces where FHI works, and from MSM networks in Phnom Penh.

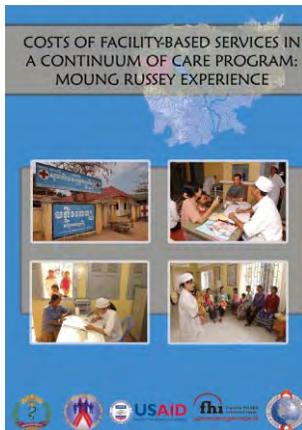
From 1994 onward, FHI has been providing technical support to NCHADS to develop and use a second generation surveillance system. The USAID/ANE bureau provided initial support for the initiative with the USAID/Cambodia mission assuming overall financial responsibility in 2001.

FHI’s support to NCHADS emphasizes building the capacity of local partners to conduct surveillance and manage the system. Staff and consultants have worked with the NCHADS team to develop plans for integrated surveillance, analyze data, conduct consensus workshops, interpret and disseminate surveillance information, assure data quality, and fine-tune data collection systems to improve and adapt to changing needs. The development, implementation and sustainability of the surveillance system—due primarily to the strong skills of NCHADS staff—are considered to be critical achievements of FHI programming.

Special studies

Besides the support that FHI provides for surveillance at the national level, the organization also conducts numerous *ad hoc* surveys to evaluate the impact of FHI-supported programming and to learn more about the epidemic's trends.

In 2005, the Ministry of National Defense and FHI conducted a survey among the military to evaluate the coverage and impact of the uniformed services peer education program. This survey demonstrated the existence of a close relationship between the number of peer education contacts and the adoption of safer sex behaviors.



The unit costs of facility-based services in a Continuum of Care program were also examined in 2005. This involved identifying and costing all the inputs needed to deliver care along the continuum, namely services related to TB/HIV, antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT), opportunistic infection (OI) and voluntary counseling and testing (VCT). Data from government and donors who take part in implementation were included.

In 2002, FHI worked with the East West Center to apply the Asian Epidemic Model to Cambodia. The model determines future trends in the Cambodian epidemic and identifies the relative contribution of different transmission modes, such as indirect and direct sex work, casual sex, and husband-to-wife transmission. Information from the Asian Epidemic Model was indispensable

in shaping the country's responses to HIV/AIDS over the last few years.

Ongoing, there is another study called "Enhanced Patient-Based Longitudinal Assessment of PLHA on ART." It aims to assess ART patients' quality of life (including measures of stigma and discrimination) over time, with reference to socio-demographic and general health determinants. This research will provide crucial information for the future assessment of issues related to the well-being of PLHA.

Other special studies include a groundbreaking estimation of the presence of MSM in Phnom Penh and baseline research with the Ministry of National Defense on military couples' behaviors and levels of knowledge with respect to HIV/AIDS, reproductive health and family planning services.

Strengthening monitoring systems and processes among partners

FHI currently provides technical assistance to 23 local nongovernmental and governmental organizations, 25 STI clinics and eight referral hospitals to improve quality assurance systems and processes. Technical assistance to partners is in the form of site visits, on-site mentoring, development of data collection and management systems, data reporting, supportive supervision and feedback, quarterly meetings, consultations, formal trainings, and quality improvement. FHI Cambodia uses both quantitative and qualitative information. To be meaningful, indicators such as service and training statistics need to be complemented with information on quality, relevance and coverage. In order to do so, focus group discussions, indepth individual interviews and exit interviews are completed with target beneficiaries in order to assess if the provided services and activities are of good quality and relevant to their needs. Observations of activities such as education sessions in the community, peer education, and home care for PLHA, play a critical role in assessing quality of services and the level of knowledge of those who are delivering services. FHI staff and partners use quality assurance tools and checklists to ensure quality in services and programs. FHI Cambodia conducts quarterly meetings, site visits and feedback meetings in order to maintain regular

communication with implementing agencies, monitor progress, assist the projects to meet their defined targets, identify obstacles to implementation and increase opportunities for capacity building.

Contributing to the national monitoring and evaluation system

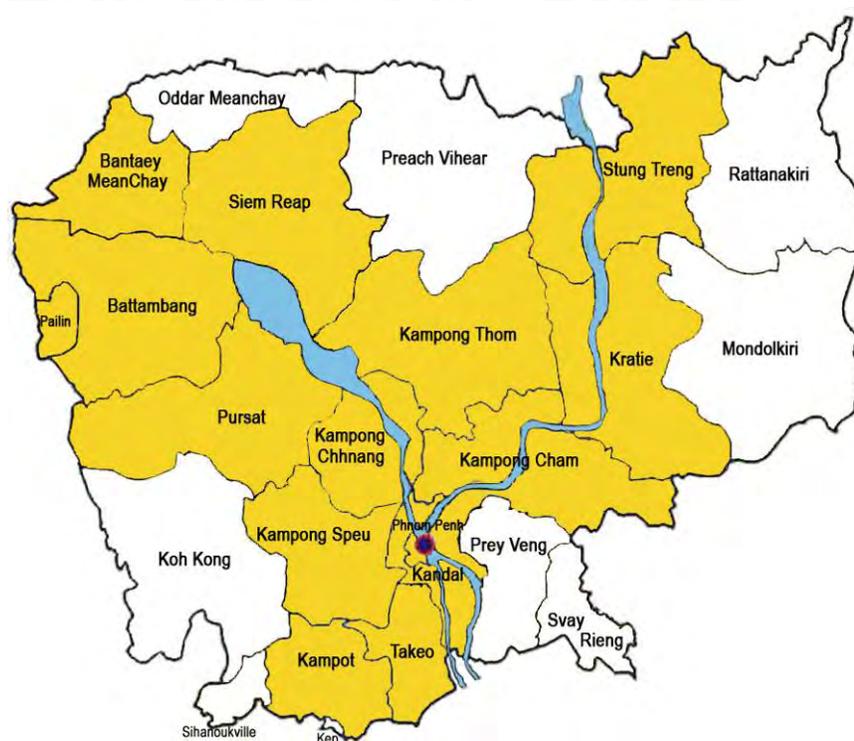
At the national level, FHI is involved in technical working groups and other networks that review country progress against national HIV/AIDS targets and strengthen the implementation of one integrated national monitoring and evaluation (M&E) system. This includes reviewing documents, providing feedback and contributing when required on matters discussed by the technical working group. FHI's programs provide information to key stakeholders such as NCHADS and the Ministry of National Defense that contribute to reaching targets set in the national M&E plan.

Future roles

In the coming years, FHI will continue to play an important role in strategic information efforts. FHI and its partners will

- provide indicators at the impact, outcome and process/output level for programming in Cambodia
- strengthen the capacity of the HIV surveillance/monitoring system and its personnel
- provide information to explain changes in HIV prevalence, including the impact of US government-funded prevention programming
- provide information for advocacy and policy
- assess effectiveness of programs that provide care and treatment to ART patients
- assess costs of programs, recurrent costs and implications of costs in the context of scale up
- develop a clear understanding of the HIV/AIDS epidemic in the country so that effective national policies and appropriately targeted programs can be developed

HIV/AIDS Prevention and Care for Women At Risk



FHI and its partners currently reach entertainment workers in 15 of 24 provinces

In 1998, when HIV prevalence rates of direct sex workers were at a peak of 43 percent, FHI programs focused on the 1,200 entertainment workers residing in the Phnom Penh municipality and the densely populated provinces of Kampong Chhnang and Kandal. Currently, FHI works in 15 provinces, reaching 11,000 entertainment workers through nine partner implementing agencies.

FHI Cambodia and its partners support direct and indirect entertainment workers to reduce their risks for contracting STIs and HIV. In an effort to increase the adoption and continued application of safer sex behaviors, the program emphasizes a variety of approaches including peer and outreach education. Alternative income generation activities for those who are contemplating leaving sex work are supported. Program managers work closely with NCHADS and provincial government counterparts to promote the 100 percent condom use policy. They also strive to promote positive health seeking behaviors, such as going to an STI clinic for care and treatment, testing and seeking counseling.

All of FHI Cambodia’s implementing agencies follow a similar rubric in their vulnerability, risk and impact reduction interventions for entertainment workers. Three strategies are emphasized:

- Support entertainment workers wanting to assess their personal risks for STIs and HIV/AIDS and adopt safer sex practices consistent with the US government ABC approach.
- Using “Tools for Life”—a set of 14 participatory educational tools developed by entertainment workers themselves—outreach workers and peer educators hold weekly discussions with vulnerable women on topics such as STIs and HIV/AIDS, condom negotiation, counseling and testing, nutrition, hygiene, drug use, stigma and discrimination, and the rights of PLHA. Drop-in centers offer a safe space where entertainment workers can come to discuss their problems with outreach staff, learn some supplementary skills, and participate in trainings and meetings.
- Increase the incidence of correct and consistent condom use among entertainment workers and their clients.

FHI and its partners collaborate with Population Services International (PSI) to develop ways to promote condom use. The plans use social marketing and free distribution to address the vulnerabilities and needs of entertainment workers in target areas. The dual function of condoms (safe sex and birth control) is promoted during outreach and peer education sessions. Other talking points include how to correctly use condoms, the importance of consistent condom use, and how to effectively negotiate condom use with clients and regular partners.

Increase access to and use of prevention, care, support, and treatment services

FHI collaborates with NCHADS to strengthen the services and referral systems of government STI clinics to sex workers and their families in each of 15 target provinces. Support consists of technical training in STI management; provision of medical equipment such as microscopes, reagents and specula; provision of drugs and consumables through NCHADS, and quality assurance monitoring.

Counseling and testing is an integral part of the program. The key message—“know your status”—provides the entry point to effective care and treatment. Testing serves as a valuable prevention tool for helping people remain HIV negative. It helps reduce stigma and discrimination among individuals, families and communities. In Phnom Penh, FHI supports Médecine de l’Espoir Cambodge (MEC), a community-based NGO clinic, which provides STI and VCT services to at-risk groups such as entertainment workers, MSM and drug users.

provinces (military in 19 provinces and police in 24 provinces in FY07—see map).

To meet objectives and maximize reach to military personnel, program developers adopted a cascade peer education approach. It features a four-tier structure—core trainers, peer trainers, peer educators and peer beneficiaries—that mirrors the hierarchical structure of the uniformed services. Program managers train core trainers from the ministerial, regional, provincial, division and brigade levels, who in turn guide and support peer educator trainers at the provincial, brigade, battalion and commissariat levels. The peer trainers then train and support peer educators at the district, company and platoon levels. The educators’ task is to provide information, education and links to services in military barracks.

In 2005, with surveillance trends showing that wives were being disproportionately affected by STIs and HIV/AIDS, the program expanded its work with uniformed services’ families. The “Smiling Family” program examines issues of spousal communication, domestic violence, reproductive health and HIV/AIDS. It also aims to increase spousal communication about sexual health issues and to promote the use of health services. Initially pilot tested at one site, this program has been expanded with funds from Global Fund Round 5 to others. Male and female peer facilitators, supported by outreach workers, take responsibility for its implementation.

A collaborative effort in 2006 with Equal Access resulted in the use of audio technology within the program. Topics relating to risk assessment, VCT, STIs, and being faithful were introduced by audio recordings and now peer educator trainers facilitate discussions using these tools. This aspect of the program reaches beyond military personnel. The audio episodes are also broadcast to the general population in Phnom Penh, Kampong Thom, Svay Rieng, Kampong Cham and Battambang.

Overall, the uniformed personnel and military family program has the following objectives:

- supporting uniformed personnel and their families to assess their personal risks for STIs and HIV/AIDS and to adopt safer behaviors
- increasing access to STI, VCT and HIV/AIDS care, support and treatment services
- building the capacity of the National Defense and Interior ministries to plan, manage and implement effective HIV/AIDS interventions among uniformed services
- facilitating connections among stakeholders and supporting the development of an HIV/AIDS sustainability plan within the National Defense and Interior ministries.

Support uniformed personnel and their families

At formal events and through informal discussions, uniformed servicemen receive HIV/AIDS information and discuss ways to decrease their personal risk. Prevention activities promote behaviors that reduce or eliminate risk and emphasize faithfulness and correct condom use. Education, activities and messages aim also to increase the demand for appropriate sexual health services and reduce the stigma associated with their use. Alcohol and drug-use prevention education reduces the vulnerability of uniformed services personnel to HIV/AIDS. FHI and its partners encourage communication between partners on sexual topics, challenge gender norms, and promote messages against gender violence in an effort to create a more enabling environment for HIV prevention programming.

Increase access to quality care, support and treatment services

Besides strengthening connections with civilian health services, FHI and the Ministry of National Defense also work to strengthen the military health system. FHI works with the Ministry of National Defense to boost STI case management capacity and service delivery in 15 military infirmaries. The support consists of technical training with respect to managing STI syndromes; provision of medical equipment such as microscopes, reagents and specula; provision of drugs and consumables through

NCHADS, and quality assurance monitoring. Education sessions provide information on signs and symptoms of STIs and promote the importance of regular screening for both men and women, even in the absence of symptoms. In selected areas, extension STI services are also provided.

Counseling and testing is an integral part of the program. The key message, “Know your status,” suggests an entry point to effective care and treatment. As well, it serves as a valuable prevention tool, encouraging people to remain HIV negative, and it helps reduce stigma and discrimination among individuals, families and communities. While VCT is promoted everywhere, with civilian VCT sites being promoted and transportation assistance provided in remote areas, FHI and the Ministry of National Defense work in particular to strengthen VCT services in Military Region V. To this end, FHI supports infrastructure renovation, equipment, capacity building and quality assurance while NCHADS provides test kits and reagents.

The program also strives to decrease stigma and discrimination and to increase equitable access to Care, Support & Treatment processes by strengthening the capacity of the military health system in Military Region V to prepare for the provision of HIV/AIDS care, support and treatment. Health providers receive training on topics such as basic health assessments and clinical staging, OI prophylaxis including diagnosis and treatment, TB screening and treatment, ART, data management and social support for PLHA. Linkages between the military and civilian health system ensure access to programs such as PMTCT, which are not available within the military health system.

Build capacity of the National Defense and Interior ministries

The aim of capacity building measures is to strengthen the National Defense and Interior ministries’ HIV/AIDS structure to lead and manage all aspects of the program. Training, ongoing mentoring, and technical assistance are critical to the effectiveness and quality of the program. Building capacity within the military structure has promoted ownership of the program by those involved. Monitoring and technical assistance provided by FHI assure that quality is maintained in a large program. Capacity building focuses on topics such as strategic planning, project cycle management, monitoring, leadership, and technical topics on HIV prevention, care, support and treatment. To strengthen systems, FHI focuses on improving program, financial, administrative, human resources and resource development processes.

Connect stakeholders and support sustainability plans within the ministries

FHI emphasizes the active collaboration of appropriate government, civil society, and private sector institutions as the best means for implementing activities and making interventions sustainable. FHI works closely with the Ministry of National Defense and Ministry of Interior to incorporate HIV/AIDS activities in their national strategic plans and national training curricula. This ensures integration of the HIV/AIDS peer education program within the existing structure and encourages commitment from high ranking personnel for combating the epidemic.

Men who have sex with men

Like MSM in other countries, men who have sex with men in Cambodia have little in common apart from their sexual behavior. Some are young; others older. Some have a university education; others left school at an early age. Some MSM are bisexual and have families and children. Some are openly MSM while others prefer to keep their sexual preference secret. In Cambodia, some MSM are considered “long hair,” which indicates that they are transgendered persons who prefer to be known as female. Others are “short hair.”

Despite their differences, MSM may all face the same risk when it comes to STIs and HIV. A survey undertaken in 2000 of Cambodian MSM points to common levels of vulnerability.

- MSM are often a hidden population and therefore have not been on the receiving end of targeted health information.
- There are few health facilities that provide specialized services to MSM.
- Awareness on the part of MSM and health professionals with respect to the signs and symptoms of STIs (particularly those that affect the mouth, anus and rectum) is inadequate.
- One-third of MSM surveyed believed that they are at lower risk of HIV than heterosexuals.
- Unprotected anal sex and oral sex are common.
- Condom and lubricant use is inconsistent with both casual and regular partners.
- Alcohol, and to a lesser extent drug use, is associated with unsafe sexual practices.

Family Health International has a mandate to work with people thought to be most at risk of HIV infection. The 2005 STI Surveillance Survey made it clear that MSM were in this category—with an alarming 8.7 percent of MSM in Phnom Penh testing positive for HIV.

Accurate estimates of the number of MSM in Phnom Penh are difficult to come by because MSM and bisexual men are not easily identified. However, there is general agreement that by 2007 there were an estimated 4,000 men in the city who could benefit from a sexual health intervention aimed at MSM. FHI-supported projects reach more than 2,000 of them.

Program planners face some key questions: “How do we design an intervention that will achieve the objectives? What training, what activities, what services do we need to ensure success?” In the case of MSM programming, four crucial activities became immediately clear:

- raising awareness of risks
- making condoms and lubricants easily available
- making MSM-friendly STI and VCT services available
- offering care and support for HIV-positive MSM.

As a result, the program objectives include

- reducing the risk of HIV and STI transmission among MSM
- increasing the number of MSM reporting using condoms and water-based lubricants correctly and consistently
- increasing access to and use of “MSM-friendly” STI HIV/AIDS prevention, care and treatment services
- building the capacity of the implementing agency’s staff and stakeholders to plan, implement, manage and monitor the program
- creating a more enabling environment for MSM around HIV/AIDS prevention and care.

In order to accomplish these objectives in a meaningful way, MSM had to be reached and drawn into the program. A peer education approach was chosen. Today, well-trained outreach workers and peer educators from the implementing agencies can be found during the day or evening talking with men in parks, in cafes and discos, near the river, at karaokes, at gyms, and on the streets. They distribute small discrete cards with information about safer sex and about the location of MSM-friendly clinics. They invite men to visit the four drop-in centers in Phnom Penh in order to meet friends, get health exams from the mobile STI clinics, learn about safer sex and VCT, relax and make friends. This approach is bringing increasing numbers of men who self-identify as MSM to the drop-in centers.

Reducing the HIV Vulnerabilities of High-risk Families

The Cambodia 2003 HIV Sentinel Surveillance (HSS) survey confirmed the fears of health care and social service providers. While HIV incidence among those populations traditionally thought to be most-at-risk was falling, incidence among married women and their children was rising quickly. Husband-to-wife transmission constituted nearly half of all new HIV infections and mother-to-child transmission was expected to account for 45 percent of new infections. Partners of high-risk men, such as military personnel, were considered especially vulnerable. And their vulnerability was further compounded by poverty, isolation, insufficient or inaccessible health services available at military sites, gender inequalities, and lack of knowledge on sexual and reproductive health issues.

Combined with the HSS, a behavioral survey was also conducted and showed that military men's consistent use of condoms in commercial sex had increased to 89 percent. Now, however, the HSS and BSS seemed to indicate that as a result of previous risky sexual behaviors—or perhaps some current unsafe behaviors—the virus was entering military family life. The Ministry of National Defense contacted FHI and stressed the urgent need to reach the families with a program that would be complementary to the successful male-oriented peer education program. The Commanders argued that military families are at a higher risk than other families in rural Cambodia and the impact of HIV and other health issues is even greater among this population.

FHI undertook formative research in Brigade 21 and Memot Battalion 212 in Kampong Cham to determine the need for such a program. Results were clear and vulnerabilities were identified.

- **insufficient knowledge levels** (Women's knowledge of reproductive health, STIs and HIV/AIDS issues is fragmentary and intermingled with myths and misconceptions. Men and women in military communities report feelings of stigma against PLHA).
- **unsafe sexual and reproductive health practices** (Married couples do not typically use condoms. Married women are reluctant and/or unable to discuss issues of reproductive health and sexuality with their husbands. Parents don't discuss sexuality and risk reduction with their children).
- **inconsistent health seeking behaviors** (Some women do not seek appropriate antenatal care because of the associated costs, the distance to health centers or simply because they believe such care is not necessary. Married women do not have access to information about STIs and HIV and rarely seek STI or VCT services. Women who may be HIV-positive do not seek advice or support to protect a newborn from HIV transmission and do not use preventative infant feeding procedures).

Armed with this knowledge, FHI and stakeholders worked to design a program in Military Region 2 (Kampong Cham) and pilot tested the new approach. The objectives of the resulting program include

- increasing the accurate knowledge of STIs, HIV/AIDS and other selected health topics among military families
- strengthening the capacity of military families to discuss issues of sexuality and reproductive health, including HIV/AIDS risk reduction, in order to increase the safety of sexual encounters
- ensuring the accessibility and promoting the use of condoms among military couples, especially for dual protection purposes
- increasing the number of military couples that avail themselves of appropriate health services for birth spacing, antenatal care, the treatment of STIs and other reproductive or sexual health problems
- increasing the capacity of peer facilitators to provide sexual health education to their peers.

Increase the accurate knowledge and strengthen the capacity of military families

Military couples—either separately or together—participate in monthly education sessions on sexual and reproductive health. Sessions are interactive, relevant and focus on increasing knowledge, challenging gender norms and enabling communication between spouses and family members.

Collaboration and connections with the peer education program allows for couples education sessions jointly facilitated by peer educators, some male and some female. Each educational session focuses on a particular educational theme and activity taken from the Smiling Family lifeskills curriculum. Participants are provided with calendars that identify the dates of upcoming educational sessions in an effort to ensure participation. Health center staff and other technical experts are also invited to facilitate sessions.

On a quarterly basis, program managers organize “family day” special events with edutainment activities, designed to increase or test their RH/HIV knowledge, challenge gender norms and facilitate communication about sexual issues.

Ensure the accessibility and promote the use of condoms

Collaborating with PSI and other agencies, FHI Cambodia promotes a dual protection method in each educational session. The closest outlets for condoms, distributed as part of social marketing campaigns to the targeted military barracks, are identified and other sales outlets are promoted.

Increase the number of military couples accessing health services

Reproductive and sexual health services are not generally found close to military bases. Transportation is irregular and often an expense that military families cannot afford. As a result, they may not have access to appropriate health care services. FHI has been working closely with the Ministry of National Defense to strengthen STI, VCT and HIV/AIDS care and treatment services in military hospitals, infirmaries and via mobile services. To help military families access these services, efforts are made to promote access to existing mobile and stationary military health services.

Increase the capacity of peer facilitators to provide quality sexual health education

Peer facilitators are military wives, some of whom have limited knowledge and literacy skills. However, over a period of time they have been mentored and trained to conduct activities with little supervision. At their first training session, they discussed sexual language, gender roles and active learning techniques. They learned how to organize groups of wives into monthly discussion sessions. They learned how to organize quarterly education sessions with local health center staff. They discussed how to facilitate the quarterly sessions for couples. They learned how to keep monthly records of participant attendance. They did not, however, learn a lot about STIs, HIV, or reproductive health issues at this initial stage of their training. To avoid overloading new peer facilitators with complex concepts and information, FHI prefers to address substantive topics at intensive and focused training sessions, one topic each month. By following this practice, over the course of project implementation the facilitators gained the skills and knowledge they needed to facilitate discussion sessions on a variety of health topics.

Strengthening the Response to Sexually Transmitted Infections

FHI first started working on strengthening STI-related services in 1999 with the help of private sector, government and NGO partners. The focus was on in-service training to health providers and improving technical knowledge and skills on STI issues. Initially, support was provided to four government clinics, six NGOs (MDM, Pharmaciens Sans Frontières, Servant, Friends, Cambodia Women's Clinics, CUHCA) and private sector companies including Coca-Cola, Cambrew, British American Tobacco, Tiger Beer.

From 2001–2002, in collaboration with NCHADS, FHI worked to strengthen STI case management capacities and systems at sites where the entertainment worker program was being implemented. This resulted in 22 government clinics in 15 provinces being technically supported in the form of capacity building, infrastructure strengthening, quality assurance and improvement. Gradually, with increasing numbers of military men and their partners, MSM and other high-risk individuals seeking STI services, FHI Cambodia started working with military and NGOs to strengthen STI case management capacity and service delivery. As a result of some changing circumstances including support to partners, FHI scaled down and focused its effort on six provinces (Pailin, Battambang, Banteay Meanchey, Pursat, Kampong Cham, Siem Reap), a single NGO clinic (MEC) and 15 military clinics and infirmaries. As of 2007, 10 government clinics, 15 military outlets and one NGO clinic have received support in terms of in-service and other training, ongoing mentoring and supervision, quality assurance and quality improvement.

Objectives of the program include

- increase access to and use of STI services by populations most at risk
- strengthen STI case management and service delivery
- build the capacity of health staff to deliver quality services.

Increase access to and use of STI services

Female entertainment workers, their clients and MSM are considered to be those most at risk of HIV infection. FHI, through its extensive network of peer educators and partner organizations, promotes STI-related programs and services to these vulnerable individuals, expanding the circle to include uniformed military personnel and their partners. The promotion includes educational sessions (offered by collaborating agency outreach staff and peer facilitators) and communications materials describing available services and how to access them.

As FHI strengthens government STI clinics, an effort is made to link programs and improve access to services. FHI also reinforces STI services and education at military clinics/infirmaries (both fixed and extension services), improving access in remote barracks and locations.

For specialized groups (and their partners) such as MSM, FHI works closely with such organizations as MEC, Urban Sector Group (USG), Khemara, Men's Health Cambodia (MHC) and MHSS. Together they refer clients, provide services at drop-in centers and improve knowledge about asymptomatic STIs. Such services are linked with outreach education sessions on HIV/AIDS and with VCT services.

Strengthen STI case management and service delivery

Correct STI case management and quality service delivery is crucial to getting the population most at risk to regularly access services. Clinics are equipped with all the necessary equipment and medical supplies. Lab specimens are sent regularly to the National Clinic for Dermatology and STI (NCDS)

for quality control. Efforts are made to maintain a high standard clinical set-up to ensure patient satisfaction, focusing on appropriate infection control standards and patient privacy.

Clinic staff learn about management and delivery at formal workshops, during in-service sessions and through on-site mentoring. Approximately 282 staff from government clinics, military infirmaries, NGO clinics and health centers have received training in STI case management through a combination of formal training and other approaches. During regular monitoring and supervision visits, FHI technical staff provide on-site training and capacity building to providers.

Build the capacity of health staff

To service a growing number of patients, clinic staff need to be fully competent in STI case management and able to diagnose and prescribe appropriate treatment regimens for most-at-risk populations. In addition, all staff need to be able to communicate with patients in a friendly and professional way. Ongoing training sessions and supportive supervision by FHI have improved the quality of the services provided at the sites.

Working with the Private Sector

FHI started working with the private sector in 2000 with companies such as Caltex, Cambrew, British American Tobacco, and Tiger Beer. The effort was interrupted for a period due to shifting strategic priorities but restarted in 2003. That year, FHI arranged for Médecine de l'Espoir Cambodge to work with Angkor Beer, under the Cambrew Company. Then later, in 2005, Coca-Cola contracted with FHI to provide technical assistance for development of its HIV/AIDS program. In 2006, with the termination of CARE activities in Banteay Meanchey, FHI began working with area casinos.

Ensure companies are guided by the “Prakas”

FHI has supported Coca-Cola's effort to understand the “Prakas” (law) guidance and accordingly develop an HIV/AIDS Committee to manage workplace interventions.

Build the capacity of organizations to manage their own HIV/AIDS program

By providing training for trainers and working through company focal points and task forces, FHI enables companies to construct and manage their own HIV/AIDS programs.

Make workplace responses sustainable

FHI undertakes to do this by encouraging management to take a leadership role with respect to general HIV/AIDS education within the context of their broader programs and activities. A special focus is building capacity for and commitment to the effort within companies, and addressing the issues of time and cost commitments.

Establish commitment within management and staff

FHI/IMPACT involves multiple levels of staff at all phases of programming, including needs assessment, intervention design, implementation and monitoring. Key staff including management, company health workers and trainers are involved early in the process with the aim of building consensus approval for the program and ensuring a firm commitment to the intervention. In this way, programs can be tailored to different staff needs and gain the support of company leaders.

Help key stakeholders collaborate

FHI communicates with broad networks including the Ministry of Labor and NGOs active in the sector, including the International Labor Organization.

Provide STI and VCT clinical services

FHI works to link STI and VCT services, to ensure employees can access them. Clinical services are also connected with outreach education.

Providing Care, Support and Treatment

Promote counseling and testing

In early 2003, there was a growing realization of the need to strengthen facility based care to provide early diagnosis and treatment for PLHA to reduce morbidity and mortality and improve the quality of life for adults and children living with HIV/AIDS. This led to a policy shift in the Ministry of Health and the development of the Continuum of Care approach for PLHA. The continuum includes voluntary counseling and testing, management of opportunistic infections, PLHA support group meetings, TB/HIV services, prevention of mother-to-child transmission, antiretroviral therapy and home-based care.

Prior to the initiation of the CoC approach in the country, there were fewer than 20 VCT sites restricted to the capital and provincial towns. After 2003 there was a national scale up of the CoC approach and by early 2007 the number of VCT sites had grown to 134. As a result of this expansion, the country has gained an effective point of entry to HIV/AIDS care and treatment. VCT sites are, in addition, a valuable support in helping people remain HIV-negative and preventing mother-to-child transmission.

FHI was one of the first partners to support NCHADS in its effort to make the CoC approach operational. In 2003, FHI supported three public VCT sites. In 2007, FHI provides technical assistance to 19 VCT sites in four provinces.

FHI's strategy with respect to counseling and testing is to ensure that services are closely linked through a referral system with other prevention, care and treatment components. Objectives of the program include

- increasing the quality of counseling and testing services
- increasing the access to and use of counseling and testing services, especially among most-at-risk populations
- strengthening the capacity of health providers and partners to deliver high quality counseling and testing services.

FHI promotes and strengthens VCT services within the CoC program, and also strengthens links with its extensive prevention network. Specific strategies and activities include developing infrastructure, strengthening logistics, building capacity, advocating change and mobilizing communities, taking part in technical working groups, establishing and strengthening referral systems and establishing quality assurance/quality improvement (QA/QI) systems. Commodities and reagents are provided by NCHADS.

The broadcast media of radio and TV have proven effective for disseminating information about VCT and its benefits. Dramatic presentations, in particular, are used to promote VCT and raise awareness in general. Besides these, posters and leaflets with the "Know your Status" message are used to get people talking about VCT and its benefits.

Village health support groups, peer educators, home-based care providers, and PLHA networks are useful ways to convey information about and promote the use of VCT.

Commune and village leaders play key roles in providing information and encouraging communities to use health-related services. They are encouraged to use opportunities to provide information during local special events.

Provider-initiated testing and counseling was introduced in health facilities. Premarital and couples counseling are included in services available at VCT sites. Linkages and referral systems are also established between components: for example, lines of connection exist between STI and VCT services and TB and VCT services (and vice versa).

Integrated VCT, STI and health information mobile services have proven useful in remote areas to increase uptake of services, especially in the military program supported by FHI.

Prevent mother-to-child transmission

As HIV continues to spread to the general population, particularly to married women and their children, PMTCT (prevention of mother-to-child transmission) programming is critical. While direct implementation of PMTCT programs is part of the mandate of the National Center for Maternal and Child Health, it is also included in the NCHADS operational framework for HIV/AIDS CoC.

FHI's strategy for preventing mother-to-child transmission is to ensure that services are closely linked through a referral system with other prevention, care and treatment components. FHI promotes and strengthens PMTCT services within the CoC program, and also strengthens links with its extensive community network. Objectives of the program include

- improving the quality of PMTCT services
- increasing the access to and use of PMTCT services
- strengthening the capacity of health providers to deliver high quality PMTCT services.

Specific strategies and activities include infrastructure development and strengthening, capacity building, advocacy and community mobilization, representation in technical working groups, establishment and strengthening of referral system/mechanisms, and establishing QA/QI systems.

PMTCT services are incorporated within the antenatal care program at the health center on the grounds of the referral hospital. This boosts the number of pregnant women making contact with the program and maximizes its sustainability. PMTCT is best implemented as a CoC component because the mother can receive complementary care through other programs on the continuum, increasing her longevity and bringing a range of direct benefits for child and family.

Increasingly, the approach being promoted nationally is “provider-initiated counseling and testing.” Pregnant women who attend mothers’ classes to receive health, nutrition and prevention education will be informed about PMTCT services. Willing clients will be tested and women who test positive will be referred to appropriate care, treatment and social support services. Partners of pregnant women are also encouraged to come to the centers, and increasing emphasis is being placed on discordant couple counseling and “positive” prevention.

Treat opportunistic infections and provide antiretroviral treatment

To reduce AIDS-related morbidity and mortality, FHI works closely with the Ministry of Health and NCHADS to strengthen decentralized models for care and treatment, following the CoC approach. The key is to work through the public health system to improve facility-based care and provide a broad set of support services that benefit from a wide range of partnerships. This collaborative approach gave rise to the decision to first implement the CoC in the Moung Russey referral hospital in Battambang province in 2003. Since then, FHI has supported the government's effort to expand OI and ART services into nine service outlets. FHI works to ensure that national and provincial governments, local organizations and community members are fully committed to and involved in these processes.

FHI promotes and strengthens OI and ART services within the CoC program and also strengthens links with its extensive prevention network. Services are closely connected through a referral system with other prevention, care and treatment components on the continuum. Objectives of the program include

- increasing the quality of OI and ART services in targeted areas
- increasing access to OI and ART services for people living with HIV/AIDS
- strengthening the capacity of health providers and partners to deliver high quality OI and ART services.

Specific strategies/activities include

- strengthening systems, which includes putting in place ART selection committees, case discussions and new forms of infrastructure development
- building capacity in technical areas and initiating onsite mentoring by technical teams from national and provincial organizations and FHI
- strengthening logistics management
- advocacy and community mobilization
- getting involved in developing strategic operating procedures and national guidelines
- establishing and strengthening referral systems
- establishing and strengthening QA/QI systems and data management.

Partnerships with organizations such as UNICEF and the Global Fund (for drugs and supplies) ensure that efforts in each of the sites are both complementary and comprehensive.

With FHI increasingly working in clinical care settings, capacity building for health care providers on universal precautions and waste management for injection safety is a critical feature of all FHI-supported CoC programming. Training is also provided on post-exposure prophylaxis to healthcare providers.

Since 2006, two FHI/USAID supported sites, Battambang and Moung Russey, initiated pediatric AIDS treatment. Care providers are trained on specific pediatric AIDS issues. Through the network of home-based care providers, teams were given training in adherence issues for children. Children as well as adults now attend monthly PLHA support group meetings.

The attempt to strengthen the CoC network involves facilitating connections between clinical (referral hospital and health center) and community services. FHI supports its partners' efforts to provide comprehensive services including psychosocial and spiritual support, pain diagnosis and

management, management and treatment of opportunistic infections, PMTCT, nutrition, hygiene, access to social and material assistance, drug adherence and end-of-life care.

Addressing links between TB and HIV

In advanced HIV epidemics when more cases of AIDS emerge, tuberculosis (TB) often resurges in a major way, especially in urban settings. FHI targets TB because it is a major, potentially lethal, yet curable disease. It is also one of the infectious diseases that, although fueled by the HIV epidemic, does not remain confined to HIV-positive individuals. As one of the first opportunistic infections to appear in HIV-infected people, TB may be the earliest sign suggesting HIV infection.

FHI first started working in the area of TB in collaboration with the Gorgas Memorial Institute of Tropical and Preventive Medicine at the University of Alabama. The initial pilot project looked at the prevalence of active TB and determined mycobacterial resistance profiles among hard-to-reach urban populations. It provided TB-related training to home care providers, and AIDS-related training to TB DOTS (Direct Observed Therapy Short Course) providers. On completion of the initial pilot, NCHADS and the National Tuberculosis program requested that FHI start pilot testing Isoniazid (INH) preventative therapy in Battambang province.

In resource-poor settings like Cambodia, it is important to avoid duplication of efforts. There are a number of opportunities to integrate TB and AIDS efforts and services; the key is to establish networks and platforms for communication between TB and AIDS care workers at different levels.

When members of the community seek ways to improve their TB-related health, there will be a decrease in the number of cases that remain unnoticed, untreated and, therefore, infectious. To this end, FHI educates and trains healthcare providers in the community as well as the general population about TB and how to detect it.

By educating TB patients and their families about the importance of treatment compliance, FHI aims to limit the emergence of multi-drug resistant TB.

FHI aims to make use of existing health information channels, health center workers, home care team members and community based volunteers to direct information about TB and HIV to community members.

Hospital and health center staff members, and—at the community level—front line village health support groups, receive training in TB diagnosis, screening and x-ray reading.

To ensure that its programs are highly sustainable, FHI directs messages to information gate keepers, makes maximum use of existing structures and networks and limits the use of incentives for new activity.

Continuous monitoring of the way the program is functioning, aimed at acquiring constant feedback from people at the grassroots level, ensuring flexibility and quick adaptation to external change. Both quantitative and qualitative monitoring and evaluation are integral parts of all FHI interventions.

Under the TB Expanded Response and Access project, FHI has collaborated with the Gorgas TB initiative to research and report on the results of TB treatment-seeking behavior, the prevalence of TB among HIV-infected persons and the roles of pharmacists and traditional healers. Sputum screening among VCT clients was carried out in PAO VCT of Battambang. In addition, FHI and Gorgas have also collaborated with the USCDC, CENAT and NCHADS on other special studies, such as improving the diagnosis of TB in HIV-infected persons.

Home-based Care and Impact Mitigation

FHI recognizes that vulnerable families are best served when there are strong connections between facility-based and community-based services. Through multi-sector partnerships, FHI ensures that a holistic package of services is provided to families infected and affected by HIV/AIDS. This family-centered approach, which combines home-based care and impact mitigation, recognizes that HIV/AIDS affects entire families, not only individuals.

FHI's program for orphans and other vulnerable children has always emphasized working with the community over institutional care. The program has focused on viable, effective ways of harnessing available family and community resources to respond to the situation and needs of OVC.

Interventions were designed to be community-based and between various sectors. By integrating OVC activities within its home-based care program, FHI trained and supported individual families to care for household members affected or infected by HIV/AIDS. Such an approach strengthens the capacity of families to not only care for orphans and other vulnerable children, but to support all household members infected by HIV/AIDS.

Program objectives include

- improving the capacity of families and communities to care for, protect and support OVC and PLHA
- reducing stigma and discrimination to create a more enabling environment for OVC, PLHA and affected family or community members
- strengthening the quality of home-based care
- building the capacity of implementing agency staff and partners to plan, implement and monitor the program.

Improve the capacity of families

FHI and its partners ensure, wherever possible, that orphans and other vulnerable children are reintegrated into the broader community rather than housed in shelters. The planning for reintegration often starts before the death of parents, so they can be involved in discussions of the future. After the death, an effort is made to place OVC within the extended family and, if that is impractical, with another family in the community. FHI's partners support the foster families with food and school materials, according to their needs and conditions. Community assistants and social workers provide regular follow up support for children in foster care to assess their situation, especially during the initial stages.

FHI worked closely with other organizations to help ensure OVC had access to essential services such as secure shelter, proper nutrition, clothing, formal and informal education, health care, birth registration, psychosocial and other socio-economic support.

Youth clubs were run by implementing partners, where children 13–18 participated in age-appropriate life skills training. These clubs used a peer-to-peer approach to provide education on topics relating to life skills, HIV/AIDS prevention, increasing self-reliance and future planning. In addition to funding, FHI offered technical assistance in the development of plans, curricula and activities. Some older children were provided with vocational training and then placed as apprentices in fields such as hairdressing and mechanics.

Affected families were offered vocational training, enabling them to partake in activities that could generate income. However, a lack of markets and an inadequate water supply kept the resulting

efforts from being as effective as expected. In addition, families were offered training in agriculture and home gardening to address nutritional needs.

Parents' clubs were created to give caregivers a forum for sharing stories and seeking support from other affected families. At their informal monthly meetings, community assistants had an opportunity to facilitate discussions on nutrition, hygiene, sanitation and other basic health topics.

Reduce stigma and discrimination

One aspect of the program involved designing appropriate Behavior Change Communication (BCC) messages and Information Education Communication materials that would help reduce stigma and discrimination, promote child rights and reduce violence. These materials were also used in advocacy and community mobilization.

To raise public awareness and promote acceptance among local authorities and the communities, HIV prevention and impact mitigation activities were held during special events such as World AIDS Day, Children's Day and the Water Festival. In addition, influential leaders (religious leaders, commune leaders and village authorities) have been mobilized to support HIV/AIDS education efforts and to speak out against stigma and discrimination in their communities.

Another effort involved supporting community playgroups for children 3–12, where they come to socialize, learn and share their experiences with others in a safe environment. In addition to developing a playgroup curriculum, FHI provided volunteer community assistants with training in child development, playgroup planning and fun activities that use materials readily available. These playgroups, facilitated by local people, have encouraged children and parents reached through the program to mix with others in the community, in an effort to reduce stigma and discrimination and foster acceptance.

Strengthen home-based care

FHI Cambodia works with local implementing agencies to provide care and support to people living with HIV/AIDS in their communities. Home-based care teams, including health center staff, PLHA, volunteers and sometimes NGO staff, visit the PLHA homes and families on a regular basis to provide symptomatic management, psychosocial support and referrals to health services. PLHA and family members are educated on self care and provided with home care kits, food and material support. In some cases, PLHA are also provided with transportation money for trips to the hospital. In addition, the home care teams play a critical role in following up with patients receiving ART to ensure drug adherence.

FHI strengthened the capacity of local NGOs by training implementing agency staff and community assistant volunteers in providing home-based care, OI management, and psychosocial support. The trained staff in turn trained their volunteers to carry on with the activities.

FHI and its implementing partners commissioned local health centers and other service providers to provide material support in the form of basic health care, food and shelter. Community assistants based in each village provided home-based care and conducted follow-up visits to each involved in the program (referring them to appropriate service providers), providing psychosocial support as well as palliative care for those affected by HIV/AIDS and reporting problems that arose to implementing agencies.

Build the capacity of partners

Over the course of the program, FHI has provided technical assistance to over 10 local NGOs and certain provincial and district government bodies on different technical aspects of HIV/AIDS, as well as program and financial management. Over the years, partners have been offered technical assistance on issues such as home-based care, counseling, approaches to child development, HIV/AIDS, palliative care, care for HIV-positive children, monitoring, financial management and strategic planning. Over 246 community assistants and local NGO staff members have been given training in these subject areas.

Seek Greater Involvement of Stakeholders

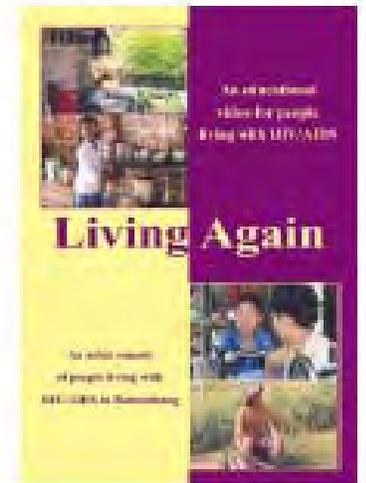
FHI and its partners work closely to ensure the involvement and participation of target groups and communities in different aspects of their programming. PLHA, sex workers, military, police, and OVC are some of those target groups, and they have been involved in activities ranging from general implementation to developing specific program materials.

Involve People Living with HIV/AIDS



People living with HIV/AIDS involved as members of home care teams provide greater psychosocial and emotional support to other PLHA and people in self help groups. At the facility level, PLHA are involved as drug counselors and facilitators for monthly PLHA meetings.

Support groups for PLHA provided a valuable forum for the exchange of information and discussion but there was still a need to strengthen the knowledge and facilitation skills of PLHA support group leaders and to get appropriate interactive educational materials into their hands. In response, PLHA volunteered to work over a six-month period at writing a script and developing an interactive educational video titled *Living Again*. The resulting video presents nine topics related to living with HIV, followed by discussion questions. All the people featured in the video are rural people living with HIV; PLHA found it to be realistic and motivational. A facilitator's guidebook was also developed and support group leaders trained in facilitating interactive sessions using the video spots.



Support group leaders who received facilitation skills training thereafter used the *Living Again* video to stimulate discussion among PLHA. The video has also been useful for advocacy, as it portrays positive lives and valuable community contributions of PLHA. The response has been very positive and the video and supporting materials were taken up for national distribution and use by the Cambodian People Living with HIV/AIDS network.

Involve entertainment workers to ensure relevant programming

FHI and its partners involve entertainment workers in many ways. Once recruited to be peer leaders and educators, they are responsible for providing education to their peers, taking or referring them to appropriate health services and providing feedback to ensure the relevance of ongoing programs. The involvement of sex workers was instrumental in creating the Women's Health Network, which was formed to support sex workers who shift locations in their search for information and support from outreach workers or their peers in the new place. The Network also allows peer educators and peer leaders who are from other areas to remain involved in peer education efforts.



Entertainment worker peer leaders took the lead in developing “Tools for Life”—a set of participatory STI and HIV/AIDS educational tools—that were used during all outreach and peer education sessions. Comprising games, cards, jigsaw puzzles, quizzes and flashcards, the tools could be used for 15 minutes to an hour to spark interest and discussion in peer education sessions. There are 14 tools altogether, covering priority topics such as condom negotiation skills, STIs, VCT, HIV/AIDS knowledge, reproductive health issues, nutrition, hygiene, savings and life planning, drug use, stigma and discrimination, rights of PLHA, and *srey sros* (transgender) issues.

Child participation and involvement

FHI and its partners working with orphans and other vulnerable children ensure the participation and involvement of their group in improving and developing programs. Clubs that are managed, facilitated and implemented by youth provide evidence of this participation. Furthermore, life skills curricula for children used in playgroups and youth clubs have all been developed by asking children for their input and creative ideas. Children have participated in developing a child-to-child “You are Special” interactive psychosocial support booklet for children affected by HIV/AIDS. During the development of the book they quickly became confident and skilled peer facilitators. They freely shared personal experiences of living in households affected by HIV/AIDS with their peers, and taught each other new skills to manage common problems.



Involve men who have sex with men in programming



FHI and its partners working with MSM ensure that they are involved as peer educators, staff, counselors and drug educators in all aspects of programming thereby ensuring relevance, commitment and ongoing involvement. Organizations such as MHC, MHSS, USG, Khemara, MEC and Chhouk Sar work with MSM by providing education or health services. They ensure sensitivity to MSM needs and involve MSM to a great extent in programs.

All strategic behavioral communication materials produced for MSM are based on ideas generated, suggestions, feedback and actual involvement of MSM. MSM have also been actively involved in recruiting their peers for estimates and surveillance surveys such as the SSS.

Strategic Behavioral Communication

In the early years of the program, priorities focused on raising awareness of HIV, preventing transmission and reducing the spread of the virus. Messages through leaflets, T-shirts and TV reflected early fears and misunderstandings about HIV/AIDS, with pictures showing skeletal HIV-positive people, or portraying HIV as a black hairy monster.

In 2001, as the FHI program expanded, FHI Cambodia established a Behavior Change Communication (BCC) Unit with technical assistance from the Program for Appropriate Technology in Health (PATH). Behavior change strategies were designed to promote and sustain individual and collective behavior change through strategically-planned activities tailored to the needs of specific

groups. A BCC approach was used to develop communications messages and materials. BCC aimed to help members of most-at-risk populations and build their skills in adopting and maintaining healthy behaviors.

The BCC process was conducted in close collaboration with implementing partners and stakeholders and involved formative research, development of key messages and materials, pretesting and refinement of the materials. It also involved training peer educators, health staff and NGO partners in how to use the material effectively.

Over time, as voluntary counseling and testing centers and care and treatment services became more widely accessible, new communications interventions were needed to address the long-term care needs of PLHA such as self care, nutrition and adherence to care and treatment.

To reflect these new communication needs, FHI changed the term Behavior Change Communication (BCC) to Strategic Behavioral Communication (SBC) in 2005. The new term emphasizes behavioral goals that cannot necessarily be classified as “behavior change.” SBC’s broader scope includes influencing and sustaining many different types of behaviors, and removes the implication that these influences are imposed from outside or are “top down.”

FHI emphasizes the participation and involvement of key stakeholders throughout the materials development process, from design to evaluation. Communication skills capacity building and follow-up support have remained important components of the process. All the materials developed by FHI are evidence of the skills, experience and resilience of the many people who were involved in the development of the materials, including uniformed services personnel, sex workers, MSM, PLHA, health care staff, and orphans and other vulnerable children. FHI involves program staff and partners in all aspects of strategic behavioral communication to ensure it is built into each program and each individual understands the importance of SBC beyond just the production of materials. Their valuable contributions have ensured that the materials are meaningful and relevant to the Cambodian context. Many of the materials have been widely used throughout Cambodia and some recent ones have been adapted by other countries in Asia and Africa.

Strategic behavioral communication is a cross-cutting theme in all programs—prevention, care and impact mitigation—as reflected in all previous sections of this report.

IMPLEMENTATION AND MANAGEMENT

In 1998, when FHI first opened an office in Cambodia, the program focused on prevention among high-risk groups such as entertainment workers and their clients. Over ten years of implementation, the program portfolio has expanded to include prevention among MSM, casino workers and illicit drug users, STI service strengthening for most-at-risk groups, family based prevention among military personnel and their families, care and treatment for people living with HIV/AIDS and impact mitigation among orphans and other vulnerable children. Implementation of these programs is carried out either directly by FHI or indirectly through different funding mechanisms with local NGOs and collaborating agencies. The range of funding mechanisms used over the past ten years of implementation includes types noted on the chart below.

Range of Funding Mechanisms, 1998–2007

Type of funding mechanism	Description	Number signed and managed	Areas
Sub-agreements	Funding instruments for providing technical, programmatic, financial and/or institutional support for the public good. These are usually legal contractual documents with local NGOs.	38	Programs targeting <ul style="list-style-type: none"> ▪ HIV/AIDS prevention and care among most-at-risk groups ▪ Impact mitigation and the provision of care and support to OVC and PLHA ▪ STI/HIV prevention among the police; strengthening of grassroots networks
Rapid response funds	Grants of up to US\$5000	11	Formative assessments
Contracts (company or organization)	Funding instruments for purchase of goods, services or products	6	<ul style="list-style-type: none"> ▪ Mentoring and training for physicians working in government hospitals ▪ Developing videos showcasing FHI programs ▪ Developing materials and tools for strategic behavioral communication
Task orders	Funding mechanism used with “pre-approved” FHI partners (PATH, ITM, UNC, PSI, MSH)	1	Strategic behavioral communication technical assistance

FHI Cambodia staff has grown from three employees in 1998 to 42 in 2006 (see chart below). Each unit is managed by a senior officer or program coordinator under the general oversight of the Associate Director(s), Deputy Director and Country Director (see Annex 2, FHI Cambodia Office). The dramatic increase in staff reflects the FHI program’s expanding coverage in response to a changing epidemic.

Program and Professional Staff in FHI Cambodia

Area	1998	1999	2000	2001	2002	2003	2004	2005	2006
Program Support (SBC, monitoring and evaluation, surveillance, research, finance, human resources, admin, management)	3	3	4	8	10	13	13	15	16
Prevention		4	5	5	6	10	11	16	16
Care, support and treatment			1	2	3	4	6	9	10
Total	3	7	10	15	19	27	30	40	42

During the first phase of implementation (1998–2002), efforts focused on prevention as the best means of curbing the spread of the virus. As the care and treatment needs of the Cambodian people grew, FHI’s second phase of programming (2002–present) incorporated care, treatment and impact mitigation. With diverse government, NGO and community partnerships forming over the years, it was possible to implement a broad range of interventions. From 1998 onwards, FHI Cambodia also has enjoyed the full support of the country’s national HIV/AIDS authorities and the local USAID mission.

PROGRAM RESULTS

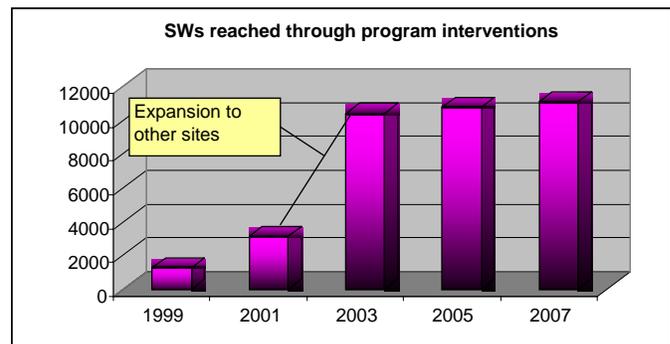
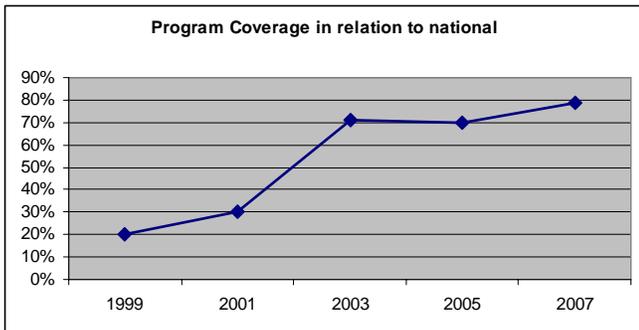
Over the years and in collaboration with government, multilateral, NGO and community partners, FHI Cambodia’s programs have had a measurable impact.

Increasing Reach and Nationwide Coverage

When FHI first started working in 1998 with entertainment workers and their clients, the program focused on just three provinces. Over the years, FHI has expanded its prevention programs with most-

at-risk populations throughout the country. FHI’s entertainment worker interventions reach 11,000 entertainment workers in 15 of Cambodia’s 24 provinces—up to 80 percent of the total projected number of sex workers in the country. The uniformed services program reaches 140,000 military and police personnel across the country, with 100 percent of the military and 87 percent of the police reached in collaboration with USAID, the Ministry of National Defense, the Ministry of Interior, Cambodian Red Cross and the Global Fund to Fight AIDS, Tuberculosis and Malaria. A 2003 FHI-supported size estimation study conducted among MSM in Phnom Penh showed that there are approximately 1,500 visible MSM. FHI Cambodia and its local NGO implementing partners reach 67 percent of them.

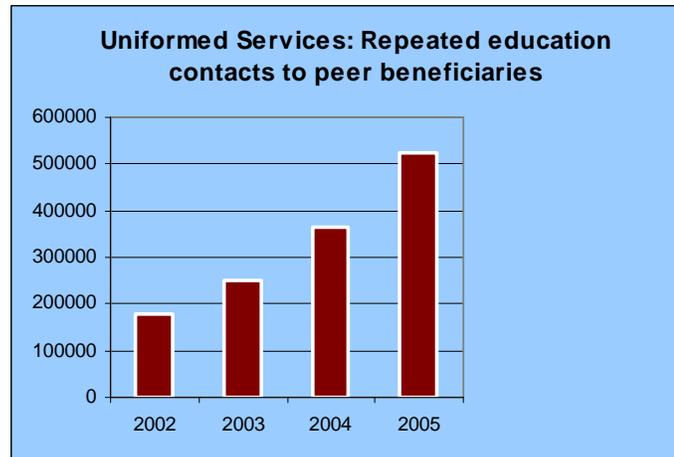
Coverage for FHI-supported entertainment worker interventions



Supporting Behavior Change

There is a positive and close relationship between education and behavior change.

FHI Cambodia’s programs can boast that extensive coverage and intensive education efforts have played a significant role in reducing the epidemic. A 2005 evaluation of the military peer education program, conducted by the Ministry of National Defense and FHI, revealed that military personnel received on average 11 information sessions in the past four years and 94 percent had attended at least one peer education session.

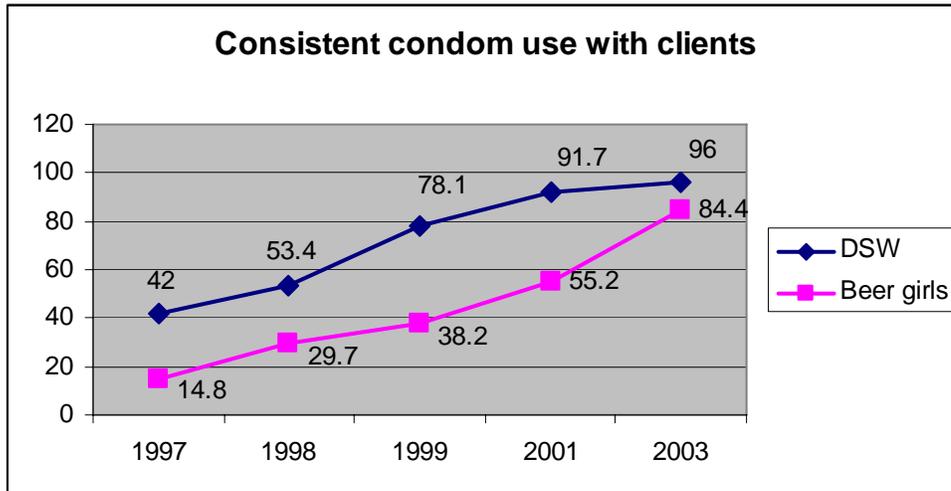
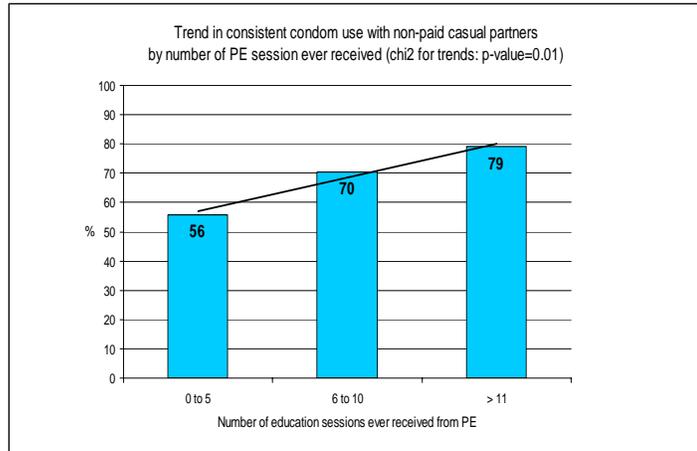


Repeated contact is an important precursor to behavior change. Over the years, FHI through its partners has had repeated education contacts with all target beneficiaries. The uniformed services peer education program has recorded over 500,000 repeated contacts between peer educators and their colleagues. In a logistic regression model, military personnel who had more peer education sessions (0-5, 6-10, >11) had better knowledge of HIV transmission mechanisms, a higher level of consistent condom use (with either sex workers or casual partners) and were more likely to have sought HIV testing.

Encouraging Consistent Condom Use

Since 1997 there have been significant increases in consistent condom use among entertainment workers and their clients. Condom use increased from just 14.8 percent and 42 percent in 1997 to 84.4 percent and 96 percent in 2003 among indirect and direct entertainment workers, respectively. The dramatic and consistent increases in condom use have been echoed by male clients: all the male sentinel groups (military, police and taxi drivers) increased their consistent condom use with sex workers. From a low of 43.3 percent and 65 percent in 1997, consistent condom use results in 2003 show that 86.9 percent of the military and 94.2 percent of police are using condoms consistently in high-risk commercial sexual encounters.

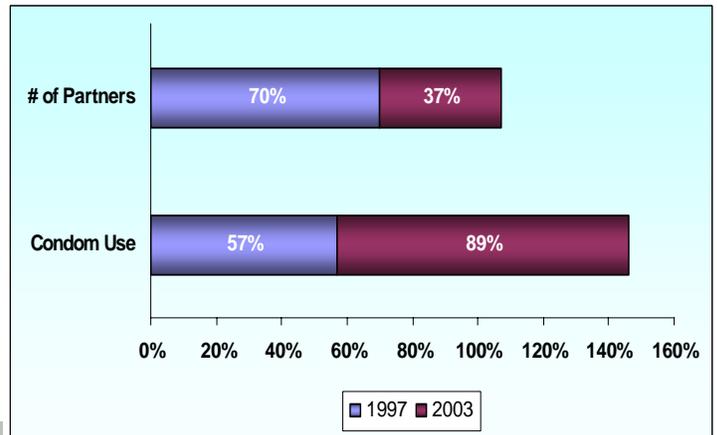
Uniformed services personnel who have participated in peer education sessions are more likely to use condoms with their casual partners.



Reducing Sexual Partners

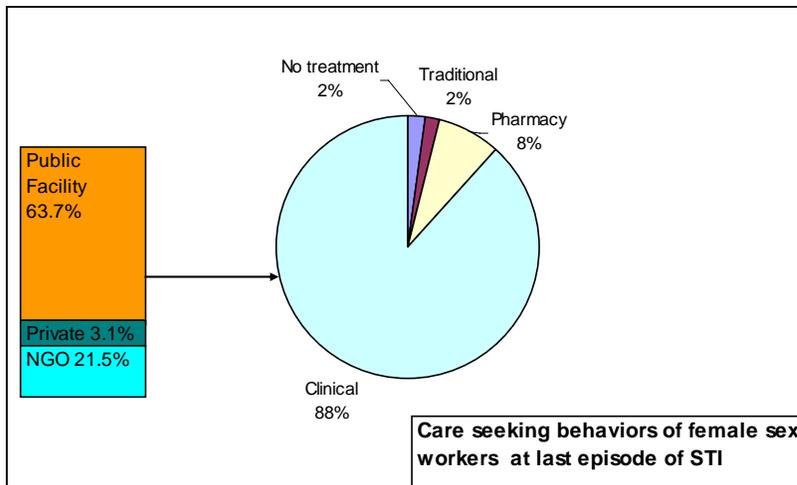
While FHI emphasizes the importance of increasing consistent condom use among those identified as most at risk of contracting or spreading HIV, epidemiological evidence shows there has been an unintended benefit to the strong “C” (condom) programming. The number of commercial sexual partners has been going down: studies show the number of high-risk men visiting sex workers has declined from 70 percent in 1997 to 37 percent in 2003.

Strong “C” programming can lead to changes in other behaviors



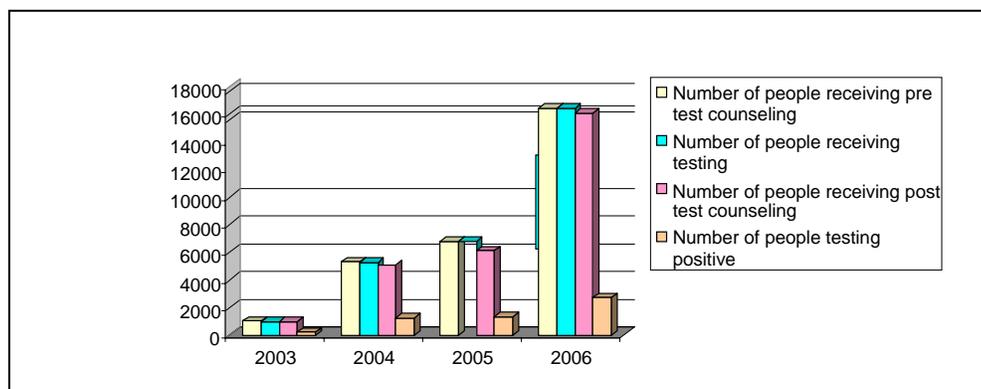
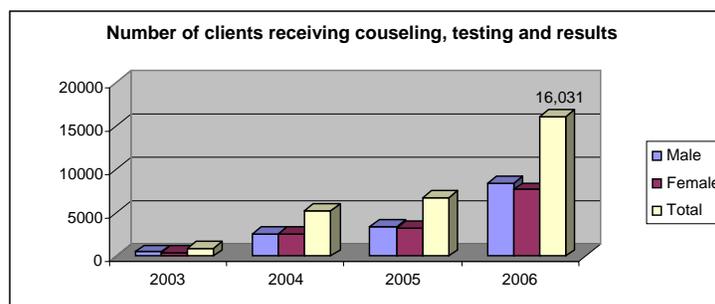
Increasing Uptake of STI Services

Over the course of IMPACT, the number of vulnerable individuals availing themselves of STI care and treatment services has increased. As part of the 100 percent Condom Use Program, entertainment workers are supported in their efforts to access clinical STI services at (primarily) government and NGO clinics, with a small proportion going to private clinics, pharmacies and traditional healers. Feedback from entertainment workers shows that they are comfortable with the health providers in the STI clinics and that the attitude of providers has significantly changed.



Increasing Uptake of Counseling and Testing Services

Since FHI began supporting VCT services, the focus has expanded from one site in 2003 to 19 sites in 2007. As well, over the last five years the number of people directly accessing counseling and testing services at FHI-supported sites has leapt from 973 in 2003 to approximately 16,000 persons in 2006, with thousands more being referred to counseling and testing through FHI’s prevention efforts. On average, 95 percent of those receiving testing also obtain post-test counseling.



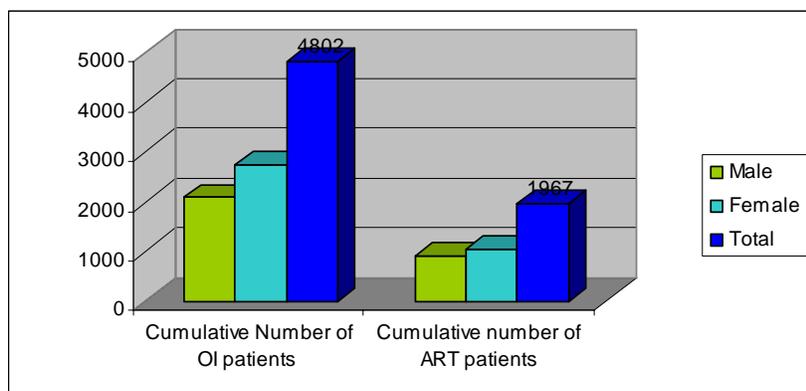
Improving Access to and Quality of Care and Treatment

Creating and Strengthening the Continuum of Care

Prior to the implementation of the CoC approach, no clear connections existed between VCT and other comprehensive care services at the level of hospital referrals. Clients who tested positive missed an opportunity to receive prophylaxis and early treatment for TB and other OIs and pregnant women missed the opportunity to receive PMTCT services.

Links have been forged and strengthened not only between components in a referral hospital, but also between health centers, home-based care and prevention interventions.

Supporting PLHA on Antiretroviral Therapy



In 2003, FHI Cambodia entered into the domain of care and treatment in collaboration with NCHADS and other partners. In May 2004, ART was provided at the first FHI-supported care and treatment site: Moug Roussey referral hospital, Battambang province. A great deal of technical assistance in the form of capacity building trainings, on-site mentoring, monitoring and supervision was provided to

healthcare providers to equip them with the confidence and skills to provide ART to PLHA.

Presently, FHI works in collaboration with its national and provincial government partners to support

nine sites for care and treatment services, with five of them providing ART. Approximately 1,970 PLHA currently receive ART from FHI-supported sites. This means over 10 percent of the national total of 12,000 individuals who received ART at the end of 2005 have been seeking their therapy at FHI-supported sites.

Clinical Mentoring

Over the course of IMPACT, FHI’s technical staff has provided ongoing mentoring and coaching to healthcare providers at FHI-supported CoC sites. Onsite assistance—in the form of clinical training, coaching, and accompanying clinicians on rounds and case management discussions—helps health care staff to manage and deliver HIV/AIDS care and treatment services better.

A Better Quality of Life for ART Patients

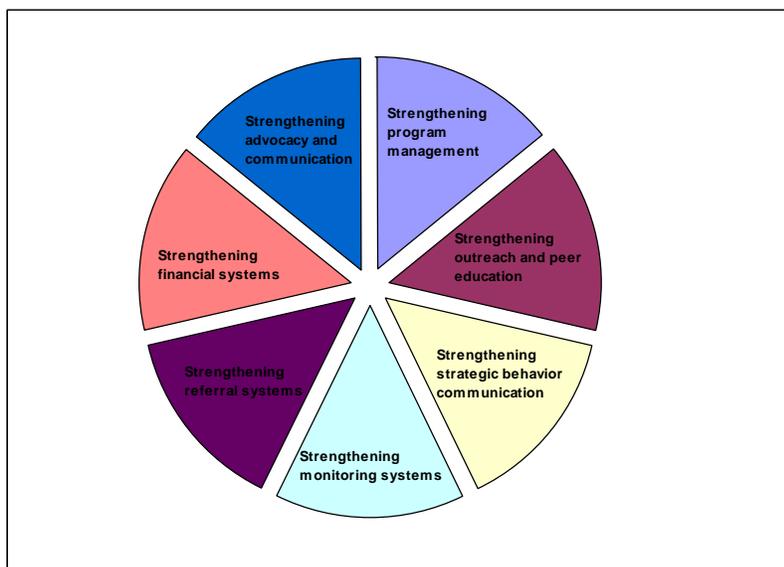
FHI initiated in 2005 a survey called “Enhanced Monitoring of the Quality of Life for Patients on ART” at two FHI-supported ART sites. A standard questionnaire is administered to study participants at repeated and regular intervals to capture improvements and changes in their quality of life. In addition to looking at socioeconomic and health status over time, the questions also monitor sexual behaviors among those surveyed.

Six month results show that ART patients feel an improved state of well-being over a period of time. They also feel less discriminated against by their families and more comfortable disclosing their status.

Identifying Costs of Facility-based Care and Treatment

FHI Cambodia undertook a study in 2005 to assess costs of facility-based services such as OI, ART, TB/HIV, PMTCT and VCT in a continuum of care. In the study, all inputs used to provide the services of the CoC program were identified and their costs estimated using data from government and NGOs who contribute to the implementation of services. The methodology used actual program expenditure data to measure financial costs. The study calculated unit costs for each of the components, annual costs and total costs. It also estimated costs for scaling up care and for treatment programs at other sites.

Strengthening Partner Capacities



Over ten years of programming, FHI has helped strengthen the organizational and institutional capacities of governmental, non-governmental and community partners working in STI and HIV/AIDS prevention, care, support, treatment and impact mitigation. FHI works with and through organizations to implement STI and HIV/AIDS interventions, and provides technical, financial and programmatic assistance to partners to equip them with the skills and capacity for sustainable interventions.

The ministries of National Defense and Interior, two FHI partners, have emerged as leaders in HIV/AIDS planning and programming within the multisectoral National AIDS Authority. Key implementing NGOs—such as Khemara, Homeland, Cambodian Women for Peace and Development and others—have developed vital and well-functioning HIV/AIDS programs.

Supporting Country Plans, Systems and Structures

FHI Cambodia participates in and provides resources for the development of national frameworks, strategies, guidelines, strategic operating procedures, training curricula, and communications materials. Staff members also sit on national and provincial technical working groups and coordination committees, assist in the development of national strategic plans (including the National AIDS Authority, NCHADS and the Ministry of National Defense) and work to improve the quality of STI and HIV/AIDS care and treatment services across the country.

Leadership in New Approaches

The Continuum of Care program, supported by FHI in nine districts across the country, has become a learning opportunity for Cambodia and the Asia-Pacific Region as a whole. FHI Cambodia's SBC messages and materials have been adapted by FHI country offices and partner agencies throughout Asia and beyond.

LESSONS LEARNED AND RECOMMENDATIONS

In the process of describing FHI Cambodia's overall contributions to the national response, a number of recurring themes consistently surface in discussions with staff, partners and other stakeholders. These themes will guide FHI and other stakeholders into the next decade of HIV/AIDS programming in Cambodia.

Strategic information highlights the best approach, identifies priority actions, and supports the national response

FHI Cambodia's comprehensive program strategy is based on epidemiological evidence that shows higher HIV prevalence rates among specific population groups. Most-at-risk populations—such as sex workers, clients of sex workers and men who have sex with men—are the targeted key beneficiaries. FHI focuses its prevention efforts on most-at-risk populations as the most effective and cost-efficient way to stem the epidemic. While injected drug use remains low, FHI Cambodia is expanding drug use education and behavior change interventions to respond to increasing cases of illicit drug use (primarily methamphetamine use) among most-at-risk populations.

As in the past, FHI Cambodia will continue to emphasize evidence-based programming—especially its support for national surveillance research, systems and plans. The organization will continue to support NCHADS to gather epidemiological information so the national program will respond appropriately and well to the changing epidemic.

Technical assistance, innovation and leadership strengthen the quality and effectiveness of the response

FHI Cambodia has both developed innovative interventions and applied international best practices over the years—particularly in the areas of HIV prevention and care. One of the organization's unique strengths is its ability to offer technical assistance on issues ranging from treatment, epidemiological surveillance and STI case management to counseling and testing. To ensure high quality programming, FHI draws on the support and resources of FHI's Asia Pacific Regional Office and its global headquarters. The organization is also increasingly relying on the technical and programmatic expertise of a growing number of Cambodian professionals.

Partnerships create synergies, better meet beneficiaries' needs and maximize available resources

FHI's strength comes from its large network of implementing agency partners that are able to respond to local community needs and build community-based responses. FHI Cambodia also works with a variety of multilateral organizations, government departments, NGOs and donor agencies to ensure greater impact and eliminate gaps. Partnerships will continue to be central to FHI's work in the coming years, not only to maximize resources and synergies, but to assure that its activities are complementary and not duplicating other programs.

HIV initiatives are effective when they are situated within government structures and follow government strategic plans and priorities

As the FHI program enters its second decade, the contribution it makes to HIV/AIDS prevention, care and impact mitigation is tied to the national HIV/AIDS support of the Royal Government of Cambodia. As in the past, all of FHI's work in Cambodia is in direct support of national priorities. FHI strategic frameworks and plans are developed in close consultation with national and provincial

AIDS bodies. FHI also supports the strengthening of structures and systems and other capacity building measures to realize national targets, objectives and strategies.

Working at a variety of levels—from national to local—allows for a more comprehensive response

As part of FHI's emphasis on strengthening country capacity for responding to HIV/AIDS, the organization is actively involved in and provides resources for the development of national frameworks, strategies, guidelines, strategic operating procedures, training curricula and communications materials for all aspects of HIV prevention, care, support and treatment. FHI sits on relevant national technical working groups and task forces that shape Cambodia's priorities and actions, and provides capacity building and quality assurance/improvement at the national, provincial and community levels.

The active involvement of beneficiaries and marginalized groups ensures the effectiveness and sustainability of interventions

Embracing the principle of greater involvement of people living with HIV/AIDS in not only assessment and research but also the development of communications tools, project implementation and monitoring has always produced better quality and more sustainable programs. FHI will continue to respond to the challenges of politics, economics, gender inequality, cultural constraints and finite systems to promote involvement of those who are most vulnerable and provide the highest quality HIV/AIDS services.

Fifteen years after mounting a concerted effort to tackle HIV/AIDS in Cambodia, the news is encouraging. Cambodia has earned the distinction—alongside its neighbor Thailand and the African country of Uganda—of being an HIV/AIDS “success story.”

FHI and its partners are honored to have played a part, however large or small, in Cambodia's response. Over the coming years, our multi-pronged approach to HIV/AIDS will continue to encompass broad-based prevention programs to reduce the risks and vulnerability of high-risk populations such as sex workers, their clients and their families. We will work to reduce AIDS-related morbidity and mortality in highly affected areas by expanding our care, support and treatment initiatives and establishing a more comprehensive prevention-to-care and treatment continuum. We will strive to mitigate the impact of the epidemic on families and communities, particularly focusing on orphans and other vulnerable children, discordant couples and most-at-risk households. FHI will continue surveillance, research and data use for policy and planning. And we will carry on working in partnership with a variety of stakeholders to ensure that our programs remain relevant, comprehensive and sustainable over the short- and long-term.

FHI recognizes that our efforts are only as strong as our partnerships. We will devote much of our resources over the coming years to strengthening the capacities of our implementing agency partners to carry out and increase the quality of our initiatives. By working together, we are confident that we can continue to turn the tide on HIV/AIDS in Cambodia.

HIGHLIGHTS OF IMPLEMENTING PARTNERS' ACTIVITIES

Implementing partner matrix (FHI Cambodia's partner organizations and companies, 1998–2006)

Org name	Nature of relationship	Org type	Geographic location	Target pop	Budget (in US\$)	Intervention	Project dates
Vulnerable Men Health Program - HIV/AIDS Prevention: Royal Armed Forces – 19 provinces & municipalities; Police – 22 provinces & municipalities							
Ministry of National Defense	Collaborating agency	Government	National	Military		HIV/AIDS prevention and care for military personnel	1999–present
Ministry of Interior	Collaborating agency	Government	Kampong Cham, Battambang, Banteay Meanchey, Kampong Speu, Rattanakiri, Koh Kong, Kampot, Kratie, Kandal, Phnom Penh, Mondolkiri, Sihanoukville, Siem Reap, Pailin, Kampong Chhnang, Kampong Thom, Preah Vihear, Kep, Stung Treng, Takeo, Pursat, Oddar Meanchey	Police		HIV/AIDS prevention and care for police personnel	1999–present
Cambodian Red Cross	Implementing Agency	NGO	Battambang, Kampong Cham and Banteay Meanchey	Police	556,074	HIV/AIDS prevention and care for police personnel	01-04-2001 to present
Equal Access	Contract	NGO		Military			01-11-2006 to present
MSM - Men Who Have Sex with Men							
Men's Health Cambodia	Implementing Agency	NGO	Phnom Penh and Kandal	MSM	100,443	MSM HIV/AIDS prevention and care	01-01-2003 to present
MHSS	Implementing Agency	NGO	Phnom Penh	MSM		MSM HIV/AIDS prevention and care	
Cambodia Women's Clinics	Implementing Agency	NGO	Phnom Penh	MSM	101,315	MSM HIV/AIDS prevention and care	18-01-2001 to 30-06-2002

Org name	Nature of relationship	Org type	Geographic location	Target pop	Budget (in US\$)	Intervention	Project dates
Women at Risk - STI and HIV/AIDS Prevention and Care							
Urban Sector Group	Implementing Agency	NGO	Phnom Penh	Sex workers	273,844	HIV/AIDS prevention and care for women at risk	01-07-1999 to present
Khemara	Implementing Agency	NGO	Russey Keo / Phnom Penh	Sex workers	102,469	HIV/AIDS prevention and care for women at risk	01-11-2001 to present
Cambodian Women for Peace and Development	Implementing Agency	NGO	Phnom Penh, Battambang, Kampong Speu, Kandal, Siem Reap, Pailin, Kampong Chhnang, Kampong Thom	Sex workers	730,794	HIV/AIDS prevention and care for women at risk	01-08-1999 to present
Khmer Women's Cooperation for Development	Implementing Agency	NGO	Phnom Penh, Kampot and Takoe	Sex workers	232,708	HIV/AIDS prevention and care for women at risk	01-03-2001 to present
Women and Youth Action	Implementing Agency	NGO	Kratie	Sex workers	22,199	HIV/AIDS prevention and care for women at risk	01-09-2005 to present
Phnom Srey Association for Development	Implementing Agency	NGO	Kampong Cham	Sex workers	155,811	HIV/AIDS prevention and care for women at risk	01-08-1999 to present
Cambodia Family Development Services	Implementing Agency	NGO	Banteay Meanchey and Pursat	Sex workers	232,753	HIV/AIDS prevention and care for women at risk	18-02-2002 to present
Médecine de l'Espoir Cambodge	Implementing Agency	NGO	Phnom Penh	Sex workers	278,351	HIV/AIDS prevention and care for women at risk	01-01-2003 to present
Partners for Development	Implementing Agency	NGO	Stung Treng	Sex workers	9,939	HIV/AIDS prevention and care for women at risk	01-10-2005 to present
Rural Association for Development of the Economy	Implementing Agency	NGO	Pursat	Sex workers	41,726	HIV/AIDS prevention and care for women at risk	14-02-2002 to 30-09-2005

Org name	Nature of relationship	Org type	Geographic location	Target pop	Budget (in US\$)	Intervention	Project dates
Reproductive Health Association of Cambodia	Implementing Agency	NGO	Phnom Penh	Sex workers	60,046	HIV/AIDS prevention and care for women at risk	01-04-2003 to 30-09-2004
Oxfam Hong Kong	Implementing Agency	NGO	Phnom Penh	Sex workers	90,494	HIV/AIDS prevention and care for women at risk	01-03-2000 to 31-01-2003
Smiling Family Program - Family-Based HIV/AIDS Prevention and Vulnerability Reduction							
Ministry of National Defense	Collaborating Agency	Government	Kampong Cham (5 districts)	Military wives		HIV/AIDS prevention and reproductive health education for military wives and families	1999 to present
STI Services Strengthening							
Médecine de l'Espoir Cambodge	Implementing Agency	NGO	Phnom Penh	Sex workers, MSM and general population	278,351	Strengthening STI case management capacity and service delivery	01-01-2003 to present
Pharmaciens Sans Frontières (PSF)	Implementing Agency	NGO	Phnom Penh	Sex workers	200,799	Strengthening STI case management capacity and service delivery	01-03-2001 to 31-05-2003
Municipal Health Department	Collaborating Agency	Government	Phnom Penh (Toul Svay Prey)	Sex workers		Strengthening STI case management capacity and service delivery	2000 to present
Provincial AIDS Office	Collaborating Agency	Government	Phnom Penh, Kampong Cham, Kompong Speu, Kompong Thom, Kampot, Pailin, Battambang, Kandal, Kampong Chhnang, Pursat, Kratie and Steung Treng	Sex workers and general population		Supporting STI services	2000 to present
Military infirmaries and hospitals	Collaborating Agency	Government	Military Region II (Kampong Cham, Prey Veng, Sray Rieng, Kratie) and Military Region V (Battambang, Pursat, Banteay Meanchey, Pailin)	Military personnel and families		Strengthening STI case management capacity and service delivery	2004 to present

Org name	Nature of relationship	Org type	Geographic location	Target pop	Budget (in US\$)	Intervention	Project dates
Living with Hope - OVC and Home-based care Program in Battambang and Phnom Penh							
Homeland	Implementing Agency	NGO	Battambang	OVC	246,907	Providing care and support to OVC and strengthening home-based care	15-02-2001 to present
Kien Kes	Implementing Agency	NGO	Battambang	OVC	155,087	Providing care and support to OVC and strengthening home-based care	15-02-2001 to present
Islamic Local Development Organization	Implementing Agency	NGO	Battambang	OVC	14,421	Providing care and support to OVC and strengthening home-based care	15-12-2005 to present
Khmer Rural Development Association	Implementing Agency	NGO	Battambang	OVC	31,511	Providing care and support to OVC and strengthening home-based care	01-02-2005 to present
HelpAge International	Implementing Agency	NGO	Battambang	OVC	73,358	Providing care and support to OVC and strengthening home-based care	01-12-2003 to present
Khemara	Implementing Agency	NGO	Phnom Penh	OVC	57,922	Providing care and support to OVC and strengthening home-based care	01-04-2004 to present
Nyemo	Implementing Agency	NGO	Phnom Penh	OVC	282,545	Providing care and support to OVC	01-06-2000 to present
CORE	Implementing Agency	NGO	Banteay Meanchey	OVC and PLHA		Providing care and support to OVC and strengthening home-based care	15-02-2007 to present

Org name	Nature of relationship	Org type	Geographic location	Target pop	Budget (in US\$)	Intervention	Project dates
KYA	Implementing Agency	NGO	Banteay Meanchey	OVC and families		Providing care and support to OVC and families	01-01-2007
Friends/Mith Samlan	Implementing Agency	NGO	Phnom Penh	OVC	114,560	Providing care and support to OVC	01-08-1999 to 29-09-2002
Partners in Compassion	Implementing Agency	NGO	Takeo (Wat Oport)	OVC	5,478	Providing care and support to OVC	01-02-2002 to 29-09-2002
CARE	Implementing Agency	NGO	Koh Kong	OVC	35,626	Providing care and support to OVC	15-02-2001 to 31-01-2002
Workplace Programs							
Cambodia Family Development Services	Implementing Agency	NGO	Banteay Meanchey	Casino worker		Providing care and support to casino workers	19-02-2007 to present
CPN+	Implementing Agency	NGO	Phnom Penh	PLHA		Strengthening the capacity of CPN+	15-02-2007
Continuum of Care - 11 operational districts: Battambang (5 districts) Pailin (1 district) Kandal (2 districts) and Kampong Cham (3 districts)							
Catholic Relief Services	Implementing Agency	NGO	Battambang	PLHA and their families	380,082	Care, support and treatment for PLHA and their families	07-11-2002 to 30-09-2005
Chhouk Sar	Implementing Agency	NGO	Phnom Penh	Sex workers and PLHA	47,802	Care, support and treatment for PLHA	01-12-2004 to present
Provincial Health Department	Collaborating Agency	Government	Pailin, Kampong Cham, Battambang and Kandal	PLHA and their families		Care, support and treatment for PLHA and their families	2002 to present

Org name	Nature of relationship	Org type	Geographic location	Target pop	Budget (in US\$)	Intervention	Project dates
Surveillance and Evaluation							
National Center for HIV/AIDS, Dermatology and STDs	Collaborating Agency	Government	Phnom Penh			Providing technical assistant on surveillance	1998 to present
Center for Disease Control	Collaborating Agency	NGO	Phnom Penh			Implementing surveillance survey	
Strategic Behavioral Communication (nationwide)							
Action IEC	Implementing Agency	NGO	Phnom Penh		218,241	Providing assistance on development and designing of communication materials	15-04-2000 to 30-11-2002
Program for Appropriate Technology in Health (PATH)	Collaborating Agency	NGO	Phnom Penh		1,463,917	Providing technical assistance on strategic behavioral communication	15-11-2002 to present
Asia Works Television LTD	Collaborating Agency	Company	Thailand		22,418.80	Providing technical support to develop video highlighting CoC	07-06-2004 to 31-12-2004
Fit Media	Collaborating Agency	Company	Phnom Penh	PLHA	14,860	Providing technical support to develop video highlighting CoC	06-06-2005 to 02-08-2005
Asia Regional Program							
Social Services of Cambodia	Implementing Agency	NGO	Phnom Penh		17,321	Assessment and counseling training	15-10-2002 to 15-01-2003

Org name	Nature of relationship	Org type	Geographic location	Target pop	Budget (in US\$)	Intervention	Project dates
Others							
VBNK	Collaborating Agency	NGO	Phnom Penh	Staff	4,000	Providing training to FHI staff	17-01-2000 to 30-03-2000
GORGAS	Collaborating Agency	University	Battambang	PLHA		Operational research on TB	1999 to present
International Center for Equal Healthcare Access	Collaborating Agency	NGO	National	Physicians	93,750	Mentoring and on- site capacity building for doctors	12-01-2005 to present
Research Institute for Health Science	Collaborating Agency	University	Chiang Mai, Thailand	Physicians	4,335	Training for OI/ART physicians	10-09-2005 to 18-09-2005
Cyclo	Implementing Agency	NGO	Phnom Penh	Cyclo drivers	5,000	HIV/AIDS prevention and care for cyclo drivers	2003
Servants	Implementing Agency	NGO	Phnom Penh	Urban poor	18,305	Supporting TB treatment for urban poor	15-03-2001 to 30-06-2002

Subproject Highlights

Women At Risk

Urban Sector Group

Urban Sector Group (USG) is not new to the task of assisting the urban poor to meet their own needs. Established in 1993, USG has focused its activities on 27 squatter communities of Phnom Penh. Its mission is to facilitate the organization, development, and strengthening of urban poor groups that will work together to improve the quality of daily life through the principles of mutual aid and self-reliance.

Seeing the impact of HIV/AIDS in urban poor areas due to the preponderance of sex worker establishments, in 1999 USG expanded its program to include an HIV/AIDS component. Working in the Tonle Bassac squatter area of Phnom Penh, the organization began educating about 100 brothel-based and informal sex workers in HIV/AIDS prevention techniques. Currently USG's dedicated staff operates in 14 communes of Phnom Penh, reaching 93 percent of sex workers in the target areas. Each quarter, USG's four outreach workers, 13 peer leaders, and 70 peer educators reach over 1,200 of Phnom Penh's sex workers.

In 1999 USG was relatively new to HIV/AIDS work, so collaboration with FHI has proven beneficial for the organization. Tapping into FHI's vast network of experienced HIV/AIDS practitioners and implementing agencies, USG has built its capacity while also expanding its reach. USG's integrated approach has earned its organizers a reputation for excellence in community building.

Khemara

UNAIDS estimates that up to 20 percent of sex workers in Cambodia are Vietnamese. Many of these women are trafficked from the Mekong Delta region and arrive debt-bonded, young and ignorant of the language. In Svay Pak commune in Russei Keo District, on the outskirts of Phnom Penh, Khmer and Vietnamese sex workers can be found in a cluster of entertainment venues in Phum Lou village.

In 1995, Khemara initiated a project that eventually evolved into the Lotus Club, a drop-in health education center where sex workers in Phum Lou could speak, at any time of day, to a counselor. Khemara staff learned from this experience that knowledge of HIV transmission is insufficient—the women also need the confidence it takes to negotiate safer sex with their clients. In 2001, FHI/IMPACT Cambodia began to support Khemara's HIV prevention and care project among sex workers, allowing the organization to expand to Ponhea Leu, another town on the outskirts of Phnom Penh. Through targeted interventions, Khemara has now reached almost 400 Vietnamese and Khmer sex workers in the two target areas.

In cooperation with a host of governmental and nongovernmental organizations such as the provincial AIDS Office and Population Services International, Khemara's sex worker program has reached almost 90 percent of the most-at-risk men and women in its target areas. Building trust between sex workers, community members, health care providers and establishment owners, Khemara continues to strengthen the ability of sex workers to receive and follow HIV/AIDS prevention strategies.

Cambodian Women for Peace and Development

The July-August 1998 census of commercial sex establishments in Kandal province revealed 305 brothel-based and 58 freelance female sex workers. In that same year, serosurveillance figures showed the HIV infection rates among direct and indirect sex workers in Kandal to be 21.4 percent and 9 percent, respectively. Compared to respective national averages of 42.6 percent and 19.1 percent, infection rates in Kandal were definitely low. The potential impact of HIV prevention interventions, which would help keep infections at bay, was much greater there than in areas of higher prevalence.

Founded in 1991, Cambodian Women for Peace and Development (CWPD) is a local NGO committed to the social and economic well-being of Cambodian women. In 1999 they began a one-year HIV/AIDS education program among sex workers in Kandal and Phnom Penh, which has since expanded to six other strategically important provinces. CWPD reaches more than 5,000 sex workers per month with regular outreach and peer education.

Collaboration with a variety of groups—from brothel owners and sex workers to government organizations and private enterprise—has yielded positive results. CWPD has reached more than 90 percent of at-risk women in its target areas with VCT referrals, HIV/AIDS education and condom negotiation and vocational skills training. With a total of 36 outreach workers and 36 peer leaders in various provinces, CWPD continues constructively to engage sex workers and stakeholders and to support STI and HIV/AIDS prevention, care, and support activities.

Khmer Women's Cooperation for Development

Since 2001, FHI/IMPACT Cambodia has supported the Khmer Women's Cooperation for Development (KWCD) in providing targeted HIV/AIDS prevention and care to sex workers in Cambodia. The organization was established in 1998 as an NGO for the social development of women and children. Recognizing the immense threat that HIV/AIDS poses to the lives of Cambodian women, it soon began working to educate most-at-risk women in their target areas.

Originally they worked in three districts of Phnom Penh, but have expanded their activities to targeted areas of Kampot and Takeo provinces. Kampot is a coastal province in southern Cambodia, and as a popular tourist destination it has a burgeoning sex industry. The inhabitants of Takeo are also at increased risk for STIs, as the province's border with Vietnam makes the area attractive for migrant populations.

The KWCD strategies and activities have been improved and modified from previous years to suit the changing situation and needs of this vulnerable population. In five years of work KWCD has increased its capacity to reach over 1,300 sex workers each quarter. Currently, the organization is recruiting more sex worker peer educators to deal with the high turnover, and they are incorporating boyfriends of sex workers in their education activities. KWCD is continuing, with FHI support, to build on the skills of its outreach staff and peer educators to enhance program effectiveness.

Women and Youth Action

Kratie province is a central north province in Cambodia with a population of over 284,000. With the completion of a new highway, Kratie is a place of transit for those going to and from Stung Treng (to Laos), Mondolkiri, Ratanakiri, and Kampong Cham. The province has also seen tourist activity due to its location on the Mekong River. The lively travel and commercial activity has brought an increased demand for the sex industry.

When Women and Youth Action (WYA) began its activities in 2004, there were no other organizations in Kratie providing sexual health education or other support to sex workers. Recognizing the great need for such interventions, FHI Cambodia provided WYA with Rapid Response Funds in 2004 to begin peer education and STI activities in Kratie's two operational districts.

Working in Kratie town and two outskirt villages, WYA reaches all 156 direct and indirect sex workers in its target areas through outreach and peer education. The organization has trained 25 peer educators to conduct regular outreach activities on topics such as condom use, life planning, STI and HIV transmission and good hygiene.

Eighty-three kilometers from Kratie town, the district of Snoul will become a border checkpoint this year. Anticipating an increase in commercial and tourist traffic, in 2006 WYA expanded (with continued FHI support) its education and support services to Snoul. It is this proactive approach that has earned Women and Youth Action the cooperation of establishment owners and the trust of sex workers.

Phnom Srey Association for Development

Kampong Cham is the most densely populated province in Cambodia with a population of more than 1.7 million people. Being a huge transportation hub with vast rubber plantations, the province attracts a large number of people from all parts of Cambodia. The majority of these visitors are men and there is an increasing demand for the sex industry. Due to the national government's 100 percent Condom Use promotion, about 90 percent of direct sex workers use condoms with their clients. However, only about half of them consistently use condoms with their boyfriends or sweethearts.

In 1999, Phnom Srey Association for Development (PSAD) conducted a mapping of sex workers in Kampong Cham, which revealed that 484 direct and indirect sex workers were operating in the province. As the HIV infection rates in Kampong Cham town were substantially lower than the national average, FHI Cambodia recognized that HIV prevention interventions in Kampong Cham had the potential for widespread impact.

Since 1999 FHI Cambodia has been supporting PSAD to provide comprehensive HIV awareness education to sex workers in four operational districts of Kampong Cham province. Seven outreach workers and 79 peer educators in cooperation with a local human rights NGO and numerous government authorities currently work with almost 700 vulnerable women—95 percent of the target group—to support healthy and reduced-risk living.

Cambodia Family Development Services

Poi Pet community in Banteay Meanchey Province is located at the cross-border point to Aranyaprathet in Thailand. The area has been a major center of trade and business, attracting truckers, traders and tourists from all over the region. According to the 2003 HIV Sentinel Surveillance (HSS) conducted by the Cambodian government, 31-54 percent of brothel-based sex workers in Banteay Meanchey are HIV-positive.

Responding to the dire situation in Banteay Meanchey, Cambodia Family Development Services has been collaborating with FHI since 2002 to reduce the vulnerability of sex workers to HIV/AIDS and STIs. Working in four target areas—Poi Pet, Sisiphon, O'Beichoun, and Banteay Neang—a team of nine outreach workers and 30 peer leaders have reached 100 percent of direct sex workers and 86 percent of indirect sex workers through a variety of interventions.

CFDS's dedicated staff has succeeded in reaching almost all the sex workers in their target areas while building up their capacity to reach other areas. In 2006 CFDS expanded its operations to Pursat province, which is a major transit point for people going to Battambang, Pailin and Banteay Meanchey. Using non-threatening and cooperative interventions to reach many stakeholders, CFDS continues to improve the quality of life of at-risk women in Cambodia.

Uniformed Services

FHI/IMPACT, the Ministries of National Defense and Interior and the Cambodian Red Cross have joined forces to reduce the spread of STIs and HIV among uniformed service personnel and their partners in selected provinces of Cambodia. Informed by the Ministry of National Defense's experience of conducting peer education interventions among the military in the 1990s, these organizations first piloted and then expanded a peer education and behavior change program among military personnel and the police.

Cambodian Red Cross

Police are mobile within their provinces and in close contact with the people in the communities where they live and work. Unaddressed, these factors combine to increase the risk of HIV infection for police and subsequent potential transmission to wives and, ultimately, from mothers to children.

Since 1995 the Cambodian Red Cross (CRC) has cooperated with the Australian Red Cross to develop a local response to the AIDS epidemic, beginning with a youth peer education project that ran until 1999. Building on that success, CRC decided to focus its next project on high-risk target populations.

Beginning in April 2000, CRC has been implementing a peer education project among uniformed service personnel in Banteay Meanchey, Battambang, and Kampong Cham provinces. Over 8,000 police personnel have participated in two-day lifeskills workshops, which cover topics such as life goals, decision making, peer pressure, and safer sex. In five years of programming CRC has undertaken numerous other activities, such as

- training 784 police personnel as peer supporters
- facilitating the formation of 12 groups among police wives for the purpose of receiving HIV/AIDS education
- helping peer supporters organize and lead 40 one-day sessions on topics such as STIs/HIV/AIDS, condoms, fidelity, and referrals to care and support services
- collaborating with PSI to provide information on the availability of condom outlets in target areas.

In the three provinces currently targeted by CRC, police have become disseminators of prevention messages and role models for adoption of safer behaviors among their peers. The involvement of high ranking officials who have been influential in spreading HIV prevention messages in their constituencies is an important element of the program. To date, over 13,000 police personnel have been reached this way.

Men Who Have Sex with Men

Strong societal disapproval and legal and social taboos compound risky sexual behaviors for men having sex with men (MSM). Official indifference or hostility means that there are few HIV/AIDS prevention and care programs that specifically focus on MSM. Even where services do exist, social

stigma limits accessibility and use. From 2000 onward, FHI and its partners have recognized MSM as a most-at-risk population and have implemented STI and HIV/AIDS prevention and care interventions tailored to their needs.

Men's Health Cambodia

Men's Health Cambodia (MHC), one of FHI's partner agencies, works with MSM in Phnom Penh and Kandal provinces. Since 2003, FHI has funded Men's Health Cambodia to provide MSM with counseling on sexual health and identity issues, a safe environment for exploring sexual health topics and home care for those who are living with HIV/AIDS. MHC's activities include

- conducting outreach in 12 high-risk areas, 5 evenings per week, to clarify misconceptions about HIV/AIDS and reduce HIV vulnerability
- maintaining a drop-in center and counseling hotline to answer questions and provide referrals to health services
- collaborating with Calmette and Norodom Sihanouk hospitals for OI and ART services, and with local NGOs for home-based care
- working with PSI on social marketing efforts for condoms and water-based lubricants.

Thus far, MHC has reached over 1,000 of the estimated 1,500 high-risk MSM in the nation's capital. Hundreds of men have been referred to local clinics for treatment of STIs, and MHC has worked with the FHI strategic behavioral communication unit to produce MSM-specific SBC educational support materials. In 2006, MHC expanded its reach to approximately 1,250 MSM and is currently focusing on improving the quality of its interventions with FHI guidance.

Cambodia Women's Clinics

Cambodia Women's Clinics (CWC) have been operating in Cambodia since 1998 to provide comprehensive family planning and reproductive health services to Cambodian men and women. As a result of its presence on the ground in Phnom Penh, in 2001 CWC identified the need for a facility to address the reproductive health concerns of a broad range of men in the city. While some programs were addressing the needs of Cambodian men, many of these activities were targeted at a very specific audience.

From January 2001 to June 2002, CWC successfully reached a broad swath of men through various activities. These include

- operating a drop-in center where men can obtain information about birth control, prevention and symptoms of STIs, and the workings of the male and female reproductive systems
- conducting workshops on gender issues such as domestic violence
- identifying and recruiting local "role models" to serve as peer educators for sexual health issues.

In eighteen months of programming in the Psar Thmei district of Phnom Penh, the CWC drop-in center saw about 1,000 new visitors per month. Men of varying socioeconomic backgrounds and sexual persuasions visited the center to receive STI consultation and health promotion materials. Although FHI's collaboration with CWC ended in 2002, the organization continues to make strides in counseling and educating Cambodian males in Phnom Penh.

STI Services Strengthening

In 2002 FHI funded research about health-seeking behavior among women working in the entertainment industry as indirect sex workers. Findings showed that discrimination and stigma surrounding HIV and STIs were common and these factors often discouraged sex workers and MSM

from seeking treatment for their illnesses. FHI recognized that, in addition to improving STI services, targeted outreach was needed to educate people about STI services as well as address the stigma of seeking treatment.

Médecine de l'Espoir Cambodge

Médecine de l'Espoir Cambodge (MEC) has received support from FHI since 2003 to implement an outreach program in tandem with an STI clinic it operates in central Phnom Penh. In exchange for this support, MEC has worked with FHI partner NGOs and government authorities to strengthen the professional and management capacity of STI health care providers. MEC's activities include

- working with NGOs making behavior change interventions to improve STI treatment seeking behavior and encourage regular check-ups
- collaborating with 100 percent Condom Use Policy authorities in Phnom Penh to ensure provision of monthly STI check-ups in a sex worker-friendly environment
- training new health care providers and conducting annual supervision with FHI's STI training unit to develop national standards for care of STIs.

In three years of FHI-funded work, MEC has seen a consistent increase in the number of sex workers seeking STI consultation. More women are hearing about the services and are comfortable enough to visit the center—over 700 new clients sought STI consultation at the Psar Thmei clinic alone in the last quarter of 2005. MEC is continuing to work with NGOs and local authorities to promote and strengthen STI treatment services, and is currently working to expand its reach to Vietnamese sex workers in Phnom Penh.

Pharmaciens Sans Frontières

Pharmaciens Sans Frontières (PSF), an international NGO based in France, has been present in Cambodia since 1991 and involved in various projects aiming at strengthening the quality and distribution of medicine and services to sex workers. Government STI facilities in Phnom Penh are stretched thin, often located far from the place of residence of sex workers, and without adequate drug supplies or services.

Since 1996 PSF has worked with the Municipal Health Department and the National Center for Dermatology and STDs to operate mobile STI care services in seven red light areas of Phnom Penh. From 2001 to 2003, FHI support to PSF allowed the organization to expand its mobile health services and boost its case management capacity. The staff's activities included

- providing daily mentoring and training to government clinic staff in history taking, physical examination and STI diagnosis and treatment
- attending regular FHI workshops to improve the team's theoretical knowledge about STIs as well as education methods
- conducting outreach at entertainment establishments to educate indirect sex workers about the importance of obtaining regular STI consultations.

Collaboration with FHI was fruitful in many ways. PSF worked with another FHI partner, MEC, to plan and coordinate the activities of MEC's fixed location clinic in Phnom Penh and the mobile clinics of PSF. In addition, PSF staff increased their case management capacity to about 500 new consultations per month, while also initiating activities in a new area. PSF continues, with funding from FHI partners, to improve the quality of STI services to at-risk women in and around Phnom Penh.

Continuum of Care

The need to provide care and support to PLHA in Cambodia emerged in the mid-1990s, when Cambodian public health services were being reestablished after decades of civil conflict. Most healthcare providers in government health facilities were not fully trained to manage the medical conditions suffered by PLHA.

In early 2003, the Ministry of Health developed its guidelines for an operational framework for CoC activities in Cambodia, focusing on strengthening facility-based care and building capacity. FHI's CoC model has similarly emphasized working through the public health system to strengthen facility based care to provide a broad set of care and support services. Through partnerships between the operational district, health facilities, NGOs and communities, FHI and its partners are building the capacity of Cambodian organizations to address the needs of PLHA.

Catholic Relief Services

Catholic Relief Services, an international relief agency active in Cambodia, began its work in conflict-torn Battambang province in 1992. Working with five health centers and one district hospital, the project initially focused on improving the delivery of basic health services through the construction of essential infrastructure.

In 1994 CRS recognized that the improvement of government health services alone was insufficient in promoting better health practices. The organization revised its strategy and began the Community-Based Primary Health Care Program, which has since expanded to a total of four high-risk border districts in the province. Through its activities in 168 villages CRS seeks to build technical and management capacity at the health center, referral hospital, operational district and community levels. Their activities include

- helping communities develop and maintain support systems for PLHA by educating over 50,000 community members about HIV/AIDS transmission and the needs of PLHA
- establishing a VCT center at the referral hospital in Samphov Loun district
- strengthening local health services by training members and staff of health centers, Village Health Committees, and District AIDS Councils in basic HIV/AIDS awareness and OI treatment.

From 2002 to 2005, FHI supported CRS's unique and holistic program of care and support in Battambang province. With alternative funding, the organization continues its work of linking community-based support to nongovernmental and governmental health services. Reaching almost 60 percent of its target population with HIV/AIDS awareness, CRS remains an important and effective vehicle for the mitigation of the AIDS epidemic.

Cambodian Women for Peace and Development (CWPD) – Chhouk Sar

In 1999 when FHI began targeted behavior change interventions among entertainment workers, Cambodian Women for Peace and Development was chosen to implement the activities in Phnom Penh City and the nearby province of Kandal. With the increasing number of HIV-positive entertainment workers in the city, HIV/AIDS care and support services were deemed necessary additional activities for responding to the maturing epidemic.

In 2003, CWPD established Chhouk Sar, a peer support group for HIV-positive sex workers. At its inception the organization ran group discussions, trainings, and peer counseling, but has since expanded its activities to include clinical services. As part of the continuum of care, Chhouk Sar undertakes many activities. These include

- providing OI prophylaxis and/or treatment for up to 200 sex workers and ARV drugs for up to 40 HIV-positive entertainment workers
- facilitating the community's acceptance of PLHA by meeting with community leaders in three districts to discuss issues of discrimination, HIV transmission, and misconceptions about HIV
- working with other FHI partners to improve the quality of Chhouk Sar's palliative and home-based care.

The year 2006 in particular was very successful for CWPDP's Chhouk Sar project. Tapping into FHI's vast network of collaborating and implementing partners, Chhouk Sar has developed collaborative relationships with a variety of organizations. Out of the 241 HIV-positive sex workers supported by Chhouk Sar, only 90 are direct Chhouk Sar members. The rest are referrals from other FHI implementing agencies such as USG, Khemara, KWCD, and MEC. With FHI support in 2006 the leaders of Chhouk Sar—themselves HIV-positive—are continuing to provide their peers with integrated care and support services.

Home-based Care and Impact Mitigation

Meahto Phum Ko'mah – Homeland

When Homeland first began its work in Battambang province in 1997, epidemiological findings showed that Cambodia was suffering from the most serious HIV/AIDS epidemic in Asia. Already underserved populations were facing increasing stress due to the death or illness of breadwinners and the costs of medical care.

Originally, Homeland focused solely on providing family reunification, psychosocial support, and educational opportunities to street children. However, the changing face of HIV/AIDS in Cambodia led them to integrate an HIV/AIDS component to their support and care. With support from FHI, in early 2001 Homeland expanded its OVC program to include HIV/AIDS interventions in five communes of Battambang. The HIV/AIDS education sessions alone have reached over 5,000 residents—almost 60 percent of the target population.

Using lessons learned over the past few years of activity, Homeland has designed its next phase of care and support. Remaining active in five target communes, Homeland is reducing the dependency of OVC families on social support and expanding skills training for foster families. Since 2001 activities have reached all known OVC and 75 percent of PLHA in the target areas. These achievements were possible through the dedication of Homeland's staff and their sensitive and comprehensive approach to HIV/AIDS care and prevention.

Kien Kes Health Education Network

Due to difficult economic circumstances, many farmers in Thmar Kol district of Battambang province migrate for business across the Thailand border. In their wake they leave a substantial number of orphans and other vulnerable children. The Venerable Monk Mony Saveth has over a decade of experience working with communities around Wat Norea in this district. He has mobilized monks as well as lay people to provide orphan care, facilitate reintegration of orphans into the community, and spread messages of compassion for people living with HIV/AIDS.

The Kien Kes Health Education Network grew out of collaboration between these activities and the military infrastructure in Thmar Kol, with input from FHI/IMPACT and the NGO Buddhists for Development in 2000.

The main goal of the organization is to ensure that children and family members affected by chronic illness, including AIDS, receive assistance and support from the community in which they live. Kien Kes's 33 volunteers and staff have reached all 1,587 OVC in four target communes and all 40 known PLHA in two target communes. Due to the dire economic circumstances of many Battambang community members, Kien Kes focuses on linking beneficiaries to local income generation activities. In addition, the group encourages landowners to donate land to vulnerable women and their families and works with Nyemo and Homeland to support self-sustaining women's support groups.

The innovative partnership between monks and the uniformed services has proved highly successful. In 2005 alone, Kien Kes reintegrated 583 orphans into foster homes or extended families and served 50 PLHA with regular home care. Currently, Kien Kes is expanding its services to reach up to 2,000 OVC in the target areas. Relying primarily on volunteers to carry out its programs, Kien Kes is setting an example for other NGOs in Cambodia and is collaborating with other FHI partners to share experiences and mobilize communities.

Islamic Local Development Organization

With support from FHI in 2004, the Islamic Local Development Organization (ILDO) conducted a needs assessment among Islamic communities in Battambang. Their research revealed that poverty, migration, and lack of knowledge about STIs were putting communities at heightened risk for HIV/AIDS.

ILDO was originally established to improve children's living standards by providing educational opportunities and a safe environment. Recognizing the immense threat HIV/AIDS poses to children's well-being, they have since integrated an HIV/AIDS component to their outreach activities. FHI/IMPACT support to ILDO's program only began in November 2005, but already it has served nine villages in four communes. In addition to core care and support activities, the organization is in partnership with a local human rights NGO, LICADHO, to promote child and human rights education.

Although ILDO is a young organization, FHI/IMPACT's material and organizational support is having noticeable effects. ILDO estimates that over 4,000 community members will be reached in 2006 through indirect and direct means including awareness-raising literature, educational events, and direct support.

Khmer Rural Development Association

In 2004 FHI conducted a needs assessment in Kaus Kralor district of Battambang province that revealed that fear, hate, and an absence of knowledge surrounding HIV/AIDS issues was contributing to a hostile environment for PLHA. At the time, there were no NGOs working on HIV/AIDS home care or support in that district, and many residents could not afford the cost of transportation to distant health centers. FHI acknowledged that an appropriate intervention would have to address the stark underdevelopment of the district while also servicing at least 100 OVC and 30 PLHA.

The Khmer Rural Development Association (KRDA) was established in 1992 in a refugee camp in Thailand by Cambodian teachers who saw the need to assist poor farmers once they returned to Cambodia. Since that time KRDA has implemented successful projects in community development, microcredit, human rights, and primary healthcare in Battambang province. Beginning in February 2005, KRDA undertook a program to improve the quality of life of PLHA and OVC in Kaus Kralor through HIV/AIDS education and CoC activities.

KRDA's timely and compassionate support has reached vulnerable populations in six communes of Kaus Kralor district. Due to these interventions, 100 percent of all known OVC and PLHA—over 200

people—have benefited from an improved standard of living and over 600 residents have attended community education sessions. KRDA’s dedicated staff of 17 community assistants and volunteers continues to provide high quality palliative care, sensitization, and support to the residents of Kaus Kralor.

HelpAge International

HIV/AIDS is changing family and community structures in Cambodia, with older people becoming the primary caregivers for their sick adult children, as well as for orphans and other vulnerable children. However, prevention and awareness activities overwhelmingly target young people and overlook these older caretakers as important sources of emotional and financial support. Often they need help meeting the most basic needs of food security and sustainable livelihood.

HelpAge International (HAI) is a global network of nonprofit national, regional, and local organizations working for improved quality of life for older people. HAI has been active in Cambodia since 1992, but only began implementing an HIV/AIDS project with FHI support in 2003. Working in 30 villages in Battambang province, HAI has facilitated the development of Old People Associations (OPAs), which seek to increase the capacity of older people to meet their own needs through collective action and support. With support and cooperation from FHI and local and national authorities, HAI’s 15 staff and 58 volunteers provide technical support to 38 OPAs.

In just over two years of work, HAI has reached almost half of the 1,047 known OVC and all 55 known PLHA in its target areas. Currently the program is recruiting additional full time staff to reduce the workload on existing staff, and strengthen and expand the program. With its innovative approach to contacting and supporting overlooked OVC and their elderly caregivers, HAI continues to provide appropriate and successful responses to HIV/AIDS in Cambodia.

Khemara

As the first local NGO in Cambodia, Khemara has ample experience providing care and assistance to its target communities. Based in the sprawling semi-urban district of Russei Keo outside of Phnom Penh, Khemara’s staff implements an OVC and home-based care program that works in four communes and has reached about 80 percent of known OVC and 100 percent of known PLHA.

FHI began supporting Khemara in 2004 after a needs assessment revealed that the many orphans and other vulnerable children living in Russei Keo had little to no access to adequate food or proper health care. Frequently, the children had to work as rubbish collectors or were sold to bring income to the family. In addition, widowed and divorced women and their children were exposed to HIV infection through exploitation, abuse, and lack of education. Working with female heads of households and community and religious leaders, Khemara initiated a host of interventions in a combined impact mitigation program that has reached nearly all known OVC and PLHA in their target communes. In addition to undertaking core OVC and HBC activities, the organization encourages youth peer education and works with local temples to promote community support for PLHA.

At every step Khemara’s multilayered interventions have applied direct assistance while also fostering the development of local solutions to local problems. In 2005-2006 Khemara expanded its activities to 14 villages in five communes, reaching approximately 76 known PLHA and 950 orphans and other vulnerable children.

Nyemo Cambodia

As is often the case in developing countries, women in Cambodia are facing tremendous stress from poverty. They are vulnerable to sexual exploitation and are less educated than their male counterparts,

making a female-headed household even more vulnerable to the threats of malnourishment, disease, and prostitution. In Phnom Penh one in three households is headed by a woman.

In 1997, Nyemo Cambodia was established to combat this situation through specialized vocational training for vulnerable women and children in eight communes in Phnom Penh. In just two years 86 people graduated from the project, the majority being street children or housemaids without any salary. FHI/IMPACT's support to Nyemo began in 2000 as the organization sought to expand its focus to empowering women and children living with HIV/AIDS.

In the past five years the program has conducted a variety of activities to improve the quality of life of OVC and PLHA, including liaising with UNICEF, the National Pediatric Hospital and the French Red Cross to provide antiretrovirals to HIV-infected children. Nyemo also encourages the setting up of women's support groups and provides cooking, cleaning, sewing, and tailoring classes with supplemental language instruction.

Nyemo Cambodia attributes its success to the network of over 55 organizations it has developed in Phnom Penh. Indeed, Nyemo is able to provide high-quality services partly because it maintains strict acceptance and discharge criteria, referring women it cannot serve to other organizations. The result is that the staff and volunteers are strengthening and expanding the programs without sacrificing quality or capacity. In 2006 Nyemo Cambodia is developing a strong market plan to increase demand for the services of its trainees and is continuing to fight HIV/AIDS through innovative and sensible programs.

Mith Samlanh – FRIENDS

The homeless population of Phnom Penh is a particularly vulnerable population group because of the constant stress people endure to survive. They are mobile, often separated from their families and demonstrate high rates of alcohol/drug consumption and unsafe sexual practices. In addition, the need for money can lead many homeless men and women to provide commercial sexual services.

At the time that Mith Samlanh began to receive FHI Cambodia support in 1999, UNICEF estimated that there were over 10,000 street children in Phnom Penh. The majority of these children were based in a squatter area known as the "Building," in the Tonle Bassac area. Mith Samlanh recognized that, by targeting these children and their family members, HIV/AIDS awareness messages could reach a significant portion of the 50,000 people living in this squatter area. They identified and trained peer educators among Mith Samlanh's staff of former street children and collaborated with local NGOs to develop and distribute social marketing materials such as T-shirts and caps.

The three years of support FHI Cambodia gave to Mith Samlanh-FRIENDS has produced noticeable results. Building on success from their outreach project among street children in Tonle Bassac, Mith Samlanh-FRIENDS has expanded their HIV/AIDS program to include the provision of ART to children who need urgent treatment. In addition, they refer unaccompanied children to foster care organizations within Mith Samlanh-FRIENDS's vast network of collaborating partners. They now have the capacity to engage street children and their families through a variety of programs, from substance abuse awareness to child rights education. Each program integrates an HIV/AIDS component, thus providing a successful and holistic response to the epidemic and serving approximately 1,600 OVC per day.

Partners in Compassion

At the height of the epidemic in Cambodia, men who lost their battle with AIDS were leaving behind wives and children whose futures were grim. In the year 2000 an HIV Alliance survey found that

about one-fifth of the children in families affected by AIDS had to work to support their family, often leaving school to do so.

Two employees of the Catholic Office of Emergency Relief and Refugees saw the mounting problem AIDS was causing in Cambodia. They began Partners in Compassion, a group of Cambodians and expatriates concerned about the well-being of families affected by AIDS. With land donated by a monk in Takeo province, in 2000 they began the Wat Opot project, providing weekly outpatient and counseling services to community members. In 2002, FHI Cambodia supported Partners in Compassion to expand its project in Takeo to increase their capacity to provide a holistic response to the problem of HIV/AIDS. They trained 60 monks to disseminate information about HIV transmission and the provision of home-based care to children and adults, and worked with school teachers and local authorities to integrate HIV/AIDS awareness messages into curricula and community events.

Through FHI Cambodia's support, Partners in Compassion was able to reach thousands of community members through a variety of means. In one quarter alone, over 1,000 community members participated in HIV/AIDS awareness sessions. In addition, Wat Opot provided shelter for roughly 50 children per month and assisted foster families to care for almost 100 others. More significant, perhaps, is the networking and training the organization's staff received as a result of FHI support. Partners in Compassion continues to strengthen home-based care and support for OVC and PLHA in Takeo province with cooperation from the World Food Programme, World Vision, Maryknoll, and UNDP.

CARE Cambodia

Koh Kong is a province situated along the Cambodia/Thailand border, with 40 percent of its population under the age of 14. The promise of economic prosperity has led to a great deal of internal migration and an influx of sex workers. In 1999, Koh Kong ranked highest in the country in terms of HIV prevalence rates, with 8 percent of women attending antenatal clinics testing positive for HIV. The death and/or illness of these women and their husbands has had a significant impact on the children, including increased malnutrition, loss of identity and exposure to HIV infection. When FHI Cambodia first began its support of CARE Cambodia's Children in Distress program in 2001, there were no governmental or nongovernmental programs targeting these vulnerable children in Koh Kong.

CARE Cambodia's one-year pilot project aimed to increase the physical and mental well-being of children affected by HIV/AIDS and their families through the provision of comprehensive prevention and support services in the Mondol Seima and Smach Meanchey districts of Koh Kong. They achieved this objective by focusing on the development of lifeskills such as how to resist unwanted sex or drugs and how to overcome peer pressure.

The Children in Distress team, made up of one team leader and five youth advocates, worked in partnership with the provincial office of social affairs to reach vulnerable children. The result was that increased care was given to these children, with 15 out of 17 village leaders becoming more supportive of vulnerable children in their communities. In addition, vulnerable children were exempted from paying school fees, allowing 86 children to attend school. Almost 300 children received STI and HIV/AIDS prevention education and 240 participated in integrated playgroups.

FHI Cambodia assistance in the formative years of the project allowed CARE to build a base of support in its target areas in Koh Kong. In recent years CARE Cambodia has expanded the program in Koh Kong to include gender education, negotiation skills for condom use, and domestic violence and family planning education.

Strategic Behavioral Communication

Action IEC

In the year 2000, epidemiological findings suggested that Cambodia's epidemic could one day rival the worst affected countries of the world. The population at risk was often unaware of the problem, and behavior change to prevent further HIV transmission was only happening slowly. Few quality information/education/communication (IEC) materials were available, and the popular press and media still advertised cures for HIV and AIDS.

To combat this trend, in 2000 FHI enlisted the help of Action IEC, a nongovernmental organization working to increase knowledge about HIV through the development of targeted educational materials. In two years of work, Action collaborated with a variety of organizations to produce appropriate and accessible materials. The project entailed

- working with the ministries of Culture, Information, Education, Health, Rural Development and Women's Affairs to develop and disseminate effective messages
- producing comic albums on HIV/AIDS targeted to the unformed services, PLHA, and children affected by AIDS, respectively
- creating television commercials about HIV prevention and airing them in cooperation with local media groups such as TVK

FHI's support to Action IEC from 2000 to 2002 proved beneficial in many ways. On a direct level, the organization produced radio, television, and print materials about HIV and issues of discrimination for PLHA. However, Action IEC also shared its audience research with other FHI implementing agencies so they could improve their own targeted programming. Although official support to the organization has ended, the results of Action's research continue to be used to educate high-risk groups and community members about the epidemic.

Asia Regional Program

Social Services of Cambodia

The HIV/AIDS situation in Cambodia is shifting from being a new phenomenon in which the actors are concentrating on information and prevention, to a situation in which there are many people living with the disease who need care and support. Before Social Services of Cambodia (SSC) began its counseling training with FHI partners, there were no professionally trained counselors in the country.

In 2001, FHI cohosted a national workshop with UNICEF that identified the prevalence of mental illness as an obstacle to providing supportive counseling to families of OVC. In response, from 2002-2003 FHI supported Social Services of Cambodia to provide counselor training to FHI's OVC implementing agencies. SSC has worked in Cambodia since 1992 at the village level to develop community-based support services. Their work with FHI's implementing agencies consisted of

- training agency staff using videos, small group discussions, participatory learning, homework exercises and interactive role-plays
- addressing relevant issues in counseling such as succession planning, orphan reintegration and dealing with grief

Although this programming only lasted one year, FHI partner organizations and their beneficiaries still feel the effects. Through "echo trainings" and "training the trainer" sessions, FHI implementing agency staff continue to receive relevant information about appropriate counseling techniques. FHI and SSC see skilled counseling as a major tool in helping empower PLHA to make healthy and productive decisions that will benefit themselves and their families.

Others

Servants to Asia's Urban Poor

Servants to Asia's Urban Poor, an international health NGO, has been working in Mean Chey District, Phnom Penh, since 1993. The organization has a contract with the Ministry of Health to provide community TB services in the district under the supervision of the Municipal Health Department. In 1996, Servants met with the World Health Organization and Médecins Sans Frontières regarding the treatment of TB in Phnom Penh. The groups recognized that TB cases would dramatically increase as the HIV/AIDS epidemic developed.

In the late 1990s and early 2000, national surveillance suggested that up to 15 percent of people with TB were co-infected with HIV. To combat this trend, FHI began supporting Servants to link its TB activities with HIV/AIDS care and counseling services. Using the TB clinic as an initial point of contact, Servants provided a variety of services to community members, such as

- during home visits to TB patients, facilitating counseling and testing services for clients with symptoms suggestive of AIDS
- supporting TB/AIDS patients to purchase water, supplementary food, mosquito net, blanket, and change of clothing
- screening HIV-positive community members for TB, and referring them to health services to receive prophylaxis

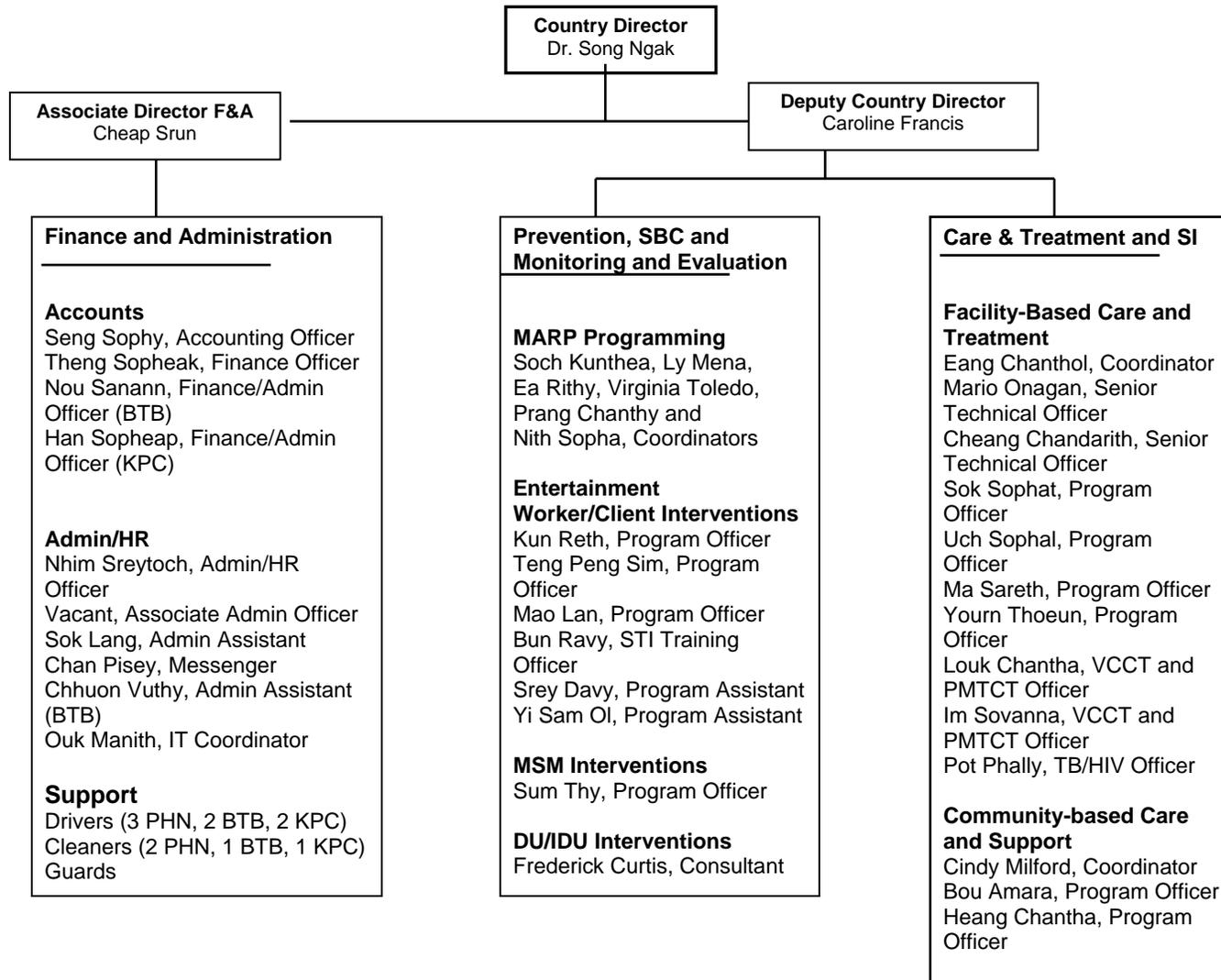
In just over one year of FHI-supported programming, Servants boasted great results. The organization regularly treated nearly 200 patients per quarter for TB and conducted follow-up care and HIV/AIDS monitoring services. Tapping into FHI's network of collaborating and implementing agencies, Servants also met with Catholic Relief Services and other organizations to learn HIV/AIDS home care techniques. Servants is continuing to mitigate the impact of AIDS in Phnom Penh by working with TB patients to address their care and prevention needs.

ANNEXES

Country Program Financial Summary

IMPACT Obligation Amount By Fiscal Year (US\$)	
1998	2,300,000
1999	500,000
2000	1,500,000
2001	2,100,000
2002	2,545,000
2003	5,150,000
2004	5,000,000
Total	\$19,095,000

FHI Cambodia Office Organization and Personnel, 2006



Case Studies

Story of Hope: Lun Keo—How one organization can make a difference

I am 39 years old and have four children. My husband abandoned me and my daughter for a new woman when my daughter was only three years old. I married again. Through the second marriage, I have three more children. My second husband got infected with HIV/AIDS. My last son and I are HIV-positive too. My husband could not believe that he had AIDS and abandoned us. I sold all our belongings just to pay for the treatment and medicines from a private clinic but my health did not improve. Since there was nothing more to sell, I decided to stop sending my children to school and instead ask them to work as rubbish collectors. We lived in the squatter in Sangkat Tonle Bassac.

Without proper nutrition and appropriate healthcare and hygiene, I was very unwell. Fortunately the village leader and Nyemo staff met me, we discussed my situation and they suggested I go to Nyemo. Since then I attended many training courses such as weaving traditional silk and sessions on literacy, HIV awareness and gender education. My eldest daughter has started going to school and also participates in the internal activities organized by Nyemo such as playgroups and extra classes. When I attend the different educational sessions, I always bring my children who are less than six to the caring center at Nyemo. My children and I get counseling services from the team in Nyemo. Nyemo has close links with Sihanouk Hospital and now my son and I receive ARVs. I am very happy. Since my 5-month stay in Nyemo, I have been working as a volunteer peer educator doing outreach activities with Nyemo staff and village leaders. I help communicate with other women such as myself about Nyemo's program so that they are able to receive training and education, school enrolment of their children and other support from Nyemo.



Lun Keo (left) with other support group members

Nyemo Cambodia has been functioning for more than six years with funding and technical support from USAID through FHI. **Nyemo Cambodia** has been assisting vulnerable women (PLHA, widows, victims of domestic violence, divorcees, single mothers) and their children. **Nyemo Cambodia** achieves this through running a support center, which provides support services and assists in socioeconomic reintegration.

During the training I met two women who also faced very difficult situations before they joined Nyemo. We decided to rent a space to live and form our own support group to do weaving and sewing. It is located next to Boeung Tumpun market. Nyemo social workers help us set up the place, providing emotional encouragement, helped advertise the products through leaflets and provide us with materials when needed. Since we started our tailoring and weaving shop and live together as a self-help group, we are able to generate some income to support ourselves and our children. On days when I am sick, the friends in my group do my share of the work and also take care of my children. Due to the fact that I can now take care of my children, I feel I am fulfilling my roles as a woman and mother. What's more, I can also help other women.

Building the Capacity of Local Organizations—Dr. Ung Prahors, *Médecine de l’Espoir Cambodge*

Médecine de l’Espoir Cambodge is a local nongovernmental organization recognized by the Ministry of Interior since December 26, 2001. Since January 2003, USAID through FHI is supporting MEC to provide STI clinical care and treatment for most-at-risk groups, particularly sex workers and MSM. In the same year, MEC established a fixed STI clinic that was strategically located in a brothel area in central Phnom Penh. During this period, all MEC medical staff got significant training, in service training, onsite mentoring on STI case management for sex workers and MSM from FHI.

From late 2003 to early 2004, MEC started collaborating with Angkor Beer Company to provide health education and STI case management services to the 700 women in the company. It was in 2004 that MEC moved from syndromic approach to etiological case management. Over this period, the MEC medical team received several trainings funded by USAID through FHI on clinical management of STIs with most-at-risk populations and STI laboratory training. In the initial period, FHI focused on strengthening the technical aspects and less on overall program and finance management. From 2004 onwards, FHI also started focusing on strengthening other areas of MEC, such as program management, monitoring and supervision, strategic planning and financial management. This was done through a combination of formal trainings, workshops as well as on site mentoring by FHI staff.

Since October 2005, the management of MEC both in terms of clinical care and overall management has been strong and recognized by other partners. The organization is seen as capable and strong enough to include a VCT component for most-at-risk populations in the program. This was certified by the NCHADS. Counselors have received training and laboratory staff has also received training in HIV testing. As this program has been endorsed by the National government, MEC receives drugs and reagents from the government.

Overall, MEC has substantially grown, expanded and become a “good model” clinical care site for STI and VCT services for most-at-risk groups.

According to Dr. Ung Prahors, program manager of MEC

“The management of MEC is very good compared to what we had in the past without FHI support, and this also includes human resource and program management. For instance, when I started to serve MEC, my skills in STI case management were very limited, but within one year with the technical support from FHI I felt managing STI cases is not difficult. Similarly, when I first started to work in the management area I did not even know what a program or work plan was; however, FHI significantly built my capacity in the field of management and up to now I am able to almost understand all the aspects for good management. Besides, MEC must commit to work more to improve the quality of both the technical and management area in the future plans.”

Leveraging Public-Private Partnerships—Coca-Cola

By Chanthy Prang, May 2006

With a commitment to prevent HIV/AIDS infection among company staff and reduce stigma and discrimination against PLHA, Coca-Cola (an international company employing 250 staff in Cambodia) approached FHI Cambodia. Company representatives asked to join hands with FHI to implement an HIV/AIDS workplace program in the company and a community based initiative in the target area where the company is located.

Coca-Cola's initiative in this partnership is a leading example of social responsibility in the private sector.

Of its 250 workers, 200 are working in Phnom Penh and the rest deployed to the provinces. The workers are mostly married males with an average age of 40, and 20–30 women. A two-phase training approach was used. The first phase included HIV/AIDS awareness raising for all Coca-Cola staff. Topics in the training sessions included risk assessment, HIV/AIDS basic knowledge and stigma and discrimination. The next phase included a training the trainer session to brief core trainers who represent different units within Coca-Cola. These core trainers will in turn provide training to other employees.



Coca-Cola employees during a training session

Coca-Cola has also collaborated with FHI to support community-based organizations such as Khemara that work with vulnerable populations such as PLHA and OVC. Coca-Cola has provided food support to 72 PLHA households in the Russey Keo area and helped renovate and provide materials for the kindergarten. Coca-Cola is also having discussions with other FHI implementing agencies in Phnom Penh on possible job options for their target groups, including HIV-positive sex workers.

Building Capacity of Local Organizations

By Helena Horal, May 2007

FHI Cambodia's Sex Worker program was launched in 1998 as a direct response to the alarming HIV/AIDS epidemic that threatened the country. The HIV Sentinel Surveillance study revealed a record high prevalence rate of 43 percent among direct sex workers and close to 20 percent among Indirect sex workers.¹ With this in mind, a comprehensive program strategy to reach sex workers was developed and implemented.

FHI developed partnerships with local NGOs to act as implementing agencies for the program activities. One of the first was Cambodian Women for Peace and Development. CWPDP dates back to 1986 when its foundation was laid with the help of UNICEF. In the early days, CWPDP worked hard to establish communication with brothel and establishment owners in order to build working relationships with them. Research was also conducted to locate appropriate target areas and to map out whereabouts and activities of direct and indirect sex workers. A peer approach was developed and implemented in the different sites.



Although foundations were laid and work was ongoing, according to Ouk Pohn, the program coordinator of CWPDP in Phnom Penh, things were very difficult in the beginning and progress was slow with many obstacles on the way. “Our knowledge about how to successfully run an NGO was limited before—we had not been given proper coaching nor received technical or material assistance and there were huge knowledge gaps among our staff that had to be filled in order for us to do our jobs efficiently.”

The problems were not only restricted to management and staff at CWPDP, but extended to the sex workers as well because they had never received education about HIV/AIDS and STIs and were engaged in risky behaviors. Many of the girls were shy and refused to join program activities and, frequently, the establishment owners would threaten to withhold their salaries if they sex workers faced problems with authorities, violence from the police and stigma were routine.

FHI came into the picture in 1998. From the very onset, knowledge gaps and needs were identified, training and workshops were initiated with the purpose of building local capacities, reaching targets, guaranteeing efficient activities and ensuring the future sustainability of the NGO. Thus, from an early start and over the years CWPDP staff, peer facilitators and peer educators have received quality training in technical areas and management, including monitoring and evaluation (M&E), report writing, data collection, counseling, efficient filing, strategy setting, time management, QI and QA, facilitation and communications.

¹ Direct sex workers are brothel based sex workers whose income is derived from sex work only. This could include freelancing and park-based sex worker, too. Indirect sex workers refer to those who supplement their income with sex work. These include karaoke bar workers, beer-garden workers, waitresses, massage parlor workers, casino workers, and hotel/guesthouse staff.

FHI has also continuously provided support and guidance to CWPD through monitoring visits where managers receive coaching and the monitoring team goes “to the field” to observe outreach activities, with the aim of ensuring quality and correct information dissemination. Moreover, during each visit, guidance and help is given to CWPD and a checklist developed by FHI is always deployed to identify gaps, needs and requests. FHI follows up after each visit to ensure that recommendations are followed.

In addition to this, every quarter a Quarterly Capacity Building Meeting is held on FHI premises, where knowledge gaps are addressed, information is exchanged and training is provided on new topics to staff of FHI’s implementing partners. FHI also has used experienced and skilled partners such as CWPD to provide training at the national level to the Provincial Support Teams and District Teams on Outreach and Peer Education.

Over time, through support from FHI, Ouk Pohn says that slowly they began to feel confident about their work and they felt that they actually were making a difference. She also insists that after communication skills training, it became easier to approach sex workers during outreach activities.

“The women in the establishments became used to us coming every week and became familiar with our program. We provided them with HIV/AIDS awareness education, client negotiation skills and prevention methods, such as correct use of condoms.”

Furthermore, establishment owners also began to accept the presence of CWPD staff and to realize that they were not there to destroy businesses, but to help the sex workers.

“In the beginning it was hard, but we were consistent and returned every week and slowly the establishment owners became used to having us there and they began to understand. The working environment is good now, and we can work together with the owners to ensure safety for the women.”

Pohn says that before many sex workers were very lonely, but now they have a network and they support each other and are not afraid to ask for help or advice and the stigma many sex workers faced before has lessened. She says that with the communication skills training and other capacity building activities provided by FHI, CWPD has been able to build the confidence of sex workers.

“Before, they were restricted, their minds were restricted, and they thought of themselves as broken women. Now, they feel different and say that they can do anything and look to the future with hope.”

Through guidance and strategic training on how to reach sex workers, CWPD was also able to expand further their services, into new provinces and locations. And they could approach an increasing number of new sex workers and provide them with HIV/AIDS education. Now, CWPD has offices in six provinces throughout Cambodia, a “sex worker network,” a working referral system, and strong links and collaborations with local authorities.

CWPD’s hard work and successful program has not gone unnoticed. Recently, the NGO was recognized by NCHADS and the National AIDS Authority as being a progressive NGO with a successful strategy on how to reach sex workers. Peer facilitators employed by CWPD have been adopted by other NGOs due to their strong skills and knowledge of how to work with sex workers and clients on HIV/AIDS and reproductive health issues.

However, Pohn affirms that without the technical assistance and support from FHI, there would be no “success story” to tell.

“Without FHI, we wouldn’t have known where to go and what to do. Before 1998, there was so much stigma in the society, so much discrimination. People blamed the sex workers for the HIV/AIDS epidemic and there was much violence. We didn’t know how to do our work efficiently, how to change the situation. It was an unsustainable environment for all parties involved. The sex workers had no knowledge, their clients had no knowledge, and we had no knowledge. But now it is different. Now people see that HIV/AIDS is something we all are responsible for, they don’t only blame the sex workers and we are all becoming stronger every day.”

Cambodia's District Hospital Dispenses anti-AIDS Drugs

By Eang Chanthol, November 2004

It is estimated that approximately 22,000 Cambodians will develop serious AIDS-related illnesses that will require medical care, including treatment with antiretroviral drugs this year. The challenge of the Cambodian Ministry of Health is to provide care and treatment to those living with HIV and AIDS.

About 3,000 people living with HIV in the country now receive ARVs. Most of these ARV recipients live in the capital or provincial towns. NCHADS plans to increase this number to 10,000 by 2005 by developing the capacity of hospitals and health staff to provide HIV care in the provinces where a majority of people reside.

Strengthening the government's health services to treat patients with HIV related illnesses including provision of antiretroviral medicines is a new effort by USAID and its contractor, Family Health International. Battambang, a province in the northwest of the country severely affected by HIV/AIDS, is where a Continuum of Care (CoC) has been implemented.

Moung Russey is the first Operational Health District in Battambang where FHI works with the Ministry of Health, and other agencies such as UNICEF, and other USAID funded agencies, KHANA (Khmer HIV/AIDS NGO Alliance), and RACHA to implement the Continuum of Care program. At Moung Russey Hospital, HIV care and treatment activities have been integrated into existing health services. FHI supported upgrading of laboratory and facilities and has been providing clinical training for health staff to treat patients with HIV related illnesses—a most effective way to reduce myths, stigma and discrimination in healthcare settings. People in Moung Russey are now able to access antiretroviral therapy, HIV counseling and testing, diagnosis and treatment of opportunistic infections, TB prevention for HIV-positive persons, and services to reduce HIV transmission from mother to infants. An effective collaboration and referral system has been established with NGOs providing home-based care to refer and follow up on patients after hospital visits. From August 2003 until October 2004, 433 HIV/AIDS patients have received treatment from the hospital.

In June 2004, the hospital began treating HIV-positive patients with antiretroviral therapy. The capability of the local hospital staff to work within the entire continuum of care, including dispensing antiretroviral drugs, is a major achievement that the Cambodian health staff and Ministry of Health can be truly proud of. Providing antiretroviral drugs changes the lives of whole families living with HIV.

“I am so happy that I receive antiretrovirals because now I can live longer to take care of my children” (—44 year old mother).

“I am very happy because now I have chance to be alive again” (—Male patient).

“When AIDS patients receive ARVs, it can reduce opportunistic infections and improved their health condition” (—Dr. Leng Kakvey).

By September 2004, the hospital had provided ARVs to 81 people. Success demonstrated in Moung Russey has inspired and motivated, and served as a national model that is being replicated throughout the country.

Story of the Women's Handicraft Center (Battambang)

By Cindy Milford, February 2006

Homeland, a Cambodian NGO working in Battambang province, has been working with OVC, PLHA and affected families since early 2001 with support from FHI/IMPACT Cambodia and funding from the US Agency for International Development. Homeland began supporting the handicraft center program in May 2002. An early assessment found that many of the common problems affecting children from poor families were exacerbated by HIV/AIDS. Children often stopped school and stayed at home to care for their sick parent or younger siblings. They sometimes lacked adequate food and often lost the opportunity to continue school. Many of these children were underage and unskilled and were subject to abuse, violence and exploitation, including sexual abuse.

Through discussions with focus groups and key stakeholders in the community, Homeland determined that members of families affected by HIV/AIDS needed support to improve income-generating opportunities. While Homeland was seeking a location to build a handicraft center, Ms. Khun Chantha, an HIV+ woman who lived with her seven children said, "I'm very pleased to donate my land to build a center for the Women's Group. I would be very happy if all children had enough to eat and the opportunity to go to school." The Handicraft Center is the result of her generosity.

The Handicraft Center welcomes all vulnerable women—those who are HIV+ and those who are heads of households. The women work a full day under the direction of a team leader. The team leader says, "There are 20 members of our team and the team has 35 children who need support. Homeland provides us with technical support to make scarves, mats and weave silk, and also helps us identify markets for our products. Homeland also provides daily lunch to us and all our children."

Ms. Ham Mohory, a HIV-positive member of the team explains, "We learn a lot from working together and from Homeland's staff. I'm now able to take care of myself and my four children, and know more about hygiene, nutrition, and self care for simple infections and sickness. Now I have confidence and believe in myself and my team. Every month we earn about 100,000-150,000 Riels (US\$25-37) from selling our products. With this amount of money we can support ourselves and send our children to school. The center also provides day care to smaller children. Before I did not think that our team would be successful. As a matter of fact, after the first six months of our work, some of us wanted to abandon this job, as we did not earn money as quickly as needed. There was a big lack of food at home, children did not go to school and some of them had to earn money in the rice fields and farms of other people. Another new thing which makes me excited is that the community has come to understand about the value of human rights and they support us by buying our products and allowing their children to join a play group with our children."

You Are Special—Sharing Feelings and Learning Skills

By Amara Bou, December 2006

How are children affected by HIV/AIDS? Who do children share their feelings with? During the process of a formative research activity it became clear that children's psychosocial needs were seriously neglected. In response to the research findings, over 60 children were invited to participate in developing a "child to child" "You Are Special" inter-active psycho- social support booklet for children affected by HIV/ AIDS.

In early March, a "You Are Special" Training of Trainers was conducted for seven staff from FHI implementing agencies and five village volunteers from Battambang. The purpose of the training was to provide the participants with the necessary knowledge, skills and tools to be able to train and provide follow-up support to children, to conduct child-to-child peer activities. Following three days of training, the participants spent two days training 10 children from five villages in Battambang about how to facilitate peer activities using "You Are Special" and "Friends Help Friends," a peer facilitator's activity booklet.

The 10 children, five boys and five girls were between 13 and 15 years old. All of them were from households affected by HIV/AIDS. During the training they created a lot of surprise, amazement and excitement. They quickly became confident, skilled peer facilitators. They freely shared with their peers personal experiences of living in households affected by HIV/AIDS, and taught each other new skills to manage common problems. Several of the children commented that it was the first time they had been given the opportunity to share their feelings and experiences. One 15 year old Khmer Muslim boy, who was extremely quiet and shy at the beginning of the training, showed visible relief when he was given the chance to openly express his love for, and his fears about his HIV-positive father. When he participated in the tree hugging activity he closed his eyes and clung tightly to his favorite tree for much longer than the other children. Later he said, "I feel peaceful and happy. I know my father is a good man. He has given me many values to help me in my life."

The ten children returned to their villages with new skills, activity booklets and smiles on their faces. They will be supported by the village volunteers, while conducting a series of eight interactive sessions with peers in their respective villages. We are looking forward to meeting them all again, at a follow-up meeting in May. If this activity is successful it is planned that the children will become the trainers of other child peer educators in their province.

Living Again—A Story of Hope

By Cindy Milford, February 2006

Phally is a former primary school teacher with three daughters. Her husband died of AIDS in August 1999. She went for voluntary counseling and testing and found out she had been infected with HIV as well.

“I was really frightened to death and was discriminated against by my own community,” she says.

When the home-based caregivers made their first contact with Phally in December 1999, she was a shattered woman at the crossroads of life. She manifested early symptoms of AIDS. There was no referral mechanism with the home-based care activities and health facility-based care. She had symptoms of depression.

“I was severely sick twice and diagnosed with active pulmonary tuberculosis and cryptococcal meningitis,” she says.

When Phally fell into a coma, she was admitted to the Moug Russey referral hospital. “My family had lost hope,” she says, “but through the care and treatment I received at Moug Russey referral hospital, I have been able to survive, and have started ART.”



Phally running activities with children on MMM day



Phally conducting drug counseling for a PLHA and a family member

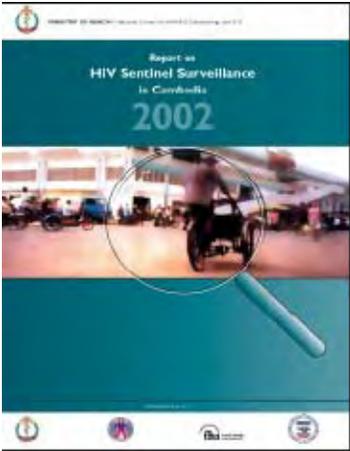
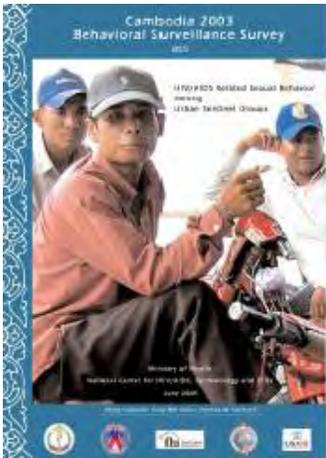
PLHA in the hospital and gives information and education to each PLHA’s family regarding HIV/AIDS and how to care for their family members.

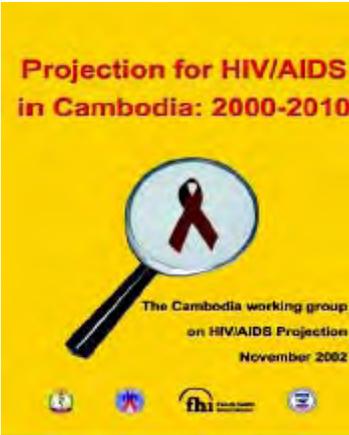
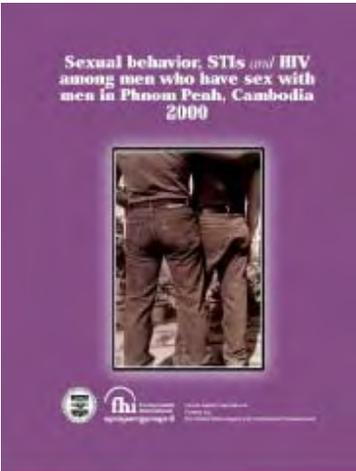
One of the reasons Phally received good care at this hospital is that Moug Russey operational district maintains comprehensive services for patients through the continuum of care (CoC). The CoC emphasizes working through the public health system to strengthen facility-based care, support services and partnerships. The aim is that the whole public health system benefit, not only HIV/AIDS services. Involvement of PLHA and the community has been central to the process.

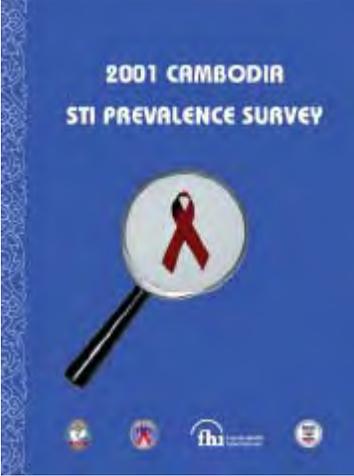
Because of the comprehensive services she received through the CoC, Phally is now doing well, and has even begun helping the OI/ART team at Moug Russey Referral Hospital. She facilitates the friends help friends monthly activity, conducts ART counseling, visits

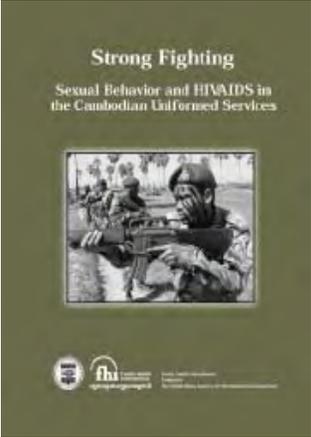
“Now, I have also developed strategies to manage my physical and mental well-being,” Phally says. “Above all, I now have courage and stamina and the ‘will to live,’ and this has been instrumental to my survival. Positive living has helped me refresh myself. I continue to be productive in my community, and to plan for myself and my family.”

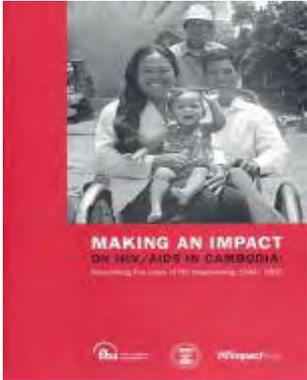
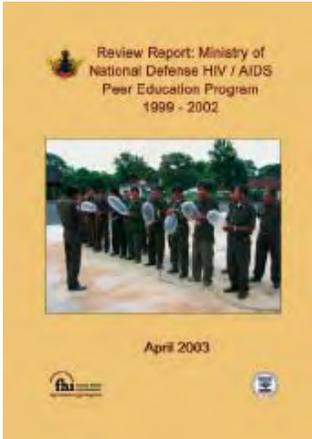
FHI Cambodia Publications Produced under IMPACT, 1998–2006

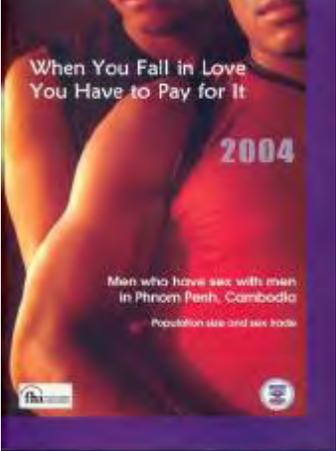
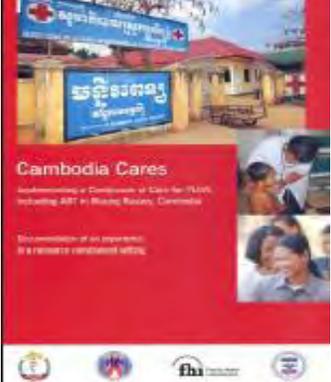
Example	Publication	Year(s)	Number of copies
1	HIV Sentinel Surveillance Surveys	94,95,96,97, 98,99,00,02	500/year
	A series of reports presenting the results of the HIV Sentinel Surveillance report conducted with sentinel groups on a regular basis since 1994		
2	Behavioral Sentinel Surveillance Surveys	97/99, 01/03	500/year
	A series of reports presenting the results of the BSS research conducted with sentinel groups on a regular basis since 1997		

Example	Publication	Year(s)	Number of copies
3	Projections for HIV/AIDS in Cambodia 2000–2010	2000	500
	<p>Scientific information for HIV program planners about HIV transmission projections in an effort to support future HIV/AIDS intervention strategies and plans</p>		
4	Sexual Behavior, STI and HIV among MSM in Phnom Penh, Cambodia	2000	500
	<p>A qualitative research report looking at the sexual behavior and incidence of STI and HIV/AIDS among MSM in Phnom Penh</p>		

Example	Publication	Year(s)	Number of copies
5	Sexually Transmitted Infections Prevalence Survey Report	2001	500
	<p>A survey determining the prevalence of the most common STIs in priority populations such as brothel based sex workers, police and women attending antenatal clinics</p>		
6	International AIDS Conference Posters	1998-2005	n/a
	<p>Over the years, FHI staff and partners have participated in international AIDS conferences such as the ICAAP in Kuala Lumpur, Melbourne and Kobe and ICA conferences in Geneva, Durban, Bangkok and Barcelona where these posters have been presented</p>		

Example	Publication	Year	No of copies
7	Strong Fighting: Sexual Behavior and HIV/AIDS in the Cambodian Uniformed Services	2002	1,000
	A qualitative research report looking at the sexual behavior and STI and HIV/AIDS risk among the Cambodian Uniformed Services		
8	TB Research Report Package	2004	500 units
	Five TB-related research reports and TB IEC materials that have been developed under the TB/ERA Project Cambodia from April 2000–December 2002		

Example	Publication	Year	No of copies
9	Making an Impact on HIV/AIDS in Cambodia: Recounting five years of FHI programming 1998-2002	2004	5,000
	An overview of FHI/IMPACT Cambodia's program, lessons learned, achievements and challenges over a five-year period, from 1998–2002		
10	Uniformed Services Peer Education Program Review Report	2004	1,000
	A mid-term internal review of the Uniformed Services Peer Education Program		

Example	Publication	Year	No of copies
11	When you fall in love you have to pay for it: MSM in Phnom Penh, Cambodia	2004	300
	A research report looking at the size estimation of the MSM population in Phnom Penh and at the exchange of money for sex among MSM in Phnom Penh		
12	Cambodia Cares: Implementing a Continuum of Care for PLHA Including ART in Moug Russey, Cambodia	2004	500
	Documentation of the process of establishing a CoC for PLHA in Moug Russey Referral Hospital, Battambang Province, Cambodia		

Example	Publication	Year	No of copies
13	Continuum of Care for Rapid Scale Up of Care and Treatment for PLHA	2006	300
 <p>The image shows the cover of a red booklet. At the top, there is a black circular graphic with a white horizontal line through it. Below this graphic, the title 'CONTINUUM OF CARE FOR RAPID SCALE-UP OF CARE & TREATMENT SERVICES FOR PEOPLE LIVING WITH HIV/AIDS' is written in white capital letters. At the bottom of the cover, there is smaller white text: 'PROCEEDINGS OF AN INTER-COUNTRY FIELD-ORIENTED WORKSHOP Battambang Province, Kingdom of Cambodia 29 February - 04 March 2005'. There are two small circular logos at the bottom of the cover.</p>	Documents a four-day inter-country workshop on the CoC for the rapid scale up of HIV/AIDS care and treatment, which was held in Battambang in March 2005		