

# Voluntary Confidential Counseling and Testing in Cambodia: An Overview

by Gillian Fletcher



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## A Note on Terminology

The abbreviations VCT and VCCT are sometimes used interchangeably in Cambodia to denote voluntary counseling and testing for HIV. There is anecdotal evidence of a widely held belief that there are two types of testing centers in Cambodia—those where confidentiality is respected and those where it cannot be expected. Research has demonstrated that confidentiality is a major concern of those seeking an HIV test (and a major reason why people avoid seeking a test). In this report, the term voluntary confidential counseling and testing (VCCT) is used to reinforce the importance of confidentiality in HIV counseling and testing.

## Caveat

This is a working document, intended to assist in practical and realistic development of VCCT services in Cambodia. It is not intended to be a definitive study of all aspects of VCCT in Cambodia. Furthermore, the situation regarding VCCT is changing so rapidly that some of the information may, even now, be out of date.

# Executive Summary

1. Voluntary confidential counseling and testing (VCCT) is a crucial link in two key areas of HIV prevention and care; first, between people who perceive themselves to be at risk of HIV and prevention/behavior change programs; and second, between people who are HIV positive and care and support services. The importance of VCCT increases as options for care and support increase. In Cambodia, care and support services are developing rapidly and will continue to grow over the next few years. It is also likely that antiretrovirals (ARVs) will soon be more widely available at the community level.
2. No single model exists for ensuring that VCCT is effective, in demand, and accessible by members of the public. The current focus is on providing services within a referral hospital/provincial health department (PHD) setting. In the course of this study, however, it was made clear to the consultant that there is great interest within the nongovernmental sector for conducting trials of different models of service delivery. It also appears that NCHADS is not averse to greater involvement of nongovernmental organizations (NGOs) in VCCT provision.
3. The study reveals a lack of coordination between the different NGO players in VCCT, particularly in relation to paying salary incentives and developing coherent training, supervision, and monitoring and evaluation (M&E) plans. This could be attributed to the lack of a single national forum in which VCCT issues are discussed. When this study was conducted in September 2002, there was no Technical Working Group on VCCT. However, everyone interviewed for this report seemed eager to strengthen collaboration and find new and innovative ways of delivering high-quality testing and counseling services. A VCCT subgroup has subsequently been convened, and the first meeting was held in January 2003.
4. A World Health Organization (WHO)/UNICEF Technical Advisor is assisting in finalizing the draft “Policy, Strategy, and Guidelines on Voluntary Counseling and Testing” and is providing a good focus for instigating greater collaboration among the multiple partners involved in VCCT. Finalization of the Policy, Strategy, and Guidelines also highlights the need for mechanisms to enable the NCHADS VCCT Sub-Unit to begin implementing VCCT initiatives.
5. Usage of existing government centers is generally low, and no research appears to have been conducted to examine the reasons for this. The most heavily used government center is at Psar Depou, the National Sexually Transmitted Infection (STI) Clinic. This site receives financial and technical support from World Vision and sees an average of 22 clients per day. The privately-run Institut Pasteur in Phnom Penh attracted such large numbers of VCCT clients that it was forced to introduce a ceiling of 45 clients per day for free VCCT tests.
6. It is not known how many private testing sites exist, whether or not they provide adequate counseling (although this is considered unlikely), or how accurate their testing procedures are. While the draft Policy, Strategy, and Guidelines on Voluntary Counseling and Testing requires all private testing sites to be licensed, this document has not yet been officially adopted by the Ministry of Health (MOH). Donor/NGO support should be provided to NCHADS to assist them in implementing such a requirement.
7. Anecdotal evidence speaks of the existence of inconsistent or nonexistent counseling within both public and private sector VCCT. Counseling training provided to date tends to place a focus on giving information rather than on reflective practice or on enabling clients to make their own decisions. During the course of this study, instances were also reported of unofficial charges being levied at public sector VCCT centers.
8. The VCCT Sub-Unit within NCHADS appears to be under-resourced and in need of capacity building. This is particularly true in the areas of data management, supervision, and M&E. Data collection systems are inconsistent, and data management skills are lacking. The current supervision focus is on quantitative issues rather than qualitative ones. A practical M&E plan within the Sub-Unit is currently under development.

9. Quality control of public VCCT sites has, to date, been carried out by the Institut Pasteur. However, NCHADS wishes to see this role handed over to the National Institute of Public Health (NIPH), although this may require financial and technical support.
10. Interviewees from both civil society and NCHADS were in general agreement that people living with HIV/AIDS (PLWHA) should play a major role in improving the quality of counseling attached to HIV/AIDS. This is true both for counseling linked to testing and community-based counseling, which is not directly linked to testing. Interest was also expressed in liaising with Cambodia's existing major psychosocial counseling organizations—Social Services of Cambodia (SSC) and the Transcultural Psychosocial Organization (TPO).
11. One of the study recommendations is that counseling professionals be contracted to work with an existing in-country advisor attached to a local NGO to develop “sensitizing” training. This training would be in addition to the existing NCHADS counseling training and would focus on developing reflective listening and empathy skills in HIV/AIDS counselors.
12. It was generally accepted that counseling services do not need to be directly linked to testing, and that community counseling networks that involve PLWHA could have a major impact on:
- Assisting community members to consider whether or not they should have an HIV test;
  - Informing community members of the developing range of care and support services for people who are HIV positive; and
  - Assisting people who are HIV positive to come to terms with their status.
13. This is an opportune time to conduct trials of different models of testing and counseling in Cambodia. Existing services need to be upgraded, government staff counseling skills can be improved, and PLWHA can be engaged as VCCT counselors to work alongside government counselors. There is scope for developing a community network of professional counseling teams, in which HIV-positive people play a major role.
14. The consultant recommends the development of community-based counseling teams that are target-group specific, in addition to government staff trained as counselors. PLWHA could play a major role in the community-based teams, which would draw on medical advice as appropriate. The teams would need to be well trained and should be recognized as professional bodies.
15. The professionalization of counseling services would highlight the role that good counseling plays as a key influencer, both in reducing people's risk behavior and assisting PLWHA to live healthily and positively. It is recommended that counseling experience that exists in Cambodia outside the HIV/AIDS arena be used.
16. PLWHA also have an important role to play in monitoring service quality from a client perspective. This is particularly true in relation to the quality of counseling provided.
17. Whichever counseling models are adopted, it is clear from the study that simple and effective referral systems must be developed. These systems need to contain details of existing care and support services, PLWHA support groups, and community-based interventions, preferably identified by target groups served. There is a need for the creation and maintenance of a database of all relevant services.
18. While the available data do not provide conclusive evidence, there are strong indications that young people and pregnant women are not using existing public sector VCCT services. It is recommended that qualitative research be conducted to explore the perspectives of these two key groups. The research should focus on what their views are on testing and what ideas they have for designing and marketing counseling and testing services that might be attractive to their peers.
19. Underpinning the findings and recommendations provided in this report is the need to develop a more client-centered approach to providing VCCT services, focusing on the key linkages among demand, access, and quality. Putting the needs of PLWHA first is a policy issue highlighted in the operational framework for Continuum of Care (CoC).

# Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ARVs	Antiretroviral treatment
BCC	Behavior change communication
BSS	Behavior Surveillance Survey
CBO	Community-based organization
CDC	Centers for Disease Control and Prevention
CHEC	Cambodian Health Education Committee
CHHRA	Cambodia Health and Human Rights Alliance
CoC	Continuum of Care
CPN+	Cambodian Positive Network
CQI	Continuous Quality Improvement
CRD	Cambodian Researchers for Development
CT	Cambodia Trust
CTR	Counseling, testing, and referrals
DFID	Department for International Development (Britain)
DHS	Demographic and Health Survey
DOTS	Directly observed therapy, short course
ELISA	Enzyme-linked immunosorbant assay (also referred to as EIA)
FAC	French Cooperation
FHI	Family Health International
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GIPA	Greater involvement of PLWHA
HACC	HIV/AIDS Coordinating Committee
HIV	Human immunodeficiency virus
HSS	HIV Sentinel Surveillance
IEC	Information, education, and communication
IPT	Isoniazid Preventive Therapy
ISO	International Standards Organization
JICA	Japanese International Cooperating Agency
KAWP	Krom Akphiwat Phum
KHANA	Khmer HIV/AIDS NGO Alliance
MCH	Maternal and child health
M&E	Monitoring and evaluation
MoEYS	Ministry of Education, Youth and Sport
MOH	Ministry of Health
MoSALVY	Ministry of Social Affairs, Labor, Vocational Training and Youth Rehabilitation
MSF	Médecins sans frontières
NAA	National AIDS Authority
NCHADS	National Center for HIV/AIDS, Dermatology and STDs
NGO	Nongovernmental organization
NIPH	National Institute of Public Health
OD	Operational district
OI	Opportunistic infection

PHD	Provincial health department
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PSF	Pharmaciens sans frontières
PSI	Population Services International
RACHA	Reproductive and Child Health Alliance
RHAC	Reproductive Health Association of Cambodia
SSC	Social Services of Cambodia
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TA	Technical assistance
TB	Tuberculosis
TBA	Traditional birth attendant
TPO	Transcultural Psychosocial Organization
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VCCT	Voluntary confidential counseling and testing
WHO	World Health Organization

# 1. Background

## 1.1 Aim of the study

This study was commissioned by CARE Cambodia and the POLICY Project and is intended to provide NGOs and the public sector with an overview of the current situation regarding VCCT in Cambodia as well as to highlight some options for developing greater NGO/government interaction in VCCT. Both CARE and the POLICY Project are committed to services that are built on a rights-based approach, and for this reason a key focus of the study is to identify ways of increasing the involvement of PLWHA in the design, development, and monitoring of services.

## 1.2 VCCT and the continuum of care

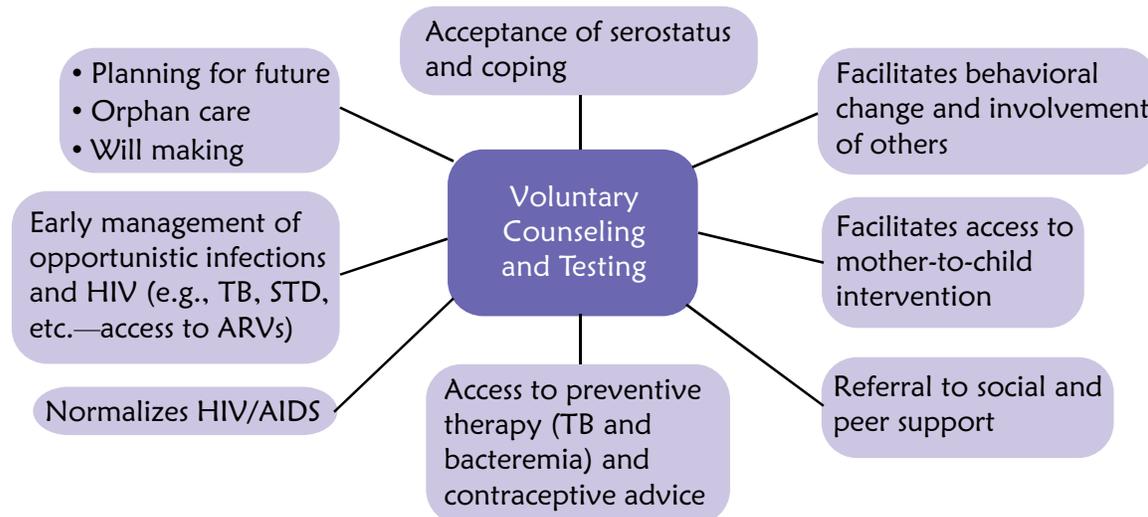
VCCT is recognized worldwide as an important link between HIV/AIDS prevention interventions and HIV/AIDS care and support services. Diagrams of HIV/AIDS prevention, care, and support activities place VCCT in a central role (see Figure 1).

According to the United Nations Program on HIV/AIDS (UNAIDS):

“Voluntary HIV testing accompanied by counseling has a vital role to play within a comprehensive range of measures for HIV/AIDS prevention and support, and should be encouraged. The potential benefits of testing and counseling for the individual include improved health status through good nutritional advice and earlier access to care and treatment/prevention for HIV-related illness; emotional support; better ability to cope with HIV-related anxiety; awareness of safer options for reproduction and infant feeding; and motivation to initiate and maintain safer sexual and drug-related behaviors. Other benefits include safer blood donation.”<sup>1</sup>

Furthermore, UNAIDS recommends that HIV testing should include:

Figure 1. VCT as an entrypoint for HIV prevention and care



Adapted from Eric van Praag/Rachel Baggaley, World Health Organization. “Voluntary Counselling and Testing for HIV Infection in Antenatal Care: Practical Considerations for Implementation.” September 1999. HIV/AIDS and Sexually Transmitted Infections Initiative.

- Available and accessible good quality, voluntary, and confidential HIV testing and counseling, during which all VCCT clients should be informed of the potential benefits and risks of being tested (with particular attention paid to women's access to such services);<sup>2</sup>
- Ensured informed consent and confidentiality;
- Quality assurance and safeguards on potential abuse before licensing commercial HIV home collection and home self-tests;
- Community understanding of, consent to, and involvement in sentinel surveillance and epidemiological surveys, plus ensuring that communities have access to the results; and
- Discouragement for mandatory testing.

The Royal Government of Cambodia is committed to VCCT as part of its HIV/AIDS work, although the Technical Working Group on VCCT is still in a formative stage. However, both the National AIDS Authority (NAA)<sup>3</sup> and NCHADS<sup>4</sup> incorporated strengthening and expanding VCCT services into their strategic plans for 2001–2005.<sup>5</sup>

Cambodia's new Law on Prevention, Care, and Control of HIV/AIDS—proposed in October 2000 and signed by the king in September 2002—carries a whole chapter on testing and counseling. The law mandates the right to voluntary testing, the banning of HIV/AIDS tests as requirements to staff recruitment, freedom from compulsion to test (except in criminal cases), the right to confidentiality, the need for testing centers to be authorized by the MOH, the requirement that every test be accompanied by pre- and post-test counseling, and the responsibility of the MOH to build up and improve HIV/AIDS testing capacity within hospitals, clinics, and laboratories.

The new law gives added support to the MOH's Policy, Strategy, and Guidelines for HIV/AIDS Counseling and Testing, first approved in 1995 and revised in September 2001 with technical assistance (TA) from WHO. The Policy, Strategy, and Guidelines have not been officially ratified by the MOH. A new WHO/UNICEF advisor is assisting NCHADS and the MOH in finalizing the guidelines and national testing algorithms. Her work also involves assistance in convening a consensus meeting on the Policy, Strategy, and Guidelines.

The Policy, Strategy, and Guidelines set out the parameters for HIV testing and counseling in Cambodia; however, the mechanisms still need to be developed to ensure that both the Policy, Strategy, and Guidelines and the HIV/AIDS Law are fully implemented and that noncompliance with either the law or the Policy, Strategy, and Guidelines can be dealt with. The NAA recognizes this in its strategic plan, in which it recommends that a working group on legal and policy issues be established. This working group would guide the development of *parkas*—guidelines for implementation of and adherence to the law.

The MOH has also developed draft Guidelines for the Expansion of the Prevention of Mother-to-Child Transmission (PMTCT) Program in Cambodia. These draft guidelines outline a package of activities that should be integrated into the routine health facility services, including “primary prevention” activities. Guidelines on primary prevention state:

“The most effective approach for PMTCT is to prevent HIV infection among women of childbearing age and to avoid unwanted pregnancy among HIV-infected women. Voluntary counseling and testing service [sic] is essential for primary prevention.”

According to UNICEF, the major external funders linked to VCCT for the year 2002 are as follows:

- \$250,000 from UNICEF;
- \$86,000 from the Asian Development Bank (ADB) (via a grant from the Japanese Fund for Poverty Reduction); and
- \$80,000 from the World Bank.

In 2003, when the British Government's Department for International Development (DFID) plans to begin a five-year, \$22 million-plus project called Strengthening Cambodia's Response to HIV/AIDS, the whole balance of donor influence will shift in regard to NCHADS. The DFID project is solely concerned with building the government response to HIV/AIDS, and NCHADS is the largest single recipient of DFID money under this project. NCHADS is likely to receive more than \$6.5 million over five years.

The Centers for Disease Control and Prevention (CDC) is a new member of the HIV/AIDS prevention and care community in Cambodia. CDC anticipates providing over \$13 million to HIV/AIDS prevention and care activities in Cambodia over a five-year period. NCHADS, as the largest recipient, will receive approximately \$8 million over five years in the form of a cooperative agreement.

Developing a continuum of care is one of NCHADS core objectives; having a continuum of care is a major motivating factor for people to discover their HIV status. With the home care network expanding, care and support for orphans and vulnerable children being initiated, and major advances taking place in the availability and delivery of ARVs, this is a crucial time for the development of good quality, accessible testing and counseling services in Cambodia.

It is generally agreed that VCCT only becomes viable and effective when it is part of a continuum of HIV/AIDS care. In the past, Cambodia's focus has been on prevention. However, as the epidemic has developed, the focus has shifted to incorporate more comprehensive

care and support systems. This is true both within the government and within civil society. ARV programs are starting, and there are strong moves—particularly from the International HIV/AIDS Alliance and Médecins sans frontières (MSF)—to make ARVs widely available within the foreseeable future. Dr. Tia Phalla, Secretary General of the NAA, feels that the greatest boost to numbers of people seeking testing will come from improved access to genuine ARV treatments. He estimates that it will cost between \$3 million and \$5 million a year to provide access to ARVs in Cambodia, and that it will be about five years before ARVs are widely available to HIV-positive people.

The International AIDS Alliance is currently investigating ways to provide ARVs at the community level;<sup>6</sup> MSF is providing ARVs both in Phnom Penh and Siem Reap,<sup>7</sup> and plans appear to be in place for nevirapine to be made available as part of Cambodia's antenatal care (ANC) program.<sup>8</sup> Several proposals for improving access to affordable ARV drugs were also incorporated in the two submissions made by the Royal Government of Cambodia to the Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria (GFATM).<sup>9</sup>

## 2. Current Services

### 2.1 Government/NGO sector

HIV testing was first officially offered in Cambodia in 1995 at Phnom Penh's Institut Pasteur de Cambodge. The service was made possible by funding from French Cooperation (FAC). The Institut Pasteur still operates as an independent testing center.

The government opened its first five VCCT centers in 1996 with funding from FAC. The majority of these services were based either within referral hospitals or PHD compounds. This is still the preferred NCHADS approach to VCCT service provision. The government target is to have one VCCT center per province by the end of 2003 and one VCCT center linked to each of Cambodia's 67 referral hospitals by 2005.

Staff at each of NCHADS' VCCT centers consists of two lab technicians and two medical staff (generally one male and one female) who have undergone the NCHADS' HIV/AIDS counseling training.

The five VCCT centers opened in 1996 all still operate and are based at:

- National STI Clinic, Phnom Penh (also known as Psar Depo STD Clinic.) VCCT is supported by World Vision<sup>10</sup> and UNICEF. World Vision refers to this service as Ponleu Chivit I Center for Counseling and Information.
- Preah Bat Norodom Sihanouk Hospital, Phnom Penh (formerly known as the Russian Hospital). VCCT is supported by UNICEF.<sup>11</sup>
- HIV/AIDS and STD Unit, Battambang, supported by ADB<sup>12</sup> and UNICEF.
- HIV/AIDS and STD Unit, Kampong Cham, supported by UNICEF.
- Siem Reap Provincial Health Center 1, Siem Reap, supported by UNICEF.

In 1999, a sixth government VCCT center was opened at the following site:

- Krong Preah Sihanouk Hospital, Sihanoukville (formerly known as Chamkar Chek Hospital). VCCT is supported by UNICEF.

2002 saw a wave of new centers opening with 100 percent support from UNICEF:

- Two in Takeo—one in the PHD compound and one on the town's Referral Hospital site.
- Kampot, on a site between the PHD and the Referral Hospital.
- Svay Rieng, near the PHD building.
- Kampong Thom, in the Referral Hospital compound.
- Sisophon town, Banteay Meanchey Province, in the compound of a health center that used to be the district hospital (UNICEF support did not include enough to completely renovate the VCCT site or pay for staff, therefore CARE and CDC have agreed to collaborate to provide additional financial and technical support to this VCCT site).
- Pursat, in the Referral Hospital compound.

Additional VCCT services, offered as the result of a collaboration between World Vision and NCHADS and staffed by secondees from the MOH, can be found in

- Kampong Speu Referral Hospital site;
- Ang Snuol Operational District Health Center, Kandal Province; and
- Kien Svay Referral Hospital site, Kandal Province.

Another testing site, initially established with World Vision support, has now been handed over to the Prey Veng PHD with financial support from ADB. This is at the following site:

- Neak Luong, Prey Veng Province.

As stated, these are the official government sites. However, community-based NGO workers say that

“unofficial” HIV testing is being offered in government sexually transmitted disease (STD) clinics at Kratie and Steung Treng. It is likely that there are other government sites offering a similar unofficial service.

UNICEF is also supporting incorporation of VCCT into selected sexual health clinics operated by the Reproductive Health Association of Cambodia (RHAC), an NGO. These clinics are in

- Psar Depou, Phnom Penh;
- Tuol Tom Pong, Phnom Penh;
- Kampong Cham;
- Battambang;
- Sihanoukville; and
- Takeo.

Clinic staff have undergone NCHADS training, and RHAC’s plans to offer testing are underway. RHAC has offered pre- and post-test counseling at its Phnom Penh, Kampong Cham, and Battambang clinics since 1998 (see *Section 4: Counseling*). However, clients were referred to the government centers in those provinces for testing, and according to the RHAC Director for Clinical Services, Dr. Ping Chutema, it was rare for clients to return to RHAC for post-test counseling or follow-up. These clients should have received pre- and post-test counseling with their government HIV test. RHAC hopes to open one new reproductive health clinic offering VCCT; this proposal is included in the latest Country Coordinated Proposal for GFATM.

In late October 2002, World Vision, supported by UNICEF, implemented VCCT at

- Red Cross Health Center, Norodom Boulevard, Phnom Penh.<sup>13</sup>

The Red Cross Health Center is also now home to the Ponleu Chivit Club for HIV-positive people (financially supported by World Vision), which acts as a drop-in point for people concerned about HIV/AIDS. Dr. Pann Sann, VCCT coordinator for World Vision, estimates that as many as 300 people use the center every month.

Five more VCCT centers definitely planned for early 2003, with support from UNICEF and other NGOs, are

- Koh Kong Referral Hospital site (supported jointly by UNICEF, ADB, and CARE Cambodia);
- Kampong Speu Referral Hospital site;
- Steung Treng Referral Hospital site;
- Kampong Chhnang Referral Hospital site (World Vision); and
- Bakan Referral Hospital site, Pursat Province (World Vision).

The CDC also plans to refurbish/build VCCT services in

- Poipet Health Center site, Banteay Meanchey Province;
- Mongkal Borei Referral Hospital, Banteay Meanchey Province; and
- Thmal Pouk Referral Hospital, Banteay Meanchey Province.

Each of these sites will also offer PMTCT services and Isoniazid Preventive Therapy (IPT) as a TB prophylaxis. The CDC can also draw on VCCT experts from other parts of the world to provide TA for VCCT in Cambodia. Out of Cambodia’s 24 provinces (including the Municipality of Phnom Penh, which is technically not a province), 16 will have at least one VCCT center by mid-2003.

## 2.2 Free testing?

All public VCCT services are officially available free. A report prepared for the MOH/Health Economics Task Force<sup>14</sup> noted that the introduction of official user fees for general health care services had significantly diminished the payments of unofficial fees for general health services within health centers. However, the report also noted that “It appears that unofficial payments are still very much in existence to varying extents in provincial referral hospitals, and particularly in national hospitals.”<sup>15</sup>

As already stated, the majority of public testing sites are linked to referral hospitals. The Coordinator of the Cambodian network of PLWHA (CPN+) reports that at one government testing site, the staff charge clients 3,000 riel before they will hand over HIV test results. A second

interviewee also spoke of government clinics offering test results in three days, instead of the usual week, provided 5,000 riel was paid for the test. The question of whether unofficial charges are being levied in other testing sites merits further research. However, lack of effective supervision and M&E systems makes it difficult to control such practices.

Furthermore, the need for sustainability in the NGO sector has led Dr. Ping Chutima, Director for Clinical Services at RHAC, to question whether her organization should and can continue to provide VCCT for free. She stated that in the future, RHAC may look to introduce a sliding scale of charges for VCCT. RHAC operates a sliding scale of charges for its other services. It is probable that improving access to and quality of VCCT and ensuring sustainability is likely to involve some measure of cost recovery.

### 2.3 Collaborative public sector/NGO initiatives

The National TB Program and NCHADS are collaborating to develop linkages between VCCT and TB prevention and treatment and are piloting this initiative in four sites: Battambang, Banteay Mean Chey, Sihanoukville, and Phnom Penh. As part of a similar initiative, Family Health International (FHI) is working with NCHADS, UNICEF, and other relevant partner agencies to develop VCCT in two ODs within Battambang Province. It is also possible that Social Services Cambodia would be involved in developing counseling skills as part of the project. The proposal is for VCCT to be provided at the health center level (one health center in each of the two ODs; one of the health centers is located on the site of the referral hospital). People who test positive for HIV will be referred for a TB test, and patients who also have TB will be offered referral to the health center directly observed therapy, short course (DOTS) system. Patients who are HIV-positive but do not have TB will have the option of being referred to an IPT program to prevent them from developing TB. Cambodia has a latent TB rate of over 60 percent.

VCCT is accepted by all of USAID's HIV/AIDS cooperating agencies as an important link between prevention and care work. The recent USAID partners' umbrella HIV/AIDS/reproductive health/maternal and

child health workplan development process, covering the period 2003–2005, incorporated Result 1.7: *The number of voluntary testing and counseling sites will be increased from the current 7 [includes Institut Pasteur] to at least one in each targeted operational district.* VCCT is also mentioned under other results.

Other USAID partners with plans for VCCT work include CARE Cambodia and the Reproductive and Child Health Alliance (RACHA).

In addition to supporting government VCCT centers (see *Section 2.1: Government/NGO sector*), CARE Cambodia will support a health center VCCT pilot in Koh Kong and/or Poipet in 2003 and is considering developing a community-level mobile testing pilot, followed by an evaluation of the mobile model, the reproductive health model, and the health center model. CARE is also considering supporting the delivery of nevirapine at the Koh Kong Referral Hospital to women attending for ANC.

RACHA plans to extend its existing PMTCT work to include financial support for VCCT in health centers close to the referral hospital in selected districts within Siem Reap and Pursat provinces.

RACHA's specific aim is to provide VCCT in sites where it can be accessed by women attending for ANC, thus strengthening PMTCT work at the health center level.

### 2.4 Private testing sites

There is no clear picture at this stage of just how many unofficial, private testing centers (or sites offering testing) exist in Cambodia. However, anecdotal reports suggest that many private laboratories, clinics, hospitals, and doctors offer HIV testing to their clients. All interviewees agreed that private testing services seem to be proliferating in Cambodia, and that clients often prefer private testing services to those provided by the government. Dr. Mean Chhi Vun stated that there are "a lot of private businesses offering testing," but that these services cannot be properly licensed until the VCCT Policy, Strategy, and Guidelines are approved. The VCCT Policy, Strategy, and Guidelines state that all institutions offering testing must be licensed by the MOH and must be run by staff who have been trained in courses approved by the MOH.

Many of the people interviewed for this report believe that private testing services are more attractive to people than public testing sites. There were a number of reasons cited for this preference: a misplaced belief in “quality” linked to cost; a belief that fewer people will know exactly what type of test the person has gone for at a private facility, whereas the public facilities are clearly identifiable and promoted as HIV testing centers; and the fact that private labs provide results more quickly than public test sites. Little is known as to whether or not an acceptable standard of (or indeed, any) pre- and post-test counseling is provided in private testing services. The Assessment of Patient Rights Within the Context of HIV Testing in Cambodia<sup>16</sup> draws on another source—“Care and Support for People With HIV/AIDS”—and states:

“They [private testing facilities] do not provide pre/post-test counseling and generally do not use acceptable testing techniques, resulting in false positive results while charging for services. According to the National Blood Transfusion Center, approximately 30% of the positive results will be false results. Private facilities are reported to sometimes lie about test results, i.e., not telling people about their HIV positive status, sometimes because of fear of losing a customer. At other times, private testing facilities do not tell the customer about positive test results but share the results with other people in the community.”<sup>17</sup>

A Rapid Knowledge, Practices, and Coverage Survey, carried out by Crossroads Consultancies on behalf of CARE Cambodia in O’Chrouv District, Banteay Meanchey Province in June 2001 found that just over 16 percent of the 390 people questioned would go to a private clinic if they wanted an HIV test. Just over 17 percent said they would go to a government hospital, and nearly 12 percent said they would go to a government health clinic. Other respondents were more vague and gave answers including “Phnom Penh,” “Battambang,” and “Thailand.” They did not indicate if they would seek public or private services in these places.

CARE Cambodia also commissioned a similar survey in Smach Meanchey District, Koh Kong; in this survey, nearly 81 percent of the 389 respondents said they would go to a hospital. It was not specified whether they would choose a public or private hospital.

Dr. Chhim Sarath, Senior Program Officer with the Khmer HIV/AIDS NGO Alliance (KHANA), said, “Probably more people go to private testing than to public because they think it is more confidential. It’s also easier to access, as there are so many private testing places.” No qualitative evidence as to why and how people make decisions on which VCCT services to access could be found.

There does not appear to be any evidence of Kru Khmer offering tests for HIV, although many such facilities do provide treatment for opportunistic infections, and some claim to be able to cure HIV/AIDS. “When You Are Ill You Always Hope: An Exploration of the Role of Traditional Healers in HIV/AIDS Care and Prevention in Cambodia,”<sup>18</sup> states:

“HIV blood tests were mentioned by many Kru Khmer—and many displayed HIV results they had collected from patients. There does not appear to be any resistance to incorporating blood tests into diagnoses of ‘AIDS.’ A few Kru Khmer in Phnom Penh stated that they might refer patients for blood tests, for example for HIV or ‘hepatitis,’ in order to confirm a diagnosis—or test a cure.”

This is further borne out by a Self Care Needs Assessment for PLWHA, carried out by FHI: “There were several cases of PLWHA testing multiple times to check if their HIV-positive status had changed following the use of traditional herbs.”<sup>19</sup>

HIV testing also appears to occur routinely in hospitals (both private and public), unlinked to medical need to know. Research from the Cambodian Health and Human Rights Alliance and Cambodian Researchers for Development shows that this is often without the patient’s consent. This issue is outside the scope of this paper but needs to be acknowledged.

## 2.5 Counseling not linked to a testing site

NGOs currently providing pre- and post-test counseling not linked to a testing site include RHAC (which will soon be providing both counseling and testing at its clinics), partners in the (largely Phnom Penh-based) Home Care Network funded and supported by KHANA, other organizations that provide home care without being officially part of the Home Care Network,<sup>20</sup> and many community-based prevention interventions.

It is likely that some degree of informal counseling linked to VCCT is likely to be taking place in most NGOs working in the field of HIV/AIDS in Cambodia. Field-based staff will, in the course of their work, meet community members who are concerned about their own HIV status and who are looking for help and information regarding what to do and where to go. It is vital that field-based staff are aware of the options available and that they are able to empathize with people who fear they may be HIV-positive and who wish to be tested. But it should be remembered that these field-based staff are often educators, not “counselors.”

One organization generally recognized as providing good quality pre- and post-test counseling without providing testing is Maryknoll. Pre- and post-test counseling is available on Mondays, Wednesdays, and Fridays when Maryknoll operates an “open door” policy. Staff, who have received both an in-house counseling training

(based on UNAIDS and WHO guidelines) plus training from the Cambodian Health Education Committee (CHEC), provide pre-test counseling, as well as carrying out other tasks. Clients who decide to go ahead and be tested—the vast majority, apparently—are then referred to the government/World Vision testing center at Psar Depou/Ponleu Chivit 1 for a blood test. It is possible that they also receive a second pre-test counseling session. Maryknoll staff will accompany clients if they request it. A member of Maryknoll staff collects sealed test results from the testing center, and these are handed to the client at the beginning of a post-test counseling session, back on Maryknoll premises. Clients who cannot read or understand the test result occasionally hand it to the counselor to read or explain for them.

Father Jim Noonan, Director of the AIDS Program at Maryknoll, feels that the seven or so Maryknoll staff who usually provide counseling do a good job with the skills they have, and stresses that Maryknoll has placed great emphasis on the need to develop empathy with clients. The organization requires that all staff spend half a day a week working in the Maryknoll AIDS hospice. An estimated 8–12 people per week currently access VCCT through Maryknoll.

Another route to counseling without testing may be through the Inthanou telephone counseling helpline, which is funded by UNICEF. However, requests for information were not answered at the time this report was written.

## 3. VCCT Management

### 3.1 Test protocols

National policy exists for HIV testing algorithms of blood. The Policy, Strategy, and Guidelines for HIV/AIDS Counseling and Testing state that all serum/plasma should first be tested using a simple/rapid test. If this is positive, the serum/plasma should be re-tested with either another rapid test or with ELISA (Enzyme-Linked Immunosorbant Assay—an older type of “rapid” test where an antibody or antigen is linked to an enzyme as a means of detecting a match between the antibody and antigen, and sometimes referred to as EIA).

The National Policy, Strategy, and Guidelines document states, “Simple/rapid tests are recognized by the Ministry of Health in Cambodia as acceptable, based on WHO recommendations.”

In 1999, a lack of acceptable rapid tests meant that government centers opened in or prior to that year—National STI Clinic, Phnom Penh; Preah Bat Norodom Sihanouk Hospital, Phnom Penh; HIV/AIDS and STD Unit, Battambang; HIV/AIDS and STD Unit, Kampong Cham; Siem Reap Provincial Health Center 1, Siem Reap; and Krong Preah Sihanouk Hospital, Sihanoukville—were equipped with the machinery to carry out ELISA tests. These testing centers still use ELISA.

A representative from UNICEF, whose funds buy the supplies for the majority of these centers, said that no decision has yet been made on whether or not these centers would change over to offering more modern rapid tests, despite the relative efficacy of the modern rapid tests (see below).

Centers opened since 1999 only use “Serodia” and “Determine” rapid tests. Although rapid test kits cost more than ELISA kits, according to a CDC factsheet,<sup>21</sup> rapid tests are in fact more cost-effective, as patients are more likely to receive their results if those results are available quickly:

“The individual kit is more costly than the per-test cost of the EIA. EIA testing

was designed for the automated processing of tests in batches (usually using a plate that can process 96 specimens at one time.) However, an analysis done in 1996 by Dr. Paul Farnham and his colleagues at CDC indicated that rapid HIV testing is more cost-effective than the current EIA-based system, because of the number of persons who actually learn their results. In other words, although EIA is less expensive, it is a waste of money to perform lab tests if the person tested never learns the test result, if two clinic visits are required to get test results, or if the clinic has to send field staff to locate people for test results. Since an EIA does not yield immediate results, most people must make a second visit to learn their results. Experience at publicly funded testing sites has shown that many persons (26% of those who tested positive for HIV and 33% of those who tested negative in 1996) do not return for their test results.”

With ELISA as used in Cambodia, there is usually a one-week wait for results (although this is sometimes shortened to three days on payment of an appropriate, but unofficial, fee). With rapid tests, the results can be known within three hours or, at most, the next day. As stated by the CDC, this can have a significant effect on patient return rates. Dr. Douglas Shaw, Public Health Physician and National Health Advisor for World Vision, estimates that about 30 percent of patients do not return to collect their test results from the National STI Center testing site (known to World Vision as Ponleu Chivit I). The center was opened in 1995 and uses ELISA. This compares with an estimated five percent non-return rate at other, more modern VCCT centers supported by World Vision that use rapid tests.

The NCHADS figures for VCCT patient numbers in 2001 only show non-return figures for three centers: Battambang, Kampong Cham, and Siem Reap. According to the figures, Battambang recorded 321 non-

returns out of 2,268 tests (14 percent). Kampong Cham recorded six non-returns out of 1,542 tests (0.4 percent) and Siem Reap recorded one non-return out of 1,207 tests (0.08 percent). The figures for Kampong Cham and Siem Reap seem very low; however, as figures are not available for the other test centers, it is difficult to tell whether they, or Battambang, represent a truer picture of non-return rates.

### 3.2 The role of NCHADS, the VCCT sub-unit

Within government services supported by either UNICEF or the ADB, the responsibility for training, management, and supervision of services lies with the VCCT Sub-Unit of NCHADS.

Within government VCCT centers supported by World Vision, the NGO takes a hands-on approach to training, management and supervision. In addition to running its own training sessions (in conjunction with NCHADS; see *Section 3.3: Technician training*), World Vision plays an active role in service management. World Vision's VCCT Coordinator, Dr. Pann Sann, carries out her own supervision, in collaboration with the directors of the referral hospitals or government services in which the World Vision-supported services are based. The MOH staff who receive salary supplements from World Vision are expected to sign contracts regarding the additional work expected from them in relation to VCCT. "The assistance of the service director is enlisted in ensuring that staff honor these contracts," said Dr. Pann Sann.

The VCCT Sub-Unit is part of the AIDS Care Unit within NCHADS, and both VCCT and AIDS care work often seem to be shared between the VCCT Sub-Unit and the AIDS Care Sub-Unit. The VCCT Sub-Unit currently includes three staff, one of whom is currently on 10 months' study leave in Japan. Two other staff have apparently requested to be seconded to the VCCT Sub-Unit from other NCHADS' departments, but at present the Sub-Unit as a discrete entity is under-staffed and under-resourced. The Sub-Unit is supposed to cover all NCHADS/national VCCT training and curriculum development, tri-monthly VCCT center supervision, assist in VCCT center management, control VCCT data collection and data analysis, and provide VCCT M&E.

This last activity is required under the Policy, Strategy, and Guidelines, but according to the Sub-Unit, a M&E plan is still under development.

The AIDS Care Unit currently has a new expatriate advisor, Dr. Julian Elliott from the National Center of HIV Epidemiological and Clinical Research, University of New South Wales, Australia. Dr. Elliott's key focus is to build quantitative research capacity in the areas of treatment and care, and possibly prevention. A second advisor joined the unit in November 2002, with WHO support. Dr. Veronique Bortolotti's primary task is to assist the MOH/NCHADS in holding a consensus workshop to finalize the draft Policy, Strategy, and Guidelines. Linked to the consensus workshop is a workshop on sharing existing experiences in developing peer support groups among HIV/AIDS organizations in Cambodia. The proposal is for this workshop to be co-hosted by NCHADS, CPN+, and GIPA (the UNAIDS' Greater Involvement of PLWHA initiative, which is currently represented in Cambodia by a United Nations volunteer based within the NAA).

There is a possibility that the contract will be extended by a year, enabling Dr. Bortolotti to work with NCHADS on improving its framework for care and support and providing direct support to the AIDS Care Unit. It is anticipated that the framework will incorporate strengthening linkages between VCCT and AIDS care (government and NGO), and a particular focus will be paid to incorporating community-based PLWHA peer support groups. While it is likely that this support will be at a fairly high technical level, it will also be important to include direct mentoring on how to implement the framework in practice. Once the Policy, Strategy, and Guidelines are formally adopted, the work of the VCCT Sub-Unit is likely to increase, potentially expanding to include the role of licensing and regulating private sector testing services.

### 3.3 Technician training

The NCHADS training for lab technicians involves five days on testing procedures, plus basic HIV/AIDS/STI facts. According to Dr. Prom Phanit, Chief of the VCCT Sub-Unit at NCHADS, the testing training was developed in consultation with MSF, FAC, and Institut Pasteur de Cambodge.

Under the NCHADS training, lab technicians spend one of their five days observing testing at the Institut Pasteur. World Vision trainees also spend a day observing testing and counseling at the National STD Center/Ponleu Chivit 1.

Among the wide range of people interviewed for this study, there was general consensus that training in checking and analyzing the blood tests is of an acceptable quality; however, there are some questions regarding quality control procedures (see *Section 3.4*).

### 3.4 Quality control, supervision, and M&E

Institut Pasteur currently provides quarterly quality control for the six government/NGO-supported testing centers in Cambodia opened prior to 2002. However, for the six new testing centers opened by the government (with NGO support) in 2002, NCHADS plans to contract quality control from the NIPH. It is not clear what training or support will be provided to NIPH to enable its staff to carry out VCCT quality control, although it is probable that NCHADS will request technical support for the NIPH, possibly from the Institut Pasteur.

It is not clear what types of mechanisms are in place for dealing with instances of poor quality, which might arise from quality control. A quality testing round, held in March 2002, revealed that two of the six centers did not analyze the test samples. The other four centers took five weeks to analyze the test samples and to return results to Institut Pasteur. The results from these four centers were in agreement with Pasteur results.

In terms of supervision, best practice acknowledges that supervision should cover qualitative issues and should have a mechanism built into it for constructive feedback, opportunities, and encouragement for staff to explore more effective ways of working. The Horizons website and UNAIDS offer field-based examples of supervision checklists that look solely at HIV-test counseling; different checklists are used for pre- and post-test counseling and, within post-test counseling, different checklists are used depending on the test result. All of the checklists cover qualitative issues such as “Did the provider explore the client’s problem?” and “Did the provider explore reasons for seeking VCCT?”

The six government VCCT clinics opened prior to 2002 have been receiving quarterly supervision from members of the VCCT Sub-Unit (sometimes supported by colleagues from the AIDS Care Unit). However, a further six are now operational, and this centralized supervision system is not sustainable. Moreover, the existing supervision checklist is solely quantitative, covering issues such as stocks of materials and reagents. In fact, there are 20 questions on supply of materials (including A4 paper, envelopes, and notebooks). The only questions relating to pre- and post- test counseling cover total number of sessions given per month, per three months, per six months, and per year.

World Vision’s VCCT coordinator is responsible for providing quarterly supervision to the testing sites supported by World Vision, and the NGO has developed its own supervision checklist. This is based on the NCHADS checklist and again places the focus on quantitative issues. World Vision is aware that this needs to be revised and is currently considering incorporating exit interviews into its supervision.

RHAC appeared to be the only organization interviewed that could provide a well-documented, clearly defined supervision system, although this supervision system—Continuous Quality Improvement (CQI)—is not specific to HIV/AIDS testing and counseling but was developed to help improve quality in RHAC’s reproductive health clinics. CQI was developed from the quality improvement tool COPE and involves 4 components: self-assessment, clinic tour, home interviews, and observation of provider/client interactions. Initially, CQI used exit interviews, but once it became clear that clients did not feel able to speak freely about the service provided by a member of staff while still on the RHAC premises, home interviews were chosen as the best method to gain clients’ perceptions. In 2002, RHAC intends to adapt the tool again to include client focus group discussions.

RHAC Director for Clinical Services Dr. Ping Chutema is personally concerned about lack of quality improvement supervision linked to HIV/AIDS counseling and testing. She and her staff are beginning to look at adapting their CQI system for use with VCCT, and she says that part of the reason for delay in beginning to provide VCCT within RHAC clinics is because of lack of a specific supervision tool. Mechanisms currently

being considered by RHAC for VCCT supervision include tape-recording counseling sessions and observation (both after informed consent). Dr. Ping Chutema also raised concerns about the lack of VCCT M&E systems.

Jenny Pearson, the director of VBNK, an NGO that specializes in organizational management training, is of the opinion that effective supervision and M&E are largely lacking in most NGOs in Cambodia. This is an area for improvement that VBNK is interested in pursuing.

## 4. Counseling

Everyone interviewed during this study recognized that there is scope for improvement in quality of both counseling training and HIV/AIDS counseling services provided. In particular, there was an identified need for greater involvement of PLWHA in developing training and in designing and providing counseling services. PLWHA interviewed for this research provided several personal accounts of situations in which counseling was either not provided or was provided but did not meet the accepted standards of genuinely assisting the person being counseled to reach his or her own decisions (see *Section 5: Testing Tales*). In more than one case, advice was given that resulted in the client suffering stigma and discrimination.

Those working in HIV/AIDS care and support say that the need for good counseling and for careful and long-term training of counselors is demonstrated by a frequent lack of empathy among NGO and government sector staff working with PLWHA. Anecdotal evidence suggests that staff whose work touches on emotional issues either over-identify with the client, which leaves them unable to take an objective view of the situation, or they create a distance between themselves and the client, which leaves the client feeling either judged or unable to express him/herself. There is a belief that this lack of empathy or excessive sympathy is largely due to a lack of capacity among the staff for dealing with their own emotions.

It has been suggested that Khmer culture does not allow for people to display emotions, as this can involve losing face. Kann Kall, the previous Managing Director of TPO, dismisses both notions, and points to the fact that, historically, Khmers have shared their problems with people who are believed to be possessed by spirits as an example of desire to talk about problems. He also refers to the positive reactions expressed by Cambodian people who are encouraged and enabled to talk about how they feel and particularly to talk about how practical problems they face affect them emotionally.

It has also been suggested that the hierarchical nature of Khmer society means that people want to be told what to do and do not wish to be assisted to reach their own solutions. This is true according to Kann Kall, TPO's

new Managing Director, Psychiatrist Dr. Chhim Sotheara, and expatriate advisors working with counselors in Cambodia. They offer reasons for this, including the cultural context in which medical people are perceived as “superiors” who should use their knowledge to direct those “below” them, and the fact that the Khmer term used for “counseling”—*p'dalkal phreuksat*—actually translates as “to give advice.” While it is crucial for a counselor to be able to inform someone of their options after an HIV test, whatever their status, the HIV/AIDS Counseling Guidance Note developed for NCHADS states that “Counseling should help those affected by HIV to live fully and productively by enabling them to resume (or assume) authority over their own lives and decision making.”

The counseling professionals interviewed all said that in their experience, the initial desire of clients to be told what to do can be overcome if the counseling is good enough and determinedly non-directive. However, they also emphasized the need to recognize and counter the toll that the job of counseling can take on the practitioner. Both NCHADS and World Vision-supported counseling staff are encouraged to meet together regularly to identify any problems they have and to identify possible methods of problem-solving, but without professional facilitation such self-supervision is unlikely to touch deeply on personal problems encountered by the counselors.<sup>22</sup>

Four major areas for development arose from discussions on how to improve and develop counseling services:

1. The need to improve counseling within existing testing services;
2. The need to expand counseling services not directly linked to testing;
3. The need to involve PLWHA in designing, providing and monitoring counseling services; and
4. The need for a more reflective practice and greater empathy in terms of HIV/AIDS counseling.

Suggestions for each of these strands are outlined in *Section 7: Recommendations*.

In terms of existing counseling training, the Policy, Strategy, and Guidelines document states that all training in counseling needs government approval and must comply with certain minimum standards defined by NCHADS. In practice, this currently means that all NGO and public health providers involved in providing VCCT are required to undertake either training developed by NCHADS or, in the case of World Vision staff, training developed by World Vision but based on the NCHADS curriculum and delivered by World Vision and NCHADS staff.

For counseling services not linked to testing, it appears that much training has been carried out by CHEC, with NCHADS' approval. CHEC trains government health center staff in sites not linked to testing, and has been involved in revising NCHADS' counseling training curriculum. Furthermore, CHEC training certificates are apparently approved by NCHADS. The CHEC training will be dealt with in more detail later in this section.

The NCHADS counseling training used to cover five days, which included one site visit to the Institut Pasteur. This training has just been revised and extended with assistance from a WHO advisor and some input from World Vision and CHEC. Cambodian psychosocial organizations with experience both providing counseling and training counselors were not involved.

The revised NCHADS counseling training represents an attempt to set national standards for counseling training<sup>23</sup> and covers some more general counseling techniques as well as specific topics on counseling in relation to HIV/AIDS.

The training is intended to cover a total of 52 hours, split into two parts. The first part (16 hours) covers HIV/AIDS awareness and orientation to counseling; the second part (36 hours) covers introduction to counseling and basic counseling skills training. Incorporated into this part of the training are sessions on counseling skills that go beyond counseling linked to VCCT.

The counseling training curriculum is intended to be used in conjunction with a Reader in Counseling,<sup>24</sup> also drawn up with assistance from the WHO advisor. Both the curriculum and the reader use quite sophisticated English language to describe feelings and emotions and ways in which to investigate these with a client. Both presuppose

a fairly high level of awareness of the practice of counseling (Western-model), counseling competency in the trainer, and a fairly high level of critical thinking skills and empathy in trainees. However, field experience shows that none of these skills can be taken as a given among either NGO or government staff.

The NCHADS training is provided by a training team, usually including VCCT Sub-Unit Chief Dr. Prom Panith, Vice-Chief Dr. Chea Chan Kosalmony, Chief of the AIDS Care Unit Dr. Kaoeun Chetra, NCHADS Deputy Director Dr. Hor Bun Leng, and invited, previously trained staff from the World Vision and the Institut Pasteur testing centers. However, none of these staff is a dedicated trainer and the training work has to fit alongside other work. Laboratory and counseling refresher training sessions are supposed to occur every three months, but this does not seem to have occurred to date. World Vision has just held its first refresher training.

Within the commercial sector, it is highly unlikely that staff have received any training recognized in relation to the MOH's draft Policy, Strategy, and Guidelines for HIV/AIDS Counseling and Testing.<sup>25</sup>

In VCCT centers supported by World Vision, testing and counseling staff are both required to follow a 10-day training that covers both testing procedures and counseling. This training is based on the pre-revision NCHADS curriculum. As previously stated, this is delivered by members of the NCHADS training team and World Vision staff. In theory, VCCT lab or counseling staff should be interchangeable in centers supported by World Vision, but this means that staff are not able to focus on key skill areas.

CHEC offers counseling training to health center medical staff and community members. Those who complete this training are expected to provide general HIV/AIDS counseling and, according to the training curriculum, to "encourage testing." CHEC has provided counseling training to NGO workers, traditional birth attendants (TBAs), Health Center Management Committee members, Village Feedback Committee members, village health volunteers, village leaders and members of village development committees. This training does not deal exclusively with VCCT, but many of the courses touch on VCCT and on pre- and post-test counseling.

A 10-day HIV/AIDS Community Management Course offered by CHEC, intended for HIV/AIDS fieldworkers, covers a wide range of subjects. For example, Day 2 includes: “The advantages of HIV antibody testing, Technical dimensions of testing, Ways to encourage testing [*sic*], Transmission of HIV, Sensitization to counseling/testing and Pre-post-testing requirements.” On Day 9, there are four modules, one of which is “Preparing clients and their families for death.”

The consultant is aware of at least two CHEC training courses for NGOs in which NGO staff expressed concern as to the quality of both the content and the delivery of CHEC training. This is perhaps not surprising if one considers that CHEC is solely a training organization. None of its staff or trainers appears to be a working counselor, despite the fact that Cambodia’s psychosocial counseling organizations insist that counseling training must be provided by practicing counselors.

Regardless of who provides training on counseling linked to HIV/AIDS, anecdotal evidence shows that currently clients accessing VCCT do not always receive pre- or post-test counseling, that results have been handed out by staff not trained in post-test counseling, and that some post-test counseling advice has led to increased stigma and discrimination for HIV-positive people (see *Section 5: Testing Tales*).<sup>26</sup> All of the above experiences are directly contrary to the Policy, Strategy, and Guidelines for HIV/AIDS Counseling and Testing. Figure 2 at the end of this section shows a possible model for improved counseling services.

#### 4.1 Improving existing counseling services within testing sites

Government testing sites are not particularly well used (see *Section 6: Client Numbers*). Assumptions are made as to why this is so, including assumptions about perceived lack of quality in the public sector and fear of lack of confidentiality. There does not appear to have been any qualitative research done to ascertain the validity of these assumptions. Evidence from other countries also shows that certain population groups (particularly young people) are unwilling to access services provided within traditional medical sites, such as referral hospitals or PHDs.

It appeared to be generally accepted that one key problem area is a lack of counseling quality, and this could be improved by greater community involvement and better counseling where provided by members of the medical profession. UNAIDS Country Program Advisor Geeta Sethi feels that mixing government and community/NGO services together could make a critical difference. She described a response to low usage of government VCCT services in India, which involved a consortium of six NGOs—including a network of HIV-positive people—taking on responsibility for providing counseling services within the testing centers. Usage of the centers increased significantly as word spread of the existence of quality, independent counseling within the testing services.

However there was some disagreement as to whether or not HIV counseling in Cambodia should be solely the preserve of NGOs/community-based organizations (CBOs), or whether the government should retain some control/responsibility for the emotional welfare of people who access HIV testing. Some also argued that counseling should remain linked to government medical service providers as a way of increasing the empathy of medical staff for people who are, or fear they are, HIV positive.

A “hybrid” model, developed in conversation between Oscar Barreneche of WHO and the consultant, would see PLWHA/government medic counseling teams being developed within government testing sites (see *Section 7: Recommendations*).

#### 4.2 Expanding counseling services not directly linked to testing

It was accepted by NCHADS representatives, Dr. Tia Phalla of the NAA, and the various international NGO/NGO/CBO representatives interviewed for this report that HIV/AIDS counseling has a life far beyond HIV testing, and that the psychological needs of people who have had an HIV test often continue long after the date on which they receive their test results and (hopefully) the accompanying post-test counseling.

Great interest was expressed in finding ways of increasing and improving counseling services not directly linked to testing. It was generally felt that, in terms of HIV/AIDS counseling, the most successful

future model would be one in which counseling is provided via a community-based network with strong referral links to care and support services and to VCCT.<sup>27</sup> This referral can either be of clients, or of blood samples (thereby cutting down the risk of the client not taking up the referral from counseling to testing).

Dr. Mean Chhi Vun of NCHADS believes that NGOs can complement a national network of hospital/health center-linked testing through developing community-based counseling and support services in high-risk areas. These counseling and support services should be highly trained, well supervised, paid, and positioned in the center of a referral network that links prevention interventions, care and support services (up to and including ARV provision), and HIV-positive support groups (see *Recommendation 7.1*).

Mr. Peter Godwin, Regional Advisor to the ADB Regional HIV Prevention Project, feels strongly that building a community-based counseling network is the way forward, and he stresses that counseling does not necessarily have to be linked to testing: “Counseling does not need to be linked to testing. Counseling without testing allows people to look at their options.”

He added that he would like to see counseling teams linked to continuum of care services, not to testing, and pointed to the AIDS Strategy developed by Msunduzi Municipality, KwaZulu-Natal Province, South Africa as a possible role model for future service development in Cambodia. A key part of the strategy is the Msunduzi Referral Network, which “seeks to ensure that every person who tests HIV positive will be referred to a range of organizations in Msunduzi, offering social, emotional, and practical assistance.”

Limited and largely informal referral networks already exist in Cambodia, either between NGO partners (often based on donor links) or between government and NGO partners. As the country’s HIV/AIDS response grows in complexity and as more and more options for care and support are being developed, greater emphasis needs to be placed on logical and cross-organizational/cross-donor-funded referrals.

The FHI VCCT/TB linkage proposal (see *Section 2.3: Collaborative public sector/NGO initiatives*) could prove a useful model for development of government/NGO referral networks if implemented.

As stated in the previous section, it is important to note that practical steps are taken to ensure that people with the job of referring clients to other services have access to a reliable and up-to-date service database or directory.

### 4.3 Involving PLWHA in designing, providing, and monitoring counseling services

Both of the models outlined above require the active involvement of PLWHA. Greater involvement of PLWHA is accepted as a key strategy for the future by NCHADS, NAA, and Cambodia’s civil society, and is a key element in the Framework for the CoC currently under development by NCHADS.

The NAA’s National Strategic Plan, 2001–2005, states, “A guiding principle of this Strategic Plan is the empowerment of Cambodians living with HIV/AIDS as partners in the national response to HIV/AIDS.” The NAA is also host to a UN volunteer working to promote the UNAIDS GIPA initiative.

The NGO Statement to the 2002 Consultation Group Meeting on Cambodia, developed by MEDiCAM, the NGO Forum on Cambodia, and the Cooperation Committee for Cambodia, includes in its recommendations consideration of the need for “Increased involvement of PLWHA in advocacy, policy formulation, and programming.”

Dr. Mean Chhi Vun of NCHADS was enthusiastic about HIV-positive people being involved in counseling services. “They [PLWHA] suffer this so they know better than other people about the problems of living with HIV/AIDS,” he said. And he signaled an important acceptance of counseling as a skill that is not just the preserve of medics when he stated that “medical professionals are not counseling professionals,” and added “not everyone can be taught to be a counselor.”

The value of involving PLWHA in developing HIV/AIDS counseling comes from recognizing that

- Stigma and discrimination against people who are identified as being HIV-positive still appears to be widespread; and

- PLWHA who are linked to existing self-help groups speak positively of being able to speak to someone else who is HIV-positive. This is a self-selecting group—those who do not benefit from the self-help groups would swiftly lose contact—but interviews with HIV-positive volunteers associated with the Phnom Penh-based Ponleu Chivit Club and CPN+ all emphasized that many HIV-positive people benefit greatly from having access to self-support groups. This was further borne out by a self-care assessment carried out for FHI,<sup>28</sup> which quotes a 28-year-old HIV-positive woman:

“I realize when I listen to other HIV+ people that it is possible to overcome problems and enjoy life. I also find that some people have more problems than me and they have found ways to solve them. We are able to joke and laugh together as we understand each other.”

However, the key to enabling PLWHA to provide effective and sustainable HIV/AIDS counseling would lie in

- The quality of counseling training and ongoing facilitation/mentoring available for HIV/AIDS counselors;
- Finding a successful model for developing high quality, paid, independent counseling teams (see *Section 7: Recommendations*); and
- Developing strong referral links among community counseling services, community prevention projects, VCCT services, home care, and the growing range of other care and support services offered, up to and including ARV provision,<sup>29</sup> including links to effective support/self-help groups for PLWHA.

Suggestions were made that Cambodia’s burgeoning HIV-positive support group network, CPN+, should be used as a base on which to build community counseling networks. However, support groups and counseling networks have a different focus, and therefore independent but complementary services are required (see *Section 7: Recommendations*).

CPN+ currently has 21 member groups (10 in Phnom Penh, two in Kampong Cham, three in Battambang, one

in Siem Reap, Banteay Meanchey, Prey Veng, and three in Takeo, with a total membership of 1,575). These are primarily linked to home care and to the KHANA network.<sup>30</sup> The links are partly historical as the support groups that existed before CPN+ were created as a means of supporting the medic-focused work of the home care teams. However, KHANA partner NGOs that are providing home-based care appear to be forming linkages with new support groups.

At present, the support groups that belong to CPN+ appear to place heavy emphasis on organized information-giving, including medical advice and, in some groups, free health checks for members. Less emphasis seems to be placed on building advocacy and encouraging PLWHA to develop their own ideas in relation to services for PLWHA. The existing support groups perform a vital role for HIV-positive people who are beginning to become ill. However, the home care focus of these support groups and the very close links they have with local NGOs—to the extent of being known only by the NGO name (e.g., Indradevi Support Group, KOSHER Support Group, etc.)—could limit their effective involvement in any community counseling network. There is the danger that existing links may create issues of territorialism and perceived “ownership” of PLWHA groups. In such a hierarchical society as Cambodia, the fact that support groups take NGO names and that support group team leaders are identified by the NGOs could limit the reach of these groups. Attempts to establish sex worker empowerment groups linked to local NGOs have run into the problem of “ownership” and territorialism between NGOs linked to different groups of women. Anecdotal reports show that referrals between local NGOs often do not take place because of issues of power and control.

Aside from the issue of VCCT, the challenges that appear to be facing CPN+ members are not unique. There do not seem to be any existing examples of independent, member-driven support groups in Cambodia. TPO is an organization that is often quoted as having had success at establishing self-help groups, and indeed the organization has a seven-year history of establishing and facilitating community mental health self-help groups. But these support groups are given 8–10 weeks of facilitative supervision by a member of TPO staff, and the groups often stop meeting once this supervision ends. The Managing Director of TPO, Dr. Sotheara Chhim, said that group members often continue to provide

informal support to each other, but none of the several hundred self-help groups established by TPO operates as an independent unit. The organization recently commissioned an external evaluation and, in the part of the evaluation that dealt with self-help groups, emphasis was placed on the need to:

- Further improve reflective listening skills;
- Allow participants freedom to explore their own ideas and develop their ownership of the group;
- Avoid treating “problems” as purely logical issues, with no emotional value or impact; and
- Revise supervision to enable reflection and activity amendment based on self help group achievements and obstacles.

These lessons learned by TPO should be borne in mind and TA provided to assist CPN+ to continue its support group development work.

#### 4.4 Toward a more reflective counseling practice

In terms of pre- and post-test counseling, it is unrealistic to assume that a one-off training for medical staff who usually have not had any previous experience counseling and who appear to be supervised on purely quantitative measures (see *Section 3.4: Quality control, supervision, and M&E*) will enable them to develop professional, reflective counseling skills.

According to two Cambodian NGOs that focus on both providing and enabling communities to provide their own psychosocial support—TPO and SSC—the process of training effective counselors is a long and difficult one. Both organizations have been working for more than seven years now, and former TPO director Kann Kall<sup>31</sup> says that, in his opinion, it takes at least six months to train someone in basic counseling skills in Cambodia. In addition, “the six months should include equal parts of theory followed by work-based practice, followed by more theory and more work-based practice.” At TPO, counselors with this basic training then receive ongoing supervision from a psychologist. Kann Kall stresses that this is a basic training and that the counselors always need to continue to learn as they practice. Common problems include staff getting angry with clients, feeling frustrated, and not being able to deal with their own emotions. Central to all counseling training should be

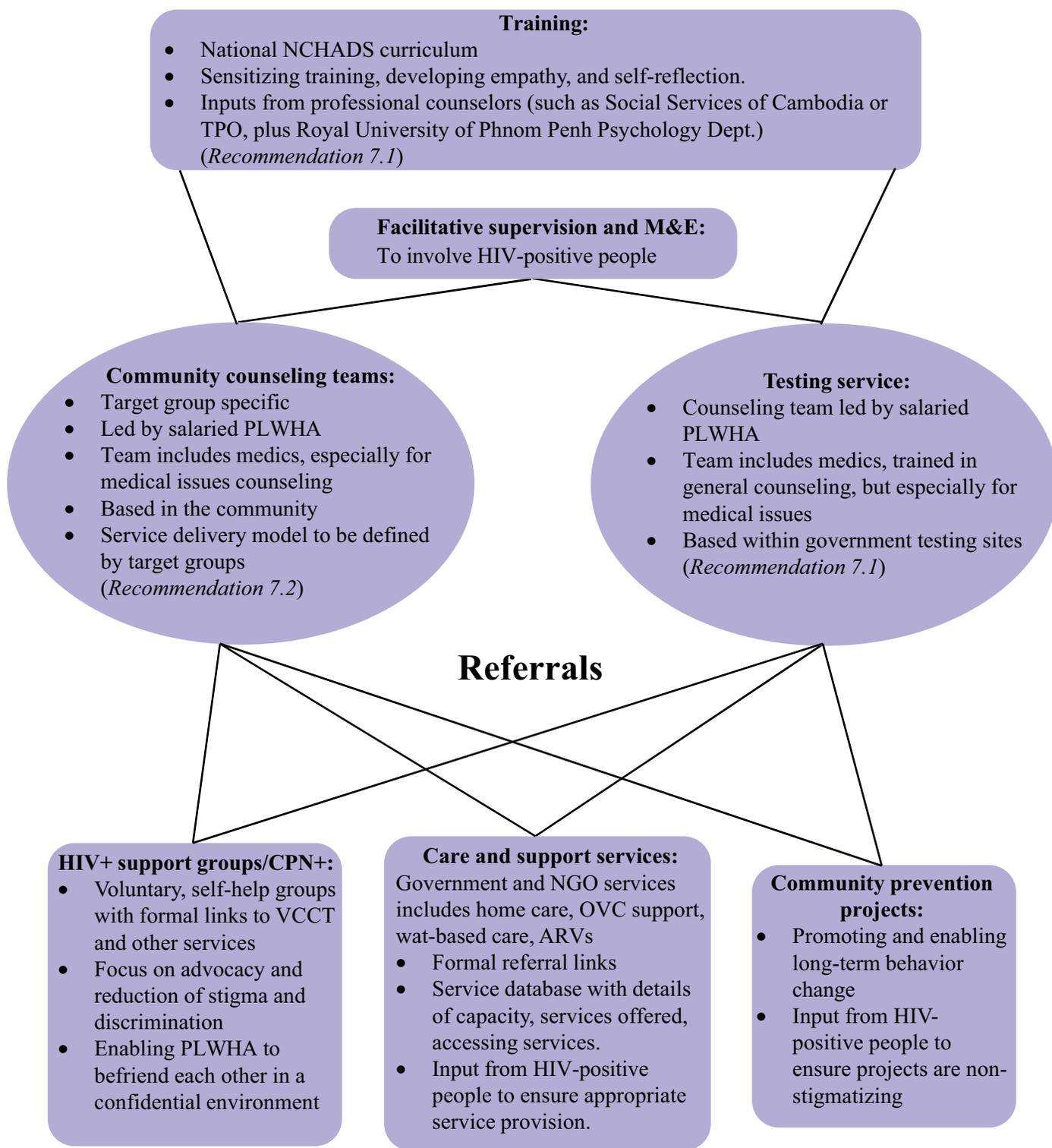
work that enables trainees to identify and begin to interpret (from a theoretical viewpoint) their own feelings, emotions, and ways of coping with or avoiding emotional distress.

Both FHI and CARE have recognized the need for greater empathy among staff working with PLWHA, and both recently commissioned SSC to run counseling training with a focus on building empathy. The training for FHI was delivered to staff from implementing agencies working with members of the uniformed services and sex workers. The CARE training was delivered to staff working on home care and caring for orphans and vulnerable children, and followed a model of one week of training per month for three months, with staff given “assignments” in between. This training is ongoing. Initial reports seem favorable although many of the staff said that the training was emotionally challenging. Some, apparently, could not understand why they needed to examine their own emotions and could not link this practice with the work they do. It could be argued that this in itself proves the need for such training. Other staff were enthusiastic to have an opportunity to examine their own emotions in relation to their work, which is often emotionally taxing.

During the course of this study, suggestions were made about developing general counseling skills within Cambodia by strengthening the University of Phnom Penh’s Psychology Department and supporting the development of a national counseling training curriculum. The psychology degree offered at the Royal University of Phnom Penh is believed to be the only national-level training that incorporates some element of counseling, and the MOH would probably prefer active involvement of a national training institution in any such scheme. Dr. Mean Chhi Vun commented, “The aim must be to improve counseling skills at a national level. The MOH does not have expertise on counseling. People get confused about counseling; they have a very narrow view and see counseling as only about HIV. But it is about much more than that, it covers a spectrum. If the University of Phnom Penh Psychology Department could develop a training program, NCHADS and the MOH would collaborate and perhaps invite them to provide training services.”

However, concerns have been raised from some quarters as to the quality of the training provided by the university’s Psychology Department.

Figure 2. Possible model for counseling services



## 5. Testing Tales

Many of the persons interviewed provided anecdotal stories describing their experiences with VCCT in Cambodia. Some of these stories are presented in the box below.

- “I’ve had three HIV tests; the first two were negative, the third was positive. The first time I got tested, it was because I wanted to emigrate to Australia and I wanted to know for myself. I’d seen on the TV and heard on the radio that there was a test for HIV, so I went to get it done. I went on my own, and the staff asked me what I would do if I was positive. The second time, which was six months later, they didn’t really ask me anything. The third test was two years later. I was getting married. I went for the results [*to a recognized testing center*] with my fiancée. At the reception desk, they told me there was a problem with my blood. There were many other people around, and my fiancée was standing next to me. I asked what the problem was, and they told me I was HIV+. I wasn’t ready to receive my result. I asked them: ‘Is the test definitely mine? Is it correct?’ The receptionist went inside, came back out and just said ‘yes, it’s correct.’

“My fiancée was HIV negative. We had been engaged for five years, but I decided to stop the relationship. I should have got counseling; I was in shock afterwards. I went home after getting the test, and stayed there for three days. I spoke to my fiancée, and I told my mother. Then I heard about the Ponleu Chivit I Center at Psar Depou. I went there, and they told me how to take care of myself; what to eat; told me that everyone will die sometime. Then they told me about Ponleu Chivit II [*support club for HIV+ people, supported by World Vision*]. The club was the biggest help in making me feel better.”

*Man 1*

- “I had my blood tested in 1997 [*at a recognized testing center*]. I was told the result in a counseling room. Before getting the result, the counselor asked a lot of questions—he was very helpful. I was a soldier, and I had already decided that if I was positive I would kill myself. I had taken my gun with me. I promised the counselor that I wouldn’t kill myself, but I thought I would still shoot myself when I went outside. Then I thought that if I killed myself I wouldn’t be reborn, so I didn’t do it.

“Because of the counseling, I understood that people with AIDS didn’t die straight away. The counselor told me to try and take care of my health, to make sure I would live longer. The counselor also told me that there were hospitals that would provide medicine free for people with AIDS. He also told me not to stay alone, and told me I should find a best friend and go to talk to him, or talk to someone else who was close to me. I followed his advice and told my sister. We were very close. But she wasn’t happy. She told my parents and my parents kicked me out. They gave me money and asked me to go and not come back. My parents thought that HIV is a sexual disease, and people who get a sexual disease are not good. They were ashamed. They also thought I would die quickly.”

*Man 2*

- “One person we knew killed himself because of his family’s reaction after he followed the counselor’s advice and told them about his disease. They wouldn’t eat with him, wouldn’t sleep in the same room as him, and then they rented a room away from their home for him to live in. He hanged himself.”

*Story recounted by volunteer at Ponleu Chivit Club, a Phnom Penh support group for HIV-positive people*

- “I had my first test in Sihanoukville, in July 1997. My husband was sick and my baby daughter was sick as well. But my husband, at the beginning, didn’t want to get tested. So I decided to do it for myself. My uncle was a doctor, so he drew my blood and took it to a clinic to get it tested. It cost \$7. Three days later, my uncle got the result and gave it to

my mother. She told me I was HIV positive. My mother was very upset—she didn't think that her daughter would have HIV. After my blood was tested, I believed 100 percent that my husband [was positive] as well. He and my daughter were tested and it was as I thought. They were both positive.

“After the test I felt really hopeless. Sometimes I wanted to give up my husband and give up my daughter because I felt so bad. Sometimes I wanted to die. But I never did anything about it; all I could think was how could I get my daughter to be HIV negative. I took her to the hospital many times; every time I went to a hospital or clinic, they took her blood again. She must have been tested for HIV about 10 times, and each time it was positive. I even brought my daughter to Kantha Bopha Hospital in Phnom Penh. They took her blood, and they asked me to test again, too. I was still HIV positive. But they gave me very good counseling. They told me how to take care of my own health and also how to care for my daughter. They told me to stop breastfeeding and gave me formula milk. They told me that if I didn't have money to buy the milk the hospital would help. But my daughter couldn't eat the formula milk so I kept on breastfeeding. Then my daughter died. She was two-and-a-half years old. My husband had also died.”

*Woman 1*

- “I took my husband to [*recognized testing center; 1998*] be tested for his liver; he had a skin condition and he had got very thin. We went to register at the desk, and the people there mentioned that if the husband takes a blood test the wife should, too. They didn't say the blood test would be for HIV; they just said it was for infection and it was free. Because it was free I decided I would do the test, too.

“When we got into the room where they wanted to do the test, there was a counselor there. I was surprised—why did they ask me to do an HIV test? But we both got tested, and three days later I went back to get my result. My husband was too ill to go that day, so I went first. The result was positive. Before they gave me the result, they asked me: ‘If you have HIV, what will you do?’ I said I didn't have HIV; I was fine. It was my husband who was ill. I had done nothing to get infected. But I was HIV positive.”

*Woman 2*

- “I know a story of one man who was engaged, but just before the wedding ceremony he got bad skin problems so he, his fiancée, and his future mother-in-law went to a clinic in Phnom Penh to try and cure his spots. It's usually said that if someone has bad skin they have a liver problem, so the clinic took his blood for testing. But because the clinic owner knew his fiancée's family very well—they were close—the clinic tested for both liver problems and HIV. When the fiancée cancelled the wedding two days before it was due to take place, the man didn't know why. He was really worried and upset, as he thought his fiancée and her mother both loved him very much before he went to get his health check. So he asked them what was wrong, and they told him that the wedding was off because his blood was HIV+. The man was very upset and went to get another test done for himself. He went to the Institut Pasteur, and the result was negative. He tried to take the clinic to court for giving a wrong result and affecting his whole future but died two months later.”

*Story recounted by NGO worker who knew the family of the fiancée*

- “My neighbor went for a test and came to see me to tell me he was HIV positive. He knew I worked with people with AIDS, and he wanted some advice. I asked him for his test paper, and he told me that he didn't have one; the lab technician just told him he was positive. He didn't get any counseling or anything, and no written result. I took him to get tested again, so we could be sure. The result was positive.”

*Story recounted by woman working with an HIV+ support group*

- “Two months ago, I went to form a PLWHA support group in Prey Veng Province. People told me that when they go to get tested at the government service, the testing is free, but if you want to get your result, you have to pay 3,000 riel. If you don't pay, they won't give you the result.”

*Story recounted by member of CPN+, the Cambodian network for PLWHA*

## 6. Client Numbers

### 6.1 Data management

There is no way of knowing how many private testing sites are in existence or how many people are currently accessing them. The only data publicly available are for the government/NGO-supported centers. NCHADS data are incomplete, and data collection and data management were identified as areas of challenge by one key member of NCHADS' VCCT staff. The six VCCT centers established prior to 2002 all have Epi-Info systems installed to enable data management, but the data collection forms exist in either English or French. It appears that, currently, center staff are often unsure how to enter data into the computer system. This, it seems, means that user statistics are often delivered to NCHADS late, incomplete, or not at all. Lack of consistent data management systems at a central level means that staff do not have a central statistics file for all government-supported VCCT.

Furthermore, the six new centers opened in 2002 do not have Epi-Info installed as the expertise to complete this task does not currently exist within the VCCT Sub-Unit. It is planned that the NCHADS' Head of Surveillance,

Dr. Heng Sopheab, will assist the VCCT Sub-Unit in developing an improved Epi-Info database (using ADB funds), and provide work-based training in Epi-Info to the Sub-Unit's two staff members. These two persons will then have to establish Epi-Info systems within the new testing centers. Dr. Prom Panith, Chief of the VCCT Sub-Unit, is keen to further develop data management skills, both within the Sub-Unit and at VCCT center level.

These inconsistencies are not reported to highlight "inefficiency" but to attempt to demonstrate the level of data management support needed. It should further be remembered that, currently, the VCCT Sub-Unit includes just two staff and that the Chief of the Sub-Unit has not yet been trained how to use Epi-Info.

### 6.2 Available statistics

The MOH/NCHADS Results of Activity of Voluntary Counseling and Testing Centers Network for HIV Infection Detection have been used as the baseline for this analysis. Table 1 shows that there has been steady growth in numbers of people being tested.

**Table 1. Numbers of people being tested**

<b>1997</b>	
Five government centers:	1,766 people tested, of whom 25.5% were HIV+
Institut Pasteur:	6,436 people tested, of whom 15% were HIV+
<b>1998</b>	
Five government centers:	3,929 people tested, of whom 24.2% were HIV+
Institut Pasteur:	8,170 people tested, of whom 18% were HIV+
<b>1999</b>	
Five government centers:	6,999 people tested, of whom 23% were HIV <sup>+32</sup>
Institut Pasteur:	10,838 people tested, of whom 15% were HIV <sup>+33</sup>
<b>2000</b>	
Six government centers:	10,447 people tested, of whom 21% were HIV <sup>+34</sup>
<i>(figures include Sihanoukville Testing Center, opened in 1999)</i>	
Institut Pasteur:	9,485 people tested free, of whom 16.5% were HIV+
PLUS	4,732 paying clients, of whom 7% were HIV+
PLUS	4,006 samples referred from other clinics/hospitals
<b>2001</b>	
Six government centers:	12,427 clients of whom 24% were HIV <sup>+35</sup>
Institut Pasteur:	9,707 people tested, of whom 19.4% were HIV <sup>+36</sup>

There is a significant and consistent differential between the percentages of positives recorded each year at the government centers (around 24%) and those recorded at the Institut Pasteur (around 17%). It would be wrong to conclude that this implies that the government centers record a higher number of false positives (although the possibility should be investigated). It is more likely that the differential is related to client profiles of those attending for testing, including the reasons for seeking the test. In either case, further research is warranted to determine the reason for these significant differentials.

In 2000, Institut Pasteur put a ceiling on the number of free HIV tests it offers in any one day, due to pressure of numbers. “It was getting to the point where we would have to put up another building, just for this!” said Dr. Philippe Glaziou, Epidemiologist at Institut Pasteur.

The ceiling was initially set at 50 clients a day, but dropped to 45 clients a day because of ongoing pressure. People who arrive for testing after that point are asked to return the next day. Alternatively, they can pay \$10 for the test. The Institut Pasteur now receives no aid money for its VCCT work although the service provided is estimated to cost just under \$100,000 a year (including

the cost of salaries for the two doctors who work full time on providing pre- and post-test counseling). Some of the cost is met from the Institut Pasteur in Paris, and the rest of the cost is covered by the Institut’s annual turnover.

It would seem reasonable to speculate that the increased number of people being tested (at both Pasteur, prior to imposition of the ceiling on numbers, and at government centers) arises from a broadening general knowledge of the problem of HIV/AIDS. Anecdotal evidence also points to increasing requirements for people about to marry to take the test. It appears that, in marriage, it is often the man who is required to have a test. Dr. Glaziou at Institut Pasteur believes that many of the clients who pay for tests, and therefore get their name on the record card, are potential marriage partners who need to prove to their fiancée’s family that they are not HIV-positive.

Despite the overall increase in numbers, however, there are large differences in attendance at the different centers. Table 2 shows daily averages, broken down from figures for 2001 (taking into account 24 public holidays in a year and assuming the centers are usually open five days a week).

**Table 2. Daily averages**

Phnom Penh’s National STI Center: <i>(also known as Psar Depou STI Clinic/Ponleu Chivit 1; supported by World Vision)</i>	5,193/year, or an average of 22/day
Preah Bat Norodom Sihanouk Hospital: <i>(formerly known as the Russian Hospital)</i>	1,624/year, or an average of 7/day
Battambang: (Provincial population: 793,129)	2,268/year, or an average of 10/day
Kampong Cham: (Provincial population: 1,608,914)	1,532/year, or an average of 6/day
Siem Reap: (Provincial population: 696,164)	1,207/year, or an average of 5/day
Sihanoukville: (Provincial population: 155,690)	603/year, or an average of 3/day

It is unclear whether the daily usage figures for the National STI Center are so high because of the well-known involvement of World Vision in the provision of services.

The penultimate draft of the second Country Coordinated Proposal for GFATM<sup>37</sup> includes the component “Increased availability of VCCT.” The prime target group is defined as antenatal women, and the activity description included in the draft refers only to increasing the number of testing facilities within antenatal clinics run by RHAC. In 2002, RHAC secured funding from UNICEF to incorporate testing into its clinics (see *Section 2.1: Government/NGO sector*), and under the GFATM submission, the plan is for RHAC to use GFATM money to open another RHAC center, offering to expand general reproductive health care and VCCT. This would take the number of RHAC clinics offering VCCT to seven.

Targets for the seven RHAC clinics were set in the GFATM submission as 11,760 in 2003, rising to 17,280 in 2004. The baseline was set as 2,500, which would mean about 3 percent of the 84,000 visits per year currently paid to existing RHAC clinics would involve an HIV test.

At present, RHAC’s six clinics see a total of about 7,000 women a month for sexual and reproductive health services. Director for Clinical Services Dr. Ping Chutema estimates that 20 percent of these women want ANC care; about 60 percent attend for STI care; 17 percent attend for family planning; and the rest for a mix of gynecological problems. About 25 percent of all RHAC clients fall into the 15–25 age group.

### 6.3 Client groups

The latest statistics available to the consultant that record a detailed breakdown of client type are the Results of Activity of Voluntary Counseling and Testing Centers Network for HIV Infection Detection for 1999. These show that a significant number of people tested (43%) said they were part of a couple. Statistics delivered at the National AIDS Conference showed that, in 2000, 65.4 percent of those tested were either married or had a sweetheart. However, it is possible that people lied about their relationship status to reduce stigma. This risk of stigma would be particularly high for unmarried

women accessing VCCT. What is also unclear is whether those people accessed VCCT as a couple or whether just one partner was tested.

In terms of gender and VCCT, the Results of Activity of Voluntary Counseling and Testing Centers Network for HIV Infection Detection for 1999 show that men of all age groups accessed testing more than women—the figures were disaggregated to 38.5 percent women (2,697) and 61.5 percent men (4,302).<sup>38</sup>

The gender split on statistics for 2000 presented at the National AIDS Conference showed that of the total tested, 61.9 percent were men (6,418) and 38.1 percent women (3,951).

According to the HIV Sentinel Surveillance (HSS) 2002 dissemination workshop, the number of HIV infections among women is still rising in Cambodia while the number of HIV infections among men is falling. There has been a massive shift in infection patterns; in 1997, 110,051 men aged between 15 and 49 were estimated to be HIV-positive. The estimate for women was 60,914. In 2002, the figures were estimated as 82,037 men and 75,446 women.

In terms of age groups accessing counseling, it is difficult to get an accurate picture due to data being collected in broad age bands and by different age bands in different years.

According to the Results of Activity of Voluntary Counseling and Testing Centers Network for HIV Infection Detection for 1999, by far the largest age group accessing testing in both genders was the group aged 20–29. This group accounted for 49 percent of all men tested, and 46 percent of all women tested. The second largest age group accessing testing (again in both genders) was the 30–39 age group. This group accounted for 15.5 percent of all men tested and 24.6 percent of all women tested.

Higher testing figures among 20–29 year olds is encouraging, if testing is in fact being accessed by people of all the ages covered—and, particularly, if testing is being accessed by those in their early 20s as this is a group causing growing concern among both government and NGO HIV/AIDS workers. However, the disaggregation of data currently available does not provide this information. And testing rates for those

below the age of 20 are low, probably because the age band is 10–19. Just 9.5 percent of males tested in 1999 fell into this age group. There are no estimates for current HIV infection rates among young males; however, NCHADS has identified a need to “identify better strategies to document the extent of HIV infection among younger persons and males;” furthermore, it recommends “more coverage and effective intervention must target the general male population.”<sup>39</sup>

Young male Cambodian students involved in Peer Ethnographic Research for Population Services International (PSI) certainly displayed poor risk perception and appeared to believe that they were safe from HIV because they use condoms with women who they perceive as “risky”. However, it also emerged that their condom use is inconsistent and that they do not use condoms with women whom they perceive as “good”.<sup>40</sup> A draft synthesis report handed out at a dissemination workshop stated:

“Male students reported often having simultaneous multiple [sexual] partners, including paid partners, casual partners, and sweethearts. While condom use ranges from being inconsistent to non-existent in these relationships, the students’ self risk assessment for HIV/AIDS is extremely low.”

Among the women, just 12 percent of those tested fell in the 10–19 year old age group. There are important implications for prevention of mother-to-child transmission, a key NCHADS objective. According to the Demographic and Health Survey (DHS) 2000,<sup>41</sup> childbearing in Cambodia starts around the age of marriage, with very few births recorded outside of marriage. The highest percentage of first births among currently married women was recorded as occurring among the 15–19 age group. The report states, “...among currently married teenage women, 43% have begun childbearing.”

At the HSS Dissemination Workshop, ANC women aged 15–19 were estimated to have the highest HIV prevalence of all age groups, at 3.1 percent. The statistic for women aged 20–24 was 2.5 percent, and 3 percent for women aged 25–49. The presentation given at the dissemination added: “There is a rapid increase in the proportion of mother-to-child transmission.”

Improving access to and use of VCCT for pregnant women is one of the government’s key objectives. Dr. Seng Sutwantha, Deputy Director of NCHADS and Chair of the Working Group on PMTCT, said that women at mother-to-be classes in the Maternal and Child Health (MCH) Center in Phnom Penh are invited to take a HIV test. Their husbands are also invited to pre-test counseling.

The idea of establishing a drop-in counselor at the hospital is apparently currently being considered, as is offering follow-up for HIV-positive women who have delivered their babies at the MCH Center.

Currently, NCHADS is focusing its ANC VCCT efforts on the MCH Center and hopes to expand initiatives developed at this hospital to other referral hospitals through the country. The expansion of VCCT into RHAC clinics and RACHA’s proposals to develop VCCT in three clinics offering antenatal care will further expand the reach of VCCT in terms of antenatal women. And as stated previously, CARE is considering incorporating nevirapine into ANC care at Koh Kong Referral Hospital. Approximately 40 women per month deliver at Koh Kong Hospital—figures well in excess of those achieved by most other referral hospitals in Cambodia. According to the DHS, just 38 percent of women who had a live birth in the five years preceding the survey had access to any sort of trained antenatal care.

Dr. Sutwantha of NCHADS does not think it is currently viable to attempt to offer VCCT at health centers offering antenatal care across Cambodia because she does not believe that confidentiality can be maintained at the health-center level (see *Section 6.4: Reasons for being tested*). Nevertheless, there is already a high unmet demand for HIV testing among women. The DHS reports that “...28% of women have a desire to be tested, and only 3% of women have been able to meet that demand, indicating that only 10% of demand has been met.”

The DHS adds, “Demand for HIV testing is high in Pursat (60%), Kampong Speu (56%) and Kampong Chhnang (60%); no more than 2% of women in any of these regions have been tested.” Women who do manage to access testing are likely to be educated and from urban areas:

“...one observes that whereas 23% of urban women’s demand for HIV testing

is met, only 6% of rural women's demand is met. The scenario is similar when comparing women's access to HIV testing services by education: among women with no education, a mere 4% of demand is met, and among women with secondary education, 21% of demand is met.”

It must be borne in mind that there are no figures for numbers, ages, or gender of people accessing private HIV testing services, and it is possible that significant numbers of male and female teenagers and antenatal women are using these services.

Disaggregated data into narrower age bands within each gender—for example, 16–19, 20–24, 25–29—would provide a clearer picture on specific target groups. However, it seems that this will not be possible until the VCCT Sub-Unit staff have training and support in Epi-Info and data management.

## 6.4 Reasons for being tested

In June 2001, CARE Cambodia commissioned two surveys on issues including HIV testing in Smach Meanchey, Koh Kong and in Poipet, Banteay Meanchey.<sup>42</sup> The surveys found that in both sites the overwhelming reasons for having an HIV test were given as “feel worried/at risk” and “feel sick.” The next most important reason given was “marriage.”

This coincides with a report by the Cambodian Health and Human Rights Alliance (CHHRA) and Cambodian Researchers for Development (CRD), which interviewed 315 AIDS patients in Phnom Penh. Of these, 52 percent said they had been tested for HIV because of suspected symptoms.<sup>43</sup> In the CARE surveys, the major reason for not getting a test was given as “scared to know/don't want to know.”

Any promotion of VCCT services (including pre-test counseling) will need to take account of the major reasons why people from different client groups seek (or avoid) an HIV test. It is clear that more research is needed in this area.

Preliminary results from the Behavior Surveillance Survey (BSS) 2001 show that figures for testing among

the target groups (military, police, motos, direct sex workers, and indirect sex workers) were in inverse proportion to the figures for knowing someone sick with AIDS. One could speculate that seeing people who are sick and dying from AIDS may increase a person's reluctance to be tested. Dr. Heng Sopheab, Chief of the NCHADS Surveillance Unit, says that in his experience of working with people who are tested as part of the HSS, this is likely to be true. In contrast, seeing someone who is sick and dying from AIDS, or having a friend or relative who is HIV positive is often cited as the critical factor that propagated a change toward safer sexual behavior. These dissonant but related phenomena have major implications for information, education, and communication (IEC) as well as behavior change communication (BCC).

The currently limited availability of care and support (particularly outside of Phnom Penh) would do little to reassure people that, if they did test positive, there would be services available to help them. Certainly in Koh Kong and Poipet, at the time of the CARE surveys, very ~~few care and support services were available.~~<sup>44</sup>

Furthermore, the *Testing Tales* section and other anecdotal evidence provided during the course of this study strongly suggests that fear of breach of confidentiality is a major disincentive to testing among more vulnerable groups. As stated in Section 6.3, Dr. Seng Sutwantha is not convinced that confidentiality could be maintained if VCCT were introduced to all Cambodia's ANC services.

Some interviewees also suggested that confidentiality cannot be maintained at existing VCCT centers, and one of the case studies gathered in the course of this study (see *Section 5: Testing Tales*) provides evidence of this concern. The CHHRA/CRD research on patients' rights in relation to VCCT also highlights this issue although the research was carried out in hospital wards and not in VCCT centers.

Lack of confidentiality is a major concern for anyone considering an HIV test; the CARE Cambodia rapid assessments carried out in Koh Kong and Banteay Meanchey showed that fear of the consequences of people discovering a person's HIV-positive status were frequently mentioned by respondents when asked: “What would be the reason not to have an HIV/AIDS test?”<sup>45</sup> In addition, for women, breach of confidentiality can

result in violence from her partner. In other countries, domestic violence has been shown to occur or increase in couples where the woman is HIV positive and the man is HIV negative. The assumption made is that the woman has been unfaithful, primarily because HIV is perceived so strongly as a disease associated with illicit sex.

Providing and maintaining confidentiality in resource-poor settings is a challenge; the Guidelines for Counseling, Testing, and Referrals (CTR) published on the WHO website<sup>46</sup> state, “Ensuring clients’ privacy and confidentiality during CTR is essential, but could present unique challenges in some non-traditional settings. Confidentiality can more easily be breached in settings where clients and providers can be seen or heard by

others.” However, the guidelines add: “Suggested strategies for maintaining privacy and confidentiality in nontraditional settings include the following:

- Use a separated area in a mobile van.
- Use rooms with locking doors.
- Mark a specific room with a “do not disturb” or “occupied” sign.
- Designate an area in the setting that provides physical privacy.
- In parks and similar locations, seek areas with as much privacy as possible.
- Provide counseling and testing services in the client’s home or other secure setting.
- Have clients return to the setting to receive test results and counseling and referral.”

## 7. Recommendations

### 7.1 Counseling services within existing testing sites need to be improved

This was the single most consistent point raised during the course of this study. Good counseling is central to effective VCCT services, and as Cambodia's continuum of care develops, counseling takes on an even more important role. This is particularly true in light of the growth of access to ARVs, which is likely to occur in the next few years.

In existing government/NGO services that provide both counseling and testing, it is recommended that multi-skilled counseling teams be developed.<sup>47</sup> These teams would link PLWHA trained in counseling with medical professionals who have also received counseling training.<sup>48</sup> Counseling would be offered by the PLWHA, who would be able to request support from the medical staff on the team if there was a need for more professional medical advice. This could include counseling linked to medical issues including treatment of opportunistic infections (OIs), living healthily, and ARVs. It is likely that this type of information would be much better accepted if it came from a medical professional, who is expected to "give advice" or instructions.

These counseling teams could then refer people to prevention programs (for longer-term behavior change work), to PLWHA support groups/community counseling networks (see below) and to care programs. The need for stronger referral mechanisms is highlighted in the draft Framework for CoC.

In terms of counseling training, the consultant favors a model in which a training pyramid is developed. At the apex would be a national HIV/AIDS counseling training team involving the NCHADS VCCT Sub-Unit, practicing Cambodian counselors (perhaps from TPO and/or SSC), at least one PLWHA, and perhaps a representative of the University of Phnom Penh's Psychology Department. This training team could be seconded/contracted to work with an in-country expatriate advisor to design and implement an empathy training that complements the NCHADS counseling training, but with an

emphasis on encouraging participants to identify and understand their own emotions and responses to situations before they try to understand other people's.<sup>49</sup> If possible, Mr. Meas Nee, now working for the National Institute of Management in Battambang, should be closely involved in any such process.<sup>50</sup> In addition, the University's Psychology Department could be funded and facilitated to evaluate the pilot, with a possible view to achieving university accreditation for the training scheme.

This training team would provide a training of trainers, enabling NCHADS to expand training beyond its one existing Training Team. The current requirement for VCCT training either to be carried out by or to involve members of the national Training Team puts a major constraint on the number of training sessions and refresher training sessions that can be carried out. UNICEF and CARE Cambodia propose decentralizing the training and monitoring role of the VCCT Sub-Unit by building regional VCCT training and monitoring teams based in/integrated into the MOH regional training center structure. A pilot is proposed for the northwest provinces.

These pilots could provide an excellent opportunity for requesting training and supervision input from professional Cambodian psychosocial counselors, PLWHA, and possibly the University of Phnom Penh, along the lines outlined above.

For such a pilot, provision of facilitative follow-up, refresher training, and supervision for regional training teams would be vital (see *Section 3.4: Quality control, supervision, and M&E*).

### 7.2 Community-based counseling networks need to be developed

Community counseling networks would provide a range of counseling services related to HIV/AIDS, acting as a conduit between community prevention interventions, testing services, HIV-positive support groups, and the growing range of services available to HIV-positive people, up to and including ARV provision.

Community counselors would be paid a basic stipend (although support would need to be secured for this; see Recommendation 7.1), be well-trained, include PLWHA, and receive ongoing facilitative supervision from counseling professionals (for example, TPO or SSC). And one size would not fit all; counseling teams would need to be developed to fit the needs of different communities affected by HIV/AIDS. For example, one team could focus on young urban males, another could focus on couples, another on ANC women, and another on indirect sex workers. The tailoring of a team to a target group should be directed by first researching the target group's own needs in relation to HIV/AIDS counseling services. For example, if they were going to speak to someone about HIV/AIDS, what sort of a setting would they want that to occur in? What opening hours would be appropriate? How should such a service market itself to members of the target group?

As outlined in Recommendation 7.1, the teams should include medical professionals, but these medical professionals would act as secondary consultants, brought in to offer medical advice when required. They would be particularly useful in discussing the issue of ARVs.

These community counseling teams should develop strong links to the burgeoning CPN+. The support groups, in turn, might benefit from increased capacity building and assistance in developing their independence from the local NGOs to which they are currently linked. Thus, they could widen their scope beyond working primarily with home care teams before any moves are made to develop a broader community counseling role for the support groups.

The support groups would require ongoing facilitative supervision, increased financial support, and TA, perhaps from an in-country expatriate advisor who could be brought in as a counterpart to CPN+ coordinator Mr. Sok Rithy. It is also suggested that lessons learned on developing self-help groups by TPO could be incorporated into further developing CPN+ and its support group members.

The training of any such community counseling networks should mirror the training outlined in Recommendation 7.1.

It is possible that a pilot could be established in Sisophon. CARE has been asked to provide additional support to the government VCCT center in Sisophon town; there is an HIV-positive support group linked to the Khmer Buddhists Association in Banteay Meanchey Province; and TPO already works there. Furthermore, ARVs are now available in Siem Reap, offering the chance for strong referral links to be made.

### 7.3 PLWHA should play an active role in developing VCCT counseling services

All interviewees agreed that HIV-positive people should be more actively involved in HIV/AIDS counseling (see *Recommendations 7.1* and *7.2*), and this area is emphasized in the draft Framework for CoC. The consultant feels that this should be widened to cover greater involvement of PLWHA in determining the most appropriate models for VCCT. This could occur through development of VCCT advisory boards and M&E of existing services from a client perspective. PLWHA should also be involved in the development of non-hospital/PHD models of care (e.g., health center VCCT and other VCCT models).

Furthermore, support group members should be encouraged and supported to act as advisors for community-based prevention projects, thus ensuring that PLWHA have a say in the development of non-stigmatizing prevention programs. Advisory links should also be established between support groups and AIDS care providers.

### 7.4 Increasing commitment to and protection of clients' rights

The concept of clients' rights in relation to VCCT are accepted worldwide and are embedded in the Royal Government of Cambodia's Policy, Strategy, and Guidelines. Client rights include the right to confidentiality, the right to decide whether to take an HIV/AIDS test, the right to decide whether to disclose the results of an HIV/AIDS test to any other person, and the right to be treated with dignity and respect. However, this study demonstrates that proactive measures need to be taken to ensure these rights are protected in practice.

Greater involvement of PLWHA in service design, delivery, and M&E should facilitate this. There is a clear need to develop a more client-centered approach to providing VCCT services, focusing on the key linkages among demand, access, and quality. Putting the needs of PLWHA first is a policy issue highlighted in the operational framework for CoC.

## 7.5 Increasing access to and usage of VCCT: Further research is needed

No evidence could be found of any research to assess what might encourage different target groups to use testing services or what presently inhibits these groups from using testing services. However, the NCHADS client data, which can be disaggregated, show that more men than women are accessing existing services and raise a question over access to existing testing services by young people and couples (see *Section 6: Client Numbers*).

In terms of encouraging and enabling young people and particularly young men to access VCCT services more readily, “A Summary Overview on Voluntary Counseling and Testing for Young People,” produced for FHI,<sup>51</sup> states, “Young people often do not attend formal health services for their preventative health needs.” The summary also outlines barriers to VCCT for young people, including “inaccurate risk perception.” Young male Cambodian students involved in Peer Ethnographic Research for PSI certainly displayed poor risk perception and appeared to believe that they were safe from HIV because they use condoms with women who they perceive as “risky”. However, it also emerged that their condom use is inconsistent and that they do not use condoms with women who they perceive as “good”.<sup>52</sup>

Pregnant women are being encouraged to access VCCT via antenatal services, but about two-thirds of pregnant women do not currently access antenatal services. The inclusion of VCCT into six or possibly seven RHAC clinics (depending on GFATM money) will increase the number of pregnant women being tested but only within a comparatively small geographic area, and it will not reach out to women who do not use ANC services. The long-term view is that as ANC services improve, more women will use them. These women should then be able to also access VCCT.

It would be informative to ask pregnant women and couples what might make VCCT attractive to them (what type of setting, which type of service provider, what opening hours, whether they would prefer standalone services or whether other services should be provided, etc.). This research could be combined with the research suggested in Recommendation 7.1 regarding standalone community counseling services.

## 7.6 Strengthening referral networks

The Home Care Network is expanding across the country. A national workshop held in 2001 (hosted by the Ministry of Social Affairs, Labour, Vocational Training and Youth Rehabilitation (MoSALVY) with support from UNICEF and FHI) captured lessons learned from programs for orphans and vulnerable children, and there is broad agreement that a “continuum of care” should continue to be developed. But a continuum of care can only be achieved with clear referral networks and clear agreements on referral mechanisms between all care and support partners. According to UNAIDS Best Practice:

“A referral system for provision of comprehensive HIV/AIDS prevention, care, and support should be developed in consultation with NGOs, community-based organizations, hospital directors, and other service managers, as well as with networks of people living with HIV and AIDS. Regular meetings should be held among service providers to review and improve the referral system.”

Currently, the only real reference material that attempts to list HIV/AIDS services and to provide contact information is the HIV/AIDS Coordinating Committee (HACC) service directory. The HACC is now planning a follow-up to its most recent directory, and technical support may be needed to ensure that the directory contains as much accurate information as possible and, where possible, follows international standards for referral information.<sup>53</sup> Furthermore, the directory should be seen to have the backing of the government and should include full information on government services. Information on these services was not included in the last HACC directory.

## 7.7 Improved coordination: A VCCT technical working group

Lack of effective coordination is a problem that is true of much of the HIV/AIDS work carried out in Cambodia, often due to low capacity within the government and concentration of funding (and, therefore, power) in the hands of NGOs and donors. Competition for “territory” has been fierce, and agreements on which work will be done by whom and where can be based solely on who has the most money on offer. This is likely to change, however, due to the more than \$6 million allocated to NCHADS under the five-year DFID program, *Strengthening Cambodia’s Response to HIV/AIDS*.<sup>54</sup> The money may enable NCHADS to require greater coordination and collaboration among its NGO partners. Greater coordination and collaboration should be enabled through the recent establishment of the Technical Working Group on VCCT. Issues to be addressed could include the setting an agreed level for salary supplements to be paid, counseling quality improvement, new VCCT models, and so forth.

## 7.8 Improving linkage between policy, strategy, and implementation

Given the reported proliferation of private VCCT sites in Cambodia, it is important that the government takes, and is seen to be taking, a tough line on imposing quality controls, at least in relation to HIV testing protocols and testing quality control. However, to achieve this, more support will be needed for the VCCT Sub-Unit. The need for support in the area of data collection and management was also identified. Donors need to consider the capacity-building needs of the VCCT Sub-Unit and provincial AIDS offices in data collection and management.

## 7.9 Improved supervision systems, introduction of M&E

Strong facilitative supervision and M&E systems fulfill two main functions: enabling the ongoing development of staff skills and ensuring that staff are aware of the need to adhere to standards set by the Policy, Strategy, and Guidelines on HIV Testing and Counseling. Breach of confidentiality contravenes the guidelines; charging

for testing services contravenes the guidelines; not providing pre- and post-test counseling contravenes the guidelines, but without effective supervision and M&E there is little either to encourage or require staff to meet the agreed standards. The current centralized supervisory systems are unsustainable as the number of VCCTs increases, and the existing focus is on quantitative not qualitative issues.

FHI, CARE Cambodia, and RHAC are already undertaking some innovative work on facilitative supervision within the health sector, while VBNK is involved in attempting to develop M&E skills and in facilitating the establishment of effective and practical M&E systems within a Cambodian context. The Cambodia Trust (CT) is the only NGO in Cambodia to hold the International Standards Organization (ISO) 9001:2000 award for meeting international standards in operational systems (including supervision and M&E). Opportunities should be explored for collaboration among NCHADS, organizations involved in VCCT (including HIV-positive people), and VBNK, in which VBNK could facilitate a NCHADS-organized supervision and M&E workshop, looking at models of supervision and M&E that exist in Cambodia today (including that used by CT) and assisting partners to develop a framework for VCCT supervision and M&E. These partners would include PLWHA. It is possible that PLWHA could also be engaged as members of monitoring teams, with a particular focus on monitoring the quality of counseling. VBNK’s role would be to offer alternative models for ongoing supervision and M&E and to assist participants in developing national guidelines for VCCT supervision and M&E.

The CDC has access to a number of VCCT professionals and would be interested in exploring ways in which these resources could support NCHADS VCCT work. A discussion with the CDC is necessary, but it is possible that they could identify an expert in VCCT M&E systems to support the development of the detailed framework.

Any framework developed should be based on the Policy, Strategy, and Guidelines for HIV Testing and Counseling and should focus on qualitative issues while recognizing the particular constraints and capacity issues in relation to implementing facilitative supervision and M&E within Cambodia. If the UNICEF/WHO consultant to be based in the AIDS Care Unit stays at NCHADS for a year, she may wish to be closely involved in this process.

A framework for improving supervision and M&E could take as its starting point the UNAIDS Best Practice Tools for Evaluating HIV Voluntary Counseling and Testing and existing experience of facilitative supervision within a health care setting in Cambodia—primarily with input from RHAC and CARE Cambodia, which have used the COPE tool as part of their work to mentor facilitative supervision at the health-center level through the Jivit Thmei Project. However, the follow-up process of training effective supervisors/evaluators would be time-consuming and may require close mentoring by an M&E advisor and the regional training teams.

## 7.10 Quality control

It is appropriate that VCCT quality control should become a function of central government. However, what is currently unclear is how the process of moving quality control from Institut Pasteur to the Institute of Public Health will be managed. Nor is it clear what financial or technical support (if any) will be needed, but this needs to be investigated further.

## 8. Summary of Study Findings and Recommendations

The main findings of the study are summarized below. To emphasize the need for a client-centered approach to HIV counseling and testing, these are categorized into findings related to demand, access, and quality.

The majority of the recommendations provided in the report have been included in the Framework for CoC, which is currently under development by NCHADS. Table 3 sets out the key recommendations of the study alongside the relevant recommendations highlighted in the Framework for CoC.

### Summary of Findings

#### General

- No single model exists for ensuring that VCCT is effective, of good quality, in demand, and accessible by members of the public; great interest (among NGOs) in conducting trials of different models of service delivery.
- Need for a more client-centered approach to providing VCCT services, focusing on demand, access, and quality.

#### Demand

- Need for better understanding of client perspectives (especially young people and pregnant women) on use and nonuse of VCCT services.
- Anecdotal evidence of high unmet demand for HIV testing, especially among women.
- Usage of existing government centers is generally low, and no research appears to have been conducted to examine the reasons for this, or to assess what might encourage different target groups to use testing services, or what presently inhibits these groups from using testing services.
- Lack of confidentiality is a major concern for anyone considering an HIV test.
- Proliferation of private testing services; numbers and quality of services largely

unknown; clients often prefer private testing services to those provided by the government.

#### Access

- Some reports of unofficial charges being levied at public sector VCCT centers.
- Concerns about test protocols and client non-return rates.
- Lack of simple and effective referral systems that contain details of existing care and support services, PLWHA support groups, community-based interventions, counseling, and testing.
- Counseling services do not need to be directly linked to testing.

#### Quality

- Anecdotal evidence that the quality of counseling within both public and private sector VCCT is inconsistent or nonexistent.
- Need to improve counseling skills within existing testing services.
- Current counseling training overemphasizes providing information rather than reflective practice and enabling clients to make their own decisions.
- Scope for developing a community network of professionalized counseling teams where PLWHA can play a major role in training and implementation.
- PLWHA also have an important role to play in monitoring quality of services from a client perspective.
- Current focus is on service delivery rather than on meeting the needs of the client.

#### Management and supervision

- Current supervision is focused on quantity, rather than quality; best practice advises that supervision should cover qualitative issues with mechanisms for constructive feedback, opportunities, and encouragement for staff to explore more effective ways of working.

- Data collection systems are generally inconsistent and incomplete; need for capacity building in data management.
- The VCCT Sub-Unit within NCHADS appears to be under-resourced and in need of capacity building.
- Quality control of public VCCT sites has, to date, been carried out by the Institut Pasteur. NCHADS plans to contract quality control from NIPH. It is not clear what training or support will be provided to NIPH to enable its staff to carry out VCCT quality control.
- Potential for collaborative public sector/NGO initiatives (NGOs can complement a national network of hospital/health center-linked testing through developing community-based counseling and support services in high risk areas; mixing government and community/NGO services together could make a critical difference, e.g., PLWHA/government medic counseling teams developed within government testing sites).

**Table 3. Recommendations**

<b>VCCT Report Recommendations</b>	<b>Draft CoC Framework</b>
+ Explore a diversity of VCCT models	The choice of model and site for VCCT services will be based on the results of the situation analysis.
+ Improve counseling services within existing testing sites	Health care workers should be provided with basic counseling skills, and selected staff should receive more advanced training.
# Develop community-based counseling networks	The community, including PLWHA, plays a critical role in the support of PLWHA to continue difficult life-long medical treatments.
# Professionalize counseling, with a greater focus on developing reflective listening and empathy skills	
# Support the involvement of PLWHA in designing, providing, and monitoring counseling services	PLWHA should be trained and employed as counselors in VCCT services. This may help to improve post-test counseling and referral.
+ Market VCCT services to increase demand and access, particularly among ANC women, couples, and young adults	Approved VCCT services could be marketed using two approaches: national marketing of HIV testing and local marketing of specific licensed VCCT services.
+ Strengthen referral networks; create and maintain a database of all relevant services	There is a need for strong referral mechanisms between the home, the community, and the institutional care level.
+ Improve coordination through the VCCT Sub-working group	The function of the CoC is complex and dependent on effective communication and coordination between the elements.
+ Strengthen legislation and licensing of private sector VCCT	All VCCT sites (public, private non profit, private for profit) should be licensed according to MOH regulations. Only services providing counseling of a defined standard will be licensed.
+ Improve supervision systems; strengthen M&E system	A national system for recording and reporting of VCCT, HBC, and HIV care activities in health care facilities should be implemented. NCHADS is currently revising the VCCT dataset and will shortly be training staff from new VCCT services in data management.
# Develop a more facilitative approach to supervision, with a greater focus on quality	Ongoing support after training is essential. This could be provided by an informal mentorship system.
+ Research needed to assess what might encourage different target groups to use testing services, or what presently inhibits these groups from using testing services (prior to marketing of VCCT)	A participatory assessment of the needs of PLWHA should be performed. There is a need to assess current HIV testing usage patterns.
# Develop a more client-centered approach to providing VCCT services, focusing on the key linkages between demand, access, and quality	Policy development should begin with the needs expressed by PLWHA within a larger dialogue between service providers and service recipients.
# Increase commitment to, and protection of clients' rights	

+ fully addressed in Draft CoC Framework

# not fully addressed in Draft CoC Framework

## Appendix: List of Interviewees

Asian Development Bank:

*Mr. Peter Godwin, Regional Advisor, Regional HIV Prevention Project*

CARE Cambodia:

*Ms. Dymphna Kenny, Sewing A Healthy Future Project Manager*

*Ms. Kim Green, HIV/AIDS Coordinator*

Cambodian HIV/AIDS Education and Care (CHEC):

*Ms. Kasem Kolnary, Director*

Cambodian Health and Human Rights Alliance:

*Dr. Mao Guech Huorng, Project Coordinator*

Centers for Disease Control (CDC):

*Mr. Jack Spencer*

Institut Pasteur:

*Dr. Philippe Glaziou, Epidemiologist*

International HIV/AIDS Alliance:

*Dr. Tom Ellman, consultant*

Family Health International (FHI):

*Dr. Chawalit Natrapatan, Director*

*Ms. Pratin Dharmarak, Program Manager*

Khmer HIV/AIDS NGO Alliance (KHANA):

*Dr. Chhim Sarath, Senior Program Officer*

KOSHER:

*Mr. Meas Ramo, Support Group Team Leader*

Maryknoll:

*Father Jim Noonan, Director of AIDS Program*

Ministry of Education, Youth and Sport (MoEYS):

*Mr. In The, Director of Department of Non-Formal Education*

National AIDS Authority (NAA):

*Dr. Tia Phalla, General Secretary*

National Center for HIV/AIDS, Dermatology and STDs (NCHADS):

*Dr. Mean Chhi Vun, Director*

*Dr. Seng Sutwantha, Deputy Director, Co-Chair of Working Group on PMTCT*

*Dr. Hor Bun Leng, Deputy Director*

*Dr. Prom Phanit, Chief of the VCCT Sub-Unit*

*Dr. Heng Sopheab, Chief of the Surveillance Unit*

*Dr. Julian Elliott, Advisor to AIDS Care Unit*

Partners for Development (PFD):

*Ms. Ann Canavan, Program Manager for Health*

Pharmaciens sans frontières (PSF):

*Dr. Farah Naureen, Project Manager*

POLICY Project:

*Ms. Misha Coleman, Resident Advisor*

*Ms. Felicity Young, Country Manager*

Ponleu Chivit Club:

*Volunteers (names unlisted for reasons of confidentiality)*

*Support Group leader Mr. Koe Chun An*

Reproductive Health Alliance of Cambodia (RHAC):

*Dr. Ping Chutema, Director for Clinical Services*

Reproductive and Child Health Alliance (RACHA):

*Dr. Marcel Reyners, Reproductive Health Advisor*

*Ms. Sam Sochea, Safe Motherhood Coordinator*

Social Services Cambodia (SSC):

*Ms. Ellen Minotti, Director*

Transcultural Psychosocial Organization (TPO):

*Dr. Sotheara Chhim, Managing Director*

UNAIDS:

*Ms. Geeta Sethi, Country Program Advisor*

UNICEF:

*Ms. Chin Sedtha, Assistant Project Officer, HIV/AIDS*

*Dr. Etienne Poirot, HIV/AIDS PO*

VBK:

*Ms. Jenny Pearson, Director*

Vithei Chivit Club:

*Mr. Deap Khoeung*

*Ms. La Kumheak*

World Health Organization (WHO):

*Dr. Oscar Barreneche, Medical Officer – Blood Safety/Focal Point for UN Theme Group on VCCT*

World Vision:

*Dr. Douglas Shaw, National Health Advisor*

*Dr. Pann Sann, VCCT Coordinator*

Independents:

*Ms. Lucy Carter, consultant / former advisor to Social Services Cambodia*

*Mr. Kann Kall, former Managing Director of TPO*

*Ms. Ingrid Quinn, former Australian Volunteers International volunteer with the Rose Center, Siem Reap*

## Endnotes

- <sup>1</sup> UNAIDS. 2002. “UNAIDS Policy on HIV Testing and Counseling.”
- <sup>2</sup> Methods recommended include providing access to ARVs, including nevirapine for prevention of mother-to-child transmission, ensuring women are given accurate information and counseling on breastfeeding options, and offering couples testing and counseling.
- <sup>3</sup> The cross-ministry strategizing body for the national response to HIV/AIDS.
- <sup>4</sup> The Ministry of Health’s operational response unit on HIV/AIDS.
- <sup>5</sup> NAA. 2001. *National Strategic Plan for a Comprehensive and Multi-Sectoral Response to HIV/AIDS, 2001–2005* and NCHADS. 2001. *HIV/AIDS Strategic Plan 2001–2005*.
- <sup>6</sup> As this report was written in October 2002, consultant Dr. Tom Ellman was writing a situational analysis on ARV opportunities for the Alliance, and it is possible that he will recommend the development of community- or health center-based HIV/AIDS care teams (with medical and HIV+ members) as focal points for assessing ARV suitability.
- <sup>7</sup> Médecins sans frontières/France is also providing ARVs to 219 patients at Preah Bat Norodom Sihanouk Hospital. The NGO has made a commitment to provide the patients with ongoing supplies of ARVs, and the scheme will be evaluated at the end of 2002. MSF Holland-Belgium has just established a contagious diseases center in Siem Reap and is beginning to provide ARVs.
- <sup>8</sup> A PMTCT pilot, based at the Maternal and Child Health Hospital and a health center in Battambang, began in November 2001 and is currently being evaluated. The operational district (OD) PMTCT implementation, supported by UNICEF and JICA, is likely to result in PMTCT being made more widely available to women attending ANC services through public hospitals and health centers.
- <sup>9</sup> One submission of particular note is a project developed by Pharmaciens sans frontières (PSF) for establishment of an ARV warehouse in Phnom Penh. PSF would procure generic or low-cost brand name ARV drugs and supply them to doctors on government-recognized ARV projects. It is possible that the project will also incorporate small-scale training for pharmacists in dispensing ARVs.
- <sup>10</sup> World Vision’s VCCT support includes materials and equipment and an incentive of \$50/month for part-time VCCT work to two MOH lab technicians. The counselors at the National STI Clinic are on contract to World Vision. In all of the sites supported by World Vision, MOH staff seconded to work on VCCT are expected to accept job descriptions and agreements on responsibility for VCCT. World Vision works with hospital directors to ensure that staff adhere to these work agreements.
- <sup>11</sup> UNICEF’s VCCT support includes materials and equipment, refurbishment/building as necessary, and a salary incentive of \$25/month for two MOH lab technicians and two MOH counselors at each center.
- <sup>12</sup> ADB provides a salary incentive of \$60 a month to two MOH lab technicians and two MOH counselors.
- <sup>13</sup> The salary incentive for this center has been set at \$45/month. Discussions are underway on possibly also providing health insurance for staff. The Red Cross Health Center is an important provider of ANC in Phnom Penh; in fact, the

clinic had already been identified as a VCCT site by RACHA. RACHA was planning to work with the health center on integrating VCCT and PMTCT, but this plan has now been dropped because of the World Vision/RHAC VCCT services opening.

<sup>14</sup> Wilkinson, D., J. Holloway, and P. Fallavier. 2001. “The Impact of User Fees on Access, Equity and Health Provider Practices in Cambodia.”

<sup>15</sup> *ibid*

<sup>16</sup> Cambodian Health and Human Rights Alliance/Cambodian Researchers for Development, September 2001.

<sup>17</sup> Bith, P. *et al.* 2000. “Care and Support for People with HIV/IDS.” Phnom Penh, Cambodia: Japan International Cooperation Agency, Center for Advanced Study.

<sup>18</sup> Khmer HIV/AIDS NGO Alliance, 2001.

<sup>19</sup> KHANA and the International HIV/AIDS Alliance. 2001. “When You Are Ill You Always Hope: An Exploration of the Role of Traditional Healers in HIV/AIDS Care and Prevention in Cambodia.”

<sup>20</sup> This includes CARE, which has home care teams in Koh Kong and Poipet and is planning to expand its home care services.

<sup>21</sup> CDC. 1998. “Rapid HIV Tests: Questions/Answers.”

<sup>22</sup> The report *Learning for Transformation: A Study of the Relationships Between Culture, Values, Experience and Development Practice in Cambodia* (Maira O’Leary and Meas Nee, Krom Akphiwat Phum, 2001) focuses on generalist development agencies, but the following comment could be applied to many HIV/AIDS NGOs: “...assumptions are made about the capacity of staff to personally deal with the issues related to HIV/AIDS and death. Support from the agency to the development practitioner to explore his or her own issues around death and dying and fear of the disease, and to deal with stress, are usually minimal.”

<sup>23</sup> The curriculum introduction states, “The 2001 revision of the National Policy and Guidelines for Counseling and Testing stipulate that all training in counseling needs government approval and must comply with certain minimum standards defined by the NCHADS. This curriculum has been prepared as a model for training workshops for people involved and interested in counseling techniques. It is intended as a first endeavor to develop a national curriculum a set a minimum standard for all counselors training in Cambodia.”

<sup>24</sup> HIV/AIDS Counseling Guidance Note; undated, unattributed, provided by NCHADS.

<sup>25</sup> However, it is possible that some staff working in commercial practice are moonlighting from public practice to boost their salaries. In such cases, staff may have received the NCHADS training in the course of their public practice work.

<sup>26</sup> Cambodian Health and Human Rights Alliance/Cambodian Researchers for Development. 2001. “The Assessment of Patient Rights Within the Context of HIV Testing in Cambodia.” Questioned 15 medical staff working on general wards in public and private hospitals in Phnom Penh and found that some of the staff involved would not tell patients the results of an HIV test “because of fear that the patient would commit suicide.” However, it is not clear if any of these staff have received any VCCT training. It is unlikely, as they are general medical staff and not specifically working on VCCT. As stated previously, the issue of HIV testing being carried out in hospitals as part

of general treatment/diagnosis, often without a patient's knowledge or consent, needs to be addressed but falls outside the terms of reference for this document.

<sup>27</sup> Clear lines of responsibility would need to be drawn between informal discussion of possibilities regarding testing at prevention project level and the work that could be carried out by such a counseling network.

<sup>28</sup> Self Care Needs Assessment for PLWHA, August 2002.

<sup>29</sup> The International HIV/AIDS Alliance is currently looking at ways of expanding monitored ARV provision into the community in Cambodia; the final report is not written, but it is understood that the consultant favors a model in which HIV/AIDS care teams are established at a community level, with PLWHA representation. These care teams would have responsibility for deciding on suitability for treatment. This model could fit nicely with the suggestions in this report for increased community counseling services and the development of counseling teams within government VCCT services.

<sup>30</sup> Currently, CPN+ lists its support group members as World Vision Cambodia, Servants to Asia's Poor, Vithei Chivit, WOMEN, Indradevi Association, Maryknoll, KOSHER, COPHA, Cambodian Prostitutes Union (CPU)/Cambodian Women's Development Association (all in Phnom Penh and all apart from CPU and COPHA believed to provide home care, although COPHA works with traditional healers), Neat Aphi What Sahatphum and Katsikoua Thmei (Kampong Cham), Battambang Women's AIDS Project, Buddhists for Development, Khmer Rural Development Association (Battambang), Banteay Srey (Siem Reap), Khmer Buddhist Association (Banteay Meanchey), Cambodian Children Affected by AIDS (Prey Veng), AFD, Partners for Compassion, and RACHANA (Takeo).

<sup>31</sup> Kann Kall worked with TPO from its inception and left in September to complete a Masters in Business Administration. He is widely accredited with having set the agenda for TPO in recent years. The organization was initially established by a Dutch psychologist in 1995. Kann Kall became director in 1998.

<sup>32</sup> Results of Activity of Voluntary Counseling and Testing Centers Network for HIV Infection Detection, Ministry of Health/NCHADS, 1997–1999.

<sup>33</sup> Institut Pasteur figures for years 1997–1999 from report on Consensus Workshop on VCCT, MOH and French Cooperation, January 2001.

<sup>34</sup> Figures for 2000 from report on Consensus Workshop on VCCT, MOH and French Cooperation, January 2001.

<sup>35</sup> Figures for 2001 from NCHADS data collection report.

<sup>36</sup> Figures for 2001 from Institut Pasteur Annual Reports, 2000 and 2001 (draft).

<sup>37</sup> Cambodia Coordinating Committee for the Global Fund to Fight AIDS, TB and Malaria, October 2002.

<sup>38</sup> This is contrary to the preliminary results from the BSS V, 2001. The BSS, which targeted members of the military, members of the police, moto drivers, direct sex workers, and indirect sex workers, reports that the numbers of women who said they had gone for an HIV test were far higher than the numbers of men (52.1% for direct sex workers, 57.2% for indirect sex workers, 19.9% for members of the military, 33.5% for the police, and 15.6% for moto drivers).

<sup>39</sup> HIV Sentinel Surveillance dissemination presentation, 2002, NCHADS.

<sup>40</sup> Wilkinson, D. and G. Fletcher. 2002. “Peer Ethnographic Research: Male Students and Waitresses in Phnom Penh.”

<sup>41</sup> National Institute of Statistics, Ministry of Planning and Directorate General for Health, Ministry of Health, 2000.

<sup>42</sup> Crossroads Consultancies for CARE Cambodia. 2001. “Rapid Knowledge, Practices, and Coverage Survey, HIV/AIDS and Other Sexually Transmitted Infections, Smach Meanchey District, Koh Kong Province” and “Rapid Knowledge, Practices, and Coverage Survey, O’Chrouv District, Banteay Meanchey Province.”

<sup>43</sup> Assessment of Patient Rights Within the Context of HIV Testing in Cambodia, CHHRA and CRD, September 2001.

<sup>44</sup> The CARE research was carried out in Koh Kong very soon after the NGO had begun to provide some care and support services. In Poipet, the research was carried out prior to any care and support services being provided by the NGO.

<sup>45</sup> As stated previously, (see *Section 6.4: Reasons for being tested*), the over-riding reason for not having a test in both sites was “Scared to know / don’t want to know.”

<sup>46</sup> U.S. CDC Technical Expert Panel, published November 9, 2001.

<sup>47</sup> The Ministry of Education, Youth and Sport (MoEYS) has an interesting model in which community members are trained by an NGO partner in nonformal education, and trainees who complete the course are then offered fixed term contracts with the ministry to provide nonformal education in a community setting. It may be possible that the PLWHA members of counseling teams could be employed on such a contract basis, thereby ensuring that the MOH retains involvement in and responsibility for counseling within VCCT centers.

<sup>48</sup> A similar approach is successfully implemented by the Home Care Model in Phnom Penh, where teams consist of medical staff from health centers and counselors from NGOs.

<sup>49</sup> Such reflection is needed in all areas of development practice in Cambodia, according to *Learning for Transformation: A Study of the Relationships Between Culture, Values, Experience and Development Practice in Cambodia*. Moira O’Leary and Meas Nee, Krom Akphiwat Phum, 2001.

<sup>50</sup> Mr. Meas holds a PhD from an Australian university and his doctoral thesis was on *Social Reconstruction in the Post-Conflict Situation – A Case Study of Rural Cambodia*. Mr. Meas has been involved in workshops for HIV+ support group team leaders, run by CPN+. He was also a founding member of Krom Akphiwat Phum (KAWP) in Battambang, and KAWP has established its own HIV+ support group, which is linked to CPN+. Mr. Meas Nee is also co-author of the much praised research report *Learning for Transformation* (see footnote 48), the findings of which underline and support many of the comments made in this report.

<sup>51</sup> Boswell, D. and R. Baggaley. 2002. “Voluntary Counseling and Testing and Young People: A Summary Overview” Research Triangle Park, NC: FHI.

<sup>52</sup> “Peer Ethnographic Research: Male Students and Waitresses in Phnom Penh,” David Wilkinson and Gillian Fletcher, PSI, 2002.

<sup>53</sup> The CDC Guidelines on Counseling, Testing and Referral state that any referral resource should contain the following: Name of the provider or agency; Range of services provided; Target population; Service area(s); Contact

names and telephone and fax numbers, street addresses , e-mail addresses; Hours of operation; Location; Competence in providing services appropriate to the client's culture, language, sex, sexual orientation, age, and developmental level; Cost for services and acceptable methods of payment; Eligibility; Application materials; Admission policies and procedures; Directions, transportation information, and acceptability to public transportation; Client satisfaction with services.

<sup>54</sup> At current exchange rates, the project budget totals more than \$22 million. Of this, more than \$6.5 million will go to NCHADS over the five years. DFID has set a ceiling on how much of the money can be used for salary supplements, but other than this restriction the money appears to be available to NCHADS to spend as it sees fit as long as spending is either on developing or implementing the NCHADS workplan. As development of VCCT is already a key strand in the NCHADS strategy, it is highly likely that some of this money will be spent on developing public health service VCCT. The primary focus is expected to remain on providing VCCT linked to referral or provincial hospital sites.



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