Population, Health and Nutrition Assessment

Office of Public Health, Cambodia

June, 2001
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>• List of Acronyms</td>
<td></td>
</tr>
<tr>
<td>• Map of Cambodia</td>
<td></td>
</tr>
<tr>
<td>• Executive Summary</td>
<td></td>
</tr>
<tr>
<td>I. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>II. Country Context</td>
<td>4</td>
</tr>
<tr>
<td>A. Historical Background</td>
<td>4</td>
</tr>
<tr>
<td>B. Key Cultural and Gender Considerations</td>
<td>7</td>
</tr>
<tr>
<td>1. Overall Development Context</td>
<td>7</td>
</tr>
<tr>
<td>2. General Social and Cultural Factors</td>
<td>8</td>
</tr>
<tr>
<td>3. Religion</td>
<td>8</td>
</tr>
<tr>
<td>4. Health Beliefs and Practices</td>
<td>9</td>
</tr>
<tr>
<td>5. Gender Issues.</td>
<td>10</td>
</tr>
<tr>
<td>C. Health Sector Development</td>
<td>11</td>
</tr>
<tr>
<td>1. Pre-1979</td>
<td>11</td>
</tr>
<tr>
<td>2. 1979 – 1993</td>
<td>11</td>
</tr>
<tr>
<td>4. Response to HIV/AIDS Epidemic</td>
<td>14</td>
</tr>
<tr>
<td>III. Overview of USAID/Cambodia Mission Strategy</td>
<td>16</td>
</tr>
<tr>
<td>IV. Reproductive and Child Health</td>
<td>19</td>
</tr>
<tr>
<td>A. Overview of Country Situation</td>
<td>19</td>
</tr>
<tr>
<td>1. Maternal Health</td>
<td>19</td>
</tr>
<tr>
<td>2. Family Planning and Fertility</td>
<td>22</td>
</tr>
<tr>
<td>3. Child Survival</td>
<td>25</td>
</tr>
<tr>
<td>B. Donor Support</td>
<td>29</td>
</tr>
<tr>
<td>C. Current USAID Reproductive and Child Health Portfolio</td>
<td>30</td>
</tr>
<tr>
<td>1. Overview</td>
<td>30</td>
</tr>
<tr>
<td>2. Activities with Nation-Wide Impact</td>
<td>30</td>
</tr>
<tr>
<td>3. Community Level Interventions</td>
<td>35</td>
</tr>
<tr>
<td>4. Capacity-Building</td>
<td>43</td>
</tr>
<tr>
<td>V. HIV/AIDS/STDs</td>
<td>45</td>
</tr>
<tr>
<td>A. Overview of Country Situation</td>
<td>45</td>
</tr>
<tr>
<td>1. HIV/AIDS/STD Prevalence</td>
<td>45</td>
</tr>
<tr>
<td>2. Key Intermediate Indicators</td>
<td>48</td>
</tr>
<tr>
<td>3. Current service availability and output</td>
<td>51</td>
</tr>
<tr>
<td>B. Donor Support</td>
<td>58</td>
</tr>
</tbody>
</table>
C. Current USAID HIV/AIDS/STDs Portfolio  
   1. Activities with Nation-Wide Impact  
   2. Targeted, Sub-national Interventions  
   3. Capacity-Building  

VI. Infectious Diseases  
   A. Tuberculosis  
      1. Overview of Country Situation  
      2. Donor Assistance  
      3. Current USAID Portfolio  
   B. Malaria  
      1. Overview of Country Situation  
      2. Donor Assistance  
      3. Current USAID Portfolio  
   C. Dengue  
      1. Overview of Country Situation  
      2. Donor Assistance  
      3. Current USAID Portfolio  

VII. Key Findings and Lessons Learned  

VIII. Potential New Directions and Activities  

Annexes:  
- A. Scope of Work  
- B. Donor Assistance Matrix  
- C. Children Affected By AIDS  
- D. Health Care Financing for HIV/AIDS Interventions  
- E. Persons Contacted  
- F. Documents Reviewed
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
</tr>
<tr>
<td>ADD</td>
<td>Accelerated District Development</td>
</tr>
<tr>
<td>ACNM</td>
<td>American College of Nurse-Midwives</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ANE</td>
<td>Asia Near East Bureau</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>ARO</td>
<td>Asia Regional Officer</td>
</tr>
<tr>
<td>AVSC</td>
<td>Association for Voluntary Surgical Contraception</td>
</tr>
<tr>
<td>BASICS</td>
<td>Basic Support for Institutionalizing Child Survival Project</td>
</tr>
<tr>
<td>BAHAP</td>
<td>Border Area HIV/AIDS Project</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>BCI</td>
<td>Behavioral Change Intervention</td>
</tr>
<tr>
<td>BHSP</td>
<td>Basic Health Services Project</td>
</tr>
<tr>
<td>BHR/PVC</td>
<td>Bureau for Humanitarian Response, office of Private and Voluntary Cooperation</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioral Sentinel Surveillance</td>
</tr>
<tr>
<td>CA</td>
<td>Cooperating Agency</td>
</tr>
<tr>
<td>CARE</td>
<td>CARE International</td>
</tr>
<tr>
<td>CBD</td>
<td>Community-based distribution</td>
</tr>
<tr>
<td>CBR</td>
<td>Crude Birth Rate</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CDCP</td>
<td>Cambodia Disease Control and Health Development Project</td>
</tr>
<tr>
<td>CDD</td>
<td>Childhood Diarrhea Disease</td>
</tr>
<tr>
<td>CDHS</td>
<td>Cambodia Demographic Health Survey</td>
</tr>
<tr>
<td>CEB</td>
<td>Children Ever Born</td>
</tr>
<tr>
<td>CEDPA</td>
<td>Center for Development and Population Activities</td>
</tr>
<tr>
<td>CEP</td>
<td>Continuing Education Program</td>
</tr>
<tr>
<td>CMA</td>
<td>Cambodian Midwives Association</td>
</tr>
<tr>
<td>CMS</td>
<td>Central Medical Stores</td>
</tr>
<tr>
<td>CMR</td>
<td>Child Mortality Rate</td>
</tr>
<tr>
<td>COC</td>
<td>Compiled Oral Contraception</td>
</tr>
<tr>
<td>COPE</td>
<td>Client Oriented and Provider- efficient</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>CRC</td>
<td>Cambodian Real Cross</td>
</tr>
<tr>
<td>CSW</td>
<td>Commercial Sex Worker</td>
</tr>
<tr>
<td>CUP</td>
<td>Condom Use Policy</td>
</tr>
<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
</tr>
<tr>
<td>CWPD</td>
<td>Cambodian Women for Peace</td>
</tr>
<tr>
<td>CYP</td>
<td>Couple-years of Protection</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>DFID</td>
<td>Department For International Development</td>
</tr>
<tr>
<td>DHF</td>
<td>Dengue Hemorrhagic Fever</td>
</tr>
<tr>
<td>DHMT</td>
<td>District Health Management Team</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Surveys</td>
</tr>
<tr>
<td>DOT</td>
<td>Directly Observed Treatment</td>
</tr>
<tr>
<td>DPT</td>
<td>Diphtheria, Pertussis, Tetanus</td>
</tr>
<tr>
<td>DSC</td>
<td>Demographic Surveys of Cambodia</td>
</tr>
<tr>
<td>EC</td>
<td>European Community</td>
</tr>
<tr>
<td>EDB</td>
<td>Essential Drugs Bureau</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Program of Immunization</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FBC</td>
<td>Feedback Committee</td>
</tr>
<tr>
<td>FC</td>
<td>French Cooperation</td>
</tr>
<tr>
<td>FEFO</td>
<td>First Expired, First Out</td>
</tr>
<tr>
<td>FHI</td>
<td>Family International</td>
</tr>
<tr>
<td>FIFO</td>
<td>First In, First Out</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FPIA</td>
<td>Family Planning International Assistance</td>
</tr>
<tr>
<td>FPLM</td>
<td>Family Planning and Logistics Management Project</td>
</tr>
<tr>
<td>GFR</td>
<td>General Fertility Rate</td>
</tr>
<tr>
<td>G/PHN</td>
<td>Global Bureau, Center for Population, Health and Nutrition</td>
</tr>
<tr>
<td>GTZ</td>
<td>German Technical Cooperation</td>
</tr>
<tr>
<td>HACC</td>
<td>HIV/AIDS Coordinating Committee</td>
</tr>
<tr>
<td>HC</td>
<td>Health center</td>
</tr>
<tr>
<td>HDT</td>
<td>Health Development Team</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/ Acquired Immunodeficiency</td>
</tr>
<tr>
<td>HKI</td>
<td>Helen Keller International</td>
</tr>
<tr>
<td>HSS</td>
<td>HIV Sentinel Surveillance</td>
</tr>
<tr>
<td>IDSW</td>
<td>In Direct Sex Worker</td>
</tr>
<tr>
<td>IE&amp;C</td>
<td>Information, Education &amp; Communication</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>IPC</td>
<td>Inter-personal Communication</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>IR</td>
<td>Intermediate Result</td>
</tr>
<tr>
<td>ISSA</td>
<td>Integrated System for Survey Analysis</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>IWDA</td>
<td>International Women’s Development Agency</td>
</tr>
<tr>
<td>JSI</td>
<td>John Snow, Inc.</td>
</tr>
<tr>
<td>JICA</td>
<td>Japanese International Cooperation Agency</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge, Attitudes and Practices</td>
</tr>
<tr>
<td>KfW</td>
<td>Kreditanstalt Fur Wiederaufbau (German bank for Reconstruction)</td>
</tr>
<tr>
<td>KHANA</td>
<td>Khmer HIV/AIDS NGO Alliance</td>
</tr>
<tr>
<td>LBW</td>
<td>Low Birth Weight</td>
</tr>
<tr>
<td>LMIS</td>
<td>Logistics Management Information System</td>
</tr>
<tr>
<td>LNGO</td>
<td>Local Non-governmental Organization</td>
</tr>
<tr>
<td>LSS</td>
<td>Life-Saving Skills</td>
</tr>
<tr>
<td>LSO</td>
<td>Logistics Support Officer</td>
</tr>
<tr>
<td>LOP</td>
<td>Life Of Project</td>
</tr>
<tr>
<td>MAQ</td>
<td>Maximizing Access and Quantity</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MIS</td>
<td>Management Information System</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
</tr>
<tr>
<td>MOND</td>
<td>Ministry Of National Defense</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry Of Health</td>
</tr>
<tr>
<td>MOI</td>
<td>Ministry Of Interior</td>
</tr>
<tr>
<td>MOSALVY</td>
<td>Ministry Of Social Affairs</td>
</tr>
<tr>
<td>MPA</td>
<td>Minimum Package of Activities</td>
</tr>
<tr>
<td>MRD</td>
<td>Ministry of Rural Development</td>
</tr>
<tr>
<td>MSF</td>
<td>Medicines Sans Frontiers</td>
</tr>
<tr>
<td>MSM</td>
<td>Men Who Have Sex With Men</td>
</tr>
<tr>
<td>MTCT</td>
<td>Mother To Child Transmission</td>
</tr>
<tr>
<td>NAA</td>
<td>National Aids Office</td>
</tr>
<tr>
<td>NAP</td>
<td>National AIDS Program</td>
</tr>
<tr>
<td>NG</td>
<td>Non-governmental Organization</td>
</tr>
<tr>
<td>NMC</td>
<td>National Malaria Center</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Survey</td>
</tr>
<tr>
<td>NIPH</td>
<td>National Institute of Public Health</td>
</tr>
<tr>
<td>NID</td>
<td>National Immunization Day</td>
</tr>
<tr>
<td>NMCHC</td>
<td>National Maternal and Child Health Center</td>
</tr>
<tr>
<td>NN</td>
<td>Neonatal Mortality</td>
</tr>
<tr>
<td>NTP</td>
<td>National Tuberculosis Plan</td>
</tr>
<tr>
<td>NRPH</td>
<td>National Reproductive Health Program</td>
</tr>
<tr>
<td>OD</td>
<td>Operational District</td>
</tr>
<tr>
<td>OPV</td>
<td>Oral Polio Vaccine</td>
</tr>
<tr>
<td>ORT</td>
<td>Oral Rehydration Therapy</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral Rehydration Salts</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>PAC</td>
<td>Provincial Aids Committee</td>
</tr>
<tr>
<td>PATH</td>
<td>Program for Appropriate Technology in Health</td>
</tr>
<tr>
<td>PCU</td>
<td>Project Coordination Unit</td>
</tr>
<tr>
<td>PDF</td>
<td>Partners For development</td>
</tr>
<tr>
<td>PET</td>
<td>Peer Education Trainers</td>
</tr>
<tr>
<td>PGE</td>
<td>Peer Group Educator</td>
</tr>
<tr>
<td>PLWHA</td>
<td>Persons Living With HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>PNN</td>
<td>Post-neonatal</td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
</tr>
<tr>
<td>PSF</td>
<td>Pharmacies Sans Frontiers</td>
</tr>
<tr>
<td>PVO</td>
<td>Private Voluntary Organization</td>
</tr>
<tr>
<td>PWHA</td>
<td>Persons With HIV/AIDS</td>
</tr>
<tr>
<td>RACHA</td>
<td>Reproductive and Child Health Alliance</td>
</tr>
<tr>
<td>RH</td>
<td>Referral Hospital</td>
</tr>
<tr>
<td>RCH</td>
<td>Reproductive and Child Health</td>
</tr>
<tr>
<td>RCG</td>
<td>Royal Cambodian Government</td>
</tr>
<tr>
<td>RHAC</td>
<td>Reproductive Health Association of Cambodia</td>
</tr>
<tr>
<td>RSM/EA</td>
<td>Regional Support Mission, East Asia</td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
</tr>
<tr>
<td>SCF</td>
<td>Save the Children Federation</td>
</tr>
<tr>
<td>SEATS</td>
<td>Family Planning Service Expansion and Technical Support Project</td>
</tr>
<tr>
<td>SES</td>
<td>Socioeconomic Status</td>
</tr>
<tr>
<td>SIS</td>
<td>Self Improvement System</td>
</tr>
<tr>
<td>SM</td>
<td>Social Marketing</td>
</tr>
<tr>
<td>SO</td>
<td>Strategic Objective</td>
</tr>
<tr>
<td>SpO</td>
<td>Specific Objective</td>
</tr>
<tr>
<td>SSDS</td>
<td>Social Sectors for Development Strategies, Inc.</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TA</td>
<td>Technical Assistance</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rat</td>
</tr>
<tr>
<td>TOT</td>
<td>Training Of Trainers</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nationals Children’s Fund</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Program</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Family Planning Association</td>
</tr>
<tr>
<td>UNTAC</td>
<td>United Nations Transitional Authority for Cambodia</td>
</tr>
<tr>
<td>USAID</td>
<td>United Stated Agency for International Development</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>VAC</td>
<td>Vitamin A Capsule</td>
</tr>
<tr>
<td>VCR</td>
<td>Videocassette Recorder</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testy</td>
</tr>
<tr>
<td>VCCT</td>
<td>Voluntary Confidential Counseling and Testing</td>
</tr>
<tr>
<td>VSC</td>
<td>Voluntary Surgical Contraception</td>
</tr>
<tr>
<td>VSO</td>
<td>Volunteer Services Overseas</td>
</tr>
<tr>
<td>VSS</td>
<td>Voluntary Sterilization Services</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WS&amp;S</td>
<td>Water Supply &amp; Sanitation</td>
</tr>
<tr>
<td>WVI</td>
<td>World Vision International</td>
</tr>
<tr>
<td>YRHPH</td>
<td>Youth Reproductive Health Program</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

Background


Country Context

A. Historical, Cultural and Gender Factors

Cambodia's tumultuous history, culminating in the genocide of more than a million people and the destruction of Cambodian social and political institutions, economy, culture and religion by the Khmer Rouge (KR) from 1975 - 1979, left in its wake a country without a functioning government or basic services for its 11 million people.

Cambodia has been at peace only for two years. Even prior to the advent of the KR, it was an extremely underdeveloped country; most of the population was illiterate subsistence farmers; and the rural majority lacked access to modern medical care. Efforts at building/rebuilding social structures and capacities only began post-1993.

Cambodian culture is extremely hierarchical and based on power and the fear it inspires. Psychologically, most Cambodians have an overriding concern for personal security. Deep class divisions continue to characterize Cambodian society, with particular implications for interactions between health care providers and clients since the former are seen as members of the upper class and resented accordingly. Many educated Cambodians in turn fear the rural masses, accounting in part for the reluctance of health workers to work in remote rural areas.

Cambodians of all classes place great faith in traditional medical practices which are often the first source of treatment of disease. This does not, however, in any way inhibit acceptance of modern treatments which are over-enthusiastically and excessively used, particularly injections and intravenous fluids. A wide range of pharmaceuticals imported from around the world, along with clever counterfeits, are readily available without prescription throughout the country. Particularly disturbing is the tendency to treat small infants and children with self-purchased drugs. Self-medication has also contributed to multi-drug resistance in malaria and tuberculosis.

The social code of conduct for women includes a strong value on virginity/chastity and submission to the authority of men, who have considerable sexual license both within and outside of matrimony. Reproduction is a private female matter. Women can independently opt to use family planning for which there is virtually no cultural resistance; but, it is difficult to get male participation and co-operation when needed, e.g., condom use or vasectomy. It is unacceptable for males to provide gynecological or obstetric care, which has important implications for maternal health services.
B. Health Sector Development

The Vietnamese-backed government, which took control of Cambodia in 1979, made efforts to reconstruct the completely shattered country. A large number of health workers were recruited rapidly, and they were poorly trained, often in a foreign language. They form the bulk of the present-day health workforce.

The 1993 elections brought international recognition and foreign assistance. Thus began the formidable task of creating a Ministry of Health (MOH) and a health service delivery infrastructure. This effort succeeded, in an astonishingly short period of time, in creating a Ministry with the capacity to plan and administer health services. It also produced a comprehensive “Health Coverage Plan” and "Operational Guidelines" which have been under implementation for the past 4 years, and which represent the first real modern health care system Cambodia has ever known. The task is formidable: the existing workforce, excessive in numbers, is grossly inadequate in skills; salaries are so low that there is little or no incentive to work; and parts of the country remained insecure until just 2 years ago.

The MOH is aware of all of these constraints. Active efforts are underway, with strong technical assistance from a variety of organizations, to address these constraints, including some extremely innovative experiments in health care financing. Rapid progress is being made in the creation of a network of Health Centers (HC) and Referral Hospitals (RH) at the Operational District (OD) level. In five years, 60 percent of planned HCs have been opened. The development of RHs has lagged behind that of HCs, and currently only about 30 percent of planned RHs are functional, mostly in provincial capital towns. Management of health services has been decentralized to the level of the OD, and District Health Management Teams (DHMT) have been created and trained. There are on going efforts to provide "refresher" training to the under-trained workforce. The MOH welcomes NGO assistance, particularly in upgrading skills and the quality of services.

The National Center for HIV/AIDS, Dermatology and STDs (NCHADS), created in 1998, is responsible for the health sector response to HIV/AIDS. At the provincial level, NCHADS has a Provincial AIDS Office (PAO), and in each OD there is a District AIDS Officer as part of the DHMT. The National AIDS Authority (NAA) is responsible for coordination of an expanded multisectoral response to the epidemic. The Provincial AIDS Committees (PACs) report to the NAA at the provincial level.

Cambodia is in the process of implementing a nascent health service system. Tangible results are evident 3-4 years after completion of the initial plans, but development of the planned system is still far from complete. There is every reason to expect that the MOH will continue to make significant progress towards the goal of accessible health services nation-wide. However, that progress will be made in stages, and it will take time. The need to deliver both RCH and HIV/AIDS interventions is urgent and cannot wait for full development of the health care system. At the same time, interventions cannot be delivered without such a system and will always be constrained by the level and pace of system development. RCH and HIV/AIDS efforts in Cambodia must therefore proceed on two tracks, simultaneously: strengthening the nascent service delivery system, and promoting the delivery of specific interventions.
Overview of Present Health Situation

The need for RCH and HIV/AIDS/STD interventions in Cambodia is compelling. Maternal, infant and child mortality rates are among the highest in the world and coverage with basic preventive services is extremely low. HIV prevalence is alarmingly high, and the epidemic has been one of the fastest growing in the world.

1. Maternal Health

The maternal mortality ratio (MMR) is approximately 600 - 620 deaths per 100,000 live births. Most maternal deaths are due to complications of unsafe induced abortion or direct obstetric causes. The majority of Cambodian women deliver at home with untrained attendants, and receive no antenatal care prior to delivery. Delivery practices of Traditional Birth Attendants (TBAs) are known to include harmful practices such as routine manual removal of blood from the uterus. Even when the delivery is conducted by a trained attendant, the skill level of the practitioner is usually low and there is widespread misuse of oxytocic drugs to speed delivery, a very dangerous practice which carries a risk of uterine rupture. Access to emergency obstetric care is limited to nil at present in the vast majority of rural areas. Vitamin A and iron deficiencies are widespread among pregnant women, and iodine deficiency is prevalent in selected areas. Postpartum services are virtually absent, despite the fact that postpartum hemorrhage is a common killer and breast-feeding practices are poor.

2. Family Planning

There has been a remarkably rapid increase in contraceptive knowledge and use in the last five years, demand-driven in spite of limited service delivery mechanisms. The CPR was 23.8 percent in 2000 (compared to 12.8 percent in 1995). For modern methods only, the CPR was 18.5 percent in 2000, compared to only 6.9 percent in 1995. There has been a very recent and significant fertility decrease in Cambodia, attributable to the equally recent rise in contraceptive use.

The current Total Fertility Rate is 4.0, while the Mean Children Ever Born to women aged 15-49 years is 5.6. Among currently married women not using contraception, only 29 percent state it is because they desire another child, and the mean number of children for women giving that reply is only 1.36. 48.9 percent of all married women want to either space their next birth or have no more children; only 9 percent wish to have another child within the two years. Clearly, with a modern method CPR of only 18.5 percent, there is enormous unmet need for family planning.

3. Child Survival

Cambodia has one of the highest levels of infant and child mortality in the world. The IMR is 95.1/1,000. Neonatal mortality is 37.3/1,000 while post-neonatal mortality is an astonishingly high 57.8/1,000. The CMR is 32.5/1,000 and the under 5 mortality rate is 124.5/1,000. Since 1990 there has been a significant and steady increase in post-neonatal mortality. While HIV/AIDS may account for some of the rise in the most recent period (and will certainly do so in the future), this trend occurred too early to be attributable to HIV/AIDS.
Executive Summary

June, 2001

PHN Assessment, USAID/CAMBODIA

The chief causes of infant and child death are neonatal tetanus, ARIs (including post-measles pneumonia), diarrhea, dysentery, meningitis, septicemia, typhoid, malaria, dengue hemorrhagic fever, and unspecified febrile illnesses.

Coverage for basic child survival interventions in Cambodia is extremely low. The majority of Cambodian children are not fully immunized and do not receive Vitamin A prophylaxis. Indigenous breast-feeding practices further expose infants to unnecessary risks of food and water borne diseases and malnutrition. When ill, the majority of Cambodian children do not receive treatment from a trained health provider. There is, therefore, enormous scope for significantly and rapidly reducing infant and child mortality through the delivery of a few key interventions.

4. HIV/AIDS/STDs

HIV was first detected in Cambodia in 1991. The pace of escalation of the epidemic has been one of the fastest in the world. By 1999 the estimated cumulative number of HIV infections had reached almost 250,000 and the cumulative number of AIDS cases nearly 22,000. The annual number of new AIDS cases is projected to reach 30,000 by 2005. NCHADS estimates that there are 40,000 children orphaned due to AIDS and that approximately 7,500 children have died of AIDS.

Given both cultural norms and the nascent state of development of the Cambodian health system, the care of AIDS patients and orphans will largely fall on immediate and extended families. This is not a new situation to Cambodia where families have coped in the past with equally large numbers of ill and dying, and absorbed large numbers of orphans. Family loyalties are very strong and families – in the most extended sense – recognize an almost inviolable obligation to care for their members.

HIV in Cambodia is transmitted primarily via heterosexual contact. Infection is highest in commercial sex workers and men who frequent them. Male clients form a bridge between the infected commercial sex worker population and the general population.

HIV prevalence in the general population was approximately 2.9 percent in 1996, increasing in only a year to 4.6 percent after which it stabilized and showed a slight decline in 1999 to 3.2 percent. In 2000, the prevalence declined to 2.8%. Estimated HIV prevalence among direct commercial sex workers (DCSWs) of all ages was 37.9 percent in 1995, peaked in 1998 at 42.6 percent, and in 1999 had decreased to 33.2 percent. Among indirect commercial sex workers (IDCSWs), rates are lower but the decline has also been less: from 19.2 percent in 1998 to 18.6 percent in 1999. Among antenatal (ANC) women tested, rates have remained relatively constant at approximately 2.6 percent, suggesting that the disease is moving into the mainstream population and in particular to women not involved in either direct or indirect sex work. HIV prevalence among military personnel was estimated to be 5.9 percent in 1996 and 7.1 percent in 1997. Among the police the level declined from approximately 8 percent in 1995 to 4.7 percent in 1999, and 4.2% in 2000.

About 44 percent of all female sex workers have at least one STD, and half of these women are asymptomatic. STD rates among Cambodian men are very high in comparison to rates for men in
other South and Southeast Asian countries. In men, primarily members of the military and police, 17 percent have at least one STD.

A vigorous campaign by the public and private sector was launched to increase the use of condoms to prevent HIV transmission, through Social Marketing and a variety of IEC efforts. A 100% Condom Use Policy (CUP) for brothels was recently approved for nation-wide implementation following a successful pilot test. The CUP aims to ensure that condoms are used in every sexual transaction in every brothel in the country. Regular STD checks for sex workers are used to monitor compliance.

These interventions are showing some positive results. According to the Behavior Sentinel Surveillance, between 1997 and 1999, there was a significant decline in the proportion of men who paid for sex the previous month. However, nearly one third of the target groups covered still regularly purchase commercial sex. Consistent condom use by CSWs and their male clients also increased sharply between 1997 and 1999, from 42 percent in 1997 to 78 percent two years later. Similarly consistent condom use has increased to between 69 and 81 percent for military, police and moto-taxi drivers. However, consistent condom use by IDCSWs, is less than 40 percent, and there is low use of condoms by CSWs and their clients with spouses and "sweethearts", creating a bridge to the general population.

Voluntary counselling and testing (VCT) services are not yet widely available; only 6 public sites have been established. VCT remains completely unavailable in 18 out of the country’s 23 provinces. Demand for VCT appears to be quite high, as evidenced by an unregulated private sector response, spontaneous popularity of premarital testing as criterion for familial consent, and by overwhelming turnout at the few testing facilities available. NCHADS plans to expand VCT services nation-wide.

There are also plans to gradually introduce nivarapine treatment to prevent MTCT. This will be quite difficult in Cambodia since the majority of pregnancies never enter the public health system. There is a notable gap in policies, strategies and interventions with regard to breastfeeding by HIV infected mothers, in part because such a policy would have to be developed collaboratively by both NCHADS and the National Maternal Child and Health Center (NMCHC); culturally, collaboration across organizational lines is extremely difficult to achieve.

5. Infectious Diseases

Tuberculosis

Even prior to the advent of HIV/AIDS, tuberculosis was a major cause of morbidity and mortality in Cambodia. The country’s estimated incidence of 539 cases per 100,000 population is the highest in the world with the sole exception of sub-Saharan Africa. Every year, 60,000 new TB cases occur and about 10,000 cases die (90 TB-related deaths per 100,000 population). It is estimated that two thirds of the population are infected with M. tuberculosis. Given the magnitude of the HIV/AIDS problem in Cambodia, an explosive increase in the already high incidence of TB over the next five years is inevitable and may well reach levels equal or exceeding those of the worst affected African nations. HIV sero-prevalence among TB patients
has increased sharply since the beginning of the HIV epidemic. In 1995, 3 percent of TB patients were HIV positive. This figure doubled to 8 percent by 1999 and is as high as 18 percent in some regions of the country.

Although national policy calls for TB treatment in HCs, the logistical and training implications are considerable and to date TB treatment has been available only in hospital level, effectively out of reach for many patients. It is estimated that the current national program detects no more than 40 percent of actual TB infections in the population, a level inadequate to curtail transmission.

The MOH has recently decided to expedite introduction of DOTS at HC level given the expected rapid increase in TB incidence. Donor support for drugs, supplies, and clinical training is adequate, as is support and TA to the National TB Program. However, HCs will require intensive assistance from NGOs to ensure proper adherence to protocol, non-diversion of drugs, and community IEC.

Malaria

Malaria is a leading cause of morbidity and mortality in Cambodia. Overall, approximately 2 million Cambodians are considered to be at risk of infection. WHO estimates there are 1 million cases annually. Ninety-two percent of these are due to *Plasmodium Falciparum*. Malaria in Cambodia has a higher case fatality rate than in neighboring countries. Multi-drug resistance is widespread, especially in the western parts of the country and the selling of counterfeit anti-malarial drugs is a significant problem. Extrapolations from hospital data yield a generally accepted estimate of 10,000 deaths from malaria per year in Cambodia. The overall case fatality rate for hospitalized severe malaria in 2000 was 9.8 percent, but runs as high as 30-88 percent in remote referral locations. Many patients die without ever receiving medical care. Although working age males have the highest incidence, pregnant women and infants are at greatest risk of death when infected. Malaria in pregnancy, particularly in the third trimester, is associated with extremely high rates of fetal loss and maternal death.

The MOH approach to malaria consists of prevention through IEC and distribution of impregnated bed nets, and treatment through both public and private sector channels. Donor funding for commodities and support to the National Malaria Center (NMC) is adequate, but experience suggests that NGO assistance at the community level is essential for successful IEC and bed net distribution/use. There are also unmet needs within the NMC for TA in social marketing.

Dengue

The leading cause of death among children aged 1-5 years, dengue hemorrhagic fever reaches epidemic proportions in Cambodia every 2-3 years, affecting both rural and urban areas. Household water jars are the prime breeding site, with an average of 85% of water storage containers testing positive for larval infestation. The most recent outbreak occurred in 1997-8, and another is feared in 2001 or 2002. The case fatality rate for DHF is much higher in Cambodia than in neighboring countries, ranging from 3.6 – 15 percent nation-wide, but
substantially lower in the capital city due to the availability of higher trained personnel and better equipped facilities. The MOH strategy with respect to DHF is one of prevention through larvicide treatment of water jars and promotion of water jar lids, and improved case management through training. Donor funding for a mass larvicide campaign this year is inadequate. There is also an as yet unmet need for TA and funding for social marketing of jar lids.

Program Strengths and Achievements

Activities in the present USAID portfolio have had significant impact on achieving the Specific Objective of Improved Reproductive and Child Health, and the Special Objective of Reduced Transmission of STD/HIV among high risk populations. Activities which have been particularly successful include:

A. Strengthening of Integrated Community-Level MCH/FP Services

Community level services in Cambodia are delivered in an integrated fashion, with HCs and HC outreach sessions as the primary source for MCH, FP, and curative care. HCs will also soon become the primary point of contact for TB treatment and HIV/AIDS detection. HCs are supported by Referral Hospitals (RHS), one per operational district, and supervised by District Health Management Teams (DHMTs).

Three USAID-funded projects (RACHA, CARE and PFD) work to strengthen these services in accordance with the MOH Health Coverage Plan and Guidelines for Operational Districts (ODs) through TA, training, mentoring, facilitative supervision and logistical support to HCs, RHS, HC Outreach, and HC feedback committees. All of them have achieved a much higher rate of service delivery and service utilization than is noted in ODs without such support. Key elements found critical to success are:

- Recognizing and addressing all essential elements of district health services and the linkages and referral network between them: HCs, HC outreach, RH and DHMT. The more completely this is done, the better the results.

- Provision of competency-based training to RH, HC and DHMT staff to improve clinical, counseling/interpersonal, and managerial skills

- Provision of intensive on-the-job follow-up, coaching and mentoring. This is essential for staff to internalize new skills, attitudes and approaches.

- Support to HC Feedback Committees (FBCs). These committees, consisting of elected representatives from each village, provide an essential mechanism for improving HC-villager relations and promoting health practices and utilization of preventive services. They empower communities and create a sense of accountability towards clients which health workers, raised and trained in an authoritarian culture, have never before had.
B. Maternal Health

TA through the USAID-funded RACHA project has contributed to the development of national policies and guidelines for safe motherhood. A competency-based training course for midwives, Life-Saving Skills (LSS), has been developed and serves as a model for the country. In USAID-funded project areas, LSS-trained midwives have significantly improved the quality and quantity of their services. Keys to this success have been careful training selection criteria, practical training provided in a setting with a high volume of deliveries, and intensive post-training follow-up.

C. Logistics Management

TA and training in logistics management of drugs and contraceptives have been conducted nation-wide through the RACHA project, augmented by district-level follow up in ODs where they work. Dramatic improvements in stock levels have occurred in areas where both the training and subsequent follow-up (including computerization down to OD level) were provided.

D. HIV/AIDS/STD Prevention

1. Condom promotion through mass media, social marketing, and BCC targeted to CSWs, police and military has directly contributed to a substantial decrease in both high risk behavior and HIV prevalence in these groups.

2. The social marketing of condoms in combination with parallel behavior change communication and IEC programs has been a key contributor to the achievement of the Special Objective. Almost all condoms presently available through commercial outlets are distributed by USAID-funded PSI. Annual sales have grown from 5 million condoms in 1995 to 16 million in 2000. PSI's Number One condom has been effectively targeted at commercial sex workers and their places of work, as well as their male clients, especially military personnel, policemen and other men who frequent brothels. Number One condoms are available in 93% of brothels recently surveyed.

3. BCI interventions with CSWs have both reduced their vulnerability to infection and provided critically needed social support. The involvement of local women’s NGOs in CSW empowerment activities is a particularly positive contribution and important step towards breaking down the barriers of social isolation that surround CSWs. Peer education and peer support, networking, and mobilization activities provide not only HIV/STD prevention information, but a much-needed sense of community.

4. Technical assistance and funding support channeled through the FHI/IMPACT project to the Ministries of National Defense (MOND) and Interior (MOI) have helped these two Ministries develop and implement a constructive and pro-active approach to the problem of HIV/AIDS. Their peer education programs have to date reached 27,000 military personnel (approximately 20 percent of the entire military forces of Cambodia) and approximately 6,000 policemen.
5. USAID-funded TA and funding through KHANA has helped develop a network of local NGOs with capacity to implement HIV/AIDS interventions at the grassroots level. This is an invaluable resource, which will greatly facilitate the ability of government and donors to deliver interventions at village level in the future. In addition, KHANA serves as a vehicle to co-ordinate and voice Local Non-Government Organization (LNGO) concerns.

E. Research and Policy

USAID-funded research has informed policy and programs in both RCH and HIV/AIDS. The HSS and BSS have raised the awareness of policy-makers in all sectors of the magnitude of the problem, and provided hard data on which to base programs and interventions. The DHS has provided government, donors and implementing agencies with reliable health indicators. RACHA studies on causes of maternal and child mortality provide the first, and only, population based information on causes of maternal and infant/child deaths. Studies by HKI have drawn attention to micronutrient deficiencies and directly contributed to policy and program interventions. Studies by CARE have shed light on attitudes and behaviors of CSWs and their clients. STD studies by FHI have added considerably to the previously weak knowledge base with regard to STDs in Cambodia, and helped inform interventions.

F. Family Planning

1. Social marketing of oral contraceptives has had a significant positive result on access and use of Combined Oral Contraceptives (COCs), especially in urban and peri-urban areas, and has the potential to do the same for injectable contraceptives.

2. Support to the Reproductive Health Association of Cambodia (RHAC) has contributed to the development of model urban private sector RH clinics, providing a full range of FP methods, diagnosis and treatment of RTIs and STDs, ante and postnatal care and counseling on HIV prevention. In addition to direct provision of a significant amount of FP and STD services, RHAC has the capacity to provide high quality training in clinical techniques, IEC and counseling to NGOs and government.

3. CAs have supported the delivery of FP services in HCs and during HC outreach through training, coaching and mentoring of HC staff, and logistical assistance with outreach sessions. Between 1998-2000, the contribution of HCs to modern method CPR rose more than five-fold. This is particularly impressive since only 60 percent of planned HCs were operational in 2000, and half of these had been open just one year. HC strengthening has tremendous potential to further increase CPR.

G. Infectious Diseases

Community-based impregnated bed net distribution and IEC by the USAID-funded Partners for Development (PFD) in a province with high malaria transmission has achieved 100% coverage of the population and a documented threefold decrease in the incidence of malaria. This effort is a model with potential for wider replication.
H. Child Survival

Formative research on vitamin A deficiency and strategies for VAC distribution have directly contributed to the establishment of a National Vitamin A Policy and incorporation of VAC in all EPI programs nation-wide.

I. Capacity Building

1. CARE and other USAID-funded CAs have made substantial contributions to the capacities of their own local staff, district level health care providers, and communities. Impressive initiative and skills have been developed in young Cambodian professionals, particularly by CAs with clear plans, policies and resource allocation for local staff development.

2. Capacity-building among district level government health workers is naturally a slower process, hampered by the low salaries and non-merit based organizational culture that typify government work. Nonetheless, significant progress has been made. Pharmacists trained in drug and commodity logistics are able to apply these skills as evidenced by a documented decrease in stock outs. Midwives with competency-based training in have an increased client caseload as testimony to their improved quality of care. Village-based “feedback committees” are now able to bring village concerns to the health care system. Villagers are empowered with basic health information with which to avoid unnecessary disease and unwanted pregnancies.

3. KHANA has helped foster the technical and organizational capacities of numerous local NGOs. A number of these have "graduated” to the point of requiring no additional TA and, in some cases, only limited funding.

Program Constraints and Missed Opportunities

There are, however, some constraints in the current portfolio and missed opportunities which, if addressed, may lead to greater impact. These include:

A. Cross-Cutting Issues

1. RCH and HIV/AIDS/STD activities are currently being implemented in a total of 18 different provinces, sometimes in a single small locality within a province. HIV/AIDS/STD activities are generally not in the same areas as RCH activities. RCH activities often fail to completely cover a whole OD, and almost never include all the ODs of a province. Lack of a critical mass of interventions/coverage both reduces potential impact and makes it more difficult to measure.

2. In the HIV/AIDS portfolio there are a number of small, potentially successful interventions for OVC and PLWA that do not have a unifying theme or strategy. In the RCH portfolio, there are instances where an overwhelming number of new innovations have been tried at once without the kind of depth, follow-up and documentation that would maximize their potential.
3. Some initiatives have been undertaken with some neglect of the larger national picture. In HIV/AIDS, there are some pilot projects in which the model used would be difficult to replicate on a large scale given the realities of the present health care system and overall level of development of the country. In RCH, there are some approaches to systemic constraints that are aimed at achieving immediate results, but may cause greater difficulties in the long run.

4. Without an overarching research agenda, some research has been done on an ad hoc basis. It would be more efficient to base research on program needs and the potential utility of the findings.

5. There has not been enough interface between HIV/AIDS/STDs and RCH programs or the overall health service delivery system. Health care providers are not well informed about some proposed interventions, including those they will have to implement.

6. The verticalization of HIV/AIDS/STD and RCH programs – both within the USAID portfolio and within the MOH – does not take full advantage of many important opportunities for synergy. Examples of some missed linkages, which can be formed in the future, include:
   - Mass media IEC, currently focused on HIV/AIDS/STD and to a lesser extent, FP, have not included key RCH messages.
   - IEC through community outreach has often focused on vertical areas rather than an integrated package of key MCH/FP/STD/HIV/AIDS messages.
   - HIV prevention efforts and messages currently do not provide health professionals, especially midwives, with specific information on universal precautions to protect the providers and to avoid HIV transmission through medical procedures. This group has been largely left out of HIV education efforts and their gaps in knowledge, and concerns, are substantial.
   - Ante-natal, obstetric and post-natal care do not currently include STD detection and treatment, or counseling on prevention of STDs and HIV to minimize risks of infection before pregnancy and MTCT.
   - Family planning services currently do not contribute enough to HIV prevention, and vice-versa. The dual protection benefits of condoms must be stressed.

7. The reach of social marketing, both for pills and condoms, is still primarily urban and peri-urban. Although about 10 percent of USAID-funded COCS are sold to NGOs for resale in rural areas, overall rural availability of both pills and condoms is low, a priority concern in a country where 85 percent of the population is rural.

8. There is as yet much potential for social marketing to increase access to and utilization of a much wider range of reproductive and child health commodities, e.g.: ORS, iron/folate supplements for pregnant and post-partum women, anti-malarial drug kits, permeable water
jar lids and larvicide, anti-helminthic drugs, STD treatment, etc. In addition, there is untapped potential for the Social Marketing Project to expand beyond project implementation and provide TA and capacity building in marketing to other agencies.

9. After the 1997 coup, USAID’s PHN activities were suspended and then resumed with restrictions on interaction with the government. At this point, it may be effective to consider interaction with the RCG so as to facilitate the delivery of essential services to the Cambodian people.

10. While there have been substantial contributions to capacity-building of individuals, local NGOs, and community level health facilities, USAID may benefit from focussing on national level health policy issues. The sustainability and long-term impact of USAID’s investments will be substantially affected by the extent to which the government is able to address fundamental sectoral constraints.

B. Intervention-Specific Issues:

1. Maternal Health

(a) While progress is being made in USAID-funded project areas in increasing the quality and coverage of antenatal services and safe delivery, post-partum interventions have been neglected. The majority of direct obstetric deaths are due to post-partum hemorrhage, and improper breast-feeding is a significant contributor to infant mortality.

(b) Delivery at home, even when conducted by a trained midwife, is apt to entail significant unnecessary risk due to widespread use of dangerous modern medical interventions. This makes the development of client-friendly delivery services in HCs and RHs all the more important. One of several factors constraining the use of health facilities for delivery is the failure of these to incorporate non-harmful traditional beliefs and practices. This was successfully done in the past with Cambodian populations in Thai refugee camps and effectively increased deliveries in hospitals.

(c) While significant resources are being directed to TBA training, it is not clear that this actually improves TBA delivery practices. Less attention has been given to partnering arrangements between HC and RH midwives and TBAs, which preserves the important psychosocial and spiritual functions of the TBA while decreasing the risks of unsafe delivery. This has been successfully done in non-USAID funded NGO areas.

(d) Unsafe abortion is a common problem in Cambodia. Currently, there is no specific linkage between hospital care for complications of abortion and the FP program.

2. Family Planning

(a) Although 10 percent of USAID-funded birth-control pill sales are through NGOs in rural areas, there is not enough penetration into the rural private sector and both condoms and
COCs were noted to be unavailable in rural villages, despite a proliferation of small shops and vendors in even the most remote areas.

(b) Emergency Contraception is not available in the FP program, a strong unmet need given the reportedly high incidence of rape and large adolescent population.

(c) There is little understanding or promotion of the dual protection (pregnancy and STD/HIV) advantages of condoms. FP providers currently give too little emphasis to condoms, which are associated with disease prevention rather than contraception.

(d) One USAID-funded organization conducts community-based distribution of contraceptives in several provinces. In areas where HCs are not yet functioning, this is the sole source of RH services at community level. However, in those areas where HCs are functioning well, the Health Development Team (HDT) program has not adjusted to reflect this change in the health system but rather continued to function in a parallel manner, missing an important opportunity to strengthen the new district-based health care system.

(e) The most commonly cited reason for both non-use and discontinuation of contraception is side effects. Nutritional deficiencies are a possible cause worthy of exploration. Folic acid and B vitamin deficiency are known to occur more frequently in users of COCs, and are also known to be frequent in the Cambodian population.

3. Child Survival

(a) Child survival has been relatively neglected. As infant (especially post-neonatal) mortality rates are high and steadily rising, this needs to be addressed.

(b) The present national EPI/VAC strategy may benefit from restructuring. Coverage levels are still inadequate and have not improved much in the last two years. Geographical realities make it difficult to achieve significant coverage through static clinic based EPI. Without external technical assistance, HCs cannot manage the complexities of rotational outreach to villages. Government funds for outreach are not reaching the periphery. Time-consuming monthly outreach to very small villages is labor intensive and costly.

(c) The majority of ill children in Cambodia are never taken to a trained health provider; when they are, the result is often incorrect treatment. Cambodians prefer to go directly to pharmacies and shops rather than to trained health providers largely because they do not perceive there to be any benefit to consultation, due to the low level of provider competency, and because they fear being treated in a derogatory manner. Unfortunately, these perceptions are at present accurate ones. There is no added value to obtaining curative treatment from a HC as opposed to a pharmacy in the vast majority of cases, and providers lack training in interpersonal skills and in bridging class barriers. None of the present USAID-funded projects currently addresses these issues.

(d) There is scope for significant improvement in infant and child health through improved breast-feeding practices. A very high burden of diarrhea and dysentery has been documented.
in Cambodian children, including dysentery in neonates, and is undoubtedly related to the practice of discarding colostrum and non-exclusive breast-feeding. In addition, inadequate provision of weaning foods is a significant contributor to the malnutrition which underlies a great deal of early child mortality. Although existing USAID funded projects promote BF, it could be done more intensively.

(c) There is untapped potential for using social marketing to improve access to and demand for child survival services, e.g. ORS, anti-helminthics, wound care kits, and possibly other simple curative drugs with clear dosage information.

4. HIV/AIDS/STDs

(a) USAID funds many of its HIV/AIDS interventions through umbrella projects, which in turn make sub-grants to NGOs. This arrangement allows the Mission to have the benefit of multiple implementing agencies, particularly LNGOs, while addressing USAID financial accountability requirements and management constraints. Direct recipients of USAID financial support should make value-added inputs to ensure improved technical competence and efficiency among the sub-grantees. The degree to which this has thus far happened is variable. Some grantees could benefit from focusing more on the provision of support to their sub-grantees, especially in the areas of strategic planning, program design, and IEC.

(b) It is essential that grantees have clear guidelines and criteria for ensuring that sub-grants fit within the framework of the USAID Mission’s strategic objectives.

(c) In some cases, reliance on sub-grantees to respond to the IEC needs of other sub-grantees has not been effective. Unmet needs for basic IEC materials were noted among some sub-grantees.

(d) While IEC and BCC efforts have contributed greatly to knowledge of AIDS and improved condom use, there are gaps in message content and targeting, e.g.:

- Care of PLWHA and CAA has gotten comparatively little emphasis;
- Messages about HIV prevention stress dangers but fail to make clear ways in which HIV is not transmitted, leading to unnecessary fear and stigmatization;
- There has been an over-reliance on printed text where more visually literate materials would reach a greater number of people;
- Current approaches and strategies have been effective in reaching CSWs and their clients, but less so in reaching IDCSWs and migrant male workers;
- Preventive messages stress commercial sex encounters; there has been too little emphasis on protection of wives and “sweethearts”.


(e) A number of small pilot projects have been undertaken for care and support of PWHA and CAA. They need critical re-examination in terms of strategic coherence, replicability and realistic potential for scale-up. It is unrealistic to expect that, in a country still far from providing widespread access to treatment for curative illnesses, every AIDS patient can receive professional home care services. There is a need to prioritize and develop selection criteria for who is to receive what level of services, and to identify non-professional first-line care providers.

(f) While condoms are readily available in commercial sex establishments, this is not the case for more informal locations, such as hotels and guesthouses, which are frequented by indirect sex workers and their clients. Such encounters usually occur at night, when shops are likely to be closed. In the absence of readily available condoms near nocturnal meeting places, intercourse is likely to be unprotected.

5. Infectious Diseases

Tuberculosis

The present portfolio has included pilot testing of home delivery of DOTS. However, DOTS is not yet available at the HC level in most of the country. The greatest priority, for both general and HIV positive TB patients alike, is the implementation of HC DOTS. Premature efforts at doorstep delivery are unlikely to achieve measurable impact, and will not represent the best use of resources, which might otherwise be focused on implementation of HC DOTS and community IEC on transmission and treatment.

Malaria

The MOH has developed and field-tested a malaria test and treatment kit for distribution through social marketing. There is a great opportunity for the USAID Social Marketing Program to assist in developing marketing capacities in the public sector through collaboration with the National Malaria Center (NMC).

Dengue

Dengue Hemorrhagic Fever (DHF) is the leading cause of death in Cambodian children ages 1-4. Epidemics occur every 2-3 years and a widespread outbreak is feared for 2001 or 2002. The present portfolio contains no activities related to prevention or case management of DHF, and overall donor funding is inadequate, especially for prevention activities. A water (but not mosquito) permeable water jar lid has been developed and successfully piloted by the MOH. There is a gap in both funding and marketing TA for the successful social marketing of these lids.
Emerging Needs

A. VCT

To date, the USAID portfolio has not critically addressed VCT. The MOH plans to expand VCT nation-wide. While other donor support for the medical aspects of testing, and the supplies will probably be adequate, there will be enormous need for training, TA, mentoring and facilitative supervision of counselors, especially at the provincial and district levels where the health system is still quite new and weak. Counseling is not an indigenous concept in Cambodia. The planned nationwide expansion of VCT in the public sector will require intensive field level inputs.

In addition, the huge demand for VCT throughout the country, both in high risk groups and in the general population, currently overwhelms public sector testing facilities where they already exist, and will probably continue to do so. There is a potential market for complementary fee-for-service VCT in areas where government has already established free services, to cater to middle class concerns and reduce the burden on government facilities. This could include a comprehensive package of premarital RH services, since premarital testing is already becoming a societal norm.

B. Children Affected By AIDS

Lack of in-country technical capacity for early testing of infant HIV status results in unnecessary institutionalization of children orphaned or abandoned due to HIV/AIDS. Polymerase Chain Reaction testing is not generally available in Cambodia. Its introduction could greatly facilitate adoption of AIDS orphans within their families and/or communities. Such an initiative would, of course, need to link closely with agencies caring for OVC and, recognizing that some children will test positive, with pediatric hospitals and hospices.

Potential New Directions

A. Cross-cutting

1. The health care system in Cambodia is only four years old, and still in the early stages of development. To be effective, disease specific interventions must be accompanied by measures to strengthen it. USAID has a comparative advantage in strengthening health care delivery systems, particularly at the Operational District level, through:

   - a systems approach addressing essential elements of district health services
   - competency-based training for district health staff
   - intensive on-the-job follow-up and coaching after training is completed
   - support for the formation and activities of HC Feedback Committees

2. USAID may benefit from nascent cooperation with the government, as well as other donors, in resolving such fundamental issues as client charges and provider compensation. Political commitment to achieving a functioning public health system needs to be supported.
3. To maximize impact and effective leveraging of resources and to minimize administrative burden, a few and selected number of provinces should be targeted with a closely linked and strategic package of RCH and HIV/AIDS interventions in tandem with support for strengthening all ODs in the provinces selected.

4. Umbrella mechanisms offer manageable means of working through a large number of smaller organizations such as LNGOs, but only if the umbrella CA provides value added, strategic planning and technical support which should be clearly specified in CA agreements. It may be easier to achieve efficient Mission oversight if bilateral rather than field support mechanisms are used to fund umbrella mechanisms.

5. USAID has a strong comparative advantage in Social Marketing. It will be important to continue social marketing strengthening to achieve product placement in rural areas and squatter settlements. It may also be sensible to encourage the SM Program to work with other CAs and government agencies to building social marketing capacities.

6. It is important to support CAs in the development of their local staff as an integral part of their programs.

B. RCH-HIV/AIDS Linkages

1. The new strategy should make maximal use of potential linkages between RCH and HIV/AIDS/STDs interventions, including (i) IEC messages, (ii) ante-natal, obstetric and post-natal care and MTCT, HIV/STD prevention; (iii) FP and VCT, STD/HIV prevention; and (iv) ANC and STD prevention and treatment.

2. USAID should consider developing approaches and strategies that reach and counsel men, especially those seeking STD treatment, about dual protection with condoms.

3. RHAC clinics are an excellent model for urban RH/STD service delivery and should be encouraged to expand to other selected cities and to offer VCT as part of a package of premarital RH/FP/HIV/AIDS services.

4. IEC and training should be given to health care providers, especially midwives, on universal precautions to protect themselves and their patients.

5. MCH/FP providers and facilities have readiest access to women who are at risk of HIV/AIDS because of their partner's risky sexual practices. They should receive appropriate training in HIV/STD prevention counseling.

6. The issue of PMTCT and breast-feeding requires further research, including exploration of the feasibility of wet-nursing. Research should then inform development of new, clear policies and guidelines.
C. Reproductive and Child Health

1. High priority should be given to ensuring that the future strategy does not lose the "C" in RCH. Programs must maintain focus on child health.

2. USAID should continue to engage in policy dialogue with other agencies, such as UNICEF, on globally funded issues such as measures to improve EPI performance and provision of iodized salt.

3. USAID should consider the provision of TA to the national EPI program (through UNICEF if necessary) to explore new strategies for improving EPI coverage.

4. Logistics system strengthening through refresher courses, on the job training, and facilitative supervision at the field level should be included as an essential components for concentration. Facilitation should be provided to agencies working in other geographical areas to assist them in doing likewise.

5. USAID should consider working with other donors to create a contraceptive security plan.

6. It may be beneficial to conduct pilot studies to determine whether Vitamin B/folic acid supplementation reduces perceived hormonal contraception side effects.

7. In consultation with Government and other partners, Emergency Contraception should be introduced into both the public sector FP mix and into the Social Marketing Program.

8. USAID and RHAC should revisit the Health Development Team strategy and consider alternative approaches in ODs where HCs function.

9. USAID participation through its CAs in the development of national Safe Motherhood policies and guidelines is important. The present model for improving delivery practices through the LSS course and intensive follow-up is quite effective.

10. Consideration should be given to improved post-abortion care to save women's lives and encourage FP use.

11. Operations research is recommended for incorporation of traditional/non-medical elements into delivery services.

12. It is important to continue to support policy guidance and research on Vitamin A and other micronutrient deficiencies.

13. Studies should be supported to determine the feasibility and potential of a widespread, integrated postpartum outreach program.

14. Support for TBAs should be limited to partnership arrangements with HC and RH midwives and fee-splitting incentives.
D. HIV/AIDS/STDs

1. Continued support for the highly successful HSS and BSS is recommended as are efforts to build provincial and district level capacities to use the data.

2. The cultural and political realities in Cambodia are not conducive to multi-sectoral HIV/AIDS activities, yet it is possible to have activities in multiple sectors. It may be helpful to support on-going and future HIV/AIDS activities in the MOND, MOI, MOE, the MOT and the MO Women’s Affairs.

3. USAID has achieved remarkable success in supporting BCI and condom interventions that have helped to stem the spread of HIV, especially among CSWs and their male clients. The Team strongly recommends that these activities be continued and enlarged.

4. It is recommended that messages be developed to inform the public about how HIV is not transmitted in order to protect PLWHAs and children orphaned by AIDS from stigmatization and isolation.

5. HIV prevalence among IDCSWs and migrant male workers has remained fairly constant. New messages and interventions for these more difficult to reach groups are recommended.

6. Recognizing that CSWs and their male clients are passing on HIV to their boyfriends and wives, preventative messages promoting the virtues of "protecting the one you love" are called for.

7. It is strongly recommended that USAID explore with the Government, partners and other donors, means of ensuring greater coordination in message design and sharing of IEC materials.

8. Developing and marketing a "sweetheart" condom and/or de-stigmatizing the current Number One condom is recommended in order to prevent the spread of HIV from high-risk groups to the general population.

9. USAID should consider supporting the MOH's planned expansion of VCT services nationwide through TA and facilitative supervision for quality control in labs, establishing monitoring, evaluation and supervisory systems and IEC to promote public awareness of the benefits and availability of VCT.

10. The Team does not recommend training private physicians in the use of ARV drugs. Instead, simpler, palliative home-based care and advocacy/IEC to encourage family and community support to PLWHAs are ideal.

11. The Team recommends that no additional care and support activities be funded until a coherent strategy is developed which articulates what interventions can and should be provided, to whom, by whom and how.
12. It is recommended that USAID consider support for the controlled introduction of the
polymerase chain reaction (PCR) test for infants born of HIV+ or suspected positive mothers
so that the infant's HIV status can be confirmed early and for those who are negative chances
are greatly improved for adoption or foster care

E. Infectious Diseases

1. USAID should consider supporting the introduction of DOTs in HCs, and not home delivery
for the foreseeable future, throughout geographic areas selected by the strategy team, with
community based IEC promoting its utilization.

2. The PFD malaria control project should serve as a model for community-level malaria
prevention. USAID should assist in making the components and results of this intervention
widely known and consider replication of it in future focus provinces.

3. DHF is a leading cause of death in the 1-5 age group in Cambodia. USAID should consider
using its comparative advantage in working at the community level to develop community-
level IEC on prevention and recognition of danger signs and training and support for early
detection and referral by HC staff

4. USAID should consider funding and TA for the social marketing of water jar lids.

F. Research, Monitoring and Evaluation

1. In view of the legislative mandate to show tangible results in 1-2 years in the area of
HIV/AIDS, USAID should take great care in constructing indicators that are both measurable
and realistic. Process indicators should prevail with service coverage indicators starting to be
applicable only in years 4-5.

2. More indicators for MCH should be introduced to call attention to effective interventions, for
example, ANC iron distribution (30 tablets x 3), complete filling out of the partogram in
labor, etc. in addition to the standard TT immunization.

3. The USAID Mission should, in consultation with key government and non-governmental
partners, develop a research agenda to ensure that resources allocated for research, whether
by the Mission or from Central funds, best serve the information needs of priority programs.
Periodic DHSs should certainly be high on that list.

4. The Mission should require pre-approval of any sub-grants for pilot activities, which should
fall within the overall research agenda, to ensure that resources are not spent on pilots with
no potential for scale-up.
I. Introduction

After the ratification of the Paris Peace Accords in 1991, the international donor community responded to the challenges of restoring societal and institutional structures in Cambodia. A decade into development efforts, overall health indicators in Cambodia remain among the worst in the Mekong Region. High rates of maternal and child mortality and morbidity, low coverage of basic health services, and widespread malnutrition remain significant issues in Cambodia. The country also has the fastest growing prevalence of HIV/AIDS, TB and drug resistant malaria in the region. Poor health status and limited human and institutional health resources clearly impede Cambodia’s development potential.

USAID has supported health activities in Cambodia since 1994. Strategic Objective Two (SO2), “Improved Reproductive and Child Health” and Special Objective Two (SpO2), “Reduced transmission of STD/HIV among high-risk populations” were developed in 1997. Political unrest in July 1997 resulted in a temporary suspension of all mission activities. Congressional restrictions curtailed USAID’s collaboration with the Royal Government of Cambodia (RGC) and restricted funding to NGOs. The immediate impact was a sizable reduction in mission funding (from approximately $40 million to $15 million/year).

In 1997, a scaled-down health program was implemented with MCH/FP and HIV/AIDS components. The current MCH portfolio emphasizes increasing supply, access and demand for high quality reproductive health and child health services for Cambodians in focus provinces. The current SO is “improved reproductive and child health” and includes three intermediate results:

1) expanded supply of RCH services;
2) increased access to RCH services;
3) strengthened demand for RCH

The current HIV/AIDS portfolio emphasizes policy development and risk reduction. The current Special Objective Two (SpO 2), is, “Reduced transmission of STD/HIV among high-risk populations” with three intermediate results:

1) Policy makers informed about the HIV/AIDS epidemic in Cambodia
2) Reduce high-risk behaviors in target areas
3) Model STD/RH service delivery program for high-risk populations piloted and replicated in target areas.

In late 2000, USAID developed a new strategic approach to HIV/AIDS worldwide with Cambodia being designated a “Rapid Scale-Up” country: HIV funding increased from approximately $2.5 million in FY 2000 to roughly $10 million in FY 2001 (includes CSD, ESF, and Orphans and Vulnerable Children funding sources). As a rapid scale-up country, Cambodia will be required to: 1) achieve significant increases in program coverage and intensity in the targeted populations within 1-2 years, and 2) work with other donors to ensure that at least 80% of the target population receives a comprehensive package of prevention and care services within 3-5 years.
The USAID Cambodia mission is in the process of developing a new strategy for the program that will cover the period of 2002-2005. As preparation for the formulation of the new strategy, it was deemed imperative to review and assess the performance of the population, health and nutrition (PHN) sector and current USAID portfolio. The objectives of the Assessment were to identify strengths, limitations, and missed opportunities in the present portfolio, to examine USAID PHN's comparative advantage and to identify the potentially strong linkages between the MCH/RH and the HIV/AIDS portfolios. The information thus provided will be used to develop a comprehensive and forward thinking PHN strategic plan.

As there is a very active international donor community in Cambodia, USAID/Cambodia also commissioned a thorough review of other donor activities and investments in the PHN sector (see Annex B).

PHN Assessment

The Scope of Work for the Assessment Team (See Annex A) set out a number of specific issues and questions to be considered with reference to 1) Reproductive and Child Health, including family planning, safe motherhood, child survival and nutrition/micronutrients, 2) HIV/AIDS/STDs, including orphans and vulnerable children and 3) infectious diseases, including TB, malaria and dengue hemorrhagic fever:

- Assess the extent to which programs are meeting their intermediate results and objectives and identify the strengths and limitations of the existing portfolio;
- Recommend the technical, geographical and programmatic areas on which USAID should focus, concentrate and invest in RCH and scale up in HIV/AIDS;
- Identify technical and programmatic gaps/missed opportunities and make recommendations for future investments;
- Identify areas where USAID should discontinue investments;
- Review the various components of the portfolio and assess how each component contributes to the overall objectives and intermediate results;
- Examine cross-cutting issues and make recommendations on critical components that will bridge across the MCH, RH, CS, HIV/AIDS areas including: geographic concentration, capacity building, health system strengthening, health communication/behavior change, training/performance improvement, social marketing, contraceptive security, reproductive health for young adults, monitoring and evaluation, partner and donor collaboration and targeting;
- Assess the current program implementation mechanisms, identify strengths and limitations and make recommendations for the future.
In addition a number of cross-cutting issues integral to many of the technical components in both portfolios were highlighted for which recommendations and action steps were to be identified to ensure maximum impact of the overall program. Included were an expanded role for the private sector (including social marketing) IEC, contraceptive security, policy and advocacy strengthening, youth, gender, and inter-sectoral collaboration and joint programming.

Given the critical need for human capacity development, the Assessment Team was requested to recommend for each programmatic area under review how best to address human capacity development needs in the short and long terms. An overall question throughout was: How best can USAID build local capacity in managing and delivering in MCH, RH, HIV and ID services in the long term, while continuing to increase the scale and reach of these services in Cambodia in the short term?

With consultants provided through The Synergy Group and from USAID/Washington, a nine-person Assessment Team was assembled consisting of the following individuals with complementary areas of competence:

<table>
<thead>
<tr>
<th>Name</th>
<th>Area of Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheryl Keller, independent consultant</td>
<td>Child survival and health systems development</td>
</tr>
<tr>
<td>Jay Parsons, independent consultant</td>
<td>Reproductive and child health-HIV/AIDS</td>
</tr>
<tr>
<td>Monica Kerrigan, USAID/W</td>
<td>FP, RH, quality of care</td>
</tr>
<tr>
<td>Mary Ellen Stanton, USAID/W</td>
<td>MCH/safe motherhood, quality of care</td>
</tr>
<tr>
<td>Elizabeth Preble, independent consultant</td>
<td>HIV/AIDS, VCT, MTCT, STDs</td>
</tr>
<tr>
<td>Paurvi Bhatt, USAID/W</td>
<td>HIV/AIDS multi-sectoral activities</td>
</tr>
<tr>
<td>Erika Barth, USAID/W</td>
<td>HIV/AIDS, youth &amp; IEC</td>
</tr>
<tr>
<td>Linda Sussman, USAID/W</td>
<td>HIV/AIDS, OVC</td>
</tr>
<tr>
<td>Monique Derfuss, USAID/W</td>
<td>Donor coordination</td>
</tr>
</tbody>
</table>

The full Assessment was conducted over a six and a half-week period from February 25 to April 11, 2001. Jay Parsons, Sheryl Keller and Sonja Schmidt, a Synergy representative, arrived in Cambodia on February 25 in order to hold initial meetings with USAID partners, including Government and Cooperating Agencies, to assemble the relevant background documentation for the mission and to make logistical arrangements. Monique Derfuss arrived at the same time and independently conducted a survey of other donor funding. The remaining team members arrived on March 11 and departed between March 24 and March 30. Jay Parsons and Sheryl Keller remained in Cambodia until April 11 to debrief the Mission and external partners and to finalize the assessment report.

The Team met with a wide array of government officials, donors, CAs and local NGOs. Field visits were made to the provinces of Battambang, Banteay Meanchey, Siem Reap, Kompong Chhang, Pursat, Kompong Cham as well as within Phnom Penh. Each team member provided written input for the draft report which was submitted to the Mission in draft and finalized upon receipt of Mission comments. The final report was submitted to USAID/Cambodia on April 11, 2001 following a formal debriefing of the Mission and partners.
II. Country Context

A. Historical and Cultural Background

Cambodia's two thousand years of known history are distinguished by almost constant warfare. A very strong militaristic orientation, and idealization of the warrior model, took deep root in the culture, along with high tolerance for violence as a means of conflict resolution. From the 8th - 15th century AD, Cambodia was a vast empire with cultural and military dominance extending as far as present day Thailand, Viet Nam, Malaysia and Java. Present-day Cambodians look upon this “golden age” of Cambodia with great pride and nostalgia. Somewhere in the 14th - 15th century an abrupt decline occurred for reasons unknown and continued for four hundred years until French colonization intervened. Militarily, economically and culturally, the empire collapsed, replaced by a smaller and weaker nation concentrated in the south central area of modern day Cambodia. This sense of previous grandeur followed by humiliating loss and defeat is deeply etched in the Khmer psyche to this day.

From earliest recorded times up to the present day, the Cambodian social order has combined an odd mix of oppression and authoritarianism on one hand and a lack of effective social sanctions for improper behavior on the other. While family units and loyalty are strong, there has never been much social cohesion beyond the extended family except in the presence of external threats against which people could unite.

It was only during and after the decline of the Angkor Empire that Theravadan Buddhism became the predominant religion. Not surprisingly, given the historical context, the Cambodian interpretation of Theravadan Buddhist teachings has a distinctly fatalistic orientation.

By the 19th century, Thailand had annexed most of present-day northwestern Cambodia, and Viet Nam had annexed much of the eastern areas. As a desperate measure to stave off the loss of the country to its neighbors, Cambodia requested establishment of a French Protectorate. Some believe that this turning to foreigners to resolve problems has remained a common theme in the culture, coexisting with a deep distrust of foreign intentions, intense nationalism and sense of belonging to an endangered race.

Under nearly 100 years of French rule, there was little development of Cambodian capacities in governance, and very little in the way of social development; what did exist was limited to the urban areas. Urban dwellers, especially in Phnom Penh and among its upper classes, absorbed French cultural influences and in some cases French education. This fact widened the already large social gap between the rural (almost uniformly poor and uneducated) majority and the urban minority.

Cambodia gained independence in 1953, and reverted to an absolute monarchy. The King (who later abdicated to take the title of Prince) enjoyed immense popularity among the rural populace, but became increasingly unpopular among the urban educated classes. By the mid 1960's the Viet Nam War began to significantly impact on Cambodia. Heavy bombings occurred in Eastern Cambodia, extending as close as 20 km from Phnom Penh and sending millions of refugees into the tiny capital. The devastation wrought on rural areas led to increasing discontent and fuelled
the previously small Khmer Rouge (KR) communist movement. A 1970 coup overthrew the monarchy and installed an ostensibly pro-democratic, pro-American government. Although welcomed by many of the urban educated minority, this move outraged the rural majority who venerated the monarchy. In addition, the new government proved extremely ineffectual and corrupt. Bombing continued, further destabilizing the countryside, and the ousted monarch joined forces with the KR, further bolstering their support among the peasantry.

The KR seized control of the country in April 1975. From then until the collapse of their rule in 1979, somewhere between 1-1.5 million people, out of a total population of about 7 million, died (i.e., about 20 percent of the population). Although no segment of the society was exempt, educated and skilled persons and those with important social or cultural roles (e.g. monks, classical dancers) were specifically targeted. The few educated people who survived disproportionately fled to refugee camps and were resettled abroad. Effectively, by 1979 there were no trained health personnel, no teachers, no craftsmen or tradesmen of any sort, and no religious institutions or clergy. Further, an entire generation of children had been denied all education, removed from their parents, brutalized, and indoctrinated in ways completely incompatible with traditional Cambodian society. The KR did not merely kill a large number of people; they intentionally and quite successfully eradicated an entire culture and civilization. "Year Zero" was, in many ways, achieved.

It is critical to understand that the violence and social destruction carried out by the KR, although orchestrated by a small number of highly authoritarian leaders, was implemented by hundreds of thousands of Cambodians, from KR cadres down to ordinary villagers. The KR achieved this through manipulation of several underlying social factors:

- a militaristic social model with emphasis on power as the basis for authority, and unquestioning obedience to, and acceptance of, authority;
- a fear-based and risk-aversive psychological orientation in which personal security is viewed constantly in jeopardy and of greatest concern to protect;
- deep class division and long-standing resentment by the rural poor of the urban minority;
- a lack of conflict resolution mechanisms other than denial/avoidance and violence with the result that throughout society a vast array of long-standing resentments -- both class-based and purely personal in origin -- lay suppressed beneath a deceptively passive exterior; and,
- a long-standing high tolerance for physical violence as an outlet for anger and as a means of achieving aims.

These pre-existing factors were in turn deeply strengthened and reinforced by the traumatic events of the Khmer Rouge genocide, and they remain very prominent features of Cambodian society today. In addition, the eradication of the Buddhist religion, and forcible introduction of behaviors completely at odds with Buddhist precepts, effectively obliterated the moral and ethical base of the culture.
A Vietnamese invasion in 1979 ousted the KR. From 1979 - 1991, Cambodia was ruled by a Vietnamese-installed government consisting of ex-KR cadre who had escaped to Viet Nam to avoid internal purges, and by Vietnamese advisors and officials. The extreme genocidal policies of the KR era ceased, but a repressive and authoritarian, albeit much less brutal, rule took its place, continuing the climate of fear and concern for personal safety. Suppressive measures regarding religion continued, and young men were not permitted to join the monkhood. Warfare continued as pockets of KR and other rebels throughout the country carried out a guerrilla campaign against the Vietnamese-backed regime.

While Cambodians welcomed the initial intervention of the Vietnamese, there was deep distrust of Vietnamese motives, which quickly mounted as the Vietnamese presence became long-term. Ethnic hatred between the Khmer and Vietnamese goes back thousands of years and would be hard to underestimate. Both groups refer to the other with a derogatory word meaning "barbarian". Cambodians deeply resent the annexation of "Kampuchea Krom" (lower Mekong delta) by Viet Nam and believe that the Vietnamese have continuing territorial designs on Cambodia. The many Vietnamese migrants in Cambodia are commonly seen as a manifestation of Vietnamese expansionist tendencies rather than as individuals in search of land and work. These are important considerations given the number of ethnic Vietnamese in the HIV/AIDS/STD high-risk population.

In 1991 as a combined result of protracted guerrilla warfare, international sanctions and pressure, and the collapse of the USSR (which had largely financed the Vietnamese presence in Cambodia) the Paris Peace Accord was signed between the various resistance groups and the Vietnamese-backed government. The entire country came under UN administration from 1991-1993 while preparations were made for national elections. However, several branches of the KR backed out of the peace process prior to elections and resumed guerrilla activities right up until their final defeat in 1999.

The UN Administration brought with it a sudden influx of 16,000 multinational soldiers and 6,000 civilians who were posted throughout the countryside. With this, and the collapse of previous communist controls, a sudden surge in demand for commercial sex was followed by an equally sudden and large response. While historically commercial sex was rare and limited to urban centers, it became a widespread and lucrative enterprise even in remote villages where it was previously unknown. UN soldiers made regular R&R trips to Thailand where HIV prevalence among sex workers was extremely high. Not surprisingly, this resulted in an exponential spread of HIV in Cambodia in border provinces and in Phnom Penh and its surrounds.

Although the UN presence lasted only 3 years, cultural taboos made it impossible for village girls who had serviced soldiers to re-enter mainstream society. The commercial sex industry became a prominent new feature of Cambodian life. By 1998 a census of commercial sex establishments found nearly 900 in Phnom Penh alone.

The royalist FUNCINPEC party won a majority of the votes in the 1993 election but not a sufficient plurality to form a government, and the ruling Cambodian People's Party (CPP)
refused to cede any significant share of administrative power. With strong international pressure, a "coalition" government between the CPP and the royalists (FUNCINPEC) was formed on paper. In practice, the CPP never ceded any significant power to FUNCINPEC and power struggles between the two continued until 1997 when open violent conflict broke out ending in the forced ouster of the FUNCINPEC party, followed by international condemnation and suspension of foreign aid. New elections were held in 1998, again resulting in a coalition government between the CPP and FUNCINPEC, which remains in place today. Most foreign aid resumed after the 1998 elections, but USAID still has restrictions in place (see Section III).

Aided by a significant and very sudden influx of foreign assistance in the last 6-7 years the government of Cambodia has begun the massive task of not only reconstructing an entire country but, in many cases, constructing basic systems and services which have never been in place. The magnitude of this task is hard to convey to anyone who has not seen firsthand what a "year zero" society is like, and the progress which has been made in less than a decade is enormous. Nonetheless, it is still very much a society and country in the making, with a deeply torn and fragile social fabric as its base.

B. Key Social, Cultural and Gender Factors

1. Overall Development Context

Cambodia has only been at peace for the past 2 years - and even that, in a context of frequent violence on an unorganized scale. Efforts to move towards democratic governance are taking place in a society which throughout its entire history has only known feudalism, colonialism, and communism. Cambodia completely missed the development which has generally occurred in the world over the last 30-40 years. It has never had most of the systems and services we take for granted in even the least developed countries. In addition, such social structures and capacities as it did have in the past were effectively wiped out by 1979, and efforts at reconstruction really began only post 1993. The country is heavily dependent on foreign assistance, and Government has not yet developed an efficient, transparent revenue base.

The establishment of legal frameworks and efforts to enforce resultant laws are at a nascent stage. There is no independent judiciary and the legal system is weak, underdeveloped and corrupt at all levels. Such laws as do exist are seldom enforced by police. The few arrests which go to court are often settled through illicit payment. Even where that is not the case, most judges have no legal training and decisions are often blatantly inconsistent with the law. Although a specific human trafficking law was passed in 1996, including establishment of a legal age of consent at 15 years, enforcement is extremely problematic. Politicians, military and police are involved with the sex trade, both actively and passively.
2. General Social and Cultural Factors

Cambodian culture is extremely hierarchical, with hierarchy based on power and the fear it inspires, rather than respect. Psychologically, most Cambodians have an overriding concern for personal security and a perception of the environment beyond the family as hostile, dangerous and unpredictable. The militaristic and authoritarian social order coexists with a lack of individual accountability, which allows large scope for individual acts of willfulness and violence. Social and legal mechanisms for curbing socially undesirable behavior are extremely weak.

The deep class divisions which have historically characterized Cambodian society, and which erupted so tragically during the KR era, remain strongly in place. This has particular implications for interactions between health care providers and clients since the former, whatever their class origin, are seen as members of the upper class and resented accordingly; for their part, most educated Cambodians lack sensitivity to class barriers and/or lack the skills to bridge them, and do indeed often behave in a derogatory or insensitive manner towards poor clients. In addition, they fear them, one of the less obvious reasons for the strong reluctance of health workers to work in rural and remote areas. This has very important implications for efforts to increase health service coverage, and for potential efforts in providing care to HIV/AIDS affected persons in rural areas.

A new generation has grown up in what amounts to a social vacuum, without the benefit of the beliefs and mores that previously informed Cambodian life. The post-genocidal society continues to have exceptionally high levels of violence, both political and personal, so that even the newer generation can be said to have been raised in a culture of violence and fear.

3. Religion

Since 1991, when temples were allowed to re-open and young men, for the first time in over 15 years, to ordain as monks, there has been a massive grass-roots effort to restore the Buddhist religion. Temples in various stages of reconstruction now dot the countryside and religious rituals have re-assumed a prominent place in daily life. Temples are full of young, recently ordained, monks, but lack senior monks to train and guide them. Due to lack of training and guidance, the new generation of monks do not match their predecessors in purity of conduct or knowledge of teachings. Nonetheless, especially in rural areas, monks are a respected strata of society and potential force for social change. Also attached to temples are a large number of Buddhist nuns and “wat (temple) grannies”, elderly women who have adapted a quasi-monastic life. Their numbers are large due to the preponderance of females in the older population (many more men than women died under the KR) and, unlike monks, they do not have a clearly prescribed role to play in temple life.

Theravada Buddhism, adhered to by 90 to 95 percent of the Cambodian people, has no objection to contraception, and its approach to sexual and reproductive matters is generally a pragmatic one. There is a small Muslim minority in Cambodia, who are more conservative than the Buddhists on such issues, but Cambodian Islam in general is quite liberal compared to that of other countries.
4. Health Beliefs and Practices

The Cambodian understanding of health and illness reflects a merging of several different paradigms. Indigenous animist beliefs, traditional Chinese concepts of “yin” and “yang”, Indian aryvedic principles and Western medical concepts all coexist. No distinction is made between mind and matter, nor between symptoms and disease process. Somatization of psychological complaints – sometimes to the dramatic extent of hysterical blindness or paralysis – is common, and a person’s subjective experience defines the presence or absence of disease. Traditional medical practices are extremely widespread, even among the educated classes, and include spiritual rites, use of herbal medications, and physical manipulations (massage, moxibustion). Traditional healers have traditionally been accorded great respect and, in rural areas, will accept payment in kind and payment according to the client’s means. There are recent reports of more exploitative behavior by “counterfeit” traditional healers in urban areas, especially with regard to purported cures for AIDS.

The widespread popularity of traditional measures does not in any way inhibit acceptance of modern treatments. If anything, the latter are over-enthusiastically and excessively used, particularly injections and intravenous fluids. A wide range of pharmaceuticals, imported from all over the world, are readily available in shops throughout the country – along with clever counterfeits which cannot be readily distinguished from the genuine article. Almost every family has at least one member who is able to administer injections and start IVs, and the home use of injections and IV therapy is routine for those who can afford it. Medical treatment is considered synonymous with the giving of medicine, and the more drugs given at once, the better. Particularly popular are “cocktails” consisting of several different drugs taken at once in a single dose. Few “pharmacies” and shops have a trained pharmacist on the premises and it is unclear how treatments are selected. There appears to be both a mix of client requests (all of the major antibiotics being well known by name) and vendor recommendations, with the latter to some extent empirically-based.

A mixture of traditional and modern practices likewise surrounds childbirth and the postpartum period. Traditional measures include “roasting” (lying near a hot fire) to restore the body to its proper balance, change the normal postpartum “cold” state to “hot,” and restore energy. Protection from ghosts and spirits is obtained through placing a white string around the waist in pregnancy or placing a string around the house for the roasting period. More dangerous traditional measures include deep massage to crush the bones of the fetus to provoke abortion, pushing on the fundus during the second stage of delivery, and manual removal of blood from the uterus after delivery. Modern practices, which are widely popular, include the administration of oxytocin in the home to induce or speed up labor (an unsafe practice carrying risk of uterine rupture), the unnecessary use of injectable or intravenous fluids, vitamins and antibiotics, and injections of other unnecessary and/or dangerous substances.
5. Gender Issues

The status of women during the zenith of Khmer civilization was initially quite favorable. Women were the primary force in commerce and conducted most trade; women owned land, had complete freedom of movement and were free to divorce and remarry without stigma or constraint. Sexual mores were liberal and egalitarian. However, as Indian cultural influences gained ascendancy with the aristocratic classes, Indian-influenced codes of behavior for women were introduced as a social ideal. These became known as the "chhbap sray"("rules for women") which still constrain women's behavior and options to the present day. Although female seclusion never took root, an idealization of female chastity did, along with an expectation of submission to male authority. An essentially patriarchal model was in effect grafted over an indigenously matriarchal society towards the end of the Angkor era, with the result that to this day, contradictory elements of both patriarchal and matriarchal social systems coexist in Khmer culture.

There is a strong emphasis on virginity/chastity, loss of which is irredeemable and places the woman outside civilized society with no avenue for re-entry; this is often a cause of entry into the sex trade. Rape is viewed as an undesirable but understandable action by the man, for which restitution is possible but an irreparable shame for the woman. Although women technically have the right to divorce, on a practical level there is no effective resource if the husband does not wish to grant it and no effective means of obtaining child support if he does not wish to provide it. Conversely, there is little or no effective sanction for men who abandon wives and children.

Once a Cambodian woman's chastity has been damaged, whether by choice or force, she is outside the pall and has little recourse for re-entry into society. The most likely alternative, life as a commercial sex worker, is one of extreme hardship. An estimated 40 percent of the CSWs have been forcibly recruited or lured with false tales of employment; once in the trade, it can be both physically and culturally difficult to get out. Approximately 50 percent of the brothel-based CSWs are debt-bonded and have to repay their debt to brothel owners.

While women are severely constrained in their sexual options, men have traditionally been allowed total license, both within and outside of matrimony. Infidelity is considered a natural failing and a wife has cause to complain only if her husband diverts significant family resources to other women. Homosexuality is not understood as a separate sexual orientation, but rather as just one of many things men do for sexual release. As long as it is conducted in private, there is virtually no taboo area with regard to male sexual behavior. This is, however, starting to change with growing recognition of the health implications of commercial sex.

Reproduction is seen as very much a private female matter. On the positive side, women can independently opt to use family planning; on the negative side, it is difficult to get male participation and co-operation when needed, e.g. condom use or vasectomy. There is virtually no cultural resistance to contraception. Prior to the introduction of family planning less than a decade ago - and still in the many parts of the country where access to services is inadequate - induced abortion, usually by TBAs or other untrained persons, was the primary method of spacing or limited births, and very widely resorted to, while simultaneously viewed by everyone (including the women undergoing them) as morally wrong. For this reason, it is a shameful affair.
that is kept secret from even close family members and husbands, a fact which makes accurate estimation of maternal deaths difficult.

Women are able to control pregnancy and delivery related decisions to the extent economically feasible, i.e., it is up to the woman to decide whom to consult and where to deliver. Husbands are not usually present at delivery with the exception of more remote rural areas, where of necessity husbands sometimes actively assist and may even be the sole provider. It is deeply unacceptable for male providers to provide gynecological or obstetric care, a fact which has important implications for the provision of maternal health services, although this taboo is waived in the case of a perceived life-threatening situation and highly skilled male provider (e.g., surgeon).

C. Health Sector Development

1. Pre-1979

Even prior to the advent of the KR, Cambodia was an extremely underdeveloped country, its economy based almost entirely on agriculture, most of the population illiterate subsistence farmers, and without access to modern medical care. Outside of a few urban centers and isolated charitable undertakings, Cambodia never really had a public health care system. Traditional medicine, including traditional birth practices, was extremely prevalent and remains so to this day.

During the KR regime modern medical care of any sort was prohibited, trained health professionals were systematically killed, and people relied exclusively on traditional treatments. Thus, at a time when traditional medical knowledge was declining in many countries, it actually increased in Cambodia of sheer necessity.

2. 1979 - 1993

The Vietnamese backed government, assisted by Vietnamese advisors, made efforts to reconstruct the completely shattered country. A large number of health workers were recruited and trained and posted throughout the country. Due to the realities of the situation - the urgent need and the lack of basic education among prospective trainees - this training was sketchy in the extreme and often provided to persons who lacked even basic literacy and numeracy. In addition, much of the instruction was provided in Vietnamese or Russian, languages not understood by the trainees. These people form the bulk of the present-day health workforce, and the grossly inadequate nature of their pre-service training and basic education is a major constraint in health service delivery.

Nurses and midwives were assigned to work at the community level, but actual delivery of public health services appears to have been nearly nil in rural areas with the sole exception of limited immunization efforts through UNICEF. Such government funds as were available for social purposes went directly to provincial Governors who had full authority to decide on allocation among sectors. The central Ministry of Health, at that time consisting of Vietnamese doctors plus a small handful of the few surviving Cambodian health professionals, never controlled a budget and had no line authority over provincial health departments. What limited
policy and planning that occurred at the central level was done by Vietnamese officials and advisors.

Private pharmacies and private medical practices were not allowed during this period, a restriction that appears to have been fairly well enforced. Traditional medicine remained the primary source of health care for rural Cambodians, augmented somewhat by limited activities (of even more limited quality) by the rapidly trained new health workers. In parts of the country near the borders, Cambodians frequently traveled to Viet Nam and to the Thai border refugee camps for medical care.

In Phnom Penh and other urban areas, hospitals were re-established, in some cases with NGO or other foreign assistance. The level of foreign support (other than Vietnamese and Soviet) was greatly limited by international sanctions and non-recognition of the Vietnamese-installed government. There was a very small and under funded multilateral presence (UNICEF, WHO) and a few, mostly faith-based, NGOs. Foreigners and foreign organizations were severely constrained in their movements and activities by the government: they were allowed only to work in the cities; they were required to live in designated foreigner hotels, and there were limitations placed on interactions with Cambodians.

3. 1993 Onward: The Health Coverage Plan

Following the 1993 elections, international recognition was given to the Cambodian government and foreign assistance followed, both multi and bi-lateral. All restrictions on foreigners were lifted and the country opened up to foreign assistance. The formidable task of creating a Ministry of Health and a health service delivery infrastructure began. This effort was spearheaded by the World Health Organization (WHO), with funding and secondment of personnel from bilateral donors. Starting with a handful of trained people, few of whom spoke English, a central Ministry with capacity to plan and administer health services was created in an astonishingly short time. Lack of human resources was, and remains, the greatest constraint. Training of personnel has had to be conducted at the same time that efforts were underway to carry out essential functions. Simultaneous with this huge capacity-building undertaking, and development of key sectoral policies, there was a mapping out of existing health workers (previously accountable only to provincial governors) and development of a master plan of location of facilities and services to be provided at various levels, rationalized to population.

The resulting "Health Coverage Plan" and "Operational Guidelines" were completed by 1997; since then the MOH has been actively striving to implement these plans which represent the first real modern health care system Cambodia will have ever known. The task is formidable: the existing workforce, although excessive in number, is grossly inadequate in skills; salaries are so low as to create little or no incentive to work; staff had historically been free to do as they pleased in the communities with no ministerial control; there were virtually no structurally sound buildings to be used as static health facilities; and parts of the countryside remained insecure until just 2 years ago.

Despite all these obstacles, rapid progress has been and is being made in the creation of a network of Health Centers (HCs) at the commune level and Referral Hospitals (RHs) at
Operational District (OD) level (districts redefined from existing administrative district boundaries so as to constitute a rational and uniform catchment areas). In addition, policies have been developed and implemented decentralizing management of health services to the level of the ODs, and District Health Management Teams (DHMTs) created and trained. Simultaneously there are ongoing efforts to provide "refresher" training to the under-trained health workforce, and to develop protocols and guidelines for management of common diseases, essential drug use, logistics systems, etc. The following table shows progress, by year, in creation of the health care system as measured by the number of health centers meeting minimal MOH standards of staff, facility and training:

Table 1: Health Care System Development as Indicated by Opening of MPA Health Centers

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Of HCs</td>
<td>59</td>
<td>157</td>
<td>280</td>
<td>402</td>
<td>565</td>
</tr>
<tr>
<td>Percent of Planned</td>
<td>6.3%</td>
<td>16.9%</td>
<td>30.1%</td>
<td>43.3%</td>
<td>60.8%</td>
</tr>
</tbody>
</table>

Source: Ministry of Health Planning Unit 2000

While the MOH has succeeded in opening 60 percent of planned HCs from a baseline of less than 10 percent, it must be understood that the vast majority of these facilities have been open for a year or less, and are still in very early stages of staff and service development. Due to the extremely low skill level and pressing need to get some sort of system in place, these HCs do not yet include the full package of services planned. Specifically, IUD insertions, and treatment of tuberculosis, STDs, and chronic diseases (hypertension etc) have not yet been widely introduced. About 40 percent of planned HCs still do not exist at all.

Although the HCs each cover a catchment area of only about 10,000 people, roads are poor and distances can be considerable. Consequently, immunization and other key preventive services must be provided on an outreach basis for remote villages. This system of outreach is not yet working well except in areas with technical and logistical support from NGOs or other external agencies.

There are also plans for the development of Referral Hospitals (RH) (one per operational district) to which the HCs would link, but development of the RHs has lagged behind that of HCs; currently only about 30 percent of planned RHs are functional as defined by capacity to treat inpatients, manage emergencies and perform simple emergency surgery. Most of these are the Referral Hospitals located in provincial capital towns. Only 10 percent of RHs in districts other than provincial capitals (i.e., in rural areas) currently have even minimal emergency surgical capacity. Many still lack structurally sound inpatient wards, and some are completely non-existent. The higher cost of hospital development and lack of human resources - particularly, lack of medical assistants and doctors willing to work in rural areas, and nationwide lack of trained surgeons - have been the main constraints to the development of the RHS, but more attention and resources are starting to be allocated now that HC development is nearing completion.
As noted above, Health Centers do not yet deliver tuberculosis treatment, with the result that it is limited to Referral Hospitals - and these are fully functional in only about 30 percent of planned locations. This means that tuberculosis treatment in Cambodia at present is for the most part available only at the tertiary level (provincial hospital or Phnom Penh), well out of reach of the majority of patients. The urgent need to expand access to TB treatment led the MOH to conduct a pilot feasibility study of Health Center DOTs treatment from 1999-2000 in 9 different HCs nation-wide. Based on lessons learned in this pilot, efforts have now begun to introduce DOTs in all Health Centers - no small task given the newness of those facilities and the substantial training, logistical and management requirements.

The MOH is aware of all of these constraints, as it is also aware of the problems of human resource capacity and inadequate salaries/motivation. Active efforts are underway, with strong technical assistance from a variety of organizations, to address these constraints, including some extremely innovative experiments in health care financing. Although the MOH is committed to the development of a public health care system, it is open to alternative service delivery arrangements and public/private partnerships, and has in fact used government funds to contract out health service delivery to private providers on a pilot basis. User fees have been introduced virtually from the start and work is ongoing to explore means of making this work well without disenfranchising the poor. In addition, the MOH not only welcomes but also strongly encourages the participation of NGOs at the provincial and district level as long as their efforts contribute to the overall strategic plans of the MOH. In particular, NGO assistance in upgrading skills and quality of services, a labor and TA-intensive effort, is highly valued by the MOH at all levels.

4. Response to the HIV/AIDS Epidemic

The MOH was quick to recognize the threat posed by HIV/AIDS, establishing a National AIDS Program (NAP) in late 1991 (the first year in which HIV was documented in Cambodia). This later became the National Center for HIV/AIDS, Dermatology and STDs (NCHADS) in 1998. NCHADS is responsible for the health sector response to HIV/AIDS as well as for provision of technical support to other government agencies and national partners. It is broadly oriented towards biomedical and behavior change interventions. It is the lead agency for both behavioral and prevalence surveillance, as well as the lead in development of strategic plans. It has developed an excellent capacity in both of those areas, and has separate units devoted to Research and Surveillance, IEC, STD management, and AIDS care.

At the provincial level, NCHADS has Provincial AIDS Offices (PAO) which play a critical role in implementing the National Strategic Plan. NCHADS provides direct technical support to the PAOs. At OD level there is a District AIDS Officer as part of the District Health Management Team. Capacities at provincial and district level are variable.

To help ensure a multi-sectoral approach, the Government established the National AIDS Committee in 1993, succeeded in 1999 by the National AIDS Authority (NAA). The NAA is responsible for coordination of an expanded multisectoral response to the epidemic across all sectors. It works with an Advisory Board made up of the Secretaries of State from 12 ministries to develop policy and strategic plans for each sector and to mobilize resources in support of these plans. At the technical level, these line ministries work with the NAA on a Technical Board to
II. Country Context

June, 2001

PHN Assessment, USAID/CAMBODIA

15

develop objectives and measurable performance indicators for their strategic plans. The NAA consolidates these plans into one National Strategic Plan and monitors its implementation. The NAA reports directly to the Prime Minister's office.

At the provincial level, reporting to the NAA are Provincial AIDS Committees (PACs), chaired by the governor, which serves as the Policy Board and Provincial AIDS Secretariats which serve as the provincial Technical Board. There are plans to also develop District and Commune level AIDS Committees to oversee and coordinate the grassroots response.

NAA activities are constrained by several factors:

1. It is comparatively under-resourced, as most donor assistance to date has gone to NCHADS;

2. The effective leadership of NCHADS and NAA are affiliated with different political parties, making co-operation even at lower levels problematic;

3. Its mandate for coordination of multi-sectoral response has been largely understood to refer to government sectors. In practice, only the Ministry of Health has as yet developed any significant capacity, with the Ministry of Education running a distant second and all other Ministries close to non-functional. This leaves the NAA largely partner-less, since the MOH directs its activities through NCHADS.

The NAA has the benefit of some talented technical staff, and may shortly receive resources through an ADB loan. There is potential for it to play a more effective role, particularly if it can expand its horizons beyond line Ministries and identify non-governmental approaches to sectors.

Given the enormous progress that has been made in the development of a public health sector in an extremely short time, and the very positive policy environment and openness to new approaches and NGO/private sector involvement, there is every reason to expect that the MOH will continue to make significant progress towards the goal of accessible health services nationwide. However, it will make that progress in stages, and it will take time. Meanwhile, with the development of the basic skeleton of a health care delivery system still in progress, and exceptionally high levels of infant, child and maternal mortality, the country now faces a major HIV/AIDS epidemic.

The need to deliver both RCH and HIV/AIDS interventions is urgent, and cannot wait for full development of the health care system. At the same time, interventions cannot be delivered without such a system and will always be constrained by the level and pace of system development. Any effort to improve health conditions in Cambodia must, therefore, incorporate development/strengthening of service delivery systems along with a focus on specific, high-impact, cost effective interventions.
III. Overview of USAID/Cambodia Mission Strategy

USAID's current program in Cambodia traces its roots to humanitarian assistance in support of Cambodian non-communist resistance groups beginning in 1986. Known as the "cross-border program", the activity was administered from an Office of Khmer Affairs in Bangkok as there were no bilateral relations with the Vietnamese-dominated government in Phnom Penh. The program provided medical equipment and supplies, transportation, food and training to support community development and health care to displaced Cambodians along the northwestern border with Thailand.

With the signing of the Paris Peace Accords in 1991, U.S. assistance accelerated sharply. USAID/Cambodia's program evolved towards a more traditional USAID program with emphasis on meeting basic human needs across Cambodia as a whole and supporting the UN-sponsored move to establish a freely elected government. Once that was accomplished, emphasis shifted toward building the foundations for democratic governance and sustainable economic growth. The thrust of USAID's program was to support the nation-building effort being undertaken by the Cambodian people and to promote sustainable development by assisting to establish effective public and private delivery systems for improving basic health and education services throughout Cambodia and sound regional environmental management of natural resources.

The program was designed taking into account USAID's assessment of Cambodia's needs and constraints, the Royal Government of Cambodia's (RGC) reconstruction plan, other donor assessments and intentions, lessons learned from neighboring countries which have realized significant growth and equity and USAID's comparative advantage for delivery program services. From the outset funding has been delivered through contracts and grants to private voluntary organizations (PVOs) or international organizations, and no funding has gone to the RGC.

Having financed the bulk of the UNTAC operation, the U.S. had a significant stake in preserving the fragile peace and democracy that prevailed from the time of the elections in 1993 up to the "events" of July 1997. During that period, based on strong economic growth and a continuing fragile peace, USAID shifted to a sustainable development program, and the U.S. was the second largest bilateral aid donor after Japan. Other important donors included Australia, France, the Netherlands, Sweden and the World Bank.

When Second Prime Minister Hun Sen ousted his coalition partner, First Prime Minister Ranariddh, in a violent military clash in early July 1997, the result was a dramatic shift and setback for the evolving USAID development program. The U.S. suspended two-thirds of its $37 million program until the government made measurable progress toward free and fair elections. Left in place were activities that were demonstrably humanitarian in nature and/or were promoting the democratic process without directly benefiting the Royal Cambodian Government (RCG). In addition to the suspension of on-going activities, during fiscal year 1998, under Washington instructions, $24.6 million of FY 1998 and prior year funds had to be de-obligated and returned.
The July 1997 events and their aftermath marked a clear setback to Cambodia's transition to democracy as well. They further isolated the government from the international community and highlighted the difficulty of overcoming the country's long history of autocratic governance. In this climate preparations for national elections began. Unable to work with the RGC, USAID supported the establishment of three indigenous election monitoring organizations which worked to raise voter awareness and which fielded over 22,000 monitors countrywide for the national elections held on July 26, 1998. With over 93% of registered voters casting their ballots, the ruling CPP won the majority of votes but did not win the two-thirds seats necessary to form a new government. There was a stalemate during which the policy restrictions on USAID's program remained. In addition legislative restrictions added in 1999 prevented assistance to the RGC until a series of conditions were met.

After a four month deadlock in which tensions remained high and sporadic political violence occurred, a coalition government was formed on November 30, 1998 between the CPP and FUNCINPEC parties. Following the formation of the government, the National Assembly and a newly formed Senate started functioning and other donors responded to Cambodia's request for development assistance.

From 1997 until the time of this assessment in early 2001, the USAID program continued unchanged, still operating under policy and legislative restrictions imposed in 1997 and 1998. However a new waiver allowing work with Government for HIV/AIDS only has just been granted. In 1999, USAID operated at 31% of the resource level requested two years earlier. For FY 2000 it operated with less than $12 million. The resources support implementation of only a portion of the approved strategic plan, and USAID is still not authorized to work directly with the Cambodian government except in the field of HIV/AIDS. In addition to the reduction of funds, funding levels have been unpredictable from year to year necessitating an ad hoc arrangement with projects and impeding the ability to plan and program effectively.

The program framework presented in the spring of 1997 was a logical evolution from past frameworks and on-going activities, yet it presented major changes that would set the stage for the next generation strategy. Customer surveys and team discussions resulted in a number of decisions to bring better definition and tighter focus to on-going activities as well as to build linkages among the various sectoral programs to make them more mutually reinforcing. Additional resources and emphasis were to be directed toward gender considerations.

USAID/Cambodia was in the process of moving into a program focused more on sustainable growth and development for the long term. This shift was intended to build upon previous achievements and generally be the foundation for a more strategically focused, results-oriented program. Based upon careful assessment of Cambodia's long-term development needs and the activities of other donors, USAID/Cambodia cast its program in terms of four interlocking and mutually supporting strategic objectives:

1. Strengthening democratic institutions and the rule of law;
2. Increasing access to improved basic and maternal child health services;
3. Increasing the quality of and access to primary education; and
4. Implementing and strengthening sustainable rural economic growth.
However, since the political events of July 1997, USAID has had to recast and redefine its program and strategy to fit the policy and legal restrictions imposed and the reduced resource levels for program and OE budgets and staff. In February 1998 a new program based on three Strategic Objectives and four Special Objectives as follows was approved:

<table>
<thead>
<tr>
<th>SO-1:</th>
<th>Strengthening Democratic Processes and Respect for Human Rights</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO-2:</td>
<td>Improved Reproductive and Child Health Care</td>
</tr>
<tr>
<td>SO-3:</td>
<td>Improved quality of Primary Education (retained but with no funding or activities)</td>
</tr>
<tr>
<td>SpO-1:</td>
<td>Enhanced Assistance for War and Mine Victims</td>
</tr>
<tr>
<td>SpO-2:</td>
<td>Reduced transmission of STIs and HIV/AIDS in High Risk Populations</td>
</tr>
<tr>
<td>SpO-3:</td>
<td>Improved NGO Capacity to Manage Natural Resources (new FY1999)</td>
</tr>
<tr>
<td>SpO-4:</td>
<td>Expanded Access to Sustainable Financial Services (new for FY1999, currently funded under the PVO co-financing project)</td>
</tr>
</tbody>
</table>

Following a continuing reduction of funds in FY2000 to approximately 30% of the amount originally requested, SO-3 and SpO-3 were dropped and SpO-4 was extended another year using PVO co-financing project funds.

Even with its reduced program, USAID/Cambodia continues humanitarian support to vulnerable groups, especially amputees, orphans and the very poor. In addition, given the widespread poverty in Cambodia, the estimated 85% unmet need for credit and the success of USAID-funded micro-finance activities, USAID plans to continue these micro-finance activities which were part of the cancelled rural economic growth strategy as a stand-alone new Special Objective.

As it has been throughout the life of the program, a persistent underlying theme throughout the USAID portfolio will continue to be increased popular participation and continued strengthening of Cambodian civil society, largely through the support and nurturing of indigenous NGOs.
IV. Reproductive and Child Health

A. Overview of Country Situation

1. Maternal Health

Levels and Causes of Maternal Mortality

The first population based data on maternal mortality in Cambodia was obtained in 1995 using the sisterhood method, yielding an MMR of 473 per 100,000 live births (Sprechman et al 1996). Due to security constraints, the most isolated, war-affected and under-served provinces, which would be expected to have higher than average maternal mortality, were excluded from the sampling frame. Hence, the 473 estimate is clearly lower than the actual national level at that time.

A sentinel surveillance conducted in four provinces yielded an MMR estimate of 541 per 100,000 live births for the six year period 1993 – 1999 (van der Paal and Kertsana 2000). The last year of this six-year period captured actual deaths observed through direct surveillance while family recall was relied upon for the preceding five years. The population included in this study consisted of all families in 40 randomly selected rural villages in four provinces located in different regions of the country; the urban strata were specifically excluded. It is therefore statistically representative of the rural population of those four provinces. Judging from indicators for which there are reliable national estimates, it is fairly representative of rural Cambodia as a whole. Geographical variations among rural areas were considerable, ranging from a low of 250 in Stung Treng to a high of 690 in Siem Reap (a province with high malaria prevalence).

High as they are, the 473-541 survey estimates are much lower than previous estimates in the range of 700 - 900 from both the UNICEF field office and a number of field-based NGOs. The truth probably lies somewhere in between, with the difference due to an inability of surveys to capture abortion-related deaths. There is both an unusually high prevalence of abortion and an unusually intense social stigma attached to it in Cambodia. Therefore, among deaths to women of reproductive age (reportedly) who are not pregnant, it can safely be assumed that a proportion are due to unsafe induced abortion. This supposition is supported by a surprisingly high, “non-maternal”, death rate for women of reproductive age, and by data on hospital admissions for abortion-related complications. Among deaths to women of reproductive age identified in the rural survey cited above, 20 percent were classified as maternal. Among the remaining 80 percent, however, are a number of deaths suggestive of abortion related mortality if one disregards the reported pregnancy status (e.g.: “acute abdomen”, unspecified “infection”). Factoring those in would yield a revised estimate of 634 deaths per 100,000 births for this rural population. Assuming urban levels to be lower, this suggests a true national MMR of about 600 - 620 deaths per 100,000 live births.

Bearing in mind large underreporting of complications of induced abortion, causes of maternal death in a rural population of over 34,000 women for the period 1993-1999 were found to be as follows (based on verbal autopsy conducted by Obstetricians):
Table 2: Causes of Maternal Deaths in a Rural Population 1993-1999

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Obstetric:</td>
<td>29</td>
<td>60%</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>14</td>
<td>29%</td>
</tr>
<tr>
<td>Sepsis</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Eclampsia</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Unknown</td>
<td>7</td>
<td>15%</td>
</tr>
<tr>
<td>Indirect Obstetric Causes:</td>
<td>19</td>
<td>40%</td>
</tr>
<tr>
<td>Infection</td>
<td>11</td>
<td>24%</td>
</tr>
<tr>
<td>Injuries</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Unknown</td>
<td>4</td>
<td>8%</td>
</tr>
</tbody>
</table>

Source: van der Paal etc al, 2000

Notes:
1. Total reported maternal deaths probably under represents abortion related mortality by as many as 41 additional deaths beyond the 239 accounted for in this table.
2. There was a considerably higher proportion of deaths due to infectious disease (primarily malaria) in specific geographical areas of the sample.

Maternal Health Service Coverage Indicators

As noted above, most maternal deaths in Cambodia are due to either complications of unsafe induced abortion or direct obstetric causes. Unmet need for family planning will be discussed in detail in the following section. With regard to direct obstetric causes, the majority of Cambodian women deliver at home with untrained attendants, and receive no antenatal care prior to delivery. Delivery practices of Traditional Birth Attendants (TBAs) are known to include harmful practices such as routine manual removal of blood from the uterus. Even when the delivery is conducted by a trained attendant, the skill level of the practitioner is usually low and there is widespread misuse of oxytocic drugs to speed delivery, a very dangerous practice which carries a risk of uterine rupture. Access to emergency obstetric care is limited to nil at present in the vast majority of rural areas at present (see Section II.C.)

Vitamin A and iron deficiencies are widespread among pregnant women in Cambodia. Iodine deficiency is also prevalent in selected areas. There is no data available on postpartum services and it appears to be a largely neglected area, despite the fact that postpartum hemorrhage is a common killer. On the other hand, there is a great deal of attention being paid to the postpartum period through the traditional system with a number of physical and spiritual rituals carried out, and widespread use of injectable modern drugs (IV or IM iron, for example) by those who can afford it. These home practices include both benign and harmful elements.
Table 2: Maternal Health Service Coverage Indicators

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Nationwide (%)</th>
<th>Phnom Penh (%)</th>
<th>Range by Province</th>
<th>Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC, trained provider</td>
<td>37.6%</td>
<td>83.8%</td>
<td>15.7% (Monol/Ratanakiri) 58.2% (K. Chhnang)</td>
<td>DHS 2000</td>
</tr>
<tr>
<td>Delivery in health facility</td>
<td>9.7%</td>
<td>N/A</td>
<td>3.4% (remote provinces) 7.0% (“accessible” rural areas)</td>
<td>NHS 1998</td>
</tr>
<tr>
<td>Delivery by trained attendant</td>
<td>34.4%</td>
<td>76.6%</td>
<td>14.8% (Mondul/Ratanakiri) 46.0% (Kandal)</td>
<td>DHS 2000</td>
</tr>
<tr>
<td>Anemia in pregnancy</td>
<td>68%</td>
<td>N/A</td>
<td>N/A</td>
<td>HKI 2001</td>
</tr>
<tr>
<td>Reported Nightblindness in Pregnancy</td>
<td>2.5 – 9.3%</td>
<td>2.5 – 8.4%</td>
<td>HKI 2001</td>
<td></td>
</tr>
<tr>
<td>Unmet Need for Emergency Obstetric Care</td>
<td>N/A</td>
<td>N/A</td>
<td>81% (Siem Reap Province)</td>
<td>Von Schreeb 2001</td>
</tr>
</tbody>
</table>

Lack of antenatal care and delivery by trained attendants is understandable given the fact that public health services are not yet established in many rural areas, and that the number of midwives and quality of their training is inadequate. Another major constraint, especially with regard to delivery in a health facility, is the state of rural roads, which are poor at best and in the rainy season often washed out. Even if roads are passable, the major form of transportation is motor bike—a less than ideal way to transport someone in hard labor, bleeding or convulsing to a HC or hospital.

Additional factors are class barriers, poverty, and cultural practices and beliefs not well addressed by the modern health system. Trained health providers are consistently described by Cambodians as behaving in a rude and abusive manner to their clients, particularly clients of lower socio-economic status. They require payment in cash at the time of service, whereas TBAs accept credit and payment in kind. TBAs are perceived to provide, in addition to physical care, spiritual protection for the woman, and delivery at home readily allows for traditional practices and rituals believed important for the woman’s health. To date, the public health system has not experimented with incorporating any of these to render maternity services more acceptable. This was, however, done with great success with Cambodian refugee populations in Thai border camps between 1980-1993.

Lastly, and very problematic, is the issue of strong client demand for harmful modern practices not permitted under MOH protocols, which can provide an incentive for home delivery among both clients and trained midwives. Unnecessary drugs and intravenous transfusions (IVs) are actively sought by clients and are profitable for midwives to provide. Particularly popular and widely available is oxytocin, a drug which can be life-saving to stop blood loss in a postpartum
hemorrhage, but deadly when used to initiate or stimulate labor—resulting in prolonged, intense uterine contractions causing lack of blood flow to the fetus and possibility of uterine rupture.

2. Family Planning and Fertility

Contraception was illegal in Cambodia under every previous government in its turbulent history. It was only after the 1993 elections and onset of significant donor assistance that this policy changed. Family planning services have thus been available in Cambodia for less than a decade in the urban centers, and no more than five years nationwide. Access to services is still limited in many rural areas, although improving as the health care system is put in place (see Section IIC).

Current government policy is to provide a full range of methods, both temporary and permanent, and to encourage spacing of births. There is no policy or effort with regard to limiting family size. There does not appear to need to be, as demand for FP services is enormous and desired family size considerably lower than actual. As figures 1 and 2 below demonstrate, there has been a remarkably rapid increase in contraceptive knowledge and use in the past decade, very much demand-driven and occurring in spite of still limited service delivery mechanisms.

**Figure 1: Trends in Knowledge of Contraception**

![Knowledge of At Least 1 Modern Method and Source of Supply](chart)

Source: HSS 1998
Although government policy permits a complete range of methods, both temporary and permanent, service delivery lags behind policy and the only methods currently available to any significant extent in the rural areas are pills, injectables and condoms. IUDs are provided primarily in hospitals, although efforts are underway to gradually introduce them in HCs. Sterilization is available in only a handful of urban facilities. Norplant is being provided in only a few urban NGO clinics. Not surprisingly, given the pattern of availability and cultural factors, which tend to support female methods, injectables and pills are the leading methods. Little change in method mix occurred between 1998-2000.

Low use of sterilization probably reflects both the low level of development of surgical capacities in the country (and resulting wide-spread fear of surgery among the population) and the fact that the cohort of women of reproductive age in Cambodia is an extremely young one, who have had few children. Low condom use reflects both cultural factors which support female methods, and a stigma due to its strong association in the public mind with STDs and HIV/AIDS.

Notably lacking in availability is emergency contraception. It is both unknown and unavailable outside of a few NGO clinics, but the potential need given the reportedly high incidence of rape and large adolescent population is high.
Table 5: %Currently Married Women By Contraceptive Method

<table>
<thead>
<tr>
<th>Method</th>
<th>1998</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injectable</td>
<td>7.0%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Daily Pill</td>
<td>4.0%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Monthly Pill</td>
<td>1.8%</td>
<td>2.7%</td>
</tr>
<tr>
<td>IUD</td>
<td>1.8%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Female Sterilization</td>
<td>0.9%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Condom</td>
<td>0.6%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Other modern</td>
<td>0.6%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Traditional</td>
<td>5.6%</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

Injectables, the leading method, are primarily obtained through the public sector, whereas pills are primarily obtained through shops and pharmacies. It is notable that between the 1998 NHS and 2000 DHS a very marked increase in receipt of methods from Health Centers occurred, consistent with the establishment of those facilities (see Table 1, p.13). This suggests that HCs have the potential to substantially meet contraceptive needs of rural women.

There has been a very recent and significant fertility decrease in Cambodia, almost all of which appears attributable to the equally recent rise in contraceptive use. The current Total Fertility Rate is 4.0, while the Mean Children Ever Born to women aged 15-49 years is 5.6. Among currently married women not using contraception, only 29 percent state it is because they desire another child, and the mean number of children for women giving that reply is only 1.36 (NHS 1998). 48.9 percent of all married women want to either space their next birth or have no more children; 28 percent are undecided. Only 9 percent wish to have another child within the two years. Clearly, with a modern method CPR of only 18.5 percent, there is enormous unmet need for family planning.

The most commonly cited reason for both non-use and discontinuation of contraception is side effects. While menstrual irregularities may be amenable to reassurance, there appears to be a high incidence of nausea and vomiting (with resultant weight loss), and other systemic complaints such as vertigo and headache, among pill and injectable users. Although hard data is unavailable, the frequency and uniformity with which these symptoms are reported by women who hold no cultural beliefs or superstitions regarding control of fertility suggests that there may be some factor in this population causing these known side effects of hormonal contraceptives to be unusually frequent and severe. Nutritional deficiencies are a possible cause worthy of exploration. Folic acid and B vitamin deficiency are known to occur more frequently in users of COCs, and are also known to be frequent in the Cambodian population.
3. Child Survival

Levels, Trends and Causes of Infant and Child Mortality

The most recent estimates of infant and child mortality in Cambodia are as follows. These rates are calculated for a five year period 1995-2000 (DHS 2000):

<table>
<thead>
<tr>
<th>Mortality Type</th>
<th>Rate</th>
<th>per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality</td>
<td>95.1</td>
<td>live births</td>
</tr>
<tr>
<td>- neonatal mortality</td>
<td>37.3</td>
<td>live births</td>
</tr>
<tr>
<td>- post neonatal mortality</td>
<td>57.8</td>
<td>live births</td>
</tr>
<tr>
<td>Child Mortality</td>
<td>32.5</td>
<td>children surviving to 12 months of age</td>
</tr>
<tr>
<td>Under 5 Mortality</td>
<td>124.5</td>
<td>live births</td>
</tr>
</tbody>
</table>

These represent the highest levels of infant and child mortality in Southeast Asia, and among the highest in the world. Particularly high is the level of post neonatal mortality, accounting for 61 percent of infant deaths. Deaths in the post neonatal period are usually a result of infectious disease.

Both the 1998 National Health Survey and the 2000 Demographic and Health Survey obtained complete birth histories and data on the survival of all live births to women aged 15 – 49 at the time of those surveys. It is thus possible to estimate mortality levels from the start of the KR regime (1975) to present. Both surveys yielded extremely similar results.

All mortality rates (neonatal, post-neonatal and child) were very high during the KR years, and rapidly declined in the decade that followed the end of the KR regime. Since 1990, however, the trends have diverged. Neonatal mortality has continued to show modest declines, but child mortality has remained essentially unchanged, and there has been a significant and steady increase in post-neonatal mortality. An increase in post-neonatal deaths only, without a simultaneous change in neonatal or child deaths, usually indicates a change for the worse in the incidence and/or treatment of infectious diseases. While HIV/AIDS may account for some of the rise in the most recent period (and will certainly do so in the future), this trend occurred too early to be attributable to HIV/AIDS. Although the causes of the currently high levels can be fairly well identified, the reason for the deterioration starting in 1991 is unclear. It is only in the last few years that reliable population based data on causes of death and key health coverage indicators (e.g., immunization coverage) became available.
Until quite recently the only data on causes of infant and child deaths were facility based. Data from health facilities (primarily hospitals, since HCs are an extremely new development) indicate neonatal tetanus, ARIs (including post-measles pneumonia), diarrhea, dysentery, typhoid, malaria, dengue hemorrhagic fever, sepsis and unspecified febrile illnesses as the chief causes of infant and child death. There is enormous geographical disparity in the occurrence of malaria.

A one-year sentinel surveillance was conducted in 1998 in 40 rural villages in four provinces, covering a total of 8,948 children. Village monitors tracked all births and deaths in the study population. Causes of death were determined by a working group of Cambodian health professionals based on verbal autopsy reports obtained from the caretakers. This study yielded mortality rates consistent with those of the DHS and NHS, suggesting a high degree of accuracy in capturing mortality events.

While verbal autopsies are always subject to limitations, the causes identified are remarkably consistent with facility-based deaths with the exception of a lower reporting of typhoid and malaria. The surveillance was conducted exclusively in rural villages, while typhoid is most prevalent in urban areas with a density of population and poor water/sanitation; and most of the villages included in the surveillance were not in a high malaria transmission area.
### Table 4: Causes of Rural Infant and Child Death By Sentinel Surveillance

<table>
<thead>
<tr>
<th>Age</th>
<th>Cause of Death</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal (N=35)</td>
<td>Neonatal Tetanus</td>
<td>15.8%</td>
</tr>
<tr>
<td></td>
<td>Prematurity</td>
<td>15.8%</td>
</tr>
<tr>
<td></td>
<td>Hypoxia</td>
<td>13.2%</td>
</tr>
<tr>
<td></td>
<td>Septicemia</td>
<td>13.2%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>42.0%</td>
</tr>
<tr>
<td>Post Neonatal (N = 74)</td>
<td>Meningitis</td>
<td>21.6%</td>
</tr>
<tr>
<td></td>
<td>Pneumonia</td>
<td>19.3%</td>
</tr>
<tr>
<td></td>
<td>Diarrhea/Dysentery</td>
<td>17.1%</td>
</tr>
<tr>
<td></td>
<td>Septicemia</td>
<td>10.5%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>29.5%</td>
</tr>
<tr>
<td>Child (N= N/A)</td>
<td>Acute hemorrhagic fever</td>
<td>23.8%</td>
</tr>
<tr>
<td></td>
<td>Drowning</td>
<td>14.1%</td>
</tr>
<tr>
<td></td>
<td>Diarrhea/dysentery</td>
<td>9.5%</td>
</tr>
<tr>
<td></td>
<td>Pneumonia</td>
<td>9.5%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>42.9%</td>
</tr>
</tbody>
</table>

Source: RACHA 2000

**Notes:**
1. Sentinel locations were predominately not in endemic malarial areas
2. Surveillance period coincided with a nationwide epidemic of DHF

Indicators show that Cambodian infants and children have an extremely high burden of disease, as would be expected given the high levels of mortality. The 1998 NHS found that 27 percent of children under the age of five were reported to have been ill or injured in the 30 day period prior to interview: 18.8 percent moderately or severely ill (by perception of the caregiver) and 8.2 percent “slightly” ill. These figures are based on recall in response to a general question about illness or injury among household members. When mothers were questioned specifically about signs of ARI and occurrence of diarrhea or dysentery, it was found that in the two week period prior to interview:

- 25.9 percent of children under five were reported to have had cough accompanied by fast breathing;
- 15.0 percent were reported to have had watery diarrhea; and
- 6.7 percent were reported to have had dysentery.

This data was collected in the early rainy season (May-July) which is not a peak season for diarrhea and dysentery in Cambodia. There was little difference in ARI prevalence by socio-economic status or place of residence, but considerably higher prevalence of diarrhea and dysentery among lower socio-economic groups and in remote rural areas.
Child Survival Intervention Indicators

Coverage for basic, high-impact child survival interventions in Cambodia is extremely low. The majority of Cambodian children are not fully immunized and do not receive Vitamin A prophylaxis. Indigenous breast-feeding practices further expose infants to unnecessary risks of food and water borne diseases and malnutrition. When ill, the majority of Cambodian children do not receive treatment from a trained health provider. There is, therefore, enormous scope for significantly and rapidly reducing infant and child mortality through the delivery of a few key interventions.

Table 5: Child Survival Coverage Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>National</th>
<th>Phnom Penh</th>
<th>Range by Province</th>
<th>Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization(^{(1)})</td>
<td>39.9%</td>
<td>61.8%</td>
<td>26.6% (Koh Kong) 62.9% Battambong</td>
<td>DHS 2000</td>
</tr>
<tr>
<td>VAC Receipt(^{(2)})</td>
<td>48.6%</td>
<td>69.5%</td>
<td>30.8% (Isolated Provinces) 51.0% Accessible Provinces</td>
<td>1998 NHS</td>
</tr>
<tr>
<td>ORT treatment rate(^{(3)})</td>
<td>47.6%</td>
<td>62.7%</td>
<td>29.3% (Kampong Cham) 72.6% (Prey Veng)</td>
<td>DHS 2000</td>
</tr>
<tr>
<td>ARI treated by trained Provider(^{(4)})</td>
<td>30.9%</td>
<td>56.5%</td>
<td>20.7% (Isolated Provinces) 32.3% (Accessible Provinces)</td>
<td>1998 NHS</td>
</tr>
</tbody>
</table>

| Breast-feeding:                        |          |            |                            |                |
| Breastfed (0-5mos)                     | 98.8%    | N/A        | N/A                        | DHS 2000       |
| Colostrum (BF\(^{1}\)st day)          | 50.6%    | N/A        | N/A                        | DHS 2000       |
| Exclusive BF (0-5 mos)                 | 6.8%     | N/A        | N/A                        | DHS 2000       |
| Child Nutrition                        |          |            |                            |                |
| Solid/semi-solid food supplementation (6-9 mos) | 74.3% | N/A | N/A | DHS 2000 |
| Prevalence of stunting (chronic malnutrition) 12-59 mos | 50% | N/A | N/A | SES 1996 |

Notes:
1) Complete immunization among children aged 12-23 mos, not necessarily given by 12 mos
2) Any VAC in last 12 mos
3) ORS, home solution or rice water
4) % children w/ cough and fast breathing in last 2 weeks who were taken to a trained provider

The low levels of immunization coverage, despite substantial donor investments in the EPI program, are directly related to inadequate quantity and quality of HC outreach. As noted in Section II.C, villages which are beyond walking distance from the HC are supposed to be visited by an outreach team monthly to deliver EPI and other preventive health services. However, most HC's are just getting established as static facilities, and the logistics and management demands of simultaneously providing static services and rotational outreach to villages are considerable. Funds to support outreach costs (transportation, ice etc.) have generally not reached the periphery, although there are efforts being made to redress this situation. Staff numbers are often
inadequate to support the demands of clinic and outreach services. Health workers are underpaid, face significant class barriers in interacting with villagers, and lack skills in community mobilization and rapport building. Roads are extremely bad and often impassable during the rainy season.

The MOH strategy for Vitamin A Capsule supplementation is to provide mass distribution every six months in tandem with the immunization program. Initial concerns that this might result in not reaching children 24-59 months (because they are not targeted for immunization) were found in pilot studies to be unfounded. When the previously mentioned barriers are overcome and outreach sessions take place, it has been found that satisfactory VAC coverage of all under fives is achieved. Postpartum coverage, however, is an entirely different matter, and has been found to be extremely low even in villages with otherwise high VAC coverage for children.

The low use of trained providers for children with ARIs reflects both poverty and lack of confidence in and/or fear of mistreatment by, trained health providers. Poverty is a relative issue since the vast majority of mothers surveyed purchased drugs at a shop or pharmacy, and the cost of getting treatment at a HC or private provider is not much higher -- in fact, if a functioning HC is close by, it is cheaper than private purchase of drugs. Stronger factors are for people’s choices are doubt as to the knowledge and skill of trained providers, and fear of being treated in a derogatory manner. In addition, in rural areas not close to a functioning HC, costly and time-consuming travel may be involved with no guarantee of adequate treatment at the other end.

The lack of exclusive breast-feeding, failure to initiate immediate breast-feeding (colostrum), and common failure to introduce adequate weaning foods all reflect indigenous cultural practices and absence of health information.

B. Donor Support

In the area of maternal and child health, the other principal donors and multilateral agencies are ADB, World Bank, GTZ, DFID, UNICEF, AusAID, CIDA, UNFPA, WHO, and the French Cooperation (completely described in Annex B). There is at present adequate support for physical infrastructure, drugs, equipment and consumable supplies, and substantial technical support being provided to the MOH at the central level. Significant but not completely comprehensive support is also being provided at provincial level in many but not all provinces. Although many donors fund assistance through NGOs to strengthen community level health services, this is often done at an inadequate level of coverage (a few villages, or a few HCs, out of an entire OD - and there are many geographic gaps).

JICA supports the National Maternal and Child Health Center and Hospital. MCH/FP was identified during a recent Joint Japan-US Project Formulation Mission to Cambodia as an area for USAID/JICA collaboration. Specific Common Agenda activities were support for the NMCHC teaching hospital by JICA, and training of HC and RH personnel by USAID. Both are in fact taking place, as further described in Section C to follow. The Common Agenda also identifies, as an area for joint implementation, support to the EPI program. This is being done on USAID’s side through the Global Bureau contribution to UNICEF.
Two very important donor initiatives are being considered which could have important ramifications for selection of future USAID focus areas. One is a possible scale-up, contingent on findings of an evaluation scheduled later this year, of the ADB-financed pilot contracting of health services. The extent and location of scale up, if any, is not yet known but would be probably fall within the present ADB supported provinces of Prey Veng, Kampong Cham and Takeo.

The other is “Boosting”, a new initiative in which donor resources will be provided comprehensively to specific provinces to comprehensively address sectoral constraints and improve sector performance. The emphasis will be on civil service issues and increasing provincial health department capacities. Boosting is expected to be implemented in 2002 in Kampong Cham (USAID), Kampong Thom (GTZ) and possibly Takeo (Swiss) in the near future. There is also a possibility of Belgian funding for “boosting” in Siem Reap Province but probably not before 2003.

A scale up of contracting, if it encompassed all or most ODs in a province, would make those provinces inappropriate for USAID focus. “Boosting”, on the other hand, would not be inconsistent with likely future USAID activities and might increase their chance of success by providing a stronger health system to work with. On the other hand, “boosting” is a new initiative and it is not yet known how well it will work or what implementation problems it may encounter in its early stages. There are therefore both potential benefits and elements of risk in working in the same province where “boosting” occurs.

C. Current USAID Program

1. Overview

USAID/Cambodia’s Strategic Objective 2, Improved Reproductive and Child Health, has the following intermediate results: (1) expanded supply of reproductive and child health services; (2) increased access to reproductive and child health services; and (3) strengthened demand for reproductive and child health services.

The USAID/Cambodia RCH portfolio includes both activities with national level application (either national/urban or nationwide) and activities to strengthen the provision of services at the rural community level. These two will be discussed separately.

2. National Level

Social Marketing

Since 1993, USAID has provided core support to Population Services International (PSI) for social marketing of oral contraceptives and condoms. This activity contributes to both the reproductive and child health objective and the special objective for HIV/AIDS/STDs (see Section V). PSI/Cambodia has successfully leveraged funding from several donors, receiving pills and condoms from UNFPA and DFID respectively, while USAID funds core support and
some media work. PSI uses sales revenues generated by the commodities to fund IEC and advertisement campaigns.

The Social Marketing Program has consistently exceeded its performance objectives. As of February 2001, over 68 million condoms have been sold with sales in 2002 expected to average over 1.4 million units per month. Their overall share of the condom market is 80 percent, and 93 percent of brothels in a recent survey had PSI condoms for sale on the premises. The condom promotion campaign has been very successful and the name Number One is synonymous with condom. More information regarding Number One can be found in Section V.

In 1995, only 6.9 percent of married women used a modern contraceptive, and only 1.1 percent used combined oral contraceptives (COCs). In 1997, PSI launched OK Birth Spacing Pills. Since then, PSI has distributed more than 930,270 cycles, which translates into 71,599 couple-years of protection. OK sales far exceeded projected levels. By 2000, use of modern contraception had increased to 19 percent of married women, and use of COCs to 4.5 percent, almost half of which are purchased from shops and pharmacies. Of commercially sold COCs, PSI’s OK brand accounts for 80 percent, making its total contribution to COC use 35.2 percent.

PSI is in the process of pilot testing the feasibility of social marketing of injectable contraceptives, using its own funding. Since injectables are the most popular method in Cambodia, and home use of injectable drugs is a cultural norm, this could have significant potential.

Social marketing is having a significant positive result on access and use of both COCs and condoms, and has the potential to do the same for injectable contraceptives. However, the program’s reach is still primarily urban and peri-urban. Although about 10 percent of PSI COCS are sold to NGOs for resale in rural areas, overall rural availability of both pills and condoms remains quite low, a priority concern in a country where 85 percent of the population is rural. Demand for contraception in rural areas is extremely strong, and more efforts need to be made to ensure that social marketing reaches rural areas, although this will of necessity require different and more complex and costly retailing arrangements.

USAID has received a significant return on its investment in this program. The potential for impact on both RCH service availability and HIV/STD prevention in the future continues to be high, but could be substantially increased through expansion of the range of products and introduction of strategies to specifically target distribution to rural retailers and retailers in special population segments (e.g., slums, military bases).

In addition, given its comparative advantage in market research, the Social Marketing Program would be an excellent venue for exploring new approaches to one of the major constraints to family planning in Cambodia: management of side effects of hormonal contraceptives. Side effects are the leading reason for non-use and discontinuance of family planning among Cambodian women. It would be well worth exploring whether supplementation with folic acid/Vitamin B complex reduces the frequency and severity of side effects in pill and injectable users. If so, there would be scope both for sharing this information with the public sector and for
social marketing of nutritional supplements for women using family planning – who in any event are already spending money on less effective and sometimes dangerous remedies.

National Logistics Management System

The USAID funded Reproductive and Child Health Alliance (RACHA) project provides technical assistance and leadership in the development of a national logistics management system for contraceptive commodities and essential drugs in Cambodia. A long-term expatriate logistics advisor has worked with the MOH Essential Drug Bureau (EDB) to develop a logistics management information system and curricula, and training manuals for personnel at the central, provincial, and the OD level. More than 1,500 participants nation-wide were trained to manage the essential drug logistics system. RACHA also assisted the MOH EDB in forecasting and projecting contraceptive needs for a five-year period. With this information, the MOH submitted a proposal to donors for contraceptive supplies and gained tentative funding commitments for Cambodia for the next five years.

In selected ODs in Siem Reap, Kampot and Pursat Provinces, the logistics training has been augmented by intensive facilitative supervision, on-the-job training and computerization of the system down to the OD level. Monitoring of stock level status in these ODs demonstrates the effectiveness of these inputs – stock-out levels are decreasing and notable improvements have occurred in satisfactory stock levels. Field level follow up, computerization at the OD level, facilitative supervision, monitoring, and assistance in the use of data for decision making have been critical to achieving this. In other provinces, although the initial training was provided, success is anecdotally reported to be more variable and highly dependent on whether or not another agency was able to provide the needed field level follow-up.

The logistics management intervention has national coverage and has played an important role in improving logistics management and monitoring the flow of contraceptive supplies from the central to the peripheral level, although this has been more successful in provinces where RACHA or other agencies have been able to provide field level follow up. The long-term impact on strengthening the national capacity of the health logistics management system is significant, and could be further enhanced by a coordinated effort to ensure that the necessary follow up is done at the provincial and district levels in as much of the country as possible.

Safe Motherhood

Through the RACHA Project, which has fielded an experienced expatriate Safe Motherhood advisor for several years, USAID has contributed to the Safe Motherhood national policy, strategy and workplan and provided technical assistance for the clinical practice guidelines. The RACHA advisor participates in an MOH technical working group on midwifery training—an activity that has the potential to start a sustainable program in capacity-building of the frontline providers for maternal and newborn care.

A competency-based Life Saving Skills (LSS) course for midwives, developed by RACHA, has been a model for the country and both the curricula and the trainers are being used for other donor-funded courses. There is both demand and potential to expand this capability.
Private Sector Urban Reproductive Health Services

The USAID portfolio includes support to the Reproductive Health Association of Cambodia (RHAC), which is the largest private provider of family planning and reproductive health services in Cambodia with five clinics based in urban areas: Phnom Penh (2 clinics), Sihanoukville, Battambang and Kampong Cham. The latter is supported by funding from IPPF, while the remainder are USAID-funded. All clinics provide a range of birth spacing methods, diagnosis and treatment of RTIs and STDs, ante and postnatal care and counseling on HIV/AIDS. The method mix and choice of methods is wider than that generally available in Cambodia, either in the public or private sector. One of the two Phnom Penh clinics provides Norplant and male and female sterilization. The other clinics provide a range of contraceptive choices including oral contraceptives, injectables, IUDs, and condoms.

In 2000, the four USAID-funded RHAC clinics served 4,857 new family planning clients and provided a total of 15,218 family planning visits. Over 50,000 RTIs/STD visits took place, both male and female. RHAC clinics see a significant number of men as well as women for STD care, and clinics have separate waiting rooms for men and women. Several of its clinics are designated as “youth friendly” and provide separate private entrances as well as waiting rooms for adolescents, and host BCI activities targeted to youth (karaoke sessions with RH messages, etc.).

Laboratory services include cervical and vaginal smear, blood group identification, white blood cell differential count, hematocrit, syphilis testing, pregnancy testing, urine analysis, etc. HIV testing and counseling is relatively new, and RHAC would seem to have a comparative advantage in both laboratory and counseling aspects. Tests are sent to the local Pasteur Institute, though RHAC is currently considering alternative testing methods. Its clientele are predominately urban middle-class, among whom there is high demand for HIV testing, especially prior to marriage.

Clinic waiting rooms and offices have IEC materials, and staff provide health education to clients. In addition, RHAC conducts IEC campaigns through mass media and through outreach with peer educators for youth. It has developed a wide range of reproductive health IEC outreach materials, which are used by multiple agencies throughout the country.

The clinics have clear FP/RH protocols and guidelines that are used in training, supervision, and follow up, and the Continuous Quality Improvement approach is being used in all clinics to monitor quality services. A clinical assessment is conducted quarterly for staff and this tool provides feedback to staff to ensure good performance.

A special Training Department provides training not only to RHAC staff but also to other organizations countrywide. In 2000, RHAC provided reproductive health training to 1,041 participants from the public and NGO sector. The total training days in 2000 added up to 208. Local NGOs pay RHAC to train their participants and this department is a viable revenue-generating unit. The training courses are interactive competency-based and include: IUD insertion and removal, STD treatment and prevention, IEC techniques, Sexuality and Reproductive Health, HIV/AIDS prevention and counselling, Life Skills, and Youth RH.
RHAC is also a subcontractor with CARE International to provide clinical FP/RH services and training support in five garment factories in Phnom Penh. Garment factories employ an estimated 190,000 workers, most of them young female migrants from the countryside and highly vulnerable to exploitation in the absence of their families. This initiative has been supported by the EU/UNFPA Youth Reproductive Health Initiative. It received a positive review during the recent EU/UNFPA mid-term evaluation, and plans to extend coverage to other factories.

Nutrition

With USAID funding, Helen Keller International (HKI) provides technical assistance to the government for development of policies and programs to combat Vitamin A and other micronutrient deficiencies, and conducts and disseminates related research.

Major accomplishments under this project have been (1) formative research demonstrating a high prevalence of Vitamin A deficiency in Cambodia; (2) the establishment of a National Micronutrient Technical Working Group and National Vitamin A Policy; (3) operational research to test the feasibility and effectiveness of delivering VAC in conjunction with EPI; (4) establishment of National Guidelines for VAC supplementation based on this research; (5) research demonstrating a high prevalence of goiter in specific regions of the country; (6) ongoing TA and policy dialogue with UNICEF and the RCG on salt iodization; and (7) a nationwide survey on the prevalence of micronutrient deficiencies.

HKI’s position in Cambodia is unique; there is no other organization with the capacity and credibility to guide national policy and programs in the area of Vitamin A supplementation and nutrition. Its activities in this regard have substantially contributed to increased access of VAC supplementation and increased awareness, among government, donors and implementing agencies, of other micronutrient deficiencies.

HKI has also pilot tested a model home gardening intervention and has provided materials, training and technical assistance to NGOs around the country in implementing it in existing NGO areas. To date, 12,620 home gardens have been supported through seven different NGOs across the country.

As the home gardens were originally viewed as a pilot nutritional intervention, an intensive monitoring system was developed to track food produced, whether eaten or sold, income generated, and changes in family nutritional status. Findings have already been published based on a full year of such monitoring and showed increased consumption of micronutrient-rich fruit and vegetables among young children in families with home gardens. The Assessment Team is uncertain of the necessity of continuous monitoring now that the program has gone beyond the pilot stage, given that the monitoring is labor-intensive for HKI and limits the number of additional NGOs it can assist.
IV. Reproductive and Child Health  June, 2001

PHN Assessment, USAID/CAMBODIA

35

Research

USAID has funded several studies which have had widespread impact on government and donor policies and programs. Foremost among these is the 2000 Demographic and Health Survey (DHS), co-financed with UNICEF and UNFPA.

Also of great importance have been studies by RACHA on the causes of maternal and infant/child mortality. These reports, gathered through sentinel surveillance in 40 villages, provide the first and thus far only population-based data on causes of maternal, infant and child death and as such are an invaluable tool for decision making and program design.

Through HKI, a number of nutritional surveys and studies have been conducted, particularly with respect to Vitamin A deficiency in women and children, and other micronutrient deficiencies.

3. Community Level

As has been noted previously, Cambodia is in the process of implementing a health service system starting from a zero base. Tangible results are evident 3-4 years after completion of the initial pans, but development of the planned system is still far from complete. Efforts to improve reproductive and child health services in Cambodia must therefore proceed on two tracks, simultaneously: assisting in the development and strengthening of the nascent service delivery system, and promoting the delivery of specific interventions. Furthermore, it should be noted that community level services are delivered in an integrated fashion, with HCs and HC outreach sessions as the primary source for MCH, FP, and curative care. HCs will also soon become the primary point of contact for TB treatment and HIV/AIDS detection.

Strengthening of Integrated Health Services At the District Level

Three USAID-funded projects strengthen the integrated delivery of basic preventive and curative services and community mobilization/participation within operational districts in accordance with the MOH Health Coverage Plan and Guidelines for Operational Districts. A number of other, non-USAID funded CAs provide similar interventions in other operational districts. The Assessment Team had the opportunity to observe the various approaches across CAs as well as the differences in health system development in areas with and without CA technical assistance, and the approaches of non-USAID funded NGOs engaged in similar work.

As can be seen from the following list, coverage is scattered across five different provinces. Only in Pursat are all the ODs of a single province included. This spotty coverage has resulted in large part from the unpredictable year by year funding (see Section III) as well as disruption in implementation of a prior MCH strategy by the “events” of 1997 and subsequent restrictions on US assistance. Lack of a critical mass of inputs in a single province both reduces potential impact and makes it harder to measure.
Although each project has its own unique strong and weak points, all of them have succeeded in strengthening community health services, with a much higher rate of service delivery and service utilization than is noted in ODs without such support. Key activities common to all three projects and to non-USAID funded NGO projects working successfully elsewhere in the country, are as follows:

- A systems approach is taken, recognizing the essential elements of district health services and their interdependency. HCs, HC outreach, Referral Hospital and capacities of the Operational District Health Team must all be addressed, along with referral mechanisms and linkages between them. The more completely a CA does this, either on its own or in coordination with other agencies working in the same OD, the better the results.

- Competency-based training, through both formal and informal mechanisms, is provided to health center staff and operational district managers to improve clinical, counseling/interpersonal, and managerial skills.

- Training is complemented by intensive on-the-job follow-up, coaching and facilitative supervision. This is essential if HC staff are to integrate and apply new skills, attitudes and approaches.

- Assistance is given in the formation and activities of HC Feedback Committees (FBCs). These committees, consisting of elected representatives from each village, provide an essential mechanism for improving HC-villager relations, mobilizing the community for outreach sessions and promoting health practices and utilization of preventive services. Most importantly, they empower communities and create a sense of accountability towards clients which health workers, raised and trained in an authoritarian culture, have never before had. Although the formation of FBCs is a required element in the MOH Health Coverage Plan, in practice it does not occur without external facilitation. With such assistance however, FBCs are playing a very important role in strengthening HC services.

Although all three projects have achieved higher levels of service delivery in the ODs in which they have concentrated inputs – in some cases, levels dramatically higher than the average for that same Province – there is room for improvement and enhancement of results.
By far the most common weakness is a failure to completely address the critical elements of OD health services: the District Health Management Team, Referral Hospital, Health Centers, and Health Center Outreach. Most commonly this was noted to take the form of supporting some, but not all, of the HCs in an OD. Other instances were noted in which the CA supported HCs but did not work systematically to strengthen the DHMT which manages and supervises them, and/or did not also have a strategy for strengthening the capacities of the Referral Hospital. It is not surprising that this is the case given that the current projects, and present Mission MCH Strategy, preceded the development of the MOH Health Coverage Plan by several years, and also given the constraints of uncertain and year-by-year funding. However, it is critical that future strategies and projects reflect and support the decentralized operational district aspect of the Health Coverage Plan and address OD health services as a system in order to maximize results.

The three projects vary considerably in the extent to which they take a development approach to strengthening community level services as opposed to primary emphasis on immediate term outputs. Some have a clear development focus and strategies for the long-term, including ultimate phase-down of activities, and address constraints with the larger national picture in mind. For example, CARE has a seven year plan for gradual phase-in and phase out of HC support, from an initial level of intensity of daily TA (Stage 1) to visits once a month (Stage 6) followed by “graduation”. Others seek quick improvement in performance through provision of material incentives such as motorcycles upon achievement of performance targets. While the latter approach provides a strong stimulus to staff, it may set an unsustainable precedent; motivation may again drop once the incentive has been obtained unless follow-on incentive schemes are introduced, and it is not an approach that would be acceptable or replicable on a national scale. In addition, it has been noted to create difficulties in neighboring ODs where incentives aren’t provided, and to disrupt the provision of services not specified in the performance contract.

While some of the projects are stronger in long-term development approaches, others stand out in terms of innovation and creativity, and have pioneered a number of extremely interesting and novel approaches. These include, but are not limited to, use of nuns and “wat grannies” (elderly women living a quasi-monastic life) as health promoters, introduction of a HC quality assurance tool developed by EngenderHealth called “COPE” (Client- Oriented and Provider-Efficient), and popular participatory approaches to community health education such as health promotion contests and lotteries. These initiatives have been piloted in an informal manner and not systematically studied, but it was evident during Assessment Team field visits that among them are a number of “gems” worthy of closer attention and replication.

In particular, there is tremendous potential of Buddhist nuns and “wat grannies” as a volunteer health workforce at the community level. Theirs is a unique situation free of many of the constraints which typically hinder health volunteer efforts:
they are free of family and work obligations, with sustenance is already provided for;

they perceive themselves as being in the last phase of life and have made a conscious, sincere commitment to dedicate their remaining years to the accumulation of spiritual merit through good works;

they are present in large numbers throughout the countryside, and respected and credible in the villages;

their age and monastic status give them the freedom to discuss intimate topics without fear of loss of reputation; and,

they have significant amounts of free time and are searching for meaningful roles to play.

Although nun/wat granny initiatives have thus far been limited to promotion of better breastfeeding practices and CDD, the nuns met by the Team indicated both willingness and potential to assist in a number of other reproductive health areas – and, perhaps most importantly, in care of AIDS patients in the community.

The “COPE” quality assurance mechanism is working very well and HC staff find it easy to use and beneficial. Other CAs have also chosen to use it, further indicating its utility. Aside from enabling HC staff to identify and solve service delivery problems, it was found to greatly improve teamwork and the ability of staff to articulate problems and concerns. Another quality assurance tool, the SIS (Self-Improvement System) has been effectively developed and used to improve the quality of antenatal services through peer review among midwives.

While such innovations are very valuable, there is also a need to strike a balance between breadth and depth, and to resist the urge to experiment with new approaches to such an extent that no approach is sufficiently implemented and/or documented to do justice to its potential. The projects vary in the extent to which they are able to do this, with some well-focused but others over ambitious in trying to meet comprehensive community needs.

Maternal and Neonatal Health

In most of the USAID CA supported ODs, health education is carried out through FBCs and HC outreach teams. The quality of the IEC is good and villagers are receptive. USAID-funded CAs train and coach government counterparts to provide good antenatal care in health centers and through outreach sessions, thus bringing the effective interventions of TT immunization and iron supplementation to women who would not otherwise get them and introducing villagers to a functioning healthcare system. ANC coverage in CA areas are about double that of non-supported areas, and significantly higher than provincial and national averages. The outreach ANC brought to villages appears to be as good as in health centers with physical examination, general client education, TT immunization, iron tablet distribution and filling out the client record done in a systematic and professional manner. Follow-up and supervision are essential in maintaining the services, so the human input is intensive, but results are impressive when this is done.
Likewise in hospitals where USAID has supported midwifery in-service training in LSS, client use has doubled in a two-year period. LSS-trained midwives and trainers had attended 1,500 deliveries and made over 2,200 postpartum visits by December, 2000. This does not represent high volume but these midwives are well placed and now will be able to expand their practices as demand increases.

Most facility-based deliveries occur in RHs, but some of the HCs supported by USAID CAs and other donor funded NGOs are starting to perform deliveries, particularly HCs with an LSS-trained secondary midwife on staff. The caseload in such situations was found to range from 1-5 deliveries per month for a catchment area of about 10,000 persons. A particularly interesting approach seen in a non-USAID funded NGO project area was a fee-splitting arrangement between HCs and TBAs who brought women to the HC for delivery. Deliveries in HCs without external TA, and without LSS trained secondary midwives, are rare. In addition, it appears that women are increasingly calling LSS trained midwives to attend their births at home. This avoids the moto ride, allows for traditional practices to be observed, but also carries the risk of dangerous and unnecessary modern treatments not permitted in HCs (such as IVs and oxytocin induction/augmentation of labor—see section II.B.4). These client expectations were openly discussed with the Team by HC midwives.

The team did not have the opportunity to observe births in either setting so it is not possible to get even an impression of the quality of care (especially use of the partogram, immediate care of the newborn and care in the third stage of labor) in the various of settings or with the different categories of providers. LSS-trained midwives in HCs and RHs could accurately recite national protocols and stated that they followed them. Nonetheless, it is apt to be hard to resist the desires and demands of clients for potentially harmful interventions in the home, making it all the more desirable that HC and hospital deliveries be encouraged.

Some CAs have marketed safe birth kits within their project areas, with good consumer response. However the impact of the kits on birth practice has not been established. While the commodity itself could not create problems, there is some concern about possible encouragement of home delivery with TBAs if the woman feels the kit removes the need for a trained attendant.

There does not yet seem to be an effort to find out about recent births at the community level and provide early visitation (preferably within the first 24 hours) to those women who were not assisted at birth by the midwife or trained TBA in order to identify and deal with complications, promote optimal breastfeeding practices, and give appropriate advice about diet, hygiene, exercise, etc.
Family Planning

CAs have supported the delivery of FP services in HC and during HC outreach through training, coaching and mentoring of HC staff, and logistical assistance with conduct of outreach sessions. In just the brief two-year period 1998-2000, the contribution of HCs to modern method CPR rose more than five-fold, from 3 percent to 16 percent. This is particularly impressive since only 60 percent of planned HCs were operational in 2000, and half of these had opened just the year before. Clearly, HCs have tremendous potential to increase contraceptive use among rural women. The increase occurred in all methods available at HC level: pills, injectables, condoms, and IUDs. As more HCs open, HC outreach sessions increase in coverage, and IUDs are gradually introduced into more HCs, the contribution of HCs to increased CPR can be expected to continue to increase. Hence, HC strengthening activities are directly contributing to increased access to contraception. Still largely missing at rural level, however, is the potential contribution of social marketing. Although 10 percent of COC pill sales are through NGOs in rural areas, there is little or no penetration of the rural private sector and both condoms and COCs were noted to be unavailable in most rural villages, despite a proliferation of small shops in even the remotest areas. The current distribution strategy would benefit from stronger rural outreach.

Also notably missing from family planning services in Cambodia is Emergency Contraception (EC), although there is no legal impediment to it. EC is part of the protocols in the urban RHAC clinics, but generally unknown to the population and so seldom requested. EC is completely unavailable in both the public sector and on the retail market. Given both the apparently high incidence of rape and large adolescent population, this is a significant gap.

In addition to the urban clinics discussed under nationwide activities, RHAC conducts community-based distribution of contraceptives under its Health Development Team (HDT) Program in several provinces. This activity is one of the oldest outreach programs in Cambodia and pre-dated establishment of HCs and HC outreach by several years. In areas where HCs are not yet functioning, it remains the sole source of RH services at the community level.

However, in those areas where HCs are functioning well, the HDT program has not adjusted to reflect this change in the health system but rather continued to function in a parallel manner. MOH Provincial and District staff have voiced concern that this not only misses an opportunity to strengthen HC outreach, but may actually weaken HCs by diverting user fee revenue which would otherwise go to the HCs and is often their chief or sole source of operating funds; and by reducing attendance at HC outreach sessions. This is apt to become more of an issue in the future as government HCs are becoming more functional and beginning to meet the health needs of the rural populations. The Assessment Team recommends that USAID re-examine the HDT strategy and consider alternative approaches in ODs where HCs function. These might include directing the same staff and resources towards strengthening of HC outreach activities, or having the HDTs conduct complete HC outreach (i.e., EPI, ANC as well as FP on a regular basis) under contract to the HCs.
Child Survival

Present USAID-funded activities in child survival consist of (1) strengthening of HC and HC outreach services, thereby increasing EPI/VAC coverage and access to simple curative care; and (2) health education to mothers on proper breast-feeding, and prevention and management of diarrhea through HC outreach, FBCs, and, in one CA site, through use of nuns trained as health promoters. In addition, family planning activities have a positive effect on family planning through better spacing of births.

Current EPI and VAC coverage is abysmally low nationwide – and has remained consistently so throughout the three year period for which population based data has been available, despite considerable donor resources for EPI. VAC coverage for children follows the levels of EPI coverage since these interventions are delivered in tandem. However, this strategy does not effectively reach lactating women, for whom another approach is needed, perhaps in conjunction with provision of postpartum care (see the preceding section on maternal and neonatal health).

It is generally accepted in Cambodia that EPI/VAC coverage is low due to lack of regular HC outreach sessions. That, in turn, reflects lack of resources (money for ice, transport) for such sessions, a persistent problem despite specific donor support (through UNICEF) for such costs. Recent reforms in disbursement of funds through the MOH are hoped to reduce leakage and improve receipt of resources at the periphery; it is too early to judge the extent to which these will prove successful. In addition to lack of small scale but essential resources, it is difficult for HC staff to plan and manage outreach sessions without external technical assistance. HC staffing levels are often inadequate to allow for simultaneous service delivery in HCs and at outreach locations, requiring that services be staggered by day of the week and the community somehow adequately informed of what is available when, and where. Community mobilization is difficult for HC staff with no training in it and limited interpersonal skills with which to bridge class barriers and gain villager trust. Movement of people and materials can require a variety of different modes of transport and be especially difficult during the rainy season.

Support from NGOs and other agencies, such as that provided by USAID’s CAs, certainly helps address these constraints. However, given rising levels of post-neonatal mortality and extremely poor EPI coverage levels, it would be worth revisiting the overall national strategy and considering alternative approaches. Many Cambodian villages are quite small, with only 1-2 births a month, and spending a full day each month to provide immunization in such locations may not be the most cost-effective approach. There cannot be a single uniform approach given the great variation in distances and modes of transport; there is a need to individually tailor strategies to the physical realities of each OD.

Aside from an obvious and urgent need to redress poor EPI/VAC performance, there is also a great need to improve management of common child illnesses. The HC strengthening activities undertaken by USAID projects to date, and indeed most of those funded by other donors, have made substantial progress in improving antenatal care and midwifery skills but notably omitted improvements in the skills of curative staff. Primary or secondary nurses generally conduct HC consultations, but their training has been both inadequate in content and totally didactic. The vast
IV. Reproductive and Child Health  June, 2001

majority of these practitioners are unable to accurately diagnose common problems or recognize and respond appropriately to signs of complications.

One of the reasons Cambodians prefer to go directly to pharmacies and shops rather than to trained health providers is that they do not perceive there to be any benefit to consultation; it is a simply a more time-consuming means of getting drugs, and possibly a more expensive one if travel costs are involved. Unfortunately, this perception is at present an accurate one. There is no added value to obtaining curative treatment from a HC as opposed to a pharmacy in the vast majority of cases. In the few HCs fortunate enough to have higher level staff (i.e. a medical assistant or, very rarely, a doctor) there is inevitably a much higher volume of consultations, suggesting that Cambodians will recognize and respond to quality care when available.

In addition to lack of technical knowledge, practitioners have had no training in interpersonal skills or in bridging class barriers. Clients complain about insulting behavior and “rudeness, bad speech” from health providers and cite this as a major reason for not going to them. There appears to be little awareness of this on the part of health providers, who tend to attribute low utilization to “ignorance” on the part of the people.

None of the present USAID-funded projects currently provides competency-based training and mentoring in basic diagnosis and treatment of the ill child, but they are well placed to do so and have demonstrated a capacity to achieve results through similar interventions with other cadres of staff (e.g., midwives, pharmacists). In addition, they are well placed to do sensitivity training and coaching to improve the interpersonal skills of providers.

The current pattern of self-treatment through pharmacies might indeed change if consultation with a trained health worker conveyed more benefit. Nonetheless, it is unlikely to disappear in the foreseeable future, raising the question of direct education of mothers, the persons most often responsible for diagnosis and treatment of sick children. Training of pharmacists has been tried with little success, understandably given the different profit implications of curative prescription patterns. There has to date been no systematic effort to educate mothers on the appropriate use of pharmaceuticals. Neither has there been much social marketing of health commodities, but there is considerable potential to do so with good effect, e.g., for ORS, iron and folic acid supplements, antihelminthics, anti-malarial drugs, and water jar lids.

Lastly, there is scope for significant improvement in infant and child health through improved breast-feeding practices. A very high burden of diarrhea and dysentery has been documented in Cambodian children, including dysentery in neonates, and is undoubtedly related to the practice of discarding colostrums and non-exclusive breast-feeding. In addition, inadequate provision of weaning foods is a significant contributor to the malnutrition which underlies a great deal of early child mortality. There is a strong need for intensive health education and behavior change interventions at community level in this regard. Most of the existing USAID projects are already doing this, but there is a need to better integrate IEC efforts so that maximum use is made of each contact. Getting to and from the point of contact, and achieving attendance, is 99 percent of the battle and the cost. It is grossly inefficient to have vertical IEC campaigns at the community level. More could be done on identifying a package of key messages covering MCH, FP, HIV/AIDS and STDs to be disseminated through all available channels.
Child survival is, of all the current intervention areas, the most neglected in the present USAID portfolio. It is also generally neglected by other bilateral donors. Taken together with the very poor coverage levels and rising mortality, there is clearly a need for USAID to give greater and more explicit attention to child survival interventions.

4. Capacity Building

As noted in Section II, lack of human resource capacities is a pervasive constraint to development efforts in Cambodia, and capacity-building must go hand in hand with interventions. There is an enormous demand for individual capacity-building throughout Cambodian society. Elementary schools are bursting with double shifts. Families are seeking secondary, technical and university education for youth as never before. Savings are being depleted to pay for private language training. People in every walk of life are hungry for more knowledge and skills. This will inevitably result in better-educated and more empowered people to seek services and demand quality.

In the health sector, USAID-funded CAs have made substantial contributions to the capacities of their own local staff, district level health care providers, and communities. This has been most successful when undertaken in a systematic and proactive manner rather than scatter-shot and reactive one. While all CAs are doing capacity-building, some approach it with more depth and focus than others.

With respect to CA local staff, the Team was very impressed to see the initiative and skill that has been developed by the CAs in young Cambodian professionals. Important elements of the more successful approaches have been:

- Clear plans, policies and resource allocation for local staff development rather than an ad hoc response to training requests and opportunities;
- Deployment of a critical mass of professional staff at the field level and phased in devolution of authority and responsibility to them.

Capacity-building among district level government health workers is naturally a slower process, hampered by the low salaries and non-merit based organizational culture that typify government work. Nonetheless, significant progress is being made and leading to better performance and utilization of health services. Pharmacists and managers have had training in drug and commodity logistics and are able to apply these skills as evidenced by a documented decrease in stock outs. Midwives have had both classroom and on-the-job training in life-saving obstetric skills and antenatal care, with a resultant increase in clients as testimony to their improved quality of care. Village-based “feedback committees” are being taught how to map their villages and bring village concerns to the health care system. Villagers are being empowered with basic health information with which to avoid unnecessary disease and unwanted pregnancies. In an innovative program, Buddhist nuns and “wat grannies” are being used to disseminate information about optimal breastfeeding practices and control of diarrhea.
Quality assurance and problem-solving techniques such as “COPE” and regular team meetings have had a demonstrable effect on the ability of staff to identify and address service delivery problems. HC staff in areas supported by CAs were noticeably better able to articulate the health situation in their catchment area and HC strengths, weaknesses and needs than were staff in areas without such support.

While the approach being taken – development of capacities among local CA staff who in turn provide intensive, hands-on coaching and mentoring to OD level health staff – clearly works, there are some important gaps in content. General skills of consultation staff (diagnosis, treatment and emergency management/referral) is a hugely neglected area and one that contributes to the general under-utilization of HCs in favor of self-medication. Another gap area, due to the verticalization of the MCH and HIV/AIDS program, is in knowledge of HC staff and the general village level population regarding HIV/AIDS. HC health education outreach sessions currently focus on standard MCH/FP topics but largely omit HIV/AIDS/STDs even though these are areas of great interest and concern to villagers. Nurses and midwives have unmet needs for information on how to protect themselves from AIDS.

Local NGOs are rapidly expanding organizational capacity through formal courses, on-the-job training, and mentoring, and a few have developed the capacity to attract and manage direct donor funding and diversify services. Good progress has been achieved but the present LNGO numbers and capacity will have to be expanded greatly to meet current and emergent needs in the country.

While there have been substantial contributions to capacity-building of individuals, local NGOs, and community level health facilities, USAID has largely been on the sidelines in tackling national level policy issues related to overall health system strengthening. The focus has been on individual and team capacity building. While a number of other donors and agencies (including non-USAID funded NGOs) are playing an active role in dialogue at top levels to resolve such fundamental issues as civil service reform, USAID and its partners have not been significant actors. This may reflect both legislative restrictions on working with the government and USAID’s general comparative advantage in Cambodia in working with NGOs and private sector. Nevertheless, the sustainability and long-term impact of USAID’s investments will be substantially affected by the extent to which the government is able to address fundamental sectoral constraints.
V. HIV/AIDS/STDs

A. Overview of Country Situation

1. HIV/AIDS Prevalence

HIV was first detected in Cambodia in 1991 and a Sentinel Surveillance system (HSS) was established in 1994. Currently 19 serological sites have been established throughout the country, covering every province except Preah Vihear, Mondol Kiri, and Oddar Meanchey. These sites conduct annual HIV testing of population groups that include uniformed services, direct and indirect commercial sex workers, hospital patients and married women.

Surveillance data indicate that Cambodia has alarmingly high prevalence rates across the country. The pace of escalation of the epidemic has been one of the fastest in the world, and the interval between infection and illness appears to be unusually short. By 1999 the estimated cumulative number of HIV infections had reached almost 250,000 and the cumulative number of AIDS cases nearly 22,000. The current estimate of HIV infections is 169,000. The number of new AIDS cases in 1998 was estimated to be about 7,100 with projections for the year 2005 reaching almost 30,000 new cases (HSS 1999).

HIV in Cambodia is transmitted primarily via heterosexual contact. Infection is highest in commercial sex workers and in groups of men known to have higher than average contact with them. Male clients form a bridge between the infected commercial sex worker population and the general population. There is little information available about homosexual/bisexual transmission, and there appears to be limited transmission through intravenous drug use. Due to the very limited development of the health care system, only a negligible percentage of the population ever receive transfusion of blood or blood products.

1996 HIV prevalence in the general population (males and females aged 15-49) was approximately 2.9 percent, increasing in only a year to 4.6 percent. Thereafter it stabilized and in the last year for which surveillance data has been released, showed a slight decline to 3.2 percent (HSS, 1999)\(^1\). The Population Reference Bureau indicates that the prevalence rate for 2000 was 2.9 percent (PRB 2000). There are, of course great disparities in prevalence among different population groups and geographic areas.

Estimated HIV prevalence among direct commercial sex workers (DCSWs) of all ages was 37.9 percent in 1995, peaked in 1998 at 42.6 percent, and in 1999 had decreased to 33.2 percent. However, for DCSWs less than 20 years of age, the decline from 1998 to 1999 was even more dramatic - from 40.8 percent to 26 percent. Among indirect commercial sex workers (IDCSWs), rates are lower but the decline has also been less: from 19.2 percent in 1998 to 18.6 percent in 1999. Among antenatal (ANC) women tested, rates have remained relatively constant at approximately 2.6 percent. HIV prevalence among military personnel was estimated to be 5.9 percent in 1996 and 7.1 percent in 1997. After 1997 the military were dropped from the surveillance because their prevalence rates did not differ significantly from those of the police.

\(^1\) HSS data for 2000 have now been released, but were not released at the original writing of this document.
and because it was methodologically more difficult to sample the military population (HSS, 1999). Among the police the level has declined from approximately 8 percent in 1995 to about 4.7 percent in 1999, which is statistically similar to the 1999 prevalence rate in 1999 for household males (HSS, 1999).

Figure 4:

The sharp decline in HIV prevalence among all DCSWs from 1998 to 1999, almost 20 percent, is most unusual compared to the experience from other countries. A possible explanation warranting further investigation is that the cohorts of DCSWs infected earlier in the 1990s have since developed full blown AIDS or died and have been replaced by cohorts for whom more consistent condom use is the norm. The large decrease in prevalence among DCSWs less than 20 years old would support this. However, as younger sex workers are preferred by their clients, close monitoring of the apparent decrease in prevalence in this younger age group is warranted.

It is noteworthy that, although rates are highest among direct sex workers, they are also decreasing most rapidly in that group while declines in prevalence among indirect sex workers have been minimal. This group is both harder to characterize and harder to reach. They include beer promoters in restaurants and karaoke bars, and a wide category of women frequenting bars and nightclubs as venues for selling sex.

Of perhaps greatest concern is the continuing high prevalence among antenatal women, suggesting that the disease is moving into the mainstream population and in particular to women not involved in either direct or indirect sex work. A detected decrease in the ratio of HIV-positive men to HIV-positive women suggests that transmission is increasingly occurring from men to women within households rather than as the result of sex work. The continuing high HIV prevalence levels in ANC women suggests that these women are indeed more vulnerable and that more and more children with HIV are likely to be born in these families. While there is no data available on the prevalence of pediatric AIDS or its contribution to infant and child mortality, a substantial problem is evidenced by the continuing sero-prevalence rate in antenatal women of
over 2 percent. It is estimated that by end-2000, over 5 percent of Cambodia’s HIV infections would be in children under the age of 18 (and many of these could be assumed to be due to MTCT). At present, about 3,500 HIV-positive babies may be being born each year. By 2005, the Ministry of Health predicts that there will be about 1000 new pediatric AIDS cases in Cambodia each year.

Geographically, while HIV infection was first detected in the western provinces of the country, along the Thai border, it rapidly spread and is now found in all regions of the country. However, greatest prevalence is concentrated in two distinct areas. One is on the western border and southern coast, primarily in those provinces bordering Thailand and in coastal port and fishing hubs. The second is the urban area of Phnom Penh and its surrounding provinces, notably Kompong Cham, Kompong Chhnang, Kompong Thom and Kompong Speu, which account for more than one third of the total national population.

Figure 5:

Geographic Concentrations of HIV Prevalence
2. STD Prevalence

The presence of sexually transmitted diseases (STDs), such as syphilis or gonorrhea, carries a five to tenfold increased risk of acquisition or transmission of HIV. A study conducted in 1996 by NCHADS and the University of Washington, Seattle documented prevalence rates in selected populations as follows:

Table 6: STD prevalence in three groups in Cambodia in 1996

<table>
<thead>
<tr>
<th>STD</th>
<th>Female Sex Workers (n=432)</th>
<th>High-risk Men (n=322)</th>
<th>Women Attending RH Services (n=214)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea</td>
<td>35%</td>
<td>17%</td>
<td>3%</td>
</tr>
<tr>
<td>Chlamydial infection</td>
<td>22.4%</td>
<td>2.1%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>14%</td>
<td>6.6%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Trichomoniasis</td>
<td>4.4%</td>
<td>--</td>
<td>1%</td>
</tr>
<tr>
<td>Bacterial vaginosis</td>
<td>31.5%</td>
<td>--</td>
<td>12.7%</td>
</tr>
<tr>
<td>HIV</td>
<td>41%</td>
<td>12%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

Source: STI Prevalence Survey and Algorithm Validation Study, NCHADS, October 2000

USAID-funded studies by FHI in 1997 indicate that 44 percent of all female sex workers had at least one STD, and half of these women were asymptomatic. In men, primarily members of the military and police, 17 percent had at least one STD.

STD rates among Cambodian men are very high in comparison to rates for men in other South and Southeast Asian countries - gonorrhea 5 percent compared to 1 percent and syphilis 7 percent compared to 1.4 percent respectively (Kolstad, 2000)

2. Key Intermediate Indicators

Knowledge of transmission and prevention

According to the 2000 DHS, knowledge of HIV/AIDS is nearly universal among women of reproductive age at 94.8 percent, with a slightly higher awareness among urban respondents (97.6 percent) compared to rural respondents (94.3 percent) Over three-quarters of the women could also correctly name at least one method to prevent AIDS, with condoms being mentioned by 69.9 percent. Twenty-two percent of the women, however, stated that AIDS cannot be avoided. There are large differentials between urban and rural women which probably reflects better urban access to information and services, as well as the higher literacy rate of urban women.

Cambodia exhibits a disturbing constellation of high-risk HIV/AIDS behaviors which helps to explain the explosive take off of HIV infection in the country. Three years after the first case of AIDS was diagnosed in 1993, HIV was found in about 40 percent of CSWs and in nearly 2 percent of women in antenatal clinics in border and urban areas, an infection rate that placed...
Cambodia among the hardest hit countries in Asia. Indeed, Cambodia has many of the behavioral risk factors that characterize the countries of southern Africa where the highest infection rates in the world are found.

The sex industry has been and continues to be the primary spawning ground for the HIV infection. It is a sprawling multi-million dollar industry that reaches from border to border, found in all towns and even rural areas and employing thousands of commercial and free-lance sex workers. The situation of these women, as discussed in Section I. B.3, is dismal. About 20 percent of the brothel-based CSWs are Vietnamese, while other migrant groups also figure prominently in the sex trade. The average number of clients per day is about 3.2 and the median time spent in the same brothel is approximately 3 months. Only 10 percent remain in one brothel for a year or more. While it is not known how many leave the sex trade as opposed to changing brothels or becoming indirect sex workers, it can reasonably be assumed that there is a great deal of relocation and migration within the sex industry.

Although it is generally agreed that the sex industry is catering predominantly to heterosexual clients, homosexual brothels exist in Battambang and Banteay Meanchey and male sex workers operate in Phnom Penh's nightlife. A 1999 mapping exercise found that men seeking sex with men frequented public parks, brothels and nightclub/discos (FHI: Men who have sex with men, 1999)

The Behavioral Surveillance System (BSS), established in 1997, is currently conducted in 5 cities - Phnom Penh, Sihanoukville, Kompong Cham, Battambang and Siem Reap. A third round, conducted in 1999, targeted sex workers, military, police, moto-taxi drivers and beer girls. Table 7 reports the percentage of men in different categories who purchased sex the previous month. Over the period 1997 to 1999, there has been a significant decline in the proportion of men in all categories who paid for sex the previous month. However, the fact that nearly one third of the target groups covered still regularly purchase commercial sex is cause for continuing concern.

**Table 7: Purchased commercial sex in the previous month**

<table>
<thead>
<tr>
<th>Group</th>
<th>1997</th>
<th>1998</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Military</td>
<td>64.7</td>
<td>40.8</td>
<td>32.6</td>
</tr>
<tr>
<td>Police</td>
<td>52.8</td>
<td>32.8</td>
<td>33.3</td>
</tr>
<tr>
<td>Moto-taxi drivers</td>
<td>42.1</td>
<td>33.9</td>
<td>31.1</td>
</tr>
<tr>
<td>Students</td>
<td>26.7</td>
<td>17.7</td>
<td>--</td>
</tr>
</tbody>
</table>

Source: BSS 1999

**Condom use**

In response to the threat posed by the sex industry, a vigorous campaign by the public and private sector has been launched to increase the use of male condoms to prevent the transmission of the virus (female condoms are currently not available in Cambodia although a pilot intervention was due to start in 2000). Condoms are promoted through Social Marketing and a variety of IEC efforts.
A critical national response to the HIV/AIDS epidemic was taken by the Government when a 100% Condom Use Policy (CUP) for brothels was endorsed by NCHADS following a pilot study from 1998-1999 in the port city of Sihanoukville. The CUP aims to ensure that condoms are used in every sexual transaction in every brothel in the country. Regular STD checks for sex workers are relied upon for monitoring the policy. In 1999 the Prime Minister signed a letter directing all provincial governors and local authorities to endorse and support the CUP policy in their jurisdiction. The MOH's Strategic Plan for HIV/AIDS and STD Prevention and Care, 2001-2005, calls for nation-wide implementation of 100% Condom Use, drawing on lessons learned in Sihanoukville. In 2001 the program is being introduced into five more provinces with support from WHO and using the MOH's World Bank loan.

Although the 100% CUP has considerable potential for reducing HIV transmission, there is also a potential for abuses against CSWs by brothel owners for being diagnosed with an STD. Because the CSW is often compelled by her client or the brothel owner to have sex without a condom, something for which many clients are willing to pay considerably more money, the CSW is not in complete control of the situation. This concern, which should be monitored carefully, does not diminish the fact that the "blanket" use of condoms in high-risk situations has been shown, both from the Thai experience and from modeling data, to play a significant role in reducing STD and HIV prevalence.

Preliminary results of these interventions can be seen in Table 8 which reports the proportion of individuals, by category, who report always using a condom during commercial sex.

<table>
<thead>
<tr>
<th>Group</th>
<th>1997</th>
<th>1998</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Military</td>
<td>42.9</td>
<td>55.3</td>
<td>69.6</td>
</tr>
<tr>
<td>Police</td>
<td>65.4</td>
<td>69.3</td>
<td>81.3</td>
</tr>
<tr>
<td>Female sex workers</td>
<td>42.0</td>
<td>53.4</td>
<td>78.1</td>
</tr>
<tr>
<td>Moto-taxi drivers</td>
<td>53.8</td>
<td>61.8</td>
<td>69.8</td>
</tr>
<tr>
<td>Beer girls</td>
<td>9.6</td>
<td>29.7</td>
<td>38.2</td>
</tr>
<tr>
<td>Students</td>
<td>71.5</td>
<td>77.4</td>
<td>--</td>
</tr>
</tbody>
</table>

Source: BSS 1999

However, as shown in Figure 6, the proportion of respondents always using a condom with a partner differs significantly by type of partner (BSS 1999). For example, whereas the proportion is encouragingly high for military, police and moto-taxi drivers, it is correspondingly low for use with "sweethearts". And thus the bridge between the core high-risk group and the general population is established.
3. Current Service Availability and Output

a. Voluntary Counseling and Testing (VCT)

Voluntary counseling and testing (VCT), sometimes referred to as voluntary and confidential counseling and testing (VCCT), is an essential component of comprehensive HIV/AIDS prevention and care programs. It has been proven to promote and reinforce safe sexual behavior, provide a logical link to early health care and social support for those infected, and it is a prerequisite for identifying pregnant women who could be candidates for anti-retroviral (ARV) treatment for prevention of mother to child transmission (MTCT) where ARV is available.

VCT services are only at the very early stages of development in Cambodia and the lack of these services is a major gap. The first VCT center was opened in 1995 in Phnom Penh. In subsequent years, only 5 other public sites have been established.

Figure 6:

There is one more in Phnom Penh and one each in Kompong Cham, Siem Reap, Battambang and Sihanoukville. VCT remains completely unavailable in 18 out of the country’s 23 provinces. Anecdotal evidence suggests that a large number of private sector facilities are also performing HIV testing, but the quality of the laboratory procedures and results is largely unknown (both false-negative and false-positive results are reputed to be given), and comprehensive counseling and/or links to care are rarely provided.

Demand for VCT appears to be quite high, as evidenced by the unregulated private sector response, spontaneous trends of premarital testing as a criteria for a girl’s family to consent to marriage, and by feedback obtained from commercial sex workers during the Team’s field visits. In Phnom Penh, government clinics have been overwhelmed with demand to the point of having to establish daily quotas. In Calmette Hospital, where a PMTCT pilot is in process, over 85 percent of antenatal mothers who are offered VCT accept the services, and over 90 percent return for their results – both figures are unusually high compared to other countries.

Source: BSS 1999
PHN Assessment, USAID/CAMBODIA

NCHADS has emphasized the importance of VCT and plans to expand services nation-wide. An NCHADS technical working group has drafted a testing policy to be formally reviewed and approved later this year. It calls for a two tiered “primary” and “secondary” VCT system in every province. Provincial capitals will have laboratory-equipped VCT sites, while at the OD level counselling and blood sampling will be done, blood transported to the provincial lab, and results returned to the district for disclosure with counselling. Provincial lab-equipped VCT will be based in the provincial hospitals. It is not yet clear whether the district level VCT will be done at the HC or RH level. Implementing this plan will be a long and costly process. Steps which need to be completed include developing and approving national guidelines, identifying potential counsellors, establishing training curricula for counsellors, training trainers, training counsellors, training laboratory technicians and equipping laboratories with HIV test kits, working out safe and efficient means of transporting specimens and results between the ODs and provincial labs, and establishing referral networks for care for clients who are found to be HIV-positive.

b. Prevention of Mother to Child Transmission (PMTCT)

Although PMTCT (through counselling, contraception and provision of ARV prophylaxis) is one of the 8 areas of primary focus in the Health Strategy for HIV/AIDS and STI Prevention and Care (2001-2005), NCHADS accords it relatively lower priority in relation to other HIV/AIDS-related problems and interventions. Epidemiologically, infants with HIV are not core transmitters of HIV and practically, all interventions to reduce MTCT will depend upon significant strengthening of the ANC/MCH system, which does not currently reach the majority of pregnant women (see Section IV.A.1). Many other UN partners such as WHO, UNAIDS and UNFPA have not yet developed this strategy. UNICEF, however, has been strongly promoting PMTCT, which it views as a way to introduce VCT in ANC settings, and to improve ANC.

Any PMTCT effort requires the joint participation of HIV/AIDS and MCH leadership and technical staff. Both NCHADS and the National Maternal Child Health Center (NMCHC) are separate, highly autonomous vertical programs within the MOH, and Cambodian culture is notable for its lack of constructive conflict resolution mechanisms; there is no indigenous concept of compromise and negotiation, and a pervasive distrust of others and concern for personal security (See Section II.B). This makes it unusually difficult to move forward in areas where collaboration across organizational lines is required.

In addition, there are many formidable obstacles in Cambodia to introducing the most effective means of prevention of MTCT, anti-retroviral (ARV) therapy for HIV-infected women at delivery and for new-borns. These obstacles include:

- VCT is not yet available in most of the country (a prerequisite for identifying HIV-positive pregnant woman who would be candidates for ARV);
- Most Cambodian women do not receive antenatal care;
- Few Cambodian women deliver under the care of a trained health worker, and most women deliver at home.
Three pilot projects have been designed for Cambodia to test the operational feasibility and optimal means of PMTCT through provision of Nevirapine, a drug already proven effective and safe in other clinical trials in developing country settings. The first pilot is already underway at Calmette Hospital in Phnom Penh with funding and TA from the French Agence Nationale de Recherches sur le SIDA. While data collection and analysis have not yet been completed, initial results are encouraging. However, it is not clear to what extent this approach would be replicable in less sophisticated health facilities serving a poorer and less educated population.

Two additional pilot PMTCT projects are planned for Cambodia, one at the National Maternal and Child Health Center (NMCHC) in Phnom Penh and the other at the Battambang Provincial Referral Hospital. Delays in implementing these two projects have resulted to some extent from differences of opinion on various issues between the NMCHC and NCHADS. These two sites will differ from the Calmette project in two major ways: training for the counselors and staff will be considerably longer, and testing and counseling will not be offered to women who do not appear for services until they are actually in labor (as Calmette does), due to donor (UNICEF) concerns that adequate counseling cannot be delivered when a woman is in labor. Implementation is scheduled to start before the end of 2001.

While Nevirapine has received much attention and thought, there is a notable gap in policies, strategies and interventions for PMTCT in the area of breast-feeding. There is no clearly articulated policy on how to handle the issue in the context of an HIV positive mother, perhaps in part because such a policy would have to be developed collaboratively by both NCHADS and NMCHC. NCHAD’s strategy is to “advise mothers about the potential benefits of breast-feeding”, while the general position of the NMCHC is that women should be counseled about the potential risk of transmission via breast-milk and then left “to decide for themselves”. Various facilities and organizations (donors, NGOs, etc.) have opted for various approaches, from adherence to the general national policy on breast-feeding with no adaptation for HIV status, to promotion and even subsidization of infant formula. There does not appear to have been any country specific research on this nor on exploration of the potential use of wet nurses as an alternative. It is known that breast-feeding as normally understood and practiced by Cambodian women will expose the infant to both possible HIV transmission and a heavy load of pathogens, without the immune benefits of colostrum (see section IV.B.3). It is also known that the vast majority of Cambodians cannot afford to purchase infant formula and do not have the means (educational or hygienic) to safely use it. Clearly this is an area where further policy work and strategizing is urgently needed.

c. **STDs**

The Government’s approach to STD control in Cambodia consists of two complementary strategies: targeted services for commercial sex workers and integrated services for the general population. With respect to the former, it is hoped that an aggressive approach to STD control in CSWs will help slow the spread of HIV in the country. STD services for CSWs also features prominently in the government’s 100% CUP, and STD prevalence among CSWs is used as an indicator for compliance to condom use in brothel settings.
A wide range of antibiotics (genuine and counterfeit) are readily available without prescription throughout Cambodia. The majority of patients resort to this instead of, or prior to, seeking the advice of a trained health care provider. This can lead to inappropriate treatment, treatment of symptoms but not of underlying causes, increased resistance to antibiotics among groups vulnerable to STD infection and a high cost burden.

Although STD treatment is part of the “Minimum Package of Activities” to be provided by HCs, it was not initially provided at HC level due to the complex training and drug control requirements and the need to get a large number of HCs functional as rapidly as possible. In the last year or so, a phase-wise introduction of STD treatment in HCs has begun. Two staff, one male and one female, are trained following which appropriate drugs are provided. This is still in progress and many HCs have yet to receive the training and drugs. Even in those HCs which have, the fact that only some of the staff were trained means that services are not reliably available (HC staff have rotational outreach duties away from the HC). Furthermore, experience has shown that technical follow-up and supervision are essential if newly taught guidelines are to be effectively followed, and the capacity for this is limited unless there is external (e.g. NGO) assistance. Lastly, as staff are severely underpaid and STD drugs carry a high market value, many divert the drugs to their own private practices where adherence to protocols and numbers treated cannot be ascertained.

Experience has shown that, where there is external technical support to government facilities that comprehensively address system constraints, a high volume of STD treatment results. Examples include a pilot EU intervention in the District Referral Hospital in Sihanoukville, carried out as part of the 100% CUP, and a number of NGO district health-strengthening initiatives.

The main priority gaps and issues that need to be addressed with regard to STD treatment include:

- Completion of nation-wide introduction of STD treatment at HC level accompanied by the necessary TA, supervision and monitoring to ensure adherence to protocols and non-diversion of drugs;
- Better integration between the two national vertical programs - MCH/FP and HIV/AIDS to ensure early detection of STDs during routine family planning and safe motherhood services; and
- Interventions to address the dangers of STD self-diagnosis and drug treatment.

d. Reach of IEC

The only large scale assessment of IEC materials in the area of HIV/AIDS was conducted by PATH in 1998, whereas most IEC materials development has occurred in the two years hence. The assessment is therefore of limited utility, since both the volume and variety of IEC materials have recently increased. However, an informal look at materials in use today suggests that at least some of the earlier findings are still applicable, e.g.:
• over-reliance on printed materials not suitable for a country where illiteracy and semi-literacy are commonplace;

• a heavy focus on prevention messages and dearth of materials on care and counseling for people living with HIV/AIDS; and

• a stress on commercial sex activity as the risk behavior leading to HIV with little attention given to risks in the context of sweetheart relationships.

A large number of agencies working in HIV/AIDS have developed IEC materials, sometimes at very local levels using simple materials and with no dissemination beyond the immediate project area. Although sharing and borrowing of IEC resources occurs, it is largely ad hoc and often limited to groups operating in a common province or funded by a common donor. In contrast to printed IEC materials, mass media efforts through radio, television and video have played a clear and prominent role – quite possibly the major role – in achieving the currently high levels of AIDS awareness. These include efforts by PSI, Health Unlimited/CHEDs, national radio and television, and others.

With regard to extending the reach of IEC activities, the following gaps have been identified:

• There is a serious need for USAID to develop a mechanism for its partners to help co-ordinate IEC efforts, maintain and disseminate inventory samples, and replicate them for other agencies. Such a mechanism, in collaboration with appropriate government/other donors, would then facilitate a review of what exists and identification of unmet needs, overlooked target groups etc.

• The time is ripe for a second generation of messages now that awareness of AIDS and its sexual transmission is nearly universal. These would include clarification of how HIV is and is not spread in order to reduce the fear that now surrounds those affected; messages related to care of PLWA; and messages targeting sweetheart relationships and dual protection through condoms.

• There remains a need for more visually literate materials and media, and materials in minority languages (e.g., Vietnamese).

**e. Care of AIDS patients**

In 1999 it was estimated that the cumulative number of AIDS cases in Cambodia, to date, was in excess of 22,000. Given both cultural norms and the nascent state of development of the Cambodian health system, the care and support of AIDS patients will largely fall on immediate and extended families. As noted in Section II. C, only an estimated 30% of planned referral hospitals are currently operational. Even when this level reaches 100% it will be barely adequate for the needs of people with curable diseases. Furthermore, Cambodian health professionals are oriented to a purely medical paradigm and nursing care is not viewed as an area for professional involvement. Palliation and care measures have always been the responsibility of the family,
even when a patient is admitted to a hospital. There is therefore both little reason to hospitalize patients with an incurable illness, and no capacity to receive them.

The impact of AIDS is already being felt in Cambodia where the vast majority of people live in rural areas, with few or no basic services. Even prior to the advent of AIDS, per capita family expenditure on health was exceptionally high, with poor families spending 25 percent of their income on health care; the major cause of landlessness is selling land to respond to a health crisis in the family. In addition, 50 percent of the population is under 18 years of age, giving Cambodia a high dependency ratio that will increase as those of productive age become ill and die of HIV-related illnesses. Due to the years of conflict and to the atrocities of the KR, Cambodia has a limited number of people of grandparent age to raise children orphaned by AIDS. Institutions and laws, which traditionally may have given support and protection to children orphaned by AIDS, are also still being rebuilt.

As grim as this picture may seem, it should be remembered that it is not a new one to Cambodia, and that family networks have coped in the past with equally large numbers of ill and dying, and absorbed large numbers of orphans – e.g., in the immediate wake of the KR era and its subsequent famine. Family loyalties are very strong and families – in the most extended sense – recognize an almost inviolable obligation to care for their members. The vast majority of deaths have always occurred at home and, while AIDS and its manifestations are new, nursing care of chronically and terminally ill people in general is a traditional family task.

The MOH's Strategic Plan for the period 2001-2005 identifies as one of its five key areas to address "ensuring that persons living with HIV/AIDS have access to a range of care services in an atmosphere of tolerance and respect for human rights". Of the 12 strategic areas in which activities are to be undertaken, strategy 5 identifies the need for community participation in HIV/AIDS/STD prevention, care and support and strategy 7 addresses care and support for people living with HIV/AIDS. The MOH recognizes that it cannot implement either of these without outside help and NGOs and CBOs are increasingly being relied upon to step into the breach.

Despite current international efforts to reduce the cost of anti-retroviral therapy for treatment of AIDS patients in developing countries, such therapy is likely to remain prohibitively expensive for the vast majority of Cambodians for the indefinite future. In addition, it is difficult to administer these drugs safely and effectively (to minimize and control severe side effects) in resource-poor settings. Finally, there are risks of creating resistance to these drugs if they are improperly prescribed or used. Nevertheless, recognizing that ARV drugs are appearing on the private market in Cambodia, NCHADS is taking steps to train private physicians in their use.

**f. Orphans and Vulnerable Children (OVC)**

Many factors make children vulnerable in Cambodia, nearly all of them related to poverty. Girls have more vulnerability factors than boys do, and the most vulnerable age is 7-12 years. The most vulnerable children overall are orphans from poor families.
Cambodia and Thailand currently have the highest proportion of orphans in Asia who have lost their mother or both parents due to AIDS. Predictions for the end of 2000 based on surveillance figures from 1998, indicate that over 5 percent of all infections are likely to be in children under 18 years and that approximately 7,500 children will have died of AIDS. NCHADS estimates that there are 40,000 children orphaned due to AIDS in Cambodia. These numbers vastly underestimate the number of children affected by HIV/AIDS, which would also include those whose father has died, those living with parents who are ill, those who are over 15 years of age, and those living in households in which the capacity – both financial and psychosocial – is severely limited as a result of caring for ill relatives or supporting orphans.

In June, 2000, an evaluation carried out by KHANA of a pilot home care program for people living with HIV/AIDS (PLWHA) found that:

- In 21 percent of the families of PLWHA with children, the children had to start working since the patient became sick;
- In 30 percent of the families, the children had to provide care, or take up major additional household duties;
- 40 percent of the children had to leave school, or take significant periods away from school;
- 40 percent of the families said that since the patient became sick, the children have had to go without certain things (food, clothes, books, etc.); and
- In 28 percent of the families, one or more children had to leave home.

The mandate to address the issue of CAA rests primarily with the Social Welfare Department of MOSALVY whose involvement in the National AIDS Program is supported and facilitated by the inter-ministerial National AIDS Authority.

The Social Welfare Department supports 20 children’s centers located in Phnom Penh and the provinces. The statistics for these centers is unclear, but it appears that there may be over 2,000 children being cared for. The Department operates a Children’s Center, located near Calmette Hospital in Phnom Penh that cares for babies abandoned in the hospital. Babies are tested after one year. Those who are HIV- are adopted and those who are HIV+ are cared for at the Center until they die. MOSALVY provides 15,000 riel (US$4) per month per child.

The issues and gaps confronting CAA are similar to those for home-based care. AIDS orphans are but one sub-group of a larger population of vulnerable children in a country with very high levels of mortality, low life expectancy, negligible social services and recent emergence from three decades of civil strife. The Government does not have the resources, financial or human, to make the kind of investment that will have a major impact. On a more positive note, however, Cambodian society has a long history of successfully integrating orphans into the homes of near and distant relations, and cultural norms strongly support the practice. In addition, religious and cultural beliefs are favorable for adoption of children by non-relatives.
B. Donor Support

The other donors active in HIV/AIDS/STD are World Bank, DfID, KfW, EU, AusAID, CIDA, the French Cooperation, UNFPA, UNICEF and WHO (see Annex B). However, donor coordination is weak, and the absence of coordinated, overarching strategies for addressing such issues as care and support, including OVCs, has resulted in a disjointed and unsustainable plethora of small and localized interventions.

At present adequate support is provided for purchase of Number One condoms, STD drugs and fieldwork for the national surveillance surveys. Health sector support from the WHO to the MOH provides both technical assistance and financial support for trial interventions in care and support of PWHAs. However, the possible withdrawal of KfW, which now provides nearly all public sector commodities, including STD drugs, from the health sector in Cambodia, is cause for alarm.

Given the importance to the National AIDS program of the provision of high quality condoms, DfID's continuing support to PSI for its condoms and their quality packaging is critical to the success of the program.

In its newly approved program, UNICEF is making a major financial and technical contribution to increasing the availability of VCT in all national and provincial hospitals through training of counselors, laboratory technicians and health providers. Presently lacking, however, is similar technical assistance, training and follow-up at the OD level.

UNFPA and the EU support CARE's Youth Reproductive Health Program in garment factories where an increasingly large number of young people, especially young women, are employed.

One area of potential financial support for HIV/AIDS that has yet to be investigated is the private business community. Many IDCSWs work as "beer girls" promoting national and international brands of beer. Attempts to reach this more diffuse high-risk target group have been frustrated in part by the refusal of local management to allow outreach teams to work with the women in behavior change and empowerment interventions. The same is true for the women working in the growing gambling industry, especially along the Thai border but also in Phnom Penh.

While the management of a growing number of industries, from Coca Cola to garment factories, have successfully been convinced of the economic value of providing a range of health services, including HIV/AIDS education and counseling, to their employees - in part perhaps because national legislation mandating health clinics in such establishments is more rigorously enforced - and to allowing NGOs to work with their employees, the same cannot be said with regard to many other large industries employing beer girls and hostesses.
C. Current USAID PHN HIV/AIDS/STDs Portfolio

Given the explosive nature of HIV/AIDS in Cambodia, USAID opted for a dual approach, introducing HIV prevention activities into the existing MCH Strategy as well as establishing a new strategy for HIV prevention activities in high-risk populations. Antenatal surveillance indicated a high prevalence of sexually transmitted infections (STIs), particularly syphilis, and that HIV was moving into the general MCH population. However, since MCH clinic users consist primarily of women at the end of the HIV transmission line, these interventions alone were unlikely to have a significant impact on the spread of the epidemic.

In April 1997 USAID/Cambodia developed Special Objective SpO-2: Reduced STD/HIV transmission among high-risk populations with the following intermediate results to be accomplished between 1998-2002: (1) policy makers informed about the HIV/AIDS epidemic in Cambodia; (2) reduced high-risk behaviors in target populations; and (3) model service delivery programs for high-risk populations piloted and replicated in selected provinces.

The USAID/Cambodia HIV/AIDS/STD portfolio includes activities with national level application and activities specifically targeting high-risk populations located primarily in a cluster of five central-south provinces including Phnom Penh, Kompong Cham, Kompong Chhang, Kompong Tom and Kompong Speu.

1. National Policy

Considerable progress has been made in the last three years in developing a strong national response to HIV/AIDS, including political mobilization at the highest levels of Government and establishment of sound policies. The response of the RCG to HIV/AIDS has been largely driven by the MOH, primarily because it has by far the strongest capacity of any line Ministry (see Section II.C.4).

The governmental response to HIV/AIDS in Cambodia has been both prompt and pragmatic, and there are few countries, developed or undeveloped, which rival it in that respect. Likewise, the response in the informal sectors and general society has been noteworthy for its pragmatism and rapid action (including behavioral change) in the face of a totally new disease.

By far the greatest credit for an unusually favorable policy climate, and general social response, goes to the Cambodian people and RCG themselves. Donor-funded activities have played an important role in supporting the efforts of both to face the challenge of the HIV/AIDS epidemic.

USAID-funded activities which have contributed to IR#1 (“policy makers informed about the HIV/AIDS epidemic”) include:

- Technical assistance to NCHADs in conducting, interpreting, disseminating and using information from annual HIV prevalence and Behavior surveys. These surveys, which have served to inform policy makers at all levels of the extent of the problem and prevalence of contributing factors, have played a crucial role in guiding both policy and planning.
Technical assistance and funding support, through the FHI/Impact Project to the Ministry of Interior (MOI) and Ministry of National Defense (MOND) in BCI for police and military, respectively. This assistance has helped these two key Ministries to develop and implement a constructive and pro-active approach to the problem of HIV/AIDS.

Support to the Khmer HIV/AIDS National Alliance (KHANA), an umbrella organization dedicated to increasing the capacity of NGOs to address HIV/AIDS issues in their community-based programs. Support to KHANA has helped put NGOs on the map with respect to HIV/AIDS and also provided an organizational mechanism able to coordinate and voice NGO concerns. KHANA actively participates in a variety of national and local government planning committees, providing both valued technical input and representation of grassroots views and concerns.

At the time of this assessment, awareness of the epidemic was so widespread at all levels of government, and the policy climate so favorable, that the IR as written no longer seems applicable. The main challenge from here on lies in implementing these policies. In addition, there are a few areas where existing operational guidelines are inadequate or inconsistent, such as in PMTCT and breast-feeding.

Epidemiological and Behavioral Surveillance

Cambodia is in its eighth year of HIV sentinel surveillance (HSS) and its fourth year of behavioral sentinel surveillance (BSS). These interrelated systems were instituted to track the course and spread of the HIV epidemic in Cambodia and to understand the behavioral determinants of the epidemiologic trends. The HSS now covers 19 sites throughout the country and works in all but four provinces. Throughout this period, USAID funded technical assistance to these interrelated surveillance systems through Family Health International (FHI), with NCHADS funding (provided from World Bank and other donors) covering the costs of the data collection itself. NCHADS and other donors that rely on this data applaud these surveillance systems as being the most advanced second-generation surveillance system in the region. A recent evaluation of FHI encouraged the Cambodian surveillance system to be replicated in other countries around the region.

The success of the systems has depended in part on appropriate targeting – the groups selected for both epidemiologic (HIV) and behavioral surveillance are indeed the high-risk groups that are the core transmitters of HIV in Cambodia. This surveillance system provides an essential foundation from which to better understand and reduce STD/HIV transmission among high-risk populations. For example, behavioral data that have shown an increase in condom use and decrease in commercial sex have helped explain the apparent beginning of stabilization of HIV prevalence in Cambodia that is reported to be reflected in the 2000 HSS which has still not been released.

USAID’s assistance in the area of surveillance addresses the intermediate result - “Policy makers are informed about the HIV/AIDS epidemic in Cambodia.” - and has contributed to that result. Although the policy climate for HIV/AIDS prevention in Cambodia is quite favorable, USAID’s
surveillance efforts have nevertheless provided specific data which informed more detailed policies, particularly in the areas of targeting high-risk groups. NCHADS has used both the biological and behavioral surveillance data to review and update their national strategic plans for HIV/AIDS prevention and care. These plans are used by USAID (and other donors) to provide baseline data for program planning, determine and refine future program priorities in HIV/AIDS, and evaluate program effectiveness.

USAID’s inputs also contributed to the development of longer term surveillance plans, technically-sound analysis of data, and consensus workshops to interpret and disseminate the data. This helped ensure that surveillance data could be effectively used for advocacy, situation assessment, strategic planning and national level evaluation. This type of capacity building is important not only for the health system, but other development sectors, as AIDS is increasingly recognized as a multisectoral development problem.

One example of the links between data and program planning is the use of behavioral data to illustrate that high-risk situations arise from the behavior of large numbers of both married and single men who continue to buy commercial sex. 50 percent of men in all of the male surveillance groups visited a sex worker last year, and 20-30 percent of these encounters are still not protected with condoms. Therefore, it is necessary to continue to make brothels a priority for HIV/AIDS prevention.

This year, data were also collected from married and single “household” men (in addition to “high-risk” men) and confirmed that high-risk behaviors are widespread, even in the general population. This means that interventions need to expand to include the general population, especially married men, because married men have made fewer changes in their sexual behavior than single men.

These surveillance systems have not operated without some constraints. First, with the HSS, NCHADS staff are directly involved in the data collection, rather than contracting the work out to others. While this does positively promote a sense of ownership of and confidence in the data, NCHADS’ staff have multiple responsibilities and often have insufficient time available for adequate supervision and management of the data collection. Second, USAID’s inability to provide funds to government has made it impossible for FHI to fund Cambodian staff to participate in training outside Cambodia.

The sustainability of the HSS and BSS systems is thought to be high in terms of both technical skills and institutional capacity, provided external support continues. NCHADS is technically strong and with little staff turnover to date.

While expansion of the overall surveillance system is probably not indicated, it is necessary to continually refine the surveillance methodology, as well as to identify additional population groups as they emerge (such as mobile and migrant populations, which will be added to next year’s HSS). Funds permitting, NCHADS plans to do so.
Voluntary Testing and Counseling

To date, USAID’s assistance in the VCT area has been limited to the co-funding (through FHI and with UNAIDS) of a 1999 meeting, “HIV/AIDS and Counseling”. The meeting was jointly conceived by NCHADS, FHI/IMPACT and UNAIDS and was attended by participants from government, NGOs and UN agencies. The meeting was intended to identify and prioritize strategic issues that would need to be addressed in Cambodia in order to strengthen counseling training and provision of services.

Important issues identified by the participants as relevant to Cambodia included: raising awareness about the importance of confidentiality; the need for skilled counselors; the need for follow-up after post-test counseling; and the importance of providing services linked to VCT. The meeting led to the creation of a Technical Working Group to look at issues of coordination and the monitoring and evaluation of progress.

Given the apparently large unmet demand for VCT services, by sex workers and increasing numbers of ordinary citizens, there is a pressing need to increase the availability of such services. The USAID-funded RHAC clinics (see section IV.C) have an established capacity for quality counseling, general laboratory services and training of other organizations. These clinics, which serve a large urban clientele, could be a future avenue for both private sector VCT services and training in counseling skills for public sector providers.

Free public sector VCT is already available in many of the RHAC clinic locations, but the volume of demand is overwhelming public sector capacities. In addition there is a high demand for premarital certification of HIV status, especially among the middle class, suggesting a potential niche for private sector fee-for-service VCT to complement free testing by the government and to reduce the strain on public sector services. Building on its experience in Africa, PSI has proposed, in collaboration with RHAC, the social marketing of VCT in selected private reproductive health centers. VCT could also potentially be part of an integrated package of premarital service that would also include FP and HIV prevention. Including VCT in RHAC's repertoire of RH and safe motherhood counseling would contribute to a more functional linking of MCH-HIV/AIDS vertical programs.

Condom Provision

At the time of the formulation of the Cambodia HIV/AIDS Mitigation and Prevention Action Plan, the Ministry of Health was distributing condoms for "AIDS prevention" through provincial and district health facilities. Distribution was free, primarily through STD clinics, and available to anyone who requested them. However, there was no free distribution by the government beyond clinic locations.

Given the low coverage of health facilities, low condom usage and cultural preference for self-purchase of health commodities, the USAID-funded Social Marketing Program has aggressively promoted and marketed condoms in such a way as to be readily available to potential customers in places where they were needed most, namely commercial sex establishments.
Almost all condoms presently available through commercial outlets, especially outside Phnom Penh, are distributed by PSI. Its *Number One* condom, marketed nationally, is supplied by British DfID which has just concluded a new agreement to make 81 million condoms available through 2006.

*Number One* condom sales have increased dramatically since their introduction in December 1994. Total annual sales have grown from 5 million condoms in 1995 to 16 million in 2000 with total sales over the period in excess of 65 million.

The PSI sales staff identify sales locations and sell the product for the first purchases. Subsequent efforts are devoted to re-supply to the outlets, essentially a delivery function. This is especially important for the critical commercial sex establishments, slightly over 18 percent of total sales, which have no natural link to other commercial supply links. The bulk of these sales are made to the 3 prime Phnom Penh commercial sex zones and to the larger provincial capitals.

Direct sales to pharmacies and drug sellers account for approximately 43 percent of total sales, over half of which occur in Phnom Penh. Drug wholesalers based at the city's Olympic Market provide smaller pharmacies and drug sellers around the country. This strategy is effective in saturating the Phnom Penh market. Rural coverage, however, is weaker, (especially in villages) since rural retailers must either travel to Phnom Penh or send their orders through an intermediary.

PSI also increasingly supplies condoms to NGOs, such as MSF and PDF, who carry out activities with commercial sex workers or who are involved in community based distribution. Almost one-third of all sales is with NGOs.

PSI's *Number One* condom has been effectively targeted at commercial sex workers and their places of work, as well as their male clients, especially military personnel, policemen and other men who frequent brothels. Data from the BSS indicates that effective and consistent condom use in commercial sex has apparently increased dramatically. However, it should noted that the BSS data is obtained from face to face interviews in which respondents may, for whatever reason, give the answer that is expected.

The social marketing of condoms in general and with high-risk populations in particular, in combination with parallel behavior change communication and IEC programs, has been a key contributor to the achievement of the Special Objective.

Although cost recovery is a means to reduce costs and promote sustainability - PSI currently realizes about $200,000 annually from sales - the condoms will continue to require a subsidy. At present *Number One* condoms are not financially sustainable. The cost of the commodity and packaging are approximately $0.05 but *Number One* is sold to the trade at a price of $0.01. The selling price decision was made in order to ensure access to the product by low-income groups; and because the more expensive packaging would connote high quality.
Despite the extraordinary success of the social marketing of condoms for the prevention of the transmission of HIV in Cambodia, a number of gaps and opportunities for increased impact have been identified.

- While condoms are readily available in commercial sex establishments, this is not the case for more informal locations, such as hotels and guesthouses, which are frequented by indirect sex workers and their male clients. In the absence of readily available condoms at the last minute or near nocturnal meeting places, intercourse is likely to be unprotected.

- Since PSI has been unable to link up with a nationwide distributor, the Number One condom is still not widely accessible in rural areas nor in many squatter enclaves, especially those inhabited by foreign migrants;

- "Never leave home without it" is not a slogan widely promoted or accepted with the result that in casual sex situations both partners may be caught unprepared. Innovative strategies, such as those effectively employed by Mechai in Thailand, for carrying condoms for use "in the case of emergencies" may warrant further investigation;

- Development and marketing of a "sweetheart" condom, or de-stigmatizing the current Number One condom for use in non-commercial sex situations, appears to be a major requirement if protection from HIV in the larger population is to gain momentum;

- The social marketing of a number of other health related products, given the propensity of Cambodians anyway for self-purchase of treatment, represents a potential for further growth.

Even when condoms are available and accessible, their use is often insufficient and inconsistent. Consequently, condom distribution must be accompanied by aggressive behavior change communication and IEC tailored to high-risk groups.

**National IEC/Behavior Change Communication**

The USAID Action Plan identifies two inter-linked strategies for IEC: (1) a national HIV/AIDS IE&C strategy for the general population with some stress on segmented audiences; and (2) coupling the national level strategy with more interpersonal communication (IPC) and behavior change communication (BCC) for high-risk groups, i.e., CSWs and their male clients.

**a. Mass Media**

PSI has produced and broadcast six radio drama series since 1996 (three during 2000). The three dramas in 2000 had 36 to 40 episodes each and focused on reproductive health topics, including issues concerning HIV/AIDS prevention. Each 20-minute episode was followed by a 40-minute call-in show to reinforce health messages from the drama and discuss questions posed by the listeners or who wrote letters. On-going PSI radio dramas target the general population, with a particular focus on youth. The overarching themes for the series include youth in school; youth
in rural areas who move to Phnom Penh for work; urban family life; and youth with little to no education.

The dramas are broadcast on 5 different radio stations throughout the country, and can be received in most areas of Cambodia (areas along the Lao border are an exception). Focus group discussions with 143 youth in Battambang and Kampong Cham during a midterm assessment by RHAC indicate that the total number of listeners is high – 62 percent of youth surveyed. There were many requests to continue the broadcasts (especially among in-school youth) and many would like to see video broadcasts of the episodes.

A 1996 evaluation of PSI’s radio program indicated that 70 percent of the rural population and 55 percent of the urban population had heard an episode of the radio drama. Phnom Penh’s Bayon radio station informed PSI that Prime Minister Hun Sen enjoyed the radio drama “Punishment of Love” so much that he has requested the re-broadcasting of these episodes at night.

ACTION, a local NGO with funding from FHI/IMPACT, is developing a short 30 second spot using two famous boxers (one from the military and one from the police) to "motivate men of the uniformed services to use condoms to preserve their health and strength from HIV/AIDS." The TV spot is intended to reinforce the ongoing HIV awareness peer education program with the uniformed services. The primary target audience is military and police aged 25 to 45 which represents the majority of men in the uniformed services.

The spot will be broadcast on 4 major TV channels over 6 months for a total of 224 broadcasts. Between 30 and 60 million general public viewers are expected to be reached, with between 6 and 12 million viewers in the primary target audience. It is important that an evaluatory component be attached to this program.

In January 2000, ACTION finished production of the film Man in the Storm – a feature film containing HIV/AIDS messages for the general public. ACTION showed the film directly to 15 communities along the Mekong river with an average of nearly 1000 people per showing. The film was broadcast on national television over 30 times and 200 video copies were distributed. The video is available throughout Cambodia - although most people do not own a VCR themselves, most at least have access to one, and it is often a community event to watch TV and movies. There are approximately 500,000 televisions in Cambodia and it is estimated that almost 25 percent of Cambodian families own TVs. Even small communities lacking electricity but with access to car batteries have one or two communal TV sets, and TV viewing is a popular group activity.

PSI has worked effectively with numerous TV stations in Cambodia to broadcast spots, live concerts, and game shows with STD/HIV messages. In 2001, PSI is planning to use Mobile Video Units to deliver HIV prevention and awareness messages to the general public.
b. **Print media**

PSI produces an advice column on HIV/AIDS and RH in *Popular* magazine which is directed at the general population but with particular emphasis on youth. The column provides answers to questions posed during the radio call in show that are not addressed on the air, as well as to questions received in letters from listeners.

*Popular* magazine has a circulation estimated to be 40,000 although research has indicated that each magazine is read by more than one person. A RHAC midterm assessment of PSI's media efforts found that magazines are more likely to be read in urban than rural areas. However, qualitative research found that people were slightly more likely to listen to the radio call-in show than to read the advice column in *Popular* magazine.

c. **Other IEC materials**

The production and distribution to the general public of T-shirts on World AIDS Day in 1999 and 2000 were supported with funds channeled through FHI/IMPACT. In each year 500 and 1,200 T-shirts were produced and distributed respectively. Some 50,000 HIV/AIDS leaflets were produced and distributed to the general public during the November 2000 Water Festival.

Some general observations can be made about the nationwide IEC efforts. The results of the 2000 DHS indicate that considerable progress has been made in achieving the portfolio's objective of increasing public awareness of HIV/AIDS. However a number of challenges/opportunities exist for extending the scope and reach of IEC.

First, in order to promote condom use in the general population, particularly with those bridging groups bringing HIV from high-risk groups to the general population, people's perceptions of condoms, now associated almost exclusively with commercial sex, need to be changed. In 2001, PSI will conduct behavioral research on this important bridging population and hopes to design a BCC strategy that targets “sweethearts” and attempts to de-stigmatize condom use in the general population. This will be an integral component to curbing the HIV/AIDS epidemic.

Based on this research and in order to address the sweetheart phenomena in an appealing and entertaining manner, PSI has requested USAID funding to develop a weekly soap opera TV series which is expected to reach around one million people. PSI will work with an advertising agency to develop four high-quality soap opera series containing 20-30 minute episodes and featuring popular Cambodian entertainers. The series will be broadcast over a two-year period. To leverage the reach of the soap opera’s message, a number of BCC materials and activities will be developed around the themes and characters of the drama.

Second, in order to make further strides in changing sexual behavior, interactive BCC/IEC materials and methods are essential. There is currently a disproportionate focus on passive IEC materials (such as leaflets and posters) and not a great deal of educational and/or interactive IEC material. Call-in radio shows and TV campaigns have been extremely successful in this respect and have been effectively used in a variety of reproductive health situations. For example, UNICEF supports both an HIV/AIDS information hotline and a TV campaign that references the
hotline number as a source of further information. The hotline almost always experiences a rapid influx of callers during TV campaigns (around 70 calls per day versus 190 during campaigns), indicating both that people are listening, and they react well to interactive approaches.

Third, there is too much reliance on printed materials and a need for more mass media approaches, especially TV and video. Numerous conversations during the course of the assessment indicate that Cambodians love television – even in the rural areas. In rural areas near Poipet and Sisophon, local NGO officials reported that TV is more accessible than radio and more appropriate than printed materials because of low literacy rates. This theme was echoed by Health Officials in Battambang as well as by numerous NGO officials in the Phnom Penh area.

Fourth, the focus of USAID-funded IEC has largely been on CSWs and their clients. There has been a lack IEC materials targeted specifically for youth. Although in some cases youth are encompassed in other areas – i.e. factory workers, mobile populations, military etc - there is a definite need for IEC messages for general youth populations.

2. Targeted, Sub-national Interventions

The modality USAID uses for local funding of interventions directed at high-risk groups - sex workers and their clients - as well as those affected by HIV/AIDS is primarily through an umbrella arrangement. This permits greater accountability for funds and reduces the management requirements on the Mission. However, for this mechanism to be effective, there needs to be a clearly understood and accepted overarching strategy and set of priorities guiding the granting of sub-contracts. This currently does not exist. In addition, each of the direct recipients that provide subgrants within Cambodia of USAID financial support must make value-added technical inputs to ensure improved technical competence and efficiency among the sub-grantees.

Currently, there are two umbrella organizations receiving USAID funding: FHI/IMPACT and KHANA. FHI directly implements a portion of the financial support received from USAID, for example for technical assistance from their headquarters and regional office in Bangkok for formative research, technical studies training of health providers in STD case management. and for coordination of CSW empowerment programs, such as "Speak Out". In addition a large proportion of the USAID funding received by FHI is sub-contracted out to about 15 other local and international NGOs for a specific set of activities, ranging from behavior change initiatives with CSWs to care and support for PLWHAs and CAA. Grants made to date range in size from $9,000 to $231,000 over a one to three year time frame.

USAID's support to KHANA, a NGO serving as an umbrella for 36 indigenous Cambodian NGOs, is channelled in part through the International HIV/AIDS Alliance and in part directly to KHANA. KHANA's mandate is primarily to build NGO capacity through the transfer of skills in technical, managerial and financial competencies. Small grants ranging in size from $5,000 to $7,000 finance NGO small pilot projects targeting more difficult to reach vulnerable groups and their communities. Until recently the bulk of KHANA's support was for community development and human rights, but since 2000 HIV/AIDS prevention and care and support have been added.
The absence of an overarching strategy and agreed upon set of priorities guiding the commissioning of sub-activities by USAID has made it difficult for the umbrella projects to maximize their achievement.

The value added by the two umbrella projects to their sub-grantees differs according to each organization. FHI/IMPACT has made good use of its access to international technical expertise in activities FHI/IMPACT has directly implemented, e.g., their formative and process research and evaluation and for specialized training, such as STD case management. In the future, more can be done to provide similar support to its sub-grantees, especially in the areas of strategic planning, technical support, design and support with IEC materials and monitoring and evaluation.

KHANA's value added is through its support to local NGOs and CBOs to build their managerial and technical capacity while at the same time providing limited funds for innovative pilot activities. The fact that a number of KHANA supported LNGOs "graduate" each year to the point of requiring no additional TA and, in some cases, only limited funding, attests to its success in building local capacity.

Both organizations have actively participated on a variety of national and local government planning committees, and their technical contribution as well as their representation of grassroots issues have been valued.

**Prevention and treatment of STDs to control HIV/AIDS**

USAID-funded STD interventions have included STD training for health workers that serve high-risk groups, STD surveys of prevalence and practices in Cambodia, and STD prevention and treatment of CSWs.

**a. STD Training**

The objective of USAID-funded in-service STD training has been to strengthen practical STD case management skills among health care providers working with members of high-risk populations. The four key training goals have been to teach health workers: diagnosis and early treatment of people with STDs, education of patients and the general public, treatment and education of sexual partners and targeting vulnerable groups. Three weeks of practical training is offered based within the trainees’ own health care facility. Initial training is followed up a short time later and supervision is provided by FHI.

FHI’s training was designed to focus on high-risk settings where commercial sex workers are treated and to provide practical as well as theoretical training. The decision to proceed in this fashion was taken in part as a result of earlier assessments conducted by FHI which showed that: (a) only 64 percent of STD clients in targeted facilities were treated according to national standards; (b) only 14 percent of clients were told about condoms and partner notification; (c) NCHADS basic STD training was theoretical, limited in its ability to provide practical training and did not cover the special issues related to working with high-risk groups such as CSWs; and
(d) the government tended to offer STD training primarily to male supervisors, rather than female health workers (nurses or midwives) who are preferred by CSWs.

Up to the present time, through the FHI project, 46 health workers have been trained from seven NGO clinics in Phnom Penh, two government STD clinics in Kandal Province, and four private sector health clinics (including two national breweries which hire “beer girls” and provide STD services for them). These 46 health care providers see an estimated total of 2,200 STD patients each month (an average of 48 patients per provider per month). This number appears rather small in terms of overall impact and the magnitude of contribution to human resource capacity building is questionable. Figures on cost per health worker trained were not available. FHI/IMPACT plans to extend its STD training activities to the provinces of Kamong Cham, Kamong Thom, Kampong Chhnang and Kampong Speu. Assistance has, appropriately, centered around areas of the country where there are concentrations of CSWs, on clinics that specifically serve those sex workers, and on clinics where there are female health workers (nurses and midwives). The training is closely linked with efforts to empower sex workers such as Project Speak-Out and support to the NGO - Cambodian Woman for Peace and Development (CWPD).

The USAID indicator for the STD training program is “percentage of clients reporting clinic as first source of treatment for STD-related complaints.” Monitoring in nine of the health centers that FHI trained showed that, between December, 2000 and February, 2001, approximately 16 percent of the clinics’ patients chose that clinic first for treatment. No baseline data appears to be available against which to compare this.

b. STD studies

USAID funds have been used to fund three important STD studies in recent years, improving considerably to the weak knowledge base that has existed in Cambodia in relation to STDs.

In 1996, USAID funded a study (conducted by NCHADS with the University of Washington) to document STD prevalence rates in selected populations, determine gonococcal antibiotic susceptibility, assess the validity of the proposed WHO treatment algorithms for Cambodia, and document high-risk sexual behaviors in these populations. The findings of this study were used to develop Cambodia-specific recommendations for the modification of the WHO STD syndromic guidelines for vaginal discharge.

In April 2000, FHI completed a study, “The reality of STD care: An assessment of services, as seen by health care providers, patients and observers”. The study was undertaken to determine training needs of health care facilities where FHI had agreed to provide training. Specific objectives included ascertaining the appropriateness of clinical management of STDs, determining STD clients who received appropriate advice about partner notification and condom use, and assisting in identifying problems and solutions in terms of appropriate case management of STDs. The study was instrumental in guiding the training design.

Another study, (STD Prevalence Survey and Algorithm Validation Study in Cambodia) funded by USAID is currently being implemented through NCHADS with technical assistance from FHI/IMPACT, l’Institut Pasteur de Cambodge and the Institute for Tropical Medicine. The
study focuses on female CSWs, mobile men and antenatal care/family planning clinic attendees (the first two of these groups being high-risk groups for transmission of HIV) and will fill an important void in understanding STD prevalence and treatment patterns. The study is national, and is “oversampling” in USAID priority provinces to provide data for program effectiveness evaluations. The fieldwork was completed in early 2001 and results should be available in mid-2001.

Targeted Behavior Change Communication/IEC

a. HIV/AIDS communication/outreach to CSWs

The FHI/IMPACT project aims to reduce the incidence of HIV/STIs among direct and indirect sex workers in Phnom Penh, Kompong Cham, and Kandal (phase 1), and in Kompong Chhang, Kompong Thom, and Kompong Speu (phase 2), through an empowerment approach via NGOs with sex workers. Particular IEC components of activities with female and transgender sex workers include: coordination of the ‘Speak Out’ project (a women’s empowerment project), peer education and peer support, networking, mobilization, and education of clients/boyfriends; and production of IEC materials.

In 1999-2000 ‘coverage’ (defined by the number of ‘active’ members of the sex worker network) of sex workers through Urban Sector Group, Cambodian Women for Peace and Development, Khmer Women's Cooperation for Development, Oxfam Hong Kong and Pharmaciens Sans Frontieres was 1,626 sex workers in Phnom Penh, 223 in Kandal, and 403 in Kompong Cham. Overall ‘reach’ (defined as the percentage of sex workers regularly contacted by peer educators) was estimated by FHI to be 35 percent of sex workers in Phnom Penh, 95 percent in Kandal, and 80 percent in Kompong Cham for a total of 2,590 sex workers.

There is concern that as the 100% CUP is implemented throughout Cambodia, commercial sex work will be increasingly driven underground, thus giving rise to an increase in indirect sex work. Reports indicate that implementing interventions in IDSW workplaces can be difficult – establishment owners, such as managers of beer breweries, are not always cooperative and many state that what the women do “on their own time” is not their concern.

PSI has produced posters specifically targeting CSWs that highlight PSI’s socially marketed Number One condoms. One of the posters depicts a female sex worker and her client with the Number One condom package prominently displayed. PSI staff reported that an MOH official wrote a letter to all Provincial Health Offices instructing them to display the poster in their health centers. The poster is also displayed widely in brothels. During a site visit to a brothel in Phnom Penh where PSI is active, the poster was hanging in every commercial sex room.
b. Workplace-based workers

In late 1998, FHI/IMPACT funded the pilot and subsequent expansion of a peer education program initiated by the MOND in 1995 among military service men in three densely populated provinces: Phnom Penh, Kandal and Kampong Cham.

A four-step process was developed for the peer education program:

- Training of Core Trainers (CT) at the national level;
- CTs then train Peer Education Trainers (PET);
- PETs train Peer Educators (PE); and
- PEs become ‘peers’ in educating and influencing their colleagues in the same unit/group using informal yet comprehensive risk reduction communication strategies in order to change their risk behaviors.

By 2000, the MOND, with support from FHI, had trained 11 core trainers, 153 Peer Educator Trainers and 2000 Peer Educators. It is estimated that each PET is able to ‘reach’ approximately 10 to 15 colleagues and friends within their unit/group. The program is reported to have reached 27,000 men (out of a total of 40,000 military forces) in three target provinces, representing approximately 20% of the entire military forces of Cambodia. (‘Reached’ is defined as the implementation of comprehensive risk reduction education between peers. The number of contacts with peers ranges from 3-5 each.).

In addition, a similar model is being implemented by the Cambodian Red Cross (CRC), a police peer education program which commenced in 1999. With funding received through FHI/IMPACT, the program has been implemented by the Ministry of Interior (MOI) in Phnom Penh and Kandal Province, and the CRC in Phnom Penh and Kampong Cham.

To date, two CTs, 30 PETs, and 594 PEs have been trained. The program has targeted approximately 6,000 policemen in 19 sites in Phnom Penh Municipality and 3 districts of Kandal Province.

The BCC interventions supported in the MOND and MOI have had wide coverage and have been highly effective as illustrated by the successive rounds of the HSS and BSS. Purchasing of commercial sex by the uniformed services has declined dramatically as has unprotected sex with CSWs. Furthermore, the commitment and support provided by both Ministries has been exceptional.
c. Mobile service workers

A program was recently initiated by the Cambodian Women's Clinics (CWC) directed towards men at high-risk of HIV/AIDS and STDs. This includes highly mobile populations not reached by other programs, such as moto-taxi drivers, construction workers and long-haul truck drivers. With funding from FHI/IMPACT, CWC has initiated a drop-in center in Phnom Penh that offers STD/HIV counselling, an STD clinic, information, condoms and lubricants. Outreach workers and volunteers reach men in the in the streets and in parks who may engage in risky sexual behavior. No data is yet available on coverage as the intervention began in January 2001.

d. HIV/AIDS materials availability

FHI/IMPACT provides a sub-contract, training and TA, to ACTION, a local NGO media company, to provide information, education and communication material support to all the sub-grantees receiving funding. When they were first established as a local NGO, ACTION's main capability was in the development of media production, including film and video, with less experience in IEC materials development. FHI has trained ACTION in the following areas:

- Audience based research for materials development;
- Developing creative briefs on which to base materials development;
- Pre and post testing of materials;
- Management of the production of materials.

Since the beginning of the project, over 190,000 pieces of materials have been produced and distributed primarily to the uniformed services. The vast majority of these have been T-shirts, caps, lighters with logo stickers and calendars. While these items may be much coveted by their target audience, they may have only limited IEC/BCC impact.

ACTION received a second contract from FHI/IMPACT (March 2000-2001) to broaden its scope by assisting all NGOs working under as FHI sub-grantees in materials development and production. In early 2001 FHI held a partners meeting to explain the role of ACTION in relation to all of the implementing agencies. Consequently, ACTION is about to go into production with a number of different materials for partner NGOs. This may help to provide LNGO sub-grantees with necessary, and lacking IEC materials.

KHANA builds the capacity of local NGOs to use participatory methods in determining the IEC needs of their beneficiary populations. In 2000, KHANA partners were supported to make a range of training materials for IEC. For World AIDS Day, partners, in conjunction with community members, designed puppet shows, drama, traditional songs, posters, T-shirts, hats, leaflet and flyers. Sex workers in one brothel designed their own T-shirts to encourage male clients to use condoms.
There is a critical need for coordination among donors and NGOs alike concerning the production and distribution of IEC material – especially printed materials such as posters, leaflets, and flip charts. Many local and international NGOs resort to producing their own IEC material, resulting in added labor, costs and duplication of efforts. Other NGOs (especially in rural areas) simply do not have access to any appropriate IEC materials. Further, an unintended consequence of many different IEC materials coming from many different sources is an overall lack of unity in themes and messages.

There is also a need for a clearly articulated overarching IEC strategy as to what messages should be designed for what target audiences using what types of media. The production and distribution of T-shirts, caps and other gimmicks, while perhaps useful for promoting the name of one's organization, has limited utility in conveying knowledge or bringing about behavior change.

In addition materials are often translated from English into Khmer and are not targeted well to the local culture/language/target group etc. There is a need for more appropriate and targeted IEC, as well as a need for simpler, better IEC materials, especially visually literate materials. It would be beneficial for USAID to work with its partners to coordinate its messages. This should also be coordinated with the appropriate government authorities and other donors/foundations.

**HIV/AIDS - Care and Support**

The original USAID Action Plan for HIV/AIDS did not specify care and support for people living with HIV/AIDS (PWHA) as a key operational concern. However, as the number of people with HIV/AIDS has subsequently grown and as NCHADS drafted a comprehensive AIDS care and support strategy for inclusion in the National AIDS Strategy for the period 2001-2005, USAID has made some limited funding available for piloting several home-based care models. Some of the funding is channelled through the International HIV/AIDS Alliance and its local partner, KHANA, and some through sub-agreements from FHI/IMPACT with its local NGO implementing agencies. In addition ANE Regional Bureau funds were provided to FHI Bangkok in 2000 to begin discussions with two key regional networks, Asia Pacific Council of AIDS Services Organizations (APCASO) and APN+ on PWHA's and human rights.

**a. Home-based care**

Two LNGOs, Mith Samlanh-Friends and NYEMO, receive financial support from FHI/IMPACT. The Friends project, targeting street children and their families affected by HIV/AIDS, is designed to assist these children and their families to cope with their situation in a humane way and to provide support and advice to caregivers on how to take care of PWHA. NYEMO, co-funded by UNICEF, receives FHI/IMPACT funding in order to empower women and children living with HIV/AIDS to analyze their situation and to develop their capacity to initiate responses to protect their health and improve their quality of life and that of their children.

KHANA provides technical, managerial and financial assistance to a growing number of local NGOs to integrate HIV/AIDS prevention and care and support activities in their services with
urban and rural communities. Given the reach of NGOs and the trust they have in communities where they work, the program is designed to reach its beneficiaries through partnerships between community volunteers, NGOs and government to provide outreach services which are linked with Health Centers. Given the limited funds available from USAID, the current program basically focuses on the Phnom Penh and Battambang areas.

KHANA’s Home care services in the pilot areas are provided by teams comprised of 5 members: 2 government health workers (i.e. nurses) from the local Health Center and 3 NGO representatives who serve the communities in the catchment area of the health center. The strategy is to use the health expertise of the government staff and couple it with the community trust and outreach approach of the NGO staff. In addition to the basic 5-person team, community volunteers are also involved in linking the outreach provided by the home care teams with the community. The volunteers also provide basic information about appropriate care and prevention.

Services offered as part of the home care package range from basic palliative care to welfare services through material support. Teams provide services to chronically ill adults rather than trying to search for HIV positive individuals, most of whom do not know their status or are unlikely to be able to determine it given the absence of easily accessed testing facilities. Teams are supposed to visit patients at least twice a week and more often if needed. Each team carries a home care kit consisting of basic drugs such as paracetamol, bandages, ORS, condoms, and soap. The Health Center nurse is the only member of the team authorized to dispense the drugs, all of which can be easily obtained across the counter in any pharmacy or drug seller. The team and the community volunteers provide HIV prevention information and education.

The provision of material, psychosocial and social support is primarily the role of the NGOs. Most of the material support provided consists of food to help households cope with the economic effects HIV related illnesses.

The Assessment Team visited one home-based care project in Battambang. In the 7 villages served by the health center, it was reported that 10 people had died in the last two months of AIDS-related illnesses. Approximately 35 suspected active AIDS cases were identified in the catchment area.

Given the time and language limitations of the visit, it is difficult (and perhaps unfair) to evaluate all of the home-based care trials from this one encounter. However, the Team's assessment is also based on a review of the relevant literature on the subject in Cambodia (see KHANA 2000) and knowledge of the social, economic and health system context. The following weaknesses/limitations are identified in the present models for delivering home-based care:

- an implicit assumption that professional home-based care would eventually be provided to all AIDS patients;
- an assumption that health professionals need to be among the care-givers; and
- an inadequate focus on what models are potentially replicable.
There appears to be an underlying and implicit assumption in the models now being tested that homel based care by visiting health professions can and should be available to all AIDS patients. There is no country in the world that the Team knows of where this would be feasible. Limited resources make it essential that some type of needs-based prioritization takes place. Families vary enormously in the degree to which they require external assistance.

There is also the issue of who should provide home-based care. A home-based team made up in part by HC staff is a non-starter. As discussed in sections II-C and IV-C2, HCs are still in a formative stage of development, and their staffing patterns are barely adequate for existing services. While the HCs are expected to grow stronger over the next few years, they will also be expected to greatly expand their volume and range of services during that time. Provision of adequate outreach for essential preventable services such as immunization and antenatal care is already problematic, and there is no possibility of taking on home care outreach activities on a large scale as well. Besides, given the range of home-based care interventions, it is unlikely that health professions need to be involved except in the initial development of simple guidelines. Furthermore, professional nursing as commonly understood in many parts of the world does not exist in Cambodia. Nurses diagnose and treat diseases. They do not provide nursing care as we know it; that is done by the family.

It is also unrealistic to expect that NGO staff could be frontline members of a home care team if the program went to scale. No NGO has the capacity to recruit, train and manage that large a workforce. However, NGOs still can be program managers and provide the training to others, such as Buddhist nuns and wat grannies, who in turn can provide support at the individual family and community level.

Recognizing that there is a need for a potentially replicable form of home care support, the Team recommends a careful reexamination of the present set of models of home-based care delivery, a clear set of priorities and guidelines as to who should receive what kind of care and at what frequency and who the most appropriate care givers are within the community.

b. Children Affected by HIV/AIDS

In FY1999, USAID received a Congressional appropriation of $10 million to support activities targeted to children affected by HIV/AIDS. The supplemental funding led to the initiation of a range of projects addressing orphans and vulnerable children in 13 countries, including Cambodia. Cambodia and India were the only countries in Asia to receive these funds, and no previous efforts directed at children affected by HIV/AIDS had been supported by USAID in these countries. Therefore, USAID had no previous experience in implementing these types of activities. Nor has there been much (if any) experience from which to learn from other donor supported activities focusing on children affected by HIV/AIDS.

Supplemental funds in FY1999 in Cambodia totaled $1 million, with the money received by projects in late 2000. Projects were implemented through KHANA and through FHI/Impact. KHANA received $350,000; FHI/IMPACT received $650,000.

---

2 For a more complete analysis of CAA, see Annex C.
Working with partner local NGOs to respond to the growing needs of orphans and children affected by HIV/AIDS is a new area of work for KHANA that began in 1999. In 2000, in an effort to assist local NGOs to respond to children affected by AIDS, KHANA carried out an appraisal of the needs of these children and resources in Cambodia. As a result a growing number of KHANA’s partner NGOs are recognizing a need to include attention to the needs of children affected by HIV/AIDS within their work. A 2000 evaluation of the home care program in Cambodia, in which a number of KHANA partners are involved, revealed that home care teams are increasingly dealing with issues related to children as part of their workload. Consequently of the 40 local NGOs funded by KHANA, 14 of these NGOs redesigned their programs in 2000 to include support for orphans and vulnerable children, with KHANA’s technical assistance.

The types of activities which KHANA funds through local NGOs on behalf of CAA include: interventions with schools to waive fees for CAA, small amounts of food for CAA and their families, psychosocial counselling and practical skills such as writing wills, foster care and placement of CAA in families within the community.

FHI/IMPACT provides support to five local and one international NGO addressing CAA. Mith Samlanh-Friends for HIV/AIDS has two projects, one supporting HIV/AIDS prevention among street children in Phnom Penh, the other providing care and support to children affect by HIV/AIDS. The Friends prevention activity provides outreach education, addresses condom use, safe sex negotiation skill development, STD symptom recognition, STD treatment seeking behavior, empowerment and self-esteem issues. Activities are undertaken in a Phnom Penh settlement.

The care and support project identifies children affected by HIV/AIDS through the AIDS care ward of Preah Norodom Sihanouk Hospital when a parent is in the ward being cared for as a result of an AIDS related illness. The project provides food and day care support to the children while the parent is in the hospital.

NYEMO, based in Phnom Penh, has a project to improve the quality of life for women living with HIV/AIDS and their children. This project is supported by both UNICEF and through a sub-grant from FHI/IMPACT. Project activities include: a network for collaboration with referral to vocational, psycho-social and medical services; a drop in center for underprivileged mothers and their children; psychosocial, medical and recreational activities; empowerment for women with their children to face their current situation and to plan their future; and improved access to health care facilities and psycho-social support services.

FHI provides a sub-grant for CARE pilot interventions for children in distress in Koh Kong. The goal of the project is to increase the physical and mental well-being of children/adolescents affected by HIV/AIDS and their families through the provision of integrated and comprehensive HIV/AIDS prevention, care and support services.

Activities supported by CARE include: a life skills and STD/HIV/AIDS prevention program for vulnerable children and adolescents in an effort to reduce their exposure to HIV infection; and a
A team consisting of one CARE staff and five youth advocates to work in conjunction with Community Caring staff and partners to provide, monitor and evaluate prevention, care and support services to children/adolescents affected by HIV/AIDS and their families.

In 2001 FHI/IMPACT also began funding two local NGOs in Battambang. The first, Kien Kes Volunteer Network, was established in response to an assessment of the needs and capacity of Cambodian military to become involved in care and support programs for children affected by AIDS. The Network’s plans have evolved from collaboration between the military unit in Thmar Kol, the activities of the Venerable Monk Mony Saveth from Wat Norea, and input from FHI/Impact and the local NGO Buddhists for Development. The main goal of the Kien Kes Volunteer Network is to ensure that children and their family members affected by chronic illness, including AIDS, receive assistance and support from the community in which they live, and that the community does not discriminate against PLWHA. The Kien Kes project will develop a volunteer network involving the local communities, monks in the local pagodas, and the military infrastructure to reunite children with their families, recognizing that functioning families are the most important unit for providing care and love to children. Family reunification will be achieved by providing psychosocial, material, technical, and/or financial support to both the children and their family members.

The second project in Battambang is with Meahto Phum Ko’mah (Homeland), a local Cambodian NGO established in 1997 to address the situation of children living on the streets of Battambang town. The goal of the project is to improve the quality of life of children orphaned by chronic illness of their parent(s), including AIDS, within 8 target communes in Battambang town and to strengthen community mechanisms for care and support of orphans, including fostering.

Because the KHANA and FHI/IMPACT funded projects are all relatively new, an assessment of their impact is premature. Nevertheless, several general observations can made:

- The relatively small number of projects supported have been selected on an ad hoc basis rather than strategic basis. The minimal strategic planning for OVC may result in a plethora of disjointed activities that don’t take full advantage of synergistic opportunities.

- There does not seem to be enough interaction and collaboration among the project implementing agencies or with Government. Complementary projects among implementing organizations, and individual comparative advantages, are not maximized, resulting in some duplication and inefficient use of time and resources.

- USAID should develop a comprehensive, coherent strategy in the are of OVCs.

- USAID should work with the various government bodies that are tasked with dealing with OVCs. In addition, USAID should work with international organizations/donors to be additive to the growing funds for OVCs.

A major factor accounting for the abandonment and institutionalization of babies born to HIV+ mothers (or mothers whose HIV status is unknown) is uncertainty of the child's HIV status. In
Calmette Hospital, for example, babies born to HIV+ or suspected positive mothers are placed in an institutional care facility for 12 months before being eligible for adoption. The conventional ELISA tests are not accurate before 18 months of age. However the polymerase chain reaction (PCR) test can be administered within days of age. A window of opportunity would be created for early determination of the infant's HIV status and for its more rapid placement with family or in a foster home. USAID should work with the variety of players to determine the feasibility of the PCR test in this resource-poor country.


An underlying theme in all of USAID's work in Cambodia is the need to rebuild local capacity for leadership roles in virtually every aspect of life following the devastating destruction of the KR era (see Section IIA).

In the field of HIV/AIDS capacity building has, primarily because of the restrictions imposed by the U.S. Government in the wake of the 1997 "events", been directed at the local NGO and CBO community which forms one of the main and critical pillars of good governance. To a more limited extent, using alternative methods of funding, capacity building has directly benefited the national government.

The support channelled through FHI's regional office for the HSS and the BSS are good examples of national capacity building and fostering ownership of the surveillance systems. Before 1997 there was virtually no in-house capacity at NCHADS to conduct and analyze the HSS and the BSS. Since then, however, with the technical assistance provided by FHI through their Bangkok office, NCHADS is now capable of conducting and analyzing these critical sentinel surveys. Continued foreign technical assistance is desirable primarily to ensure that quality remains up to international standards and that the trends, especially the declining trends in prevalence, are subject to peer review. What appears to be lacking is capacity building for secondary in-depth analysis of existing surveillance data, either by NCHADS itself or by some other nationally based groups, such as the National Institute of Public Health.

FHI/IMPACT's contribution to building the capacity of Government, especially the MOND and the MOI, in the area of behavior change interventions targeting the uniformed services is harder to evaluate. Peer education activities in the military began in 1995 and were supported by UNDP/CARARE, and in 1998 WHO provided support to the MONDs health care program for STD case management training. The police peer education program began in 1999 in partnership with the MOI and the Cambodian Red Cross, the latter having a well-developed peer education program pre-dating the involvement of FHI. The FHI/IMPACT mid-term review recommended that technical and other support would probably have best been provided to the MOND, MOI and CRC for a wide variety of related activities, including coordinated curricula, policy development and strategic planning and HIV/AIDS program management. This may be where a few opportunities for capacity-building were missed, though the potential still remains strong.

With regard to FHI/IMPACT's capacity building and collaborative arrangements with other government and NGO groups, their mid-term review identified a number of areas for improvement, ranging from the need to collaborate more closely with the MOH to ensure that
various interventions are in line with government policy, to the reduction of compartmentalization within various project teams which result in fragmented and uncoordinated activities that may lack an overall strategy.

The potential impact of FHI’s administration of sub-grants can be improved through a more clearly focused and well-articulated plan for capacity building. There should be a strategic plan developed whereas technical assistance in strategic planning, IEC and other areas are systematically provided.

KHANA has been successful in bringing new local NGOs under its umbrella, now totaling 40, a 30 percent increase over 1999. It receives an average of 70 applications a year to join the network, but because of limited staff and financial resources, it can handle only about 7 new NGOs a year. KHANA has been highly successful in "graduating" about 30 percent of the NGOs with which it works, graduating in the sense of no longer requiring technical or financial assistance from KHANA. Some of these local NGOs in turn have begun training other local NGOs who are increasingly reaching the point of being able to join the KHANA umbrella. The work which USAID has supported with KHANA and its partner local NGOs is a success story which is gradually but slowly enlarging the pool of Cambodian NGO talent which can be tapped for many innovative interventions in HIV/AIDS.

KHANA has also been very successful in developing its own capacity, as proven by success in diversifying its resource base. In its first year of operations in 1996, it was totally reliant upon financial support from USAID. By 2000 only 50 percent of KHANA's budget was provided by USAID with other donors such as World Bank, JICA, AUSAID, DfID and UNFPA providing the balance. This diversification of resources, however, has not been without some cost. Given KHANA's standing as an umbrella organization for indigenous NGOs and its track record, it is almost inevitable that other donors, each wanting to work with local NGOs but in accordance with the donors' own priorities and requirements, will flock to KHANA with offers to fund various activities. There is thus the real danger that this highly successful NGO will become overextended and its impact will be weakened.

With expansion, KHANA is beginning to have less direct involvement in their member NGO activities, concentrating instead primarily on managerial, financial and technical assistance. A decrease in the type of hands-on assistance provided in the past to LNGOs that were quite inexperienced may hamper KHANA’s future contribution in the nurturing of new LNGOs. With increased funding for KHANA to take on more staff and to provide financial support, KHANA could further enlarge its pool of NGOs and continue to provide critical hands-on assistance.
VI. Infectious Diseases

A. Tuberculosis

1. Overview of Country Situation

Even prior to the advent of HIV/AIDS, tuberculosis was a major cause of morbidity and mortality in Cambodia. The country’s estimated incidence of 539 cases per 100,000 population is the highest in all of Asia, and the highest in the world with the sole exception of sub-Saharan Africa. Every year, 60,000 new TB cases occur and about 10,000 cases die (90 TB-related deaths per 100,000 population). It is estimated that two thirds of the population are infected with M.tuberculosis. Given the magnitude of the HIV/AIDS problem in Cambodia, the unusually rapid pace of escalation and apparently short interval between infection and illness in this population, an explosive increase in the already high incidence of TB over the next five years is inevitable and may well reach levels equal or exceeding those of the worst affected African nations. HIV sero-prevalence among TB patients has increased sharply since the beginning of the HIV epidemic. In 1995, 3 percent of TB patients were HIV positive. This figure doubled to 8 percent by 1999 and is as high as 18 percent in some regions of the country.

As noted in Section I.C., the public health care system is still in a formative stage of development. Although national policy calls for inclusion of TB treatment in the minimum package of activities to be provided at the community (Health Center) level, the logistical and training implications of introducing DOTs at the periphery are considerable and implementation has been delayed pending initial establishment of functional Health Centers. In the interim, TB treatment has been available only at the hospital level and thus effectively out of reach for many patients. It is estimated that the current national program detects no more than 40 percent of actual TB infections in the population. The WHO target for case detection is 70 percent.

The case fatality rate for TB patients who enter the public health system is 17 percent. Taking into account an even greater number of patients who never receive treatment and die at home, it is evident that TB is a major cause of mortality in Cambodia. Further, the currently low level of case detection is inadequate to curtail transmission.

The MOH had initially intended to phase in TB and other chronic disease treatment at the HC level after the initial phase of district health system development – creation of over 900 HCs, 60 RHs and 60 DHMTs nationwide ---- was completed. This approach made sense given the already enormous challenges inherent in rapid creation of a health care system and the complexity, in terms of clinical skills, logistics and management, of this intervention. However, the advent of HIV/AIDS and corresponding increase in TB cases (expected to double within 1-2 years from an already high rate of incidence) has made it imperative to escalate the introduction of TB treatment at community (HC) level. A pilot project was implemented from October 1999 in 9 health centers in 7 operational districts nationwide to identify implementation issues and approaches. Results indicated that treatment at HC level is feasible and will substantially increase case detection; it was also found to strengthen community confidence in the HCs and overall improved HC utilization. The pilot project assessment concluded that about 70 percent of all TB cases could be diagnosed and treated at the HC level, and the MOH has committed to
nationwide implementation of HC DOTs. The technical assistance needed to implement this policy, however, will be considerable. Many of the HCs are not yet even open, and those that are have been so for only a short time; staff in general are inadequately trained and management and supervision systems have only recently been established. With an expected doubling of TB incidence, the sheer volume of caseload will present an enormous challenge to these new, and often understaffed, facilities. In addition the introduction of DOTs at HCs involves complex logistical and management mechanisms: obtaining sputum samples, transporting these to a laboratory facility, obtaining results and ensuring patient follow-up and compliance, ensuring drug security and control, etc. Health Centers and DHMTs will need considerable hands-on technical assistance, coaching and support if this challenge is to be effectively met.

2. Donor Assistance

JICA provides substantial technical assistance to the National Tuberculosis Program (NTP), including a fulltime long-term expatriate advisor. Inputs focus on strengthening of capacity of program managers and clinical skills of health personnel at the central, provincial and RH level, research and surveillance. The basic curricula and protocols necessary for use in treating TB at the HC level have been developed and piloted, but the scope of JICA’s TA will not be sufficient to meet all technical assistance needs in implementation at the HC level.

TB is one of the areas of collaboration identified in the USAID-JICA Common Agenda for Cambodia. It outlines JICA’s role in support to the NTP and proposes USAID involvement through funding of NGOs, presumably (but not specifically stated) for community-based activities such as IEC and HC DOTs.

Anti-TB drugs are currently purchased by the Government through both the national budget and a health sector loan from the World Bank, which expires in 2002. Initially all drugs were imported, but the MOH has recently begun to use a locally produced INH/rifampin combination which has not had adequate quality assurance testing. In addition to concern about quality of the drugs, there have been problems with leakage into the unregulated private sector, a serious public health concern given the problem of multi-drug resistance. Although private practitioners, clinics and pharmacies are prohibited by law from selling TB drugs, a survey on perceptions on TB and health care seeking behaviors conducted by FHI in a slum settlement in Phnom Penh found that drug sellers sold rifampacin and ethambutol. JICA is actively considering provision of anti-TB drugs, which will facilitate their ability to monitor both quality and distribution.

In summary, research and surveillance, policy formulation, protocol development and clinical training materials are adequately supported by other donors, as are drugs and related material needs (laboratory etc). However the expansion to HC level nationwide will require community-level TA and training well beyond what present donors can support. These inputs will be labor intensive and require a systems approach as the primary constraints and needs are operational, not clinical. Once community level services are established, community-level IEC will obviously take on importance as well.
3. Current USAID Portfolio

The prevention and control of TB is not explicitly addressed in the current USAID strategy. However, several USAID CAs are providing support to Health Centers (see Section IV.C), some of which participated in the HC DOTs pilot, and all of which will be expected to incorporate DOTs in their range of services in the near future, with the training and TA needs this entails. Most importantly, USAID’s current portfolio and partners have demonstrated a capacity to strengthen the provision of basic preventive and curative public health services in Health Centers, and this will be as applicable to the introduction of HC DOTs as it has already been to the provision of maternal and child health and family planning services. The main constraints in HC DOTs and support required are not specifically clinical in nature but rather a matter of general capacity building and systems development.

FHI/Impact has provided a small subgrant to an NGO, Servants to Asia’s Poor, to pilot home delivery of DOTs to PLHA in the catchment area of a Phnom Penh Health Center which was part of the HC DOTs pilot study. Khana has proposed similar initiatives through several of its partner NGOs. In addition, CARE has also proposed including DOTs into their existing program. KHANA and CARE’s inclusion of DOTs has been positively greeted by JICA. While home delivery of DOTs to PLHA is undoubtedly a need, it is not going to be replicable on a large scale in the foreseeable future since neither HC TB treatment nor HIV/AIDS home care are yet established in the country.

FHI/Impact conducted and disseminated a study of TB health seeking behavior among the urban poor in 1999. A regionally funded study of prevalence, drug resistance and health-seeking behavior among HIV positive patients, prisoners and slum dwellers is underway through the FHI Regional Office in collaboration with the Gorgas Institute.

B. Malaria

1. Overview of Country Situation

Malaria is a leading cause of morbidity and mortality in Cambodia despite the fact that transmission is largely limited to specific and usually sparsely populated parts of the country. Approximately 5 percent of the population live in endemic areas, while a much larger number of people are temporarily exposed in the course of migrant work e.g. military, gem miners, loggers, rubber plantation workers, etc. In addition, the post-war environment has seen a large internal resettlement of non-immune people into previously insecure forested areas of transmission. Overall, approximately 2 million Cambodians are considered to be at risk of infection. The incidence of transmission in endemic areas can be extraordinarily high. Prevalence of over 50 percent has been documented in some areas. Malaria is the leading cause of hospitalization in Cambodia; in 2000, a total of 129,167 (11.3 per 1,000 population) cases of malaria were confirmed and treated within the public health system. Given the cultural preference for self-treatment of illnesses (see Section I.C.), widespread availability of anti-malarial drugs in the general market, and still limited reach of public health services, this can safely be assumed to represent only a fraction of true total incidence, which WHO estimates at 1 million cases annually.
Malaria in Cambodia has a higher case fatality rate than in neighboring countries. 92 percent of slide-confirmed malaria in Cambodia is due to Plasmodium Falciparum, and multi-drug resistance is widespread, especially in the western parts of the country. In addition, the selling of counterfeit anti-malarial drugs is a significant problem and contributes to mortality. Malaria is the single leading cause of all hospital deaths. Extrapolations from hospital data yield a generally accepted estimate of 10,000 deaths per year in Cambodia (WHO 1999). The overall case fatality rate for hospitalized severe malaria in 2000 was 9.8 percent, but runs as high as 30-88 percent in remote referral locations. Although working age males have the highest incidence, pregnant women and small children are at greatest risk of death when infected. Malaria in pregnancy, particularly in the third trimester, is associated with extremely high rates of fetal loss and maternal death.

The MOH’s malaria strategy emphases both reduction of transmission and reduction of mortality. Insecticide-impregnated bed nets are distributed in endemic areas along with community health education. Health centers have been provided with dipsticks for rapid diagnosis and anti-malarial drugs, and providers have been trained in case management. Community education has also been conducted to encourage prompt treatment at health facilities, and efforts have been made to crack down on the sale of counterfeit drugs in the market. All of these interventions are ongoing, and there are encouraging signs of progress, including a recent decrease in incidence (both by public sector reports and survey of private clinics), and a significant decrease in the case fatality rate.

In addition to efforts in the public sector, the MOH has explicitly acknowledged the important role of the private sector in the treatment of malaria, and has conducted a pilot study of pre-packaged drugs and a dipstick test for distribution through drug vendors. Results were encouraging and donor support is being sought for large-scale implementation. The MOH has also developed collaborative agreements with a large network of NGOs for both preventive and case management activities.

Nonetheless, much remains to be done in combating this leading cause of death. Bed net distribution and use promotion requires intensive community-level efforts, and it is difficult to effectively target and reach migrant populations. The poor state of rural infrastructure and lag in development of Referral Hospitals means that the vast majority of malaria cases occur in settings where inpatient treatment is unavailable or limited (e.g., no blood bank facilities). This presents the greatest danger to those groups most likely to progress rapidly to severe complications – pregnant women and small children. Although it is MOH policy to provide malaria diagnosis and treatment as part of the OPA in all Health Centers, training of staff and provision of drugs and materials has had to be phased in as HCs are established and become operational. Understandably, the MOH first targeted facilities located in areas of endemic transmission. However, since the onset of malaria occurs several weeks after vector inoculation, cases can and do appear at Health Centers in non-endemic locations as well, and distribution of diagnostic supplies and anti-malarial drugs, along with training of health workers, has not yet reached all HCs.
An additional and more problematic constraint is that the distribution of HCs, generally one per 10,000 population, does not provide adequate access to services in the more sparsely populated and mountainous provinces where malaria is most endemic. Policies to provide outreach services or satellite health posts in such places have yet to be developed, and will in any event be extremely hard to implement especially in areas populated by migratory ethnic minority groups. It is hoped that social marketing of drugs, combined with IEC, will help extend access to curative services in such areas.

2. Donor Assistance

WHO (with DFID funds) and the EU provide support to the National Malaria program, as does the World Bank loan. This includes strengthening of Central and Provincial level capacities, training of health personnel, and provision of laboratory supplies. Anti-malarial drugs are purchased through the World Bank loan, national budget and by KfW, as part of general support for essential drugs. The MOH is currently seeking donor funding for initial capitalization of social marketing of anti-malarial drugs and has submitted a request to JICA for this. The EU will support related IEC efforts and materials development. The World Bank loan as well as a government-sponsored charitable contribution campaign support the cost of procurement and social marketing of impregnated bed nets. The USAID Global Bureau provides support for surveillance and research on drug resistance.

In short, support for capacity-building within the NMC and research/surveillance activities seems adequate, and there is adequate provision for procurement of materials (bed nets, drugs, testing materials) to be used in public health facilities at the periphery. There is a possible gap in funding of commodities to capitalize a large-scale social marketing effort, as well as unmet needs for technical assistance in marketing. There are also gaps in technical assistance at the community level to ensure the effective distribution and use of bed nets, and strengthen access and quality of community level treatment.

3. Current USAID Program

Community outreach health education activities of USAID CAs include messages about mode of transmission and the use of bed nets. In addition, some of the HCs receiving training and TA from these two projects diagnose and treat malaria. Ultimately, all will, as the phasing in of malarial testing and treatment in HCs progresses nationwide. The on-the-job coaching, training and management support provided by CAs at the HC level thus play an important albeit indirect role in improving access to effective treatment, and this potential will expand as malaria treatment extends to all HCs nation-wide in the coming years.

The USAID-funded PFD Project in Kratie Province – an area of high transmission – has a specific focus on malaria prevention and has carried out intensive and highly successful efforts to decrease malaria morbidity and mortality through village-based impregnated bed net distribution and intensive village level health education, both occurring in the context of a comprehensive grass roots integrated rural development project using highly participatory approaches which have succeeded in building trust and credibility among villagers.
PFD has a formal collaborative agreement with the MOH Malaria Control Program to implement the distribution and periodic re-impregnation of bed nets throughout the Province, along with intensive community IEC. As of the end of CY2000, over 100,000 family bed nets had been distributed to a total population of 263,000 persons, achieving 100 percent coverage of the endemic areas in the province. An intensive system of monitoring and follow-up has ensured near universal use of the nets, and a dramatic decline in malaria incidence has been documented in health facility statistics, through household interviews, and in a survey of 121 private drug sellers. Between 1998 and 1999, the number of patients treated in five HCs for malaria decreased from 1500 to 500. A nominal fee was charged for the nets and used by PFD to purchase and distribute anti-malarial treatment.

An external mid-term evaluation conducted in 1999 described PFD’s malaria control efforts as “an unqualified success and a model for other provinces”. The Assessment Team concurs with this evaluation. Although the initial inputs required to achieve results were intensive, the final product is an internalized behavior change and demand for bed nets that will be sustainable with only modest recurrent costs (insecticide for periodic re-impregnation, and replace of nets every few years).

In addition to the above mentioned USAID/Cambodia supported activities, there is a centrally funded grant through WHO/Cambodia for malaria control at a level of $300,000 for five years. Activities supported include surveillance, and research on patterns of drug sensitivity and resistance.

C. Dengue Hemorrhagic Fever

1. Overview of Country Situation

Dengue hemorrhagic fever is endemic, but reaches epidemic proportions in Cambodia every two to three years. It is spread by Aedes, a day-biting mosquito which breeds in stagnant water. Studies have shown household water jars to be the prime breeding site in Cambodia, with an average of 85% of water storage containers testing positive for larval infestation. The most recent such outbreak occurred in 1997-8, and affected both rural and urban areas. As noted in section IV.A.3, DHF is the leading cause of death among children aged 1-5 years. The case fatality rate for DHF is much higher in Cambodia than in neighboring countries, ranging from 3.6 – 15 percent nationwide, but substantially lower in the capital city due to the availability of higher trained personnel and better equipped facilities. Over the six-year period 1995 – 2000, a total of 36,796 cases of DHF were registered with the MOH National Center for Epidemiology, Parasitology and Malaria Control, with a total of 1,259 deaths among them. These already high figures obviously under represent the true burden of morbidity and mortality as they are limited to cases diagnosed in a public health facility and reported to the National Center.

As with malaria, the MOH’s dengue strategy consists of prevention through health education and improved case management. However, both are technically more difficult than in the case of malaria. The dengue vector is a day-biting mosquito, making it extremely hard to avoid exposure. Efforts to promote covering of water jars and larvicide treatment have so far met with limited success, but it is anticipated that this may improve when a successfully piloted new,
water-permeable water jar lid is widely available. Donor assistance for social marketing of it is being sought.

There is considerable concern that it is now 3 years since the last outbreak, meaning that another one is likely to be imminent. The MOH plans a massive larvicide campaign in April and May of this year, targeting a population of over 3 million persons in high-risk areas.

Case management of dengue is likewise more complex than that of malaria, and requires a higher level of care. While most cases of malaria can be effectively treated at Health Centers or through self-purchase of anti-malarial drugs, management of DHF requires inpatient treatment at a hospital equipped with laboratory, blood banking and higher level personnel. The majority of Cambodians do not have access to these because only 30 percent of planned Referral Hospitals have as yet been fully established.

2. Donor Assistance

There is not much donor assistance specifically slated to DHF. The Swiss government gives substantial support to a private children’s hospital (Kantha Bopha) established by a Swiss pediatrician-philanthropist which, together with the World Vision-supported National Pediatric Hospital receives most DHF cases hospitalized in the Phnom Penh area; a second such hospital has recently opened in Siem Reap. The French Cooperation provides support to the Pasteur Institute, which conducts laboratory-based surveillance for the MOH. Both the World Bank and ADB loans provide support for construction and equipment of RHs in a total of 16 provinces, which as they become operational will begin to handle increasing numbers of dengue cases.

Preventive activities are under-funded, and the MOH still faces a shortfall of approximately $100,000 to capitalize the proposed social marketing of water jar lids. There is also a shortfall in funding the intensive larvicide treatment campaign about to commence.

3. Current USAID Program

There are no activities directly relating to dengue in the present USAID/Cambodia program. However, there is a centrally funded USAID grant administered through WHO/Cambodia for control and management of DHF. Activities supported include disease and vector surveillance, vector control, community health education, and training of health care providers in case management.
VII. Key Findings and Lessons Learned

A. Cross-Cutting Concerns

1. Program Design

- USAID’s areas of comparative advantage are in Technical Assistance, Social Marketing, working with the private sector, and working at the community level through NGOs.

- Disease-specific interventions in Cambodia need to be complemented by interventions which support development of the health care service delivery system. USAID has a comparative advantage in doing this at community level and its current projects have played a significant role in strengthening district Referral Hospitals, Health Centers, and Health Center outreach to villages.

- For maximum impact, interventions to strengthen health services must take a systems approach, addressing all five critical elements of community level service delivery and their linkages: the District Health Management Team, the Referral Hospital, Health Centers, HC Feedback Committees (FBCs) and Health Center Outreach.

- In interventions to strengthen the health system the “larger picture” must be kept in mind, particularly when dealing with constraints of national policy importance. Active participation in national forums is required to ensure that nationally systemic issues are addressed in a manner that is potentially replicable and acceptable to policy makers.

- PHN projects, even when implemented through NGOs and the private sector, are vulnerable to disruption when political events lead to deterioration in the bilateral relationship. USAID may benefit from nascent cooperation with the government, as well as other donors, in resolving such fundamental issues as client charges and provider compensation. Political commitment to achieving a functioning public health system needs to be supported.

- Both within the current USAID portfolio and the national programs, HIV/AIDS/STDs is highly verticalized with little or no interface with RCH programs or the overall health service delivery system. Health care providers have thus far been left out of the planning process and are poorly informed about proposed interventions, including those they will have to help implement. Health providers also have unmet needs for information on HIV transmission and universal precautions.
There are numerous potentials for linkages between RCH and HIV/AIDS/STD interventions which would render both more effective, e.g.:

- HIV/AIDS/STD and RCH IEC efforts
- ante-natal, obstetric and post-natal care and PMTCT, HIV prevention
- Family Planning and VCT, STD/HIV prevention
- ANC and STD prevention and treatment
- VCT and FP.

In community outreach IEC, getting there is 99 percent the battle and cost. No opportunity should be missed to provide key messages in the areas of MCH, FP, HIV/AIDS and STDs at each outreach session.

Youth, a key segment of the population who will largely determine future trends in both RCH and HIV/AIDS, are not optimally reached unless there is a specific focus and strategy for doing so.

Use of umbrella-type mechanisms to fund a large number of implementing agencies provides a suitable range and number of NGO implementing partners on the one hand, while meeting USAID financial accountability requirements and management constraints on the other. However, care must be taken to see that the umbrella agency provides value added technical support in exchange for the increased cost such arrangements entail.

### 2. Capacity-Building

- In addition to providing a vehicle for funding an otherwise, unmanageable but essential cadre of implementing agencies, umbrella mechanisms can and should provide added value in the form of technical assistance, access to coordinated IEC and other materials, and programmatic guidance and organizational capacity-building. Co-operative agreements for sub-agreements need to spell out clearly to sub-grantees specific expectations such as technical inputs from CAs, and specific strategies need to be developed to ensure this takes place.

- In the Cambodian context, where human resource capacity is extremely weak, and change is needed not only in information and skills but in basic attitudes and expectations, effective TA and training requires extensive, prolonged, hands-on follow-up, coaching and mentoring at the actual service delivery point.

- To achieve the above, it is critical that implementing agencies systemically approach, and allocate resources for, capacity-building of their own national staff so that they are well positioned to serve as mentors.

- USAID should develop a strategic plan with proper oversight to ensure that subgrantees receive needed TA.
3. Research, Monitoring and Evaluation

- Both impact and monitoring of impact is hampered when activities are scattered across a large number of provinces without complete coverage of Operational Districts within a province. Achieving a critical mass both within ODs and among all ODs in a province will enhance effectiveness and make it easier to measure.

- Research activities, whether Mission or centrally funded, will maximally reflect priority program information needs only if there is a clearly established USAID PHN research agenda and strategy to inform them. The possible range of research in Cambodia is virtually limitless and needs to be Mission, rather than researcher and CA, driven.

- Pilot interventions, in particular, need to occur within the framework of a strategic research agenda to ensure that they are potentially replicable in the context of the current level of health care system and overall socioeconomic development.

B. Intervention Specific Concerns

1. Reproductive and Child Health

- Child survival has been relatively neglected both within the present USAID portfolio and among bilateral donors to Cambodia overall. As infant (especially post-neonatal) mortality rates are high and steadily rising, this needs to be addressed.

- The present Cambodian national EPI/VAC strategy is not working. Coverage levels are grossly inadequate and have not improved in the last two years. Geographical realities make it impossible to achieve significant coverage through static clinic based EPI. Without external technical assistance, HCs cannot manage the complexities of rotational outreach to villages. Government funds for conducting outreach are not reaching the periphery. Time-consuming monthly outreach to very small villages is a labor intensive and cost-inefficient approach. The overall strategy needs re-appraisal.

- Competency-based training of midwives has significantly improved the quality of their services and utilization. Keys to this success have been careful training selection criteria, practical training provided in a setting with a high volume of deliveries, and intensive post-training follow-up.

- Community-level health providers are not adequately trained in the management of common child illnesses, so that there is little if any added advantage to the client in consulting a health worker. There is an urgent unmet need for competency-based training of HC and RH curative staff, as has been successfully done with midwives.

- Fear of abusive or impolite treatment, often based on prior experience, is a significant factor in non-utilization of trained health providers in Cambodia. Providers lack skills in bridging class barriers and their training has not stressed communication with clients or
interpersonal skills. There is an urgent need to train providers in interpersonal skills, quality assurance and to sensitize them to class barriers.

- Social marketing is an appropriate and cost-effective strategy for increasing access and demand for family planning methods. However, current marketing strategies do not effectively reach the rural areas where the majority of the population resides.

- There is untapped potential for using social marketing to improve access to and demand for RCH services, e.g. ORS, iron/folate supplements, etc.

- While progress is being made in increasing the quality and coverage of antenatal services and safe delivery, the post-partum period and post-partum interventions have been neglected. As the majority of direct obstetric deaths are due to post-partum hemorrhage, and as improper breast-feeding is a significant contributor to infant mortality, post-partum interventions could have a potentially large impact on both maternal and child survival, and on MTCT of HIV.

- Delivery at home, even when conducted by a trained midwife, is apt to entail significant unnecessary risk due to widespread use of dangerous modern medical interventions. This makes the development of client-friendly delivery services in HCs and RHs all the more important.

- One of several factors constraining the use of health facilities for delivery is the failure of these to incorporate non-harmful traditional beliefs and practices. This was successfully done in the past with Cambodian populations in Thai refugee camps and effectively increased deliveries in hospitals.

- Although significant resources are being directed to TBA training, it is not clear that this actually improves TBA delivery practices. An alternative approach, which takes into account the important psychosocial and spiritual functions of the TBA, is partnering arrangements with HC and RH midwives.

- Emergency Contraception is not generally available in the FP program, and is a strong unmet need given the reportedly high incidence of rape and large adolescent population.

- Post-Abortion care is also not generally available in the USAID FP program and should be explored.

- There is little understanding or promotion of the dual protection (pregnancy and STD/HIV) advantages of condoms. FP providers currently give too little emphasis to condoms, which are associated with disease prevention rather than contraception.

- Condom security is an area that must be further explored in Cambodia.
2. HIV/AIDS/STD

- The national response to the HIV/AIDS epidemic is thus far largely a health response; responses in other sectors have been relatively muted. This reflects two things: (1) the much stronger capacities of the MOH relative to other line Ministries, and overall low level of activity in many sectors; and (2) deeply rooted cultural factors which make inter-departmental, let alone inter-sectoral, collaboration extremely difficult to achieve.

- While there has been good utilization of the HSS and BSS data by government and donors at national level, there is an unmet need for building the capacity of provincial and district levels to use the data in development and evaluation of province and district specific strategies.

- USAID-funded efforts to reach CSWs and their male clients, especially men in the uniformed services, have been highly successful and have contributed to declines in high-risk behavior and HIV prevalence in these groups. Key to this success have been the participation of local women’s NGOs, and the strong commitment of the Ministries of Interior (MOI, responsible for the police) and National Defense (MOND, responsible for the military). Both the MOND and MOI would benefit greatly from additional TA in developing their own HIV/AIDS strategies, policies and guidelines to ensure that the entire military and police services are covered nationwide.

- The association of condoms with prevention of STD/HIV has led to a stigmatization and under-use with wives and “sweethearts”. Attention to these groups should be a priority to contain the spread of HIV/AIDS to the “generalized” population.

- IEC/BCC through mass electronic media, particularly television and video, has a greater range and impact on target audiences than other forms of media.

- While IEC and BCC efforts have contributed greatly to a near universal knowledge of AIDS and improved condom use, there are some important gaps in message content and targeting, e.g.:
  - Care of PLWHA and CAA has gotten comparatively little emphasis;
  - Messages about HIV prevention stress dangers but fail to make clear ways in which HIV is not transmitted, leading to unnecessary fear and stigmatization;
  - There has been an over-reliance on printed text where more visually literate materials would reach a greater number of people;
  - Current approaches and strategies have been effective in reaching CSWs and their clients, but less so in reaching IDSWs and migrant male workers;
  - Preventive messages stress commercial sex encounters; there has been too little emphasis on protection of wives and “sweethearts”.
• There is a huge unmet demand for VCT throughout the country, both in high-risk groups and in the general population. Public sector testing facilities are inadequate in number and location, and overwhelmed with clients where they do exist. There is a potential market for complementary fee-for-service VCT in areas where government has already established free services, to cater to middle class concerns and reduce the burden on government facilities. In addition, there is a need to develop VCT services in “private” health centers.

• Counseling is not an indigenous concept in Cambodia. The planned nationwide expansion of VCT in the public sector will require intensive TA, training, follow-up, social marketing and facilitative supervision.

• Present interventions for care and support of PWHA and CAA are ad hoc and need to be re-examined in terms of strategic coherence, replicability and realistic potential for scale-up.

• It is unrealistic to expect that, in a country still far from providing widespread access to treatment for curative illnesses, every AIDS patient can receive professional home care services. There is a need to prioritize and develop selection criteria for who is to receive what level of services, and to identify non-professional first-line care providers.

♦ Lack of in-country technical capacity for early testing of infant HIV status results in unnecessary institutionalization of children orphaned or abandoned due to HIV/AIDS. PCR testing is not generally available. There should be an analysis to determine the feasibility of PCR testing in Cambodia.

3. Infectious Diseases

• Current TB treatment availability is inadequate to reach the majority of patients or decrease transmission, and the incidence of TB is likely to double in a few years due to HIV/AIDS. Introduction of DOTs at the HC level is by far the greatest priority.

• Introduction of HC DOTs will require significant, hands-on TA, training and mentoring at HC level, to ensure correct treatment protocol and non-diversion of drugs.

• Collaboration with JICA and the National TB Program is important to complement their current programs.

• Very dramatic reductions in malarial morbidity and mortality can be achieved through a combination of IEC and insecticide impregnated bed net distribution when carried out by NGOs in a structured, intensive manner at community level, accompanied by careful monitoring and evaluation of both behavioral change (maintenance and use of bed nets) and impact (decrease in incidence of malaria).
VII. Key Findings and Lessons Learned

Population-based data indicates that DHF is the leading cause of child mortality, suggesting a need for greater emphasis on prevention and on development of district Referral Hospitals as a child survival priority.

There is untapped potential for using social marketing to improve access to and demand for ID control measures, e.g. water jar lids, malaria treatment kits.
VIII. Potential New Directions and Activities

A. Cross-Cutting

1. The health care system in Cambodia is only four years old, and still in early stages of development. To be effective, disease specific interventions must be accompanied by measures to strengthen the health care delivery system, particularly its decentralization at the level of the Operational District. USAID has a comparative advantage in doing this through NGOs. Important features of such support, which have proven successful under the current portfolio, include:

   - A systems approach, recognizing and addressing the essential elements of district health services (HCs, HC outreach, Referral Hospital and the Operational District Health Team) and the referral mechanisms, and linkages between them.

   - Competency-based training, through both formal and informal mechanisms, for HC, RH and DHMT staff to improve clinical, counseling/interpersonal, and managerial skills.

   - Intensive on-the-job follow-up and coaching after training is completed, to assist staff in internalization and application of new skills, attitudes and approaches.

   - Assistance for the formation and activities of HC Feedback Committees (FBCs). These committees, consisting of elected representatives from each village, provide an essential mechanism for improving HC-villager relations, mobilizing the community for outreach sessions and promoting health practices and utilization of preventive services. Most importantly, they empower communities and create a sense of accountability towards clients which health workers, raised and trained in an authoritarian culture, have never before had.

2. The new health system’s development and maturation is fundamental to achieving success in all intervention areas: maternal health, family planning, child survival and HIV/AIDS prevention and care. Without this, all other interventions are just tinkering around the edges. A number of innovative experiments in health sector reform (contracting in/out, “boosting”, the MSF “New Deal”, etc) and active policy dialogues between government, donors and implementing agencies are underway. USAID may benefit from closer collaboration with the government, as well as other donors, in resolving such fundamental issues as client charges and provider compensation. Political commitment to achieving a functioning public health system needs to be supported.

3. To maximize impact and effective leveraging of resources, and minimize management burden, it is strongly recommend that a few provinces be selected for intensive focus, in addition to continuation of selected national-level interventions. Within these provinces, a closely linked and strategic package of maternal, infant/child, family planning, STD, and HIV/AIDS interventions should be provided, in tandem with general support to strengthen the health service delivery system, in all Operational Districts.
4. The following criteria are suggested in selection of focus provinces:

- HIV/AIDS prevalence (RCH needs are equally severe throughout the country);

- Progress in health service system development. Interventions need to have some degree of a functioning health system to start with, as well as to be accompanied by inputs to further strengthen those systems. It is suggested that geographical areas selected have at least 75 percent of planned HCs open with MPA; functional RHs in every OD (not necessarily surgical capacity if there are other surgical referral points within an hour of the OD), and a fully staffed and functional District Health Management Team in every OD;

- It is important to take into consideration other donor interventions with significant impact on the health system. It would not be appropriate to select a province in which the ADB-financed contracting pilot may be scaled up. A strategic decision will need to be made with regard to provinces slated for “boosting” (see Section IV.B.). On one hand, “boosting” is expected to result in a stronger health system with which USAID projects could interface; on the other hand, like any new initiative, there are elements of risk and a possibility of significant disruptions as change is introduced. Given the Mission’s mandate to show results in 1-2 years, this may be a risk too great to take. Close collaboration and consultation with the MOH and other donors is imperative.

5. Aside from major systems interventions such as “boosting” and contracting of health services, most other donor-funded assistance need not influence selection of geographical focus; a “template” of key interventions at OD level should be developed and then tailored to specify which elements USAID can support and coordinated with other elements which are expected from other donors within each OD.

6. Umbrella mechanisms offer a manageable means of working through a large number of smaller organizations, particularly LNGOs which have unique potentials but seldom the financial systems in place to directly receive USAID funding. The Mission should continue to use umbrella-type mechanisms, especially with regard to LNGOs, but should ensure that the umbrella CA provides value added technical support in exchange for the increased cost such arrangements entail. Assistance instruments should clearly spell out CA obligations with regard to technical assistance, provision of IEC and other materials, programmatic guidance and organizational capacity-building for sub-grantees. In addition, it would be desirable to require pre-approval of subgrants by the Mission, to ensure that these fall within the Mission’s strategy and that the umbrella CA has made provision of adequate technical support.

7. Social Marketing is both an area in which USAID has a strong comparative advantage and one with unusually high potential impact in Cambodia due to an established cultural preference for self-purchase of health commodities and a very receptive policy climate. It is therefore strongly recommended that:
VIII. Potential New Directions and Activities  June, 2001

- USAID support expansion of the present product line to include injectable contraceptives and a “sweethearth” brand of condom (if successfully piloted);

- future social marketing initiatives include specific strategies to achieve product placement in rural areas even if these are more labor-intensive and hence yield lower cost return than conventional distribution mechanisms;

- social marketing can be used to contribute to a broader range of reproductive and health needs, through expansion of product lines into health commodities e.g.: ORS, STI drug kits, malaria treatment kits, water jar lids to combat DHF, prenatal iron/folate tablets, and, possibly, safe birth kits;

- the Social Marketing Program should extend beyond project implementation to wider capacity building in the areas of marketing and marketing research, message development, IEC materials, script writing, etc. An overall strategic plan and collaborative working arrangements should be developed, both with all USAID CAs and with specific government programs (e.g., Malaria and Dengue Control).

8. Lack of human resource capacities is a pervasive constraint to development efforts in Cambodia, and capacity-building must go hand in hand with interventions. Projects in the current portfolio have demonstrated that capacity-building, particularly for public sector health staff, requires intensive, hands-on mentoring and coaching from suitably trained local counterparts. To be able to do this, USAID’s partner CAs require a growing cadre of highly skilled local professional staff. USAID should explicitly support CAs in staff development as an integral part of their programs. RFAs and assistance instruments should reflect clear plans, policies and resource allocation for local staff development, and deployment of a critical mass of professional staff (both international and local) at the field level with phased in devolution of authority and responsibility to them.

9. Given the young population in Cambodia and the tremendous RH needs of this growing population, the new strategy should try to include youth as a cross cutting theme. A youth strategy should encompass both males and females, using age appropriate approaches such as peer education, to encourage a reduction high risk behavior for HIV/AIDS, STDs and unwanted pregnancy.

B. RCH-HIV/AIDS Linkages

1. The new strategy and projects funded under it should make maximal use of potential linkages between RCH and HIV/AIDS/STD interventions, including:
   - HIV/AIDS/STD/ID and RCH IEC efforts
   - ante-natal, obstetric, ID, post-natal care and post-abortion care, MTCT, HIV prevention
   - Family Planning and VCT, STD/HIV prevention
   - ANC and STD prevention and treatment
• CT for FP/HIV/AIDS/STDs.

2. Outreach services and IEC activities should include an integrated package of key MCH/FP/STD/HIV/AIDS interventions and messages since the greatest expenditure of time, staff and money lies in reaching these contact points. No opportunity should be wasted to convey key messages in all of these areas.

3. Through both social marketing and community level health services (HCS and health education), efforts should be made to de-stigmatize the condom and make condom use a societal norm. Program efforts should focus on promoting the condom for dual protection.

4. Men are the users of condoms; USAID should try to develop approaches and strategies that ensure the dual protection message is reaching men, and provide one to one counseling for correct and consistent condom use. At the same time, STD programs that treat men for STDs should also play a more effective role counseling them on correct and consistent condom use and communicate the dual protection message.

5. RHAC clinics are an excellent model for urban RH/STD service delivery, effectively reaching men, women and youth with a broad range of RH/STD services. Expansion to other urban locations, especially ones of growing need and risk such as Siem Reap town (tourism center, youth in-migration for employment), is highly desirable. However, establishment of new clinic sites involves considerable investment in staff development and is feasible only if there is long-term (i.e., 3-5 year) donor funding.

6. Currently the national HIV/AIDS program is very vertical and there is no effective linkage yet to health care providers nor to MCH/FP clients – despite the fact that both groups have a strong felt need for information. The recommended integrated Operational District approach will help bridge this gap. In addition, special attention should be given to health care providers, who have great unmet needs for information on how to protect themselves, and how to deal with HIV/AIDS in their health centers and hospitals. Midwives in particular need information on HIV/AIDS in pregnancy, peri-natal transmission, infection prevention practices, and PTMTC. Prevention practices by health care providers are an important element of HIV/AIDS control. Basic RH/HIV/AIDS/STDs training of health care providers is desperately needed at provincial and district levels of the health care system, and should not be overlooked.

7. The HIV/AIDS epidemic has entered the general population of Cambodia. Reaching women who are at risk of HIV/AIDS because of their partner’s risky sexual practices creates a special challenge. MCH/FP providers and facilities have the readiest access to this population, and need to develop strategies and skills to counsel women to assess their risks and provide them with negotiation skills for condom use with their partners. STD prevention should be highlighted in health education of pregnant women, especially since newly acquired HIV infection is associated with an increased viral load; an HIV infection acquired in pregnancy will increase the probably of MTCT.

8. Improper breast-feeding practices are wide-spread in Cambodia and of great concern both for child survival and PMTCT. USAID should support:
VIII. Potential New Directions and Activities

June, 2001

PHN Assessment, USAID/CAMBODIA

98

- intensified IEC efforts, including use of mass media, to better educate women on correct breast-feeding practices;

- formative research on alternative infant feeding practices for babies born of HIV+ mothers, including wet nursing;

- TA to facilitate development of new policy guidelines and training curricula for counseling mothers in the face of HIV.

C. Reproductive and Child Health

1. Very high priority should be given to ensuring that the future strategy not lose the “C” of RCH but rather explicitly address the alarmingly high and rising levels of infant/child mortality. In particular, attention should be given to:

   - innovative EPI approaches to achieve better coverage levels, and training of OD and HC staff in use of cluster surveys as tool to evaluate performance;

   - competency-based training of HC consultation staff in the management of common child illnesses and recognition, referral of complications, and in inter-personal skills. Mothers currently avoid use of trained health workers both because they are perceived as having little real knowledge and because interactions with them are perceived to be unpleasant and demeaning to the client;

   - direct education of consumers (mothers) in the use of pharmaceuticals for young children;

   - continuation of support for breast-feeding promotion and family planning activities.

2. USAID may benefit from engaging in policy dialogue with UNICEF in regard to the following areas where USAID provides significant global fund support:

   - Measures to improve EPI performance in Cambodia, including alternative mechanisms to ensure that funds for outreach sessions are actually received at the periphery, and consideration of more flexible and innovative approaches to outreach which incorporate locality-specific logistical features;

   - Provision of USAID funded TA to the national EPI program (through UNICEF if necessary due to legislative restrictions) to achieve the above;

   - Finalization and implementation of the iodized salt policy now under formulation.

3. The national logistics management system has been a significant achievement for the MOH and is one of USAID’s key accomplishments. Logistics system strengthening through refresher courses, on the job training, and facilitative supervision at the field level should be
included as an essential component in the next strategy in USAID focus provinces. Facilitation should be provided to agencies and donors working in other geographical areas to assist them in doing likewise in order to maximize return on the investments already made in nation-wide logistics training.

4. USAID should consider working closely with the government and other donors, and provide technical assistance as needed, to create a contraceptive security plan that ensures commitment of government and donors to support commodities and builds the capacity of the government to come to transfer ownership and accountability.

5. A pilot study should be done, perhaps as part of a Social Marketing project(s) to determine whether Vitamin B/folic acid supplementation reduces perceived side effects of hormonal contraception among Cambodian women, and results, if positive, should inform new social marketing initiatives.

6. In consultation with the national MCH program and other partners, Emergency Contraception should be introduced into both the public sector FP method mix and --perhaps most importantly given the need to provide access to rape victims and youth – into the Social Marketing Program.

7. USAID should re-examine the HDT strategy and consider alternative approaches in ODs where HCs function. These might include directing the same staff and resources towards strengthening of HC outreach activities, or having the HDTs conduct complete HC outreach (i.e., EPI, ANC as well as FP on a regular basis) under contract to the HCs.

8. USAID should continue to lead the way in models of high quality maternity care such as LSS for safe motherhood, and to participate through its CAs in national level SM policy making and working groups on midwifery training. The present model for improving delivery practices through the LSS course and intensive follow-up should be replicated in future areas of geographical focus. In addition, facilitation should be provided to other donors and agencies interested in replicating it in non-USAID focus provinces.

9. Unsafe abortion is a major public health issue in Cambodia. Currently, there is no specific linkage between hospital care for complications of abortion and the FP program. A PAC program in Cambodia could save women’s lives and decrease unwanted pregnancies by linking women to needed family planning services.

10. Operations research should be undertaken on the incorporation of traditional/non-medical elements into delivery services and their impact on utilization of services for delivery and treatment of complications. Research design should be informed through both existing literature and local interviews with key informants and focus groups so as to capture any locality-specific concerns. This could be done in conjunction with overall NGO support to an OD, but should include careful baseline and evaluative measurements.

11. HKI has a unique comparative advantage in its ability to provide technical and policy guidance to government, donors, and NGOs, and conduct essential research, on Vitamin A
and other micronutrient deficiencies. USAID should continue to support these functions. With respect to the model gardening component of the present project, if continued at all, it should be not as a pilot with labor-intensive monitoring but rather as a TA and training service for NGOs, provided at actual or sliding scale cost.

12. A qualitative and quantitative study should be done to determine the feasibility and potential of a widespread postpartum outreach program which includes identification of complications, counseling on breast-feeding, and Vitamin A and iron supplementation. The study should examine whether and how postpartum outreach can (1) reach mothers and newborns in the first 24 hours after birth (2) contribute to recognition and referral of life threatening complications, (3) improve breastfeeding practices, (4) enhance receipt of iron and Vitamin A supplementation, and (5) enhance the relation between medically trained providers and the community to stimulate utilization of medically trained providers for birth.

13. A focus on midwives as the frontline providers is appropriate and critical. Support for TBAs should be limited to partnership arrangements with HC and RH midwives and fee-splitting incentives for bringing women to a health facility for delivery. Such an approach preserves the important psycho-social and spiritual functions of TBAs while avoiding the dangers of unsafe delivery practices.

B. HIV/AIDS/STDs

1. The HSS and BSS have proven to be invaluable tools to both the national government and donors in advocacy, policy formulation, charting the course of the HIV/AIDS in Cambodia, prioritizing target groups for IEC/BCC and for overall program development in response to the epidemic. USAID should consider continued support for this widely recognized program as well as efforts to build provincial and district level capacities to use the data in the development and evaluation of province and district specific strategies.

2. The present IR #3 for HIV/AIDS has been both achieved and surpassed. The overall policy climate is extremely favorable, and within the health sector, detailed policies are being developed that adequately address most areas of HIV/AIDS prevention and care. However, other Ministries lag behind the MOH in development of policies and programs. The cultural and political realities of Cambodia are not conducive to multi-sectoral activities, but it is possible to have activities in multiple sectors. The Team strongly recommends that any future Mission support in other sectors, e.g. education, democracy and governance, microcredit, include an HIV/AIDS component. In addition, consideration might be given to providing TA in HIV/AIDS policy and planning for the Ministries of Interior, National Defense, Tourism and Women’s Affairs.

3. A major success story of the USAID HIV/AIDS portfolio is the extent to which funded behavior change interventions coupled with targeted provision of condoms have dramatically altered the spread of HIV in high-risk groups. In order to avoid backsliding and missing new cohorts, be they CSWs or men in the uniformed services, the Team strongly recommends that activities directed at these groups be continued and enlarged. Furthermore, provision of TA to the MOND and MOI for policy and program development and strengthening is encouraged.
to ensure that this all important intervention is replicated throughout the military and police services nationwide.

4. IEC and BCC efforts have successfully raised general awareness about HIV/AIDS and have greatly improved condom use among high-risk groups. There are, however, some important gaps in message content and targeting which require immediate attention:

- Messages about HIV prevention stress primarily what not to do, such as engaging in unprotected sex, particularly in commercial sex settings. They have done little to inform the public about how HIV is not transmitted which has left PLWHAs and children orphaned by AIDS vulnerable to stigmatization and isolation. Greater effort is required to ensure that those who are directly and indirectly affected are not unnecessarily denied care and support by their families and communities.

- IEC/BCC interventions towards the general public have relied too heavily on print media of questionable value for a largely illiterate or semi-literate population. TV and video are popular and growing rapidly in availability. In order to more effectively reach the general public and targeted audiences, greater use should be made of these relatively more expensive but effective forms of media.

- When printed IEC materials are available to the general public or to specific target audiences, there has been too great a reliance on written text - written Khmer is an extremely complicated language - to convey the message. Simpler and more visually literate materials need to be developed to reach a larger number of people.

- While HSS data indicate a recent sharp decline in HIV prevalence among CSWs and their clients as a result of targeted BCC and condom interventions, prevalence among IDCSWs and migrant male workers has remained fairly constant. New strategies and messages for these more difficult to reach target groups are required.

- Recognizing that CSWs and men who frequent commercial sex establishments are increasingly passing on HIV to their boyfriends and wives, there is a great need for preventative messages promoting the virtues of "protecting the one you love".

- There is a critical need for coordination among USAID’s CAs and grantees, government, donors and NGOs to develop an agreed upon set of messages and mechanisms for sharing of materials.

5. Condom promotion for CSWs and their clients has been highly effective and should continue to be supported. In addition, there need to be expanded efforts to promote condom use with IDSWs and “sweethearts”, e.g:

- Targeted availability in locations, such as hotels, karaoke clubs and guesthouses, which are frequented by indirect sex workers and their male clients.
• Promotion of "Never leave home without it" and investigation of innovative strategies, such as those effectively employed by Mechai in Thailand, for carrying condoms for use "in the case of emergencies" to increase use in casual sex.

• Development and marketing of a "sweetheart" condom, or de-stigmatizing the current Number One condom for use in non-commercial sex situations.

6. A huge unmet demand for VCT exists throughout the country, both within high-risk groups and increasingly in the general public. Public sector testing facilities, in those few places where they exist, are overwhelmed with clients. Routine pre-marital testing has spontaneously become a cultural practice and could be capitalized upon to create opportunities for a broader reproductive health initiative that would reach youth at a critical juncture in their lives. In larger urban settings where free VCT is already available, there is a potential niche for quality private sector initiatives to cater to middle class concerns and to reduce the burden on government facilities. It is recommended that USAID support PSI and RHAC in a trial introduction and marketing of a pre-marital package that would include VCT for HIV and STDs, FP counseling and services, and general RH information and counseling.

7. Voluntary testing for HIV is ethical only when pre- and post-counseling services are provided. However, counseling is not an indigenous concept in Cambodia. USAID should support the MOH’s planned nationwide expansion of VCT in the public sector and provide tangible assistance in the following areas:

• training of counselors, including both initial training and subsequent on-the-job intensive TA, follow-up and facilitative supervision;

• establishing quality control for laboratory aspects of testing;

• establishing monitoring, evaluation and supervisory systems at provincial and district levels;

• IEC to advocate the benefits of VCT and informing the public of the availability of services. This should be a coordinated effort with the MOH and donors/foundations.

8. Recognizing that ARV drugs are appearing on the private market in Cambodia. The Assessment Team recommends simpler, palliative home-based care and advocacy/IEC to encourage family and community support to PLWHA. Working with PLWHA organizations should be a critical component.

9. In the absence of an overarching USAID strategic framework to guide the piloting of USAID-funded interventions in the area of care and support of PLWHAs and OVC, many small activities have been undertaken in an ad hoc manner resulting in some disjointed and non-replicable projects. In addition, unreasonable expectations or assumptions have arisen as to what the range and scope of such care and support activities can be in the current country context. No additional care and support activities should be funded until there is a coherent
strategy developed which complements the RCG’s strategy and which articulates what interventions can and should be provided, to whom, by whom, and how. In that regard the Team suggests the following:

- development of simple, at-home protocols for infection control and palliative management of AIDS-related illnesses which families can use independent of health professionals. These should make maximum use of readily available, low-cost pharmaceuticals and common traditional medicines, and include clear information on infection control both to protect care-givers from HIV transmission and to protect the immunosuppressed patient from unnecessary risk of infection;

- simple, visually-literate training materials in use of the above;

- IEC to promote care and acceptance of PLWA in families and communities, with particular attention given to the potential role of monks, Wat grannies, nuns and other religious clergy as credible advocates;

- IEC to warn patients and families against quack cures and unnecessary depletion of household resources for same;

- development of needs-based criteria for which families/PLWHA should receive and what intensity and type of support;

- identification of potential non-professional community-based front-line care and support personnel to provide such targeted support, with particular attention given to the potential of nuns and “wat grannies, and

- development of job descriptions and training materials for the above, and of mechanisms linking them to Health Centers and NGO programs.

10. A major factor leading to abandonment and institutionalization of children born to HIV+ mothers (or mothers whose HIV status is unknown) is due to the uncertainty of the child’s HIV status. Conventional ELISA tests are not accurate before 18 months of age. USAID should support introduction of the polymerase chain reaction (PCR) test, with appropriate counseling and quality controls, in a manner accessible to and closely linked with institutions and agencies working with OVC. IEC on the availability of such testing should be done, as communities are confused and concerned about the risks of caring for CAA.

C. Infectious Diseases

1. USAID should support the introduction of DOTs in HCs throughout geographical areas selected for strategic focus through technical assistance, training, and on-the-job follow-up by NGOs at the level of actual service delivery. This should be done in close collaboration with the National TB program and JICA. Since a significant percentage of TB patients are HIV positive, and that trend can be expected to increase substantially over the coming few
years, support for the provision of DOTs in HCs would be significantly reduce morbidity and mortality both in the general population and among PLWHA.

2. When and as HC DOTs is available, community-based IEC to promote utilization of services and decrease transmission should be integrated into general community based health education efforts.

3. While home delivery of DOTs to PLWHA is certainly a need, it should not be addressed prior to successful implementation of DOTs in Health Centers and of large scale, community-based and home care activities. Premature efforts are unlikely to achieve measurable impact, and will not represent the best use of resources which might otherwise be focused on first ensuring the implementation of HC DOTs and general community education on transmission and treatment.

4. Skills in diagnosis and treatment of malaria at HC level should be supported in the geographic areas selected through on-the-job training, coaching and facilitative supervision.

5. The PFD malaria control project in Kratie should serve as a model for community-level malaria prevention. USAID should assist in making the components and results of this intervention widely known and consider replication of it in any endemic areas which fall within the focus provinces.

6. DHF is the single leading cause of death in the 1-5 age group in Cambodia. USAID has a demonstrated comparative advantage in working at the community (HC, HC outreach, district RH) level, and it has been previously recommended that this be the primary locus of RCH and HIV/AIDS efforts. Rural community-level IEC on prevention and recognition of danger signs, and training and support for early detection and referral by HC staff, would fit well within that framework and entail little additional resources if delivered as part of an RCH/HIV package. Strengthening of RH case management entails a greater investment and where possible could be left to other donors. However, on a case-by-case basis, where other donor support is not available in a targeted geographical area, it might be considered. This approach would complement, without duplicating, the surveillance and vector control activities supported by the Global Bureau.

D. Research, Monitoring and Evaluation

1. In view of the legislative mandate to show tangible results in 1-2 years in the area of HIV/AIDS, great care should be taken to construct indicators that are both measurable and realistic. In the Cambodian context, the most that should be expected of new activities within two years is that they be established on the ground, staff recruited and trained, an implementation plan and guidelines in place, and activities commencing. Process indicators should be constructed accordingly. Service coverage indicators would start to be applicable in years 4-5.
2. It is timely to introduce more indicators of maternal health care in order to call attention to effective interventions, for example, ANC iron distribution (30 tablets x 3), complete filling out of the partogram in labor, etc. in addition to the standard TT immunization.

3. There is an enormous range of research activities that could be carried out in Cambodia, and researcher interests will not necessarily reflect national needs and priorities. The USAID Mission should, in consultation with key government and non-governmental partners, develop a research agenda to ensure that resources allocated for research, whether by the Mission or from Central funds, best serve the information needs of priority programs. Periodic DHSs should certainly be high on that list.

4. Pilot projects, including subgrants through umbrella mechanisms, should fall within the overall research agenda and strategic objectives of the Mission. The Mission should require pre-approval of any sub-grants for pilot activities, to ensure that resources are not spent on pilots with no potential for scale-up. The needed degree of Mission oversight and ownership may be easier to achieve if bilateral, rather than field support, mechanisms are used to fund umbrella mechanisms.
ANNEX A: SCOPE OF WORK

CAMBODIA PHN SECTOR ASSESSMENT

I. Rationale

After signing of the Paris Peace Accords in 1991 the international donor community responded to the challenges of restoring societal and institutional structures in Cambodia. A decade into development efforts, overall health indicators in Cambodia remain among the worst in the Mekong Region. High rates of maternal and child mortality and morbidity, low immunization coverage, wide-spread malnutrition and micronutrient deficiencies remain significant issues in Cambodia. The country also has the highest prevalence of HIV/AIDS, TB and drug resistant malaria in the region. Poor health status and limited human and institutional health resources clearly impede Cambodia’s development potential. A more detailed summary of the Reproductive Health, Child Survival and HIV/AIDS status in Cambodia is attached (Appendix I We will send this to you later this week!)

USAID has supported health activities in Cambodia since 1994. Strategic Objective Two (SO2), “Improved Reproductive and Child Health” and Special Objective Two (SpO2), “Reduced transmission of STD/HIV among high-risk populations” were developed in 1996. Political unrest in July 1997 resulted in a temporary suspension of all mission activities. Congressional restrictions curtailed USAID’s collaboration with the Royal Government of Cambodia (RGC) and restricted funding to NGOs. The immediate impact was a sizable reduction in mission funding (from approximately $40 million to $15 million/year).

In 1997 a scaled-down health program was implemented with MCH/FP and HIV/AIDS components. The current MCH portfolio emphasizes increasing supply, access and demand for high quality reproductive health and child health services for Cambodians in focus provinces. The current SO is “improved reproductive and child health” and includes three intermediate results:

1) expanded supply of RCH services;
2) increased access to RCH services;
3) strengthened demand for RCH services.

The current HIV/AIDS portfolio emphasizes policy development and risk reduction. The current Special Objective Two (SpO 2), is, “Reduced transmission of STD/HIV among high-risk populations” with three intermediate results:

1) Policy makers informed about the HIV/AIDS epidemic in Cambodia
2) Reduce high-risk behaviors in target areas
3) Model STD/RH service delivery program for high-risk populations piloted and replicated in target areas.
In late 2000, USAID developed a new strategic approach to HIV/AIDS worldwide with Cambodia being designated a “Rapid Scale-Up” country: HIV funding increased from approximately $2.5 million in FY 2000 to $10 million in FY 2001 (includes CSD, ESF, and Orphans and Vulnerable Children funding sources). As a rapid scale-up country, Cambodia will be required to: 1) achieve measurable impact within 1-2 years, and 2) work to ensure that at least 80% of the population receives a comprehensive package of prevention and care services within 3-5 years (See Appendix II).

The USAID Cambodia mission is in the process of developing a new strategy for the mission that will cover the period of 2002-2007. The USAID mission strategy will be submitted to USAID Washington in July 2001. The next three months represents a critical time period for the PHN sector. It is imperative to review and assess the performance of the PHN Sector to identify strengths, limitations, and missed opportunities. The PHN sector needs to clearly identify its comparative advantage and provide a clear vision of what can be achieved over a five-year period (2002-2007). The performance review will provide critical information needed to develop a comprehensive and forward thinking PHN strategic plan. Along with a long-term vision, the PHN sector needs to develop a transition plan that provides bridging activities and allows key interventions to be scaled up during 2001-2002.

There are potentially strong linkages between the MCH/RH portfolio and the HIV/AIDS portfolio. In the assessment and strategic planning process, it will be critical to identify future synergies and technical cooperation between the two portfolios.

There is a very active international donor community in Cambodia. USAID/Cambodia will commission a thorough review of other donor activities and investments in the PHN sector. The results of this review will assist the assessment and strategic planning to better focus USAID/Cambodia’s program.

The Royal Government of Cambodia, the donor community and the NGOs are emphasizing the need for a multi-sectoral approach for HIV/AIDS, recognizing that HIV/AIDS is no longer “just” a health issue. The assessment and strategic planning process should produce a framework for creating a strong multi-sectoral response to HIV in Cambodia.

During the strategic design process, USAID/Cambodia will work closely with the Center for Disease Control and Prevention (CDC) to develop a joint strategy for investing USG HIV/AIDS funds over the next five years. This joint collaboration will compliment the comparative advantages of both institutions and maximize the impact and results of both agencies to best serve the needs of the Cambodian people. In May 2001 CDC is planning an assessment of the HIV/AIDS sector and the data and analysis will be shared to develop a comprehensive joint strategy.
II. Critical Assumptions

Relationship with Government of Cambodia

USAID/Cambodia has requested a waiver that if approved would allow USAID to work closely with the Government of Cambodia in the area of HIV/AIDS. This waiver does not cover the MCH/CS portfolio. Congressional response to the waiver request may be known by the time the assessment team arrives in March.

If Cambodia is successful in holding free and fair elections in 2002 and convenes a truth and reconciliation committee, USAID/Cambodia anticipates providing overall assistance to the RGC.

Funding

In terms of MCH/RH/CS, the strategy should work from the assumption that the level of funding received for the last 3-4 years will remain stable ($5-7 million/year) or experience only limited increases. In terms of the HIV/AIDS, while the mission will receive approximately $10 million dollars in FY 01 for HIV/AIDS programming in ESF ($7 million in CSD, $2 million for TB and infectious diseases and approximately $1 million in Orphans and Vulnerable Children), this level of funding may not be sustained for the entire period of the strategy.

Staffing

In order to implement the new strategy it is imperative that long and short term staffing needs be met.

III. Purpose of the Assessment Team Assignment:

This scope of work is intended to provide the USAID/Cambodia with an assessment of the PHN portfolio and to provide recommendations for input to the development of a transition plan and a PHN strategic plan 2002-2007 that includes both MCH/RH/CS and HIV/AIDS/ID.

Specifically, this scope of work consists of the following critical components:

PHN Assessment


The team should respond to the following questions and issues:

A. Assess the extent to which programs are meeting their intermediate results and objectives and identify the strengths and limitations of the existing portfolio;
B. Recommend the technical, geographical and programmatic areas on which USAID should focus, concentrate and invest in RCH and scale up in HIV/AIDS;
C. Identify technical and programmatic gaps/missed opportunities and make recommendations for future investments;
D. Identify areas where USAID should discontinue investments;
E. Review the various components of the portfolio and assess how each component contributes to the overall objectives and intermediate results;
F. Examine cross-cutting issues and make recommendations on critical components that will bridge across the MCH, RH, CS, HIV/AIDS areas including: geographic concentration, capacity building, health system strengthening, health communication/behavior change, training/performance improvement, social marketing, contraceptive security, reproductive health for young adults, monitoring and evaluation, partner and donor collaboration and targeting;
G. Assess the current program implementation mechanisms, identify strengths and limitations and make recommendations for the future;
H. Examine the current Office of Public Health’s Management structure and make recommendations on structure, staffing needs, and professional development.

III. STATEMENT OF WORK

PHN Assessment

The Scope of Work reflects the mission’s need to conduct a comprehensive assessment and analysis of the current portfolio. Given the critical need for human capacity development, the assessment team must recommend for each programmatic area under review, how best to address human capacity development needs in the short and long terms.

An overall question throughout should be: how best can USAID build local capacity in managing and delivering in MCH, RH, HIV and ID services while continuing to increase the scale and reach of these services in Cambodia?

A. Reproductive and Child Health

Specifically the team should address the following questions in the Reproductive and Child Health Program which consists of 1) family planning, 2) safe motherhood, 3) child survival, and 4) nutrition/micronutrients:

1. Assess the extent to which the programs are meeting their objectives. What are the strengths and limitations of the existing portfolio?

Since 1997, what has USAID achieved in the component? What impact has USAID had in improving quality and access to services? What impact has the component had in increasing demand for services? Have services become more client-centered? What is USAID’s comparative advantage in the component? Has USAID had significant impact on the problem? Specifically, what have been the key contributions of USAID to the overall SO? Where has USAID had limited impact or not been successful in achieving results?
2. Identify the technical, geographical and programmatic areas on which USAID should focus, concentrate and invest in for the future taking into account other donor programs;

Based on USAID’s comparative advantage, the needs in Cambodia, government priorities and activities of other donors, are the four components of equally high priority? In what specific areas could USAID make the most significant contribution? What technical and programmatic interventions have been most effective and are most appropriate? Given national strategies, such as Safe Motherhood, how could USAID best contribute and maximize results? Given the lessons to date, what key interventions are cost effective and can be expanded? What should USAID’s role be in improving quality of services and access?

3. Identify areas in which USAID should discontinue investments given other donors, past performance issues, lack of comparative advantage or need to concentrate and focus the portfolio.

4. How best can USAID build local capacity in managing and delivering services while continuing to increase the scale and reach of these services in Cambodia? How can capacity building be linked throughout the PHN sector in Cambodia?

5. How can technical components be linked effectively in the PHN sector?

6. Examine cross-cutting issues and make recommendations on critical components including: policy formulation for health system strengthening, health communication/behavior change, training/performance improvement, social marketing, contraceptive security and monitoring and evaluation.

7. Who are the key partners (NGOs, multi and bilateral donors, government, local partners) in these activities?

8. Examine USAID management capabilities and needs in this component.

B. HIV/AIDS/STDs

Specifically the team should address the following questions:

1. To what extent is the program meeting its objectives and intermediate results. What are the strengths and limitations of the existing portfolio? What should USAID’s role be in the area of STD prevention and treatment? Should new target groups be considered given the changing profile of the epidemic? What new approaches need to be designed or scaled-up to reach new target populations?

2. Given other donor priorities, past performance issues or lack of comparative advantage, identify the technical and programmatic areas in which USAID should focus, concentrate and invest for scale up;
3. What areas of long term focus should USAID primarily support?

4. How best can USAID build local capacity in managing and delivering in HIV and STD services while continuing to increase the scale and reach of these services in Cambodia?

5. How can HIV/AIDS/STDs be effectively linked with other technical components in the PHN sector?

6. Examine potential opportunities for multi-sectoral approaches; make recommendations on how mission SOs can include HIV activities/information within their portfolios.

7. Who are key partners (NGOs, multi and bilateral donors, government, local partners) in these activities? How does USAID currently collaborate with what other donors are doing and what are the strengths and weaknesses of this collaboration? With which partners has USAID had the most success in collaborating? What elements made those collaborations successful?

8. What are USAID management capabilities and needs in this component?

C. TB

1. What are the key accomplishments of the TB program? What are the lessons learned to date in this new programming area? What is USAID's comparative advantage in this area given what other donors are doing? What significant investments should be made in this area in the future?

2. How can the connections between HIV and TB referral and treatment programs be made and strengthened?

3. Examine potential opportunities for multi-sectoral approaches; make recommendations on how mission SOs can include TB activities/information within their portfolios.

4. What are USAID management capabilities and needs in this component?

D. Orphans and Vulnerable Children (OVCs)

1. What are the priorities that USAID should address in the area of orphans and vulnerable children? What is USAID's comparative advantage given the work of Government, other donors and NGOs? What significant investments should be made in this area in the future?

2. What are USAID management capabilities and needs in this component?
IV. Cross Cutting Issues:

There are several critical issues that are integral to many of the technical component in both the RCH and the HIV/AIDS portfolios. Specifically what recommendations and action steps should be taken to ensure maximum impact in the following areas?

1. Increase and expand the role of the private sector and NGOs;
2. Develop a long term human capacity development and leadership development plan;
3. Ensure targeted and effective health communication messages and effective approaches for developing healthy social norms and behavior change;
4. Ensure contraceptive security for FP and HIV/AIDS;
5. Strengthen reproductive health and HIV/AIDS policies and ensure advocacy efforts and capacity building for NGOs, faith-based organizations and local organizations;
6. Strengthen the health care delivery at national, provincial and district levels and contribute to on-going health system development;
7. Develop an effective youth component for reproductive health, HIV/AIDS and multi-sectoral approaches, including the workplace and factories;
8. Strengthen the male involvement component and gender component;
9. Improve training and performance improvement approaches to build human capacity and effectively improve on the job performance;
10. Expand the utilization of social marketing for multiple products and services and targeted groups (youth, sweethearts, high-risk populations, etc).
11. Impact of migration on programming; address issues arising from internal and external migration, cross border issues, especially HIV/AIDS, increasing regional trade and development of economic growth corridors;
12. Recommend mechanisms by which future RH, ID and HIV/AIDS and ID CAs can be required to do joint work plans and program coordination.

VI. The Common Agenda

What progress has been made to implement the Common Agenda? Should the Common Agenda be continued? What action, resources and staffing are needed to effectively implement the Common Agenda?
VII. Team Composition

The Assessment Team will be composed of the following individuals:

<table>
<thead>
<tr>
<th>Name</th>
<th>Area of Expertise</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheryl Keller</td>
<td>Child survival and health systems development</td>
<td>Co-Team Leader</td>
</tr>
<tr>
<td>Jay Parsons</td>
<td>Reproductive and child health-HIV/AIDS</td>
<td>Co-Team Leader</td>
</tr>
<tr>
<td>Monica Kerrigan</td>
<td>FP, RH, quality of care</td>
<td>USAID/W lead</td>
</tr>
<tr>
<td>Mary Ellen Stanton</td>
<td>MCH/safe motherhood, quality of care</td>
<td>USAID/W</td>
</tr>
<tr>
<td>Beth Preble</td>
<td>HIV/AIDS, voluntary counseling &amp; testing</td>
<td>Indep. Consultant</td>
</tr>
<tr>
<td>Paurvi Bhatt</td>
<td>HIV/AIDS multi-sectoral activities</td>
<td>USAID/W</td>
</tr>
<tr>
<td>Erika Barth</td>
<td>HIV/AIDS</td>
<td>USAID/W</td>
</tr>
<tr>
<td>Linda Sussman</td>
<td>HIV/AIDS, orphans and vulnerable children</td>
<td>USAID/W</td>
</tr>
<tr>
<td>Caroline F. Connolly</td>
<td>RCH, HIV/AIDS</td>
<td>Mission lead</td>
</tr>
<tr>
<td>Paljor Ngudaup</td>
<td>MCH</td>
<td>Mission member</td>
</tr>
<tr>
<td>Sonja Schmidt</td>
<td>Synergy backstopping</td>
<td>Synergy</td>
</tr>
<tr>
<td>Frances Davidson</td>
<td>Nutrition - Virtual Team Member</td>
<td>USAID/Washington</td>
</tr>
<tr>
<td>Tim Quick</td>
<td>Nutrition – Virtual Team Member</td>
<td>USAID/Washington</td>
</tr>
</tbody>
</table>

V. Schedule and Duration of Activities for Assessment

The assessment is scheduled for a full two-week period. The co-team leaders and the Synergy representative will arrive in Cambodia on February 25, 2001. The remainder of the overseas team will arrive on March 11, 2001, begin work on March 12 and conclude with a debriefing of the mission and external partners on March 24.

In order for the team to get a jump-start on the work to be completed, the team will read and analyze the assessments and internal evaluations that have been completed to date prior to arriving in Cambodia. The team will also be meeting with implementing partners in Cambodia and review impact data and results achieved to date. The team will meet with host country counterparts (NGOs, host country counterparts and local beneficiaries) to receive their feedback on the performance of the implementing partners. The team will visit project sites to assess the performance of portfolios and discuss strengths and limitations of the portfolio.

VI. Expected Deliverables

Each team member is expected to produce a designated section to feed into the draft report which will be submitted to the USAID mission before leaving the country. The final report will be submitted to USAID/Cambodia by the Co-Team Leaders by April 9, 2001.
ANNEX B: OTHER DONOR FUNDING

IO/Multilaterals

ADB

ADB’s current major program, Basic Health Services, focuses on the construction and rehabilitation of health centers and hospitals and the provision of essential drugs as requested by Ministry of Health’s National Program Center. By the end of the current program cycle (9/96-6/02), ADB’s goal is to complete construction activities of 197 health centers and 13 referral hospitals. At a budget of $25 million, it is focusing on the provinces of Kampong Cham, Kampong Chhang, Prey Veng, Svay Rieng and Takeo.

In addition, ADB recently launched a $600,000 grant activity to increase human capacity of the National AIDS Authority (NAA). It will run from March 2001 to July 2002. Also in March, in response to flood damage to health facilities, ADB funds the “Emergency Flood Rehabilitation Project”. This is a six-month, nationwide program to renovate or reconstruct 88 health facilities and 15 hospitals affected by flood.

The plan will be succeeded by the Health Development Project upon completion of ADB’s Basic Health Services program. It’s proposed to cover the period 2002-2004 and have a budget of $30-40 million. The goal will be to complete construction/rehabilitation of the remaining 65 health centers and all referral hospitals Kampong Cham, Kampong Chhang, Prey Veng, Svay Rieng and Takeo, construct district pharmacies in 3 districts in Kompong Cham (Tboung Khmum, Ponhe Krek and O Riangor) and complete construction/rehabilitation of OD offices and warehouses.

European Commission

The European Commission/UNFPA Initiative for Reproductive Health in Asia is a regional program that also covers Bangladesh, India, Laos, Nepal, Pakistan and Vietnam. It focuses on the reproductive health needs of adolescents, including HIV/AIDS, and NGO capacity building. This $6.8 million program will end in December 2001. Working with the European NGO’s SCF (UK), CARE, PSF, MEMISA (CORDAID), ALLIANCE, IPPF, Health Unlimited, the program focuses on the provinces of Kratie, Phnom Pehn, Battambang, Kg Cham, Kampot, Sihanoukville and Battambang.

Bilaterally, the EC currently has two activities. The first focuses on sexually transmitted diseases and HIV/AIDS. The $276,000 is carried out by Médecins du Monde exclusively in Phnom Penh over the period of 4/99-3/02. Activities include testing and treatment for STI’s, medical care for the poor and free HIV testing and medical care for HIV-positive individuals.

The second program is regional and addresses malaria control for Cambodia, Laos and Vietnam. Activities for Cambodia have a budget of $4.19 million for the one and one-half year period 1/98-9/01. It is being carried out in collaboration with Ministry of Health’s National Malaria Control Center in Kompong Cham, Kompong Speu, Kampot, Battambang, Pursat, Mondoliri, Ratanakiri, Koh Kong, Kratie and Kompong Thom provinces.
There is discussion in Brussels to expand EC health activities in Cambodia. However, no new programs are foreseen for the next two years.

**UNFPA**

This year, UNFPA entered its second country program for Cambodia. The five-year, $26 million program has three subprograms. The reproductive health sub-program, with a $21 million budget, is designed to strengthen the technical and program management capacity of reproductive care providers and program managers (in collaboration with WHO, UNICEF and GTZ), strengthening of midwifery skills through four-month, in-service midwifery training courses for those with only secondary-level education to be conducted by regional training centers and curriculum development for midwifery course.

Through the second subprogram, reproductive health commodity security, UNFPA plans to procure partial supply of condoms for social marketing and fully supply pills for the public sector.

The population and development strategies subprogram is designed to lead to the adoption of a gender-sensitive national population and development policy; integration of population and gender concerns in sectoral development plans and strategies; utilization of census data by policy makers, program planners and other development partners. It has a budget of $2.5 million.

As part of advocacy subprogram, UNFPA plans to take responsibility of the reproductive health component of NCHAD’s 100% Condom Use in Brothels pilot programs in Battambang province, ½ of Phnom Penh province and the port of Sihanoukville. The budget for this activity is $2 million for the period 2002-2004.

Lastly, UNFPA and the European Commission (EC) have a joint program, Initiative for Reproductive Health in Asia, which is described below in the EC section.

**UNICEF**

UNICEF’s Master Plan of Operations covers the period of 2001-2005 at a budget of $67.78 million. Focusing on the provinces of Stueng Traeng, Kampong Thom, Prey Veaeng, Svay Rieng and Kampong Spueu, its objective is to advocate for child rights and to develop human resources and strengthen public and private institutions.

In 2001, UNICEF is carrying out several health and nutrition programs, as well as a subprogram for essential drug procurement and improved drug management. In collaboration with UNFPA, WHO and GTZ, it is also supporting capacity building to strengthen safe motherhood/birth spacing activities.
WHO

WHO is focusing on the development of health policies and sustainable health services. Its activities also strive to address poverty alleviation and gender equity. For the period 2001-2005, WHO has a projected budget of $33.5 million.

For the period 2000-2001, WHO’s budget is $6.7 million, of which $3 million are from core funding. Its country program has three main components: strengthening health sector policies, systems and partnership, improved access and quality of health services, and technical support to environment health activities, with proposed tobacco control activities. WHO will collaborate with other UN agencies in carrying out its program.

Specifically, the organization will address the capacity building needs at all levels. To improve health services, WHO is providing technical support, training, supplies and equipment to strengthen the rural health infrastructure. It will also provide drugs for the prevention and control of malaria. In collaboration with UNFPA, UNICEF and GTZ, WHO is participating in a Safe Motherhood/Birth Spacing Services Strengthening scheme.

World Bank

The World Bank Disease Control and Health Development Project will end in 2002. The five-year program’s objective has been to provide national program support for the country’s malaria, TB and HIV/AIDS control programs. Its $30.4 million budget includes $10 million for construction/rehabilitation of buildings and $6 million specifically for HIV/AIDS activities. Other activities under this program include technical assistance to NCHAD, provision of essential drugs, HIV/AIDS test kits, IEC for HIV/AIDS and office equipment for provincial-level HIV/AIDS offices. The World Bank’s activities have focused on the needs of the central government, as well as those of the provinces of Siem Reap, Ratanakiri, Battambang, Kampong Thom, Kratie, Pursat, Kampong Speu, Kandal, Kampot, Phnom Penh and Krong Kep.

The Disease Control and Health Development Project will be followed by the “Health Sector Support Project”. Also a five-year program, it is proposed to expand the activities of its predecessor to health-center level, provide DOTS at rural level and strengthen existing monitoring systems. The budget for this new program has yet to be determined.

Bilaterals

AUSaid

Bilaterally, AusAID is focusing on capacity building at both the central and district levels, immunization and HIV/AIDS. In Kompong Cham, it is concentrating its activities on Tboung Khmum, Ponhe Krek and O Riangor districts. AusAID’s implementing partner is ACIL. The current program, Cambodia Health Promotion and Primary Health Care Project, has a $6.92 million budget and will complete its five-year program cycle at the end of 2001.
AusAID’s assistance focuses on three major activities. The first area is capacity building of National Centre for Health Promotion to develop health education and primary health care programs. Secondly, it is strengthening the capacity of the Kompong Cham Regional Training Centre to provide training to health staff in management, health promotion and clinical skills. Lastly, AusAID is strengthening the capacity of health staff in Kompong Cham province and 3 operational district-level individuals to improve health care and to establish and strengthen the primary health care network from district through to village level.

AusAID is considering expansion beyond the current three districts and to include health promotion and linking current district activities with community health centers. No final decision has been made.

To address the country’s immunization needs, AusAID provides $1.58 million to WHO and UNICEF under its “Expanded Program on Immunization”. The current program cycle will be completed end-2002 and will be renewed for another three-year cycle. Specifically, its objective is to reduce sickness and death due to six diseases (TB, diphtheria, pertussis, tetanus, measles and poliomyelitis) through the immunization of all infants under one year of age and the immunization of pregnant women.

Cambodia also receives AusAID assistance under the Mekong Sub-regional HIV/AIDS Grant Facility Program (SEARP). It is a one-year program with a 2001 funding level of $52,800 with the objective of improving the lives of individuals in this region in several development sectors. Specifically, AusAID is working with Cambodian Red Cross in Battambang, Cambodian Health Committee in Svey Reing, PSBI in Poipet, Khmer Buddhist Association in Thmar Puok and NCHADS home care in Siem Reap. Still to be launched in 2001 under the SEARP project is one-year support to KHANA in Kompong Cham, MSF in Svey Pak and Cambodia Health Committee in Svey Reing.

CIDA

CIDA’s activities in the health sector are currently quite limited. However, it is strongly considering increased activity in the health sector. There was an October 2000 mission and the follow-up visit at end-March will result in a final determination.

One of CIDA’s current programs falls under its Counterpart Fund Program. The objective of this activity is to improve human capacity of government health officials at the district and provincial levels. It has a revolving, three to five year cycle with a current budget of $2.6 million. Funding for these programs comes from the sale of Canadian wheat flour to Cambodia. Proceeds go into the Counterpart Fund. The MoH and CIDA co-chair a committee that reviews NGO proposals. Only proposals that have been written in collaboration with district or province-level officials will be considered.

CIDA’s second activity in Cambodia is a new HIV/AIDS prevention and care program that is carried out through World Vision. The two-year (2001-2003), $259,000 activity focuses on the Route 1 highway area.
DFID

DFID’s current activities are limited to two new programs and general support to WHO for health system reform. However, after ten years, its support for the latter will end in December 2001. DFID’s current programs are carried out through PSI. The first is a regional program, which was recently approved and will support the NGO for two years at a budget of $2.93 million. These funds will support the establishment of a regional office in Bangkok to carry out lessons learned and develop new models for 4 pilot programs. Note that a small portion of the funding will support condom procurement for Burma. The second PSI program will support condom packaging and for the first time some administrative costs, as well. This five-year initiative has a total budget of $8.35 million.

Looking forward, DFID is currently finalizing a $14.65 million, five-year proposal. A design team will go to Cambodia in April 2001 and final approval is expected in October. With $5.13 million earmarked for IEC, DFID is considering a BBC proposal for a nationwide, multi-year mass media campaign to raise HIV/AIDS awareness and on how to make better health care decisions. Indirectly, it would also build RCG capacity through their participation. The proposal expected in March 2001. Other components of the new program may include funding of UNAIDS to support NCHADS and strengthening of UNAIDS South East Asia regional office to conduct sentinel surveys.

FRENCH AID

The French are continuing their long-term support of both the Calmette hospital with the provision of equipment, budget and surgical staff and the Medical School with the provision of faculty.

GTZ

The German-Cambodian Health System Development Project is in its second cycle (01/00-12/03) with a budget of $3.55 million. It provides support at the national level, as well to the districts of Baray Santuk, Treal, Prasat, Krova in Kampong Thom province and Kampot district in Kampot province.

At the national level, GTZ provides technical assistance to the National Institute of Public Health (NIPH) and the above-mentioned provinces. In collaboration with WHO, UNICEF, MSF and AusAID, GTZ provided a second 6-month course for province and district-level health service managers. Collaborating with SEAMEO TROPMED, University of Thailand, the goal is to expand this course to develop a masters degree program. Discussions have also begun with University of Heidelberg to develop a doctoral degree program.

By the end of this program cycle, GTZ envisions Kampong Thom to be a model province. To achieve this goal, it is carrying out the following activities: through the UNFPA-led activity, it is providing technical support for strengthening safe motherhood/birth spacing services and supports a public health advisor; management capacity and service provision. It is providing financial support for the province director to begin his MPH coursework. In collaboration with
the Mother and Child Center, 86 women will receive family planning training; strengthening of
the province hospitals’ financial and systems, a financial cost analysis system will be developed
in collaboration with the NIPH. A decentralized province-level health data system will also be
created and provision of family planning services to be offered in all health centers.

In Kampot, GTZ is focusing on health system development activities. Here it is also funding a
public health advisor to work through the UNFPA-led technical support for strengthening safe
motherhood/birth spacing services activity. The German Development Department (DED) is
supporting two newly recruited safe motherhood/birth spacing trainers, who are expected to start
7/01. In order to strengthen the province’s management capacity, GTZ is supporting the
Regional Training Centre via a one-month practical coursework for nursing students. This
activity is also related to a four-month midwifery training activity that will be carried out in
cooperation with UNFPA. Lastly, GTZ is also developing a two-year midwifery course for
individuals with only primary-level education.

GTZ recently submitted two proposals for approval. The first is for a risk insurance activity,
targeting garment workers. It would be a four-year, $715,000 activity. The second is intended to
increase prevention and awareness-raising activities, with a focus on youth, prostitutes and
garment workers. It has been proposed as a $2.85 million, four-year program for Kampot Thom
and Kampot.

**JICA**

Maternal and child health (MCH) and tuberculosis are JICA’s focus areas. Its current MCH
project is in its second cycle (4/00-3/05) with a budget of $5 million. With a geographic focus of
Phnom Penh, JICA is carrying out several activities through its partner, International Medical
Center of Japan. Specifically, it is building capacity of the the country’s health staff through the
establishment of management systems and a training division. At the rural level, it is also
providing training for various staff.

JICA is also providing hardware in the form of hospital equipment maintenance and repair,
provision of midwife kits, traditional birth attendant kits, operation sets and IEC equipment.

JICA’s “National TB Control Project” is approximately at the half-way point of its program
cycle (8/99-7/04). With a $5 million budget, JICA is focusing on the needs of Phnom Penh and
working with its partners, Japan Anti-Tuberculosis Association: Research Institute of
Tuberculosis and the National Institute of Infectious Diseases in Japan. JICA is focusing on
human capacity building, development of IEC and teaching materials, research on TB prevalence
and drug resistance, and provision of HIV tests for TB patients.

JICA is currently planning for its next fiscal year and is considering the long-term provision of
the country’s TB drug needs beginning in 2002. However, activities may only begin with one
pilot province. Final decisions are scheduled to be made in April.
KfW

KfW is currently providing all public-sector commodities (except for pills, which are supplied by UNFPA). However, KfW may be considering terminating its health sector activities in Cambodia. GtZ will try to convince them otherwise during 20-22 March mission to Cambodia.

Foundations

David and Lucille Packard Foundation

The Packard Foundation will support AVSC’s Reproductive and Child Health Alliance (RACHA) for the period 2001-2006. With the objective to provide Sustainable family planning and reproductive health services, this $2,600,000 award will focus on four provinces - Kampong Cham, Svay Rieng, Takeo and Prey Veng. However, since Cambodia is not one of Packard’s priority countries, this grant will probably be a one-time award.

SUMMARY OF DONOR FUNDING LEVELS (PHN Sector/Cambodia)

<table>
<thead>
<tr>
<th>DONOR</th>
<th>PROGRAM CYCLE</th>
<th>BUDGET SUS millions</th>
<th>ANNUAL BUDGET SUS millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Bank</td>
<td>1997-2002</td>
<td>$30.40</td>
<td>$6.0</td>
</tr>
<tr>
<td>ADB</td>
<td>1996-2002</td>
<td>$25.00</td>
<td>$4.5</td>
</tr>
<tr>
<td>WHO</td>
<td>2000-2001</td>
<td>$6.70</td>
<td>$6.7</td>
</tr>
<tr>
<td>UNICEF</td>
<td>2001-2005</td>
<td>$67.78</td>
<td>$13.5</td>
</tr>
<tr>
<td>UNFPA</td>
<td>2001-2005</td>
<td>$26.00</td>
<td>$5.2</td>
</tr>
<tr>
<td>European Commission</td>
<td>1999-2002</td>
<td>$4.50</td>
<td>$1.5</td>
</tr>
<tr>
<td>DFID</td>
<td>2001-2005</td>
<td>$26.00</td>
<td>$5.2</td>
</tr>
<tr>
<td>JICA</td>
<td>1999-2005</td>
<td>$10.00</td>
<td>$2.0</td>
</tr>
<tr>
<td>GTZ</td>
<td>2000-2003</td>
<td>$3.55</td>
<td>$1.2</td>
</tr>
<tr>
<td>CIDA</td>
<td>2001-2005</td>
<td>$2.90</td>
<td>$500,000.0</td>
</tr>
<tr>
<td>AUSAID</td>
<td>1997-2001</td>
<td>$6.92</td>
<td>$1.3</td>
</tr>
<tr>
<td>FRENCH AID</td>
<td>1996-2001</td>
<td>$2.50</td>
<td>$500,000.0</td>
</tr>
<tr>
<td>Packard Foundation</td>
<td>2001-2006</td>
<td>$2.60</td>
<td>$500,000.0</td>
</tr>
</tbody>
</table>
ANNEX C: ORPHANS AND VULNERABLE CHILDREN

I. Background in Cambodia

Eighty-five percent of Cambodians live in rural areas, are poor, and lack access to the most basic services. Of the 11.4 million people living in Cambodia, 52 percent are less than 18 years old. Among school age children, only 52 percent of primary schools offer all six grades. By the age of 15, less than 5 percent of children are still in the education system. (Reference: UNICEF-Community Action for Social Development (CASD); 1996-2000; Investing in Children; Master Plan of Operations of the County Program of Cooperation 2001-2005; the Royal Government of Cambodia and UNICEF 11/2000) Many factors make children vulnerable in Cambodia, nearly all of the related to poverty. Girls have more vulnerability factors than boys do, and the most vulnerable age is 7-12 years. The most vulnerable children overall are orphans from poor families. (KHANA’s appraisal of the needs and resources of children affected by HIV/AIDS)

Cambodia and Thailand currently have the highest proportion of orphans in Asia who have lost their mother or both parents due to AIDS. (re report on Global HIV/AIDS Epidemic, ZUNAIDS/WHO, June, 1998 – from KHANA Appraisal of the needs….in Cambodia) Predictions for the end of 2000 based on surveillance figures from 1998, show that over 5 percent of all infections are likely to be in children under 18 years and that approximately 7,500 children will have died of AIDS. (KHANA’s appraisal of the needs of children). NCHADS estimates that there are 40,000 children orphaned due to AIDS in Cambodia. (Securing a Future, Mekong Children and HIV/AIDS April 2000, UNICEF East Asia & Pacific Regional Office, Bangkok) These numbers vastly underestimate the number of children affected by HIV/AIDS, which would also include those whose father has died, those living with parents who are ill, those who are over 15 years of age, and those living in households in which the capacity – both financial and psychosocial – is severely limited as a result of caring for ill relatives or supporting orphans.

In June, 2000, an evaluation of the home care program for people living with HIV/AIDS (PLWHA) found that:

- In 21% of the families of PLWHA with children, the children had to start working since the patient became sick.
- In 30 percent of the families, the children had to provide care, or take up major additional household duties.
- 40 percent of the children had to leave school, or take significant periods away from school.
- 40 percent of the families said that since the patient became sick, the children have had to go without certain things (food, clothes, books, etc.).
- In 28 percent of the families, one or more children had to leave home. (Alliance’s evaluation of Home care program, June, 2000)
II. USAID support of programming related to children affected by HIV/AIDS in Cambodia

In FY1999, USAID received a Congressional appropriation of $10 million to support activities targeted to children affected by HIV/AIDS. The supplemental funding led to the initiation of a range of projects addressing orphans and vulnerable children in 13 countries, including Cambodia. Cambodia and India were the only countries in Asia to receive these funds, and no previous efforts directed at children affected by HIV/AIDS had been supported by USAID in these countries. Therefore, USAID had no previous experience in implementing these types of activities. Nor has there been much (if any) experience from which to learn from other donor supported activities focusing on children affected by HIV/AIDS.

Supplemental funds in FY1999 in Cambodia totaled $1 million, with the money received by projects in late 2000. Projects were implemented by Khmer HIV/AIDS NGO Alliance (KHANA) and by FHI’s Impact Project in Cambodia. The HIV/AIDS Alliance received $350,000; FHI/IMPACT received $650,000. The following describes these activities:

III. KHANA

The International HIV/AIDS Alliance builds the capacity of KHANA to mobilize and, in turn, build capacity among NGOs/CBOs to provide services and support for children affected by HIV/AIDS in Cambodia. The expected outcome is increased provision of care and support services by NGOs to children affected by HIV/AIDS in Cambodia. (Summary update 8/2000)

KHANA currently works with 42 NGOs. Fourteen of these include efforts to support children affected by HIV/AIDS. Seven of the fourteen include a primary focus on these activities; the other seven NGOs include objectives with a focus on children affected by HIV/AIDS, though this is not their primary focus. There are nine other NGOs that have long term experience working with youth, 15-21 year olds. Most of the latter target their activities to prevention of HIV/AIDS; some have begun to expand their efforts by involving youth in care and support activities.

Working with partner NGOs to respond to the growing needs of orphans and children affected by HIV/AIDS is a new area of work for KHANA that began with FY1999 supplemental funds. In 2000, in an effort to assist local NGOs to respond to children affected by AIDS, KHANA carried out an appraisal of the needs of these children and resources in Cambodia to address those needs. Over 900 people participated in the appraisal in five locations, including 413 orphans. The report was widely disseminated and findings were incorporated into technical support for partners and non-partners to contribute to the development of evidence based strategies. (KHANA’s appraisal of needs and resources of children affected by HIV/AIDS).

Through their work in HIV/AIDS prevention and care and support, a growing number of KHANA’s partner NGOs are recognizing a need to include attention to the needs of children affected by HIV/AIDS within their work. A 2000 evaluation of the home care program in Cambodia, in which a number of KHANA partners are involved, revealed that home care teams are increasingly dealing with issues related to children as part of their workload. (Alliance
evaluation of home care program) The following are some of the challenges that were identified during interviews with KHANA and partner NGOs.

A) Challenges to addressing the needs of children affected by HIV/AIDS through home based care (HBC) programs:

Education – Children are required to pay fees at the initial start-up of the school year (homes visited reported approximately 200-500 riel, depending on the level of the child); then to pay the teacher each day (could be 100-500 riel) and, also to pay private fees. The latter is a common practice since the school day is ½ day, with the teacher supplementing his/her salary through private fees. In addition, there is a cost for school materials. Teachers are very poorly paid by the government (verbal reports indicate that they receive less than $20 per month).

HBC workers have tried a number of approaches to enabling children to return to school. Some have talked with the head of the school or the teachers themselves, requesting that they waive school fees. However, decreased payment by children affected by HIV/AIDS means that others in the community might be required to somehow make up the difference. This raises the possibility of discrimination against these children. Another repercussion (check spelling?) that has been identified is that the teacher might ignore the child who has not paid the fees. HBC workers have followed-up with teachers to explain the situation of the child and to influence the teacher to address the child with compassion and understanding. Another strategy by the HBC workers has been to go through chiefs who may be able to find ways to help children remain in school. Sometimes, the workers approach NGOS to help keep children in school.

Food and other material support: KHANA provides a small amount of money to the HBC workers to provide food and other material support to their patients and their families. This enables the home based care workers to provide a little bit of rice or clothes. In addition, KHANA sometimes provides bags of rice for HBC workers to access for their patients.

Future planning: HBC workers are also trained in will writing which enables an ill parent to plan for the future of the children, even though such action does not always prevent property grabbing after the death of the parent. During discussion with representatives of NGOs, the memory project was described to them and they expressed interest in learning more about it and possibly using this type of intervention in their work. The memory book began in Uganda and has been replicated in many countries in Africa. It is a tool by which PLWHA are taught to discuss their illness and the future of their children with those children through the development of a scrapbook that contains important information about their family, their past and their future.

Placement: Placement in families that are not related to the orphans poses problems because there is often suspicion that the families may exploit the child. There may also be fear about whether the children also are infected and may also become ill. The preferred choice of placement is with relatives and others in the community, but there are NGOS that operate children centers, though these are overcrowded. There are also government run orphanages. There is no government regulation of orphanages so that there are no standards by which these institutions must operate. Wats take in boys where they are educated and cared for, but the numbers are extremely limited. Interviews conducted as part of the KHANA appraisal of the
needs of children affected by HIV/AIDS in Cambodia revealed that adults often see orphanages as the answer to placement, but children – particularly those in orphanages themselves – disagreed. Overwhelmingly children said they would prefer to live in a family within the community. Group homes do not currently seem to be an existing option in Cambodia.

B) Discrimination: (see section below)

C) Capacity building:

1. KHANA through HIV/AIDS Alliance

The HIV/AIDS Alliance seconded Alliance staff to KHANA two years ago. Alliance staff will remain in residence for approximately another year. The KHANA executive director was hired a year ago. Gradually, the technical assistance needs of KHANA have decreased and the organization has taken over many of the tasks and management originally conducted by Alliance staff.

When asked, KHANA was interested in exchange activities with other countries. The International HIV/AIDS Alliance has received Global Bureau funding for capacity building activities related to orphans and vulnerable children and it may be possible to use some of those funds to facilitate inter-country and/or inter-continental exchange to enhance capacity of KHANA and partner NGOs to address the needs of children affected by HIV/AIDS in their programming.

2. The NGOs through KHANA:

KHANA works with NGOs to build capacity in program development and management, including organizational development and financial management. Training is provided, along with small grants to carry out participatory community assessments. Once needs assessments are completed, KHANA works with the NGO to develop a project proposal which, if suitable, is funded for implementation. New grants range from $5-7,000 and well-established NGOs might receive up to $15,000. Existing partners carry out review and evaluation activities before being assisted by KHANA to re-design their projects based on the updated assessment of local need. NGOs gradually graduate to the point where they receive less technical and financial support from KHANA.

Strategies used by KHANA to provide technical support to partner NGOs include field visits, workshops, NGO exchange visits, one-to-one and general partners meetings, the provision of training and resource materials. A workshop focusing on children affected by HIV/AIDS is planned for this summer for partner NGOs. An emphasis of the workshop will be on the community-based approach to support orphans and vulnerable children. The priority of community based efforts instead of institutional care is not yet universally recognized by NGOs and is an important step in building capacity of partner NGOs to develop and implement support efforts for children affected by HIV/AIDS.
KHANA partner NGOs are required to engage in a participatory review process every year. This provides an opportunity for the organization to undergo a review of their activities with their beneficiaries, with the objective of improving those activities as a result of the information gleaned.

3. Partner NGOs to general population:

NGO partners trained approximately 15,000 people to deliver HIV/AIDS prevention, care and impact mitigation services at community level. (KHANA 2000 review report-draft)

Observations during visits to KHANA and to two of its partner NGOs:

- A workshop with 35 participants representing 22 NGOs was being conducted at KHANA.

- At the same time, NGOs working with youth were participating in workshops in a different location.

- KHANA provides home care kits to the home care teams, which contain drugs, as well as other essential items. KHANA arranges for the purchase and payment of approximately $30.00 of medications to replenish the kits on a monthly basis.

- When asked how the HBC workers learned how to do specific tasks or how the NGO was able to accomplish particular achievements, the answer consistently was that the skills came from KHANA sponsored training.

Target population reached:

Responding to the needs of children and adolescents affected by AIDS was a new area of focus for KHANA in 20000. During 2000, 14 NGO partners re-designed projects to include the support for orphans and vulnerable children. Approximately 2,000 highly vulnerable children or orphans were served by NGOs that are supported by KHANA. Current partner NGOs are in 17 provinces, including the municipalities of Phonm Pehn and Kompong Som.

Potential for expansion:

KHANA’s partner organizations are increasingly recognizing the need to include a focus on children affected by HIV/AIDS. KHANA’s is currently working with 42 NGO/CBOs. The coverage of the activities of these organizations is large and is growing, with a goal of delivering a combination of prevention and care activities to at least 200-300,000 people with an identified vulnerability to HIV/ infection. Therefore, with technical assistance and support, KHANA partners have the potential to greatly expand coverage to children affected by HIV/AIDS by partner NGOs who are already working in HIV/AIDS prevention and care.
Monitoring:

An external evaluation of KHANA will take place within the year.

In May of 2001, KHANA will review all 42 of their projects, identifying new areas of concern and new strategies to address those concerns. An annual evaluation of progress takes place through review and re-planning visits by the Alliance staff to KHANA at the end of each year.

The following are performance indicators that are gathered by supported NGOs and CBOs on at least an annual basis and reported to KHANA for ongoing reporting to the Alliance as part of the annual review process:

Number of highly vulnerable children or orphans served by NGOs supported by KHANA.  
(Total as of Dec, 2000: 2,509)

Number of highly vulnerable young people aged 15-24 years being served annually by NGOs supported by KHANA.  
(Total as of Dec, 2000): 54,000)

The following are performance indicators that are gathered by KHANA through a combination of field visits and analysis of NGO reports, then synthesized and reported to the Alliance as part of the annual reporting process.

Number or percent of NGO/CBO projects supported by KHANA offering services for highly vulnerable children (under age 15), including orphans.  
(Total as of July, 2000: 14 or 43 percent of 32 NGO/CBO projects)

Number or percent of NGO projects supported by KHANA each year offering services for highly vulnerable young people aged 15-24 years.  
(Total as of July, 2000: 9 or 25 percent of 36 NGO/CBO projects)

Sustainability:

Of KHANA:

Approximately 50 percent of KHANA’s funding is from USAID. When it began in 1997, it was totally funded by USAID. Using diversity of funding as an indicator of sustainability, KHANA has quickly moved forward along that indicator. Using technical capacity as an indicator, KHANA is also moving toward technical independence, as described above.

Of partner NGOs:

The goal of KHANA is to build the capacity of partner NGOs to the point where they no longer need technical assistance or funding. Gradually, NGOs reach the point where they no longer need technical assistance. In fact, some NGOs are now providing technical assistance to others. KHANA has set up a process whereby these “graduating NGOs” meet with donors to seek other
funding, with the goal of complete independence from KHANA. However, some of the donors that are supporting these NGOs do so only for a limited period of time. To paraphrase the statement of one of the managers of a partner NGO, “The donors all want us to be independent, so they only fund us for a short time and they expect us to get other funding – but there is only a limited number of donors in Cambodia”.

An observation: What is the meaning of “sustainability”? Perhaps there is a need to re-think the meaning of sustainability in Cambodia (and in other countries as well). NGOs will continue to need funding from donors. Even if they are able to get donor funding for the life of the NGO, would they be considered “sustainable”, because they depend on donor funding?

Impact if any activities scaled down/not continued:

KHANA is currently moving forward to address the growing recognition among its partner NGOs for the need to include a focus on children affected by HIV/AIDS in their activities. Increased funds would allow them to pursue this activity with more NGOs and the scale of these activities to reach children affected by HIV/AIDS would expand. Decreased funds would limit their ability to move ahead with this work, in the face of the growing recognition and need to expand.

IV. Mith Samlanh-Friends:

A) Background

Depending on the definition and according to the figures accepted by UNICEF, there are between 600 to 1,000 street children who have completely cut ties with their families and have made the streets their home. There are approximately 10,000 street children who have kept ties with their families and return home either regularly or irregularly. Mith Samlanh-Friends adopts the latter, wider definition of street children in targeting their activities. (survey from FHI-Dec, 2000)

B) Description:

Mith Samlanh-Friends was established in August 1994 as a non-religious association working with street children in Phnom Penh. In six years it has set up a wide range of activities to address the needs of street children and their families. The project aims to help the reintegration of street children into their families, society, the public school system, the workplace, and the culture. It is organized into eleven inter-linked programs: an Outreach Program, a Transitional Home, a Boarding House, a Training Center, an Educational Center, a Family Reintegration Program, Community Outreach Program, HIV/AIDS Awareness Program, Drug Awareness Program, Project for Incarcerated children and a child rights project. (survey from FHI-Dec, 2000)
FHI/IMPACT supports Mith Samlanh-Friends to implement 2 projects:

1. HIV/AIDS prevention among street youth (August 1, 1999-June 30, 2002)  
   (Budget: $152,139)

2. Care and support to children affected by HIV/AIDS. The latter has been supported through the FY1999 funds for children affected by HIV/AIDS. (According to the mid-term review, both projects have been funded through CAA funds – not the same info as through interview)  
   (Sept 1, 1999- Sept 30, 2001; Budget: $103,911)  
   (interview and Impact mid-term evaluation )

The Friends prevention activity provides outreach education, addresses condom use, safe sex negotiation skill building, STD symptom recognition, STD treatment seeking behavior, empowerment and self-esteem issues. (survey from FHI-Dec, 2000) The base for the HIV/AIDS prevention project is the squatter settlement of Stung Mean Chey (W- Phnom Penh). Mith Samlanh-Friends is also conducting HIV prevention activities in their Transitional Home, Boarding House, Training Center and Educational Center. (FHI/impact progress report to USAID/C Q3-Fy00) Activities include peer education programs; awareness raising activities on HIV/AIDS and life skills; treating STDs; training doctors to improve attitudes and treatment of children affected by STDs (FHI/IMPACT Cambodia progress report 10/1/00)

The care and support project identifies children affected by HIV/AIDS through the AIDS care ward of the Preah Norodom Sihanouk Hospital when a parent is in the ward being cared for as a result of AIDS related illness. The project provides support to the children while the parent is in the hospital. Many are malnourished, and Friends works with World Food Program to get them some food. They bring them to the Friends’ center during the day, though this is not supported through the care and support project budget. The plan is for social workers to follow-up with the children in an attempt to integrate them back into their extended family when the parent dies.

C) Capacity Building:

FHI/Impact and Friends seem to have had a “rocky” relationship. Friends questions the utility of capacity building efforts provided to them by FHI/IMPACT; FHI/IMPACT questions cooperation received from Friends in their work together.

D) Impact if any activities scaled down/not continued

The Friends Project has a number of donors, including: Save the Children/Aus; UNFPA; EC; UNICEF, and CCFD. USAID funding accounts for approximately 18 percent of the current budget. Therefore, if USAID funds were no longer available, the project would continue, though the director has stated that their abilities would be significantly reduced. In addition, it is unclear whether HIV/AIDS would continue to be a component of their activities, since USAID is the primary (if only) donor funding these activities.
E) Meeting its targets:

The component of Friends project that works with children affected by HIV/AIDS is reaching a very limited number of children.

The quarterly activity report dated October-December 2000 indicates the following:

Number of children with sick parents in hospital:

<table>
<thead>
<tr>
<th>Month</th>
<th>October # identified</th>
<th>October # placed</th>
<th>October # follow-up</th>
<th>November # identified</th>
<th>November # placed</th>
<th>November # follow-up</th>
<th>December # identified</th>
<th>December # placed</th>
<th>December # follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19</td>
<td>15</td>
<td>0</td>
<td>10</td>
<td>5</td>
<td>0</td>
<td>32</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Number of orphaned children

<table>
<thead>
<tr>
<th>Month</th>
<th># identified</th>
<th># placed w/ relatives</th>
<th># placed in institution</th>
<th># placed foster care</th>
<th># follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>October</td>
<td>4</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>November</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

On the other hand, the HIV/AIDS prevention activities are reaching large numbers of youth. Because the project focuses on street children, the youth that they reach are likely to be among those most at risk of becoming infected with HIV/STDs in the target area. The following are examples of statistics that were reported in the Friends quarterly report dated Oct-Dec, 2000:

Number of Behavior Change Activities

<table>
<thead>
<tr>
<th>Activity/Location</th>
<th>Total</th>
<th>Friends</th>
<th>Street</th>
<th>Boarding house</th>
<th>Stung Meanchey Center</th>
<th>Club Friends</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-Total</td>
<td>114</td>
<td>8</td>
<td>52</td>
<td>11</td>
<td>9</td>
<td>24</td>
<td>10</td>
</tr>
<tr>
<td>Boys</td>
<td>76</td>
<td>6</td>
<td>34</td>
<td>11</td>
<td>5</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Girls</td>
<td>38</td>
<td>2</td>
<td>18</td>
<td>0</td>
<td>4</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Nov-Total</td>
<td>63</td>
<td>3</td>
<td>20</td>
<td>6</td>
<td>8</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>Boys</td>
<td>42</td>
<td>2</td>
<td>12</td>
<td>6</td>
<td>6</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Girls</td>
<td>21</td>
<td>1</td>
<td>8</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Dec-Total</td>
<td>107</td>
<td>6</td>
<td>27</td>
<td>13</td>
<td>37</td>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td>Boys</td>
<td>68</td>
<td>4</td>
<td>16</td>
<td>13</td>
<td>21</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Girls</td>
<td>39</td>
<td>2</td>
<td>11</td>
<td>0</td>
<td>16</td>
<td>0</td>
<td>10</td>
</tr>
</tbody>
</table>
Number of Children/People who participated in the Behavior Change Activities

<table>
<thead>
<tr>
<th>Shows/Location</th>
<th>Total</th>
<th>Friends</th>
<th>Streets</th>
<th>Boarding house</th>
<th>Stung Meanchey Center</th>
<th>Club Friends</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-Total</td>
<td>621</td>
<td>66</td>
<td>243</td>
<td>48</td>
<td>75</td>
<td>136</td>
<td>53</td>
</tr>
<tr>
<td>Boys</td>
<td>455</td>
<td>47</td>
<td>168</td>
<td>48</td>
<td>49</td>
<td>108</td>
<td>35</td>
</tr>
<tr>
<td>Girls</td>
<td>166</td>
<td>19</td>
<td>75</td>
<td>0</td>
<td>26</td>
<td>28</td>
<td>18</td>
</tr>
<tr>
<td>Nov-Total</td>
<td>342</td>
<td>28</td>
<td>75</td>
<td>19</td>
<td>67</td>
<td>111</td>
<td>42</td>
</tr>
<tr>
<td>Boys</td>
<td>226</td>
<td>17</td>
<td>46</td>
<td>19</td>
<td>54</td>
<td>65</td>
<td>25</td>
</tr>
<tr>
<td>Girls</td>
<td>116</td>
<td>11</td>
<td>29</td>
<td>0</td>
<td>13</td>
<td>46</td>
<td>17</td>
</tr>
<tr>
<td>Dec-Total</td>
<td>864</td>
<td>59</td>
<td>211</td>
<td>62</td>
<td>455</td>
<td>0</td>
<td>77</td>
</tr>
<tr>
<td>Boys</td>
<td>526</td>
<td>41</td>
<td>124</td>
<td>62</td>
<td>257</td>
<td>0</td>
<td>42</td>
</tr>
<tr>
<td>Girls</td>
<td>338</td>
<td>18</td>
<td>87</td>
<td>0</td>
<td>198</td>
<td>0</td>
<td>35</td>
</tr>
</tbody>
</table>

It is important to note that the data above measures output- numbers of activities and numbers reached. It does not indicate whether those activities reached the participants in a way that influenced their behavior. This type of analysis would necessitate an evaluation of the outcome of the activities. In fact, though the potential to reach large numbers of vulnerable youth is evident from the data, it would be advisable to assess the effectiveness of the activities in positively influencing behavior change to reduce risk of HIV/AIDS/STDs.

The prevention component of the project has the potential to reach large number of the youth most at risk of becoming infected with HIV/AIDS in Phnom Penh. In addition, a pilot project in another location is being implemented by Friends, so that there might be potential to expand to other locations as well.

The draft (3/2001) mid-term review of FHI/Impact Cambodia includes a recommendation to phase out interventions with street children. It also suggests that potential areas of expanded assistance could be for children affected by HIV/AIDS.

**Observation:**

The component of the project that focuses on care and support of children affected by HIV/AIDS seems to have hardly started and the potential for these activities to effectively provide support to children affected by HIV/AIDS to the degree that would justify the budget allocated for this project is questionable. Therefore, the remaining funds may be better utilized to “shore up” the HIV/AIDS prevention component of the Friends project. However, the effectiveness of the current prevention program has not been systematically determined. Recommendation for transition period: Phase I. Support Friends project to assess the effectiveness of their current activities in HIV/AIDS prevention (either through the re-allocation of the remainder – if any - of supplemental funds or through other funds). If the current
activities are found to be effective or if they are able to re-design a more effective methodology that is effective, then consider Phase II: USAID/Cambodia considers funding an effective prevention program that is implemented by Friends Project, to prevent HIV/AIDS and other STDs among street children. Phase III. If Friends Project can successfully achieve Phase II, and if further funds are available, consider funding the Project to reach even further into the community – so that they can expand their prevention activities to youth who may not yet be considered “street children” but are at risk of becoming street children and are also especially vulnerable to becoming infected with HIV/AIDS. Caveat: The supplemental funds for children affected by HIV/AIDS that were provided to Friends Project for care and support have been poorly utilized. The assumption should not be made that whatever caused these inadequate results will not be repeated. Future management of the project must assure that plans are developed and implemented in a timely manner that assures an agreed upon level of effectiveness, quality and coverage.

V. NYEMO Counseling Center for Woman and Children Cambodia

NYEMO I was established locally in Cambodia in 1997 with an initial focus on specialized vocational training for vulnerable women in Phnom Penh. The majority of the women graduating from the project had been abandoned by their family or had been orphaned. Funding was received from ECHOL, WFP, Canada Fund, Redd Barna, CCFD and private donations. In June 2000, NYEMO II expanded its focus to improve the quality of life for women living with HIV/AIDS and their children. This project is supported by UNICEF and FHI/IMPACT. It is being implemented in two phases (June, 2000-Feb 2001 and March-September, 2001) (3-page description received from NYEMO)

Phase one activities include initial implementation:

- A network for collaboration with referral to vocational, psycho-social and medical services is established in Phnom Penh for the program beneficiaries;
- A drop in center for underprivileged mothers and their children is organized;
- Psycho-social, medical and recreational activities are organized for the beneficiaries of the Counseling Center;

Phase two began in March and plans are to include the following:

- Women with their children living with HIV/AIDS will be empowered to face their current situation and to plan their future;
- The beneficiaries of the project will have improved access to health care facilities and psycho-social support services;
- The beneficiaries of the project will practice self-care;
- Orphaned children of women beneficiaries will be placed in extended and/or foster families;

In addition, capacity of the staff will improve to manage and implement the project. (3-page description provided by NYEMO)

Drop-in center activities include educational sessions on sexual and general health and skill training; women’s rights; behavior change; AIDS education; capacity building; gender;
NYEMO has initiated a self help group among the beneficiaries. Members accompany sick women and children to health services and also care for the children in the center if mothers are in hospital. NYEMO has also set up an internal kindergarten in the center, with activities organized by women beneficiaries. A referral system has been set up to five different health facilities in Phnom Penh for women and children when needing follow-ups for pregnancy, vaccinations, STD treatment; treatment of opportunistic disease; support for children; mental health care; and Nevirapine treatment for HIV+ women. NYEMO also organizes free STD consultation and treatment. Women contacted through NYEMO II are offered the opportunity to be enrolled in the professional training courses offered by NYEMO I. (FHI/Impact Cambodia progress report 10/1/00)

For women who are single and destitute mothers, temporary shelter is provided for 20 women and their children. Women in the shelter are supported to identify and develop alternative accommodation. Reintegration within the extended family is facilitated and monitored. Beneficiaries of the project are assisted in preparing for the care of their children when they are ill or die, through fostering in the extended family or through other women-to-women support networks.

The project was designed in collaboration between NYEMO and UNICEF and FHI/Impact. FHI provides 50 percent ($65,000) of the funding, as does UNICEF. FHI provides technical assistance. (per interview with Simone) (the mid-term review identifies the budget as follows: May 1, 2000 – September 31, 2001; Budget: $178,968)

A) Coverage:

The number of women who regularly attend the Center (between June 1, 2000- March 15, 2001) is 275. These women have received a total of 1,223 consultations. The project includes both HIV+ and HIV- women. Approximately 50 percent of the women in the residential shelter are HIV+; approximately 30 percent of the non-residents are HIV+. According to the director, there is a great need for the project as is evidenced by the fact that they are always full to capacity and must sometimes turn away women and their children.

B) Monitoring and Evaluation:

NYEMO maintains its medical quantitative database using EpiInfo and another database for reporting social indicators. They submit medical and social quantitative reports on a monthly basis. A qualitative survey tool is currently being developed by NYEMO and will be submitted to FHI/IMPACT for feedback at the end of March. A preliminary qualitative survey of residential clients to determine client satisfaction indicated that 70 percent were satisfied.
C) Capacity building:

There are 35 Cambodian staff members. The director explained that training will continue to raise the capacity of the staff so that they can take over the project and become a local NGO. FHI/IMPACT training for the staff has included proposal and report writing. IMPACT has also helped NYEMO staff to develop an abstract and presentation for the Regional Meeting on HIV/AIDS that will be held in October, 2001, in Australia. (See information below for other FHI/IMPACT capacity building activities)

NYEMO works with a network of many NGOs with whom they share information, ideas, experience, and referrals. As indicated in the description of educational activities above, training for beneficiaries is shared by the NGOs within this network.

D) Sustainability:

NYEMO is in the process of attaining NGO status. Staff are being trained, with the goal of a Cambodian-run local NGO. The project is fairly new, however, so that it is not expected that the project can effectively achieve sustainability (neither financially nor technically) by the end of the contract, Sept, 2001. The director pointed out that the other NGOs with whom they are working as a network are all faced with challenges regarding fund raising, report writing, etc. She suggests the potential of this group to eventually create a federation that might be able to work together to decrease costs and a more sustainable way of supporting their projects.

E) Impact of scaling down activities:

According to the director, NYEMO will continue to receive funds from UNICEF, though it is unclear how long that funding will continue. Decreasing USAID funding would have a significant impact on the project, especially if this were to occur within a time frame that would not allow them to seek alternative funding. With a longer time frame and explicit planning for phasing out USAID funding, NYEMO has the potential to develop technical and financial sustainability.

Other projects supported by FHI/Impact that focus on children affected by HIV/AIDS:

In February, 2001, FHI/IMPACT signed subagreements to begin three new projects focusing on children affected by HIV/AIDS:

(The following information came from the subagreements between FHI and the projects)

1. Children in Distress (CID): Piloting Interventions for Children Affected by HIV/AIDS in Koh Kong. The implementing organization is CARE International in Cambodia. The agreement is from Feb 15 – Sept 30, 2001 for $35,776. (the mid-term review of FHI/IMPACT Cambodia has different information, indicating that the budget is $43,299)

The goal of the CID project is to increase the physical and mental well-being of children/adolescents affected by HIV/AIDS and their families through the provision of integrated
and comprehensive HIV/AIDS prevention, care and support services in the Mondol Seima and Smach Meanchey Districts of Koh Kong, Cambodia. The following are objectives toward achieving this goal:

- A life skills and STI/HIV/AIDS prevention program will be developed for vulnerable children and adolescents in the target communities in an effort to reduce their exposure to HIV infection;
- A team consisting of one CARE staff and five youth advocates will work in conjunction with Community Caring staff and partners to provide, monitor and evaluate prevention, care and support services to children/adolescents affected by HIV/AIDS and their families in targeted areas.
- The capacity of the target communities to support children/adolescents affected by HIV/AIDS will be enhanced over the life of the project.

2. Community Support Project for Children Orphaned by chronic illness of their parent(s), including AIDS – Phase one. The implementing organization is Kien Kes Volunteer Network in Battambang. The agreement is from Feb 15-Sept 30, 2001 for $9,042.

The Kien Kes Volunteer Network is a local Cambodian organization, managed and directed by Cambodians. The Network was established in response to an assessment of the needs and capacity of Cambodian military to become involved in care and support programs for children affected by AIDS, which was contracted by FHI/Impact Cambodia and conducted in July 2000. Recommendations from the assessment were that the military in Thmor Kol District are very motivated to be involved in care and support activities for PLWHA in their community. The report also indicated that ongoing supporting activities for children such as the project in Wat Norea are strong interventions which have already gained substantial experience in care and support for PLWHA including children and involving the community in care and support.

The Network’s plans have evolved from a collaboration between the military unit in Thmar Kol, the activities of the Venerable Monk Mony Saveth from Wat Norea, and input from FHI/Impact and the NGO, Buddhists for Development. The main goal of the Kien Kes volunteer Network is to ensure that children and their family members affected by chronic illness, including AIDS, receive assistance and support from the community in which they live, and that the community does not discriminate against PLWHA. The Kien Kes project aims to develop a volunteer network involving the local communities in Thmar Kol, monks in the local Pagodas, and the military infrastructure to reunite children with their families, recognizing that functioning families are the most important unit for providing care and love to children. Family reunification is achieved by providing psychosocial, material, technical, and/or financial support to both the children and their family members.

3. Care & Support Project for Children Orphaned by chronic illness of their parent(s), including AIDS – Phase one. The implementing organization is Meahto Phum Ko’Mah (Homeland) in Battambang. The agreement is from Feb 15-Sept 30, 2001 for $21,703.

Meahto Phum Ko’mah (Homeland) is a local Cambodian NGO established in 1997 to address the situation of children living on the streets of Battambang town. The goal of the project is to
improve the quality of life of children orphaned by chronic illness of their parent(s), including AIDS, within 8 target communes in Battambang town and to strengthen community mechanisms for care and support of orphans, including fostering. It is a 3 year project, to be implemented in two phases. Phase one will be implemented from February until September 2001, and Phase Two will be from October 2001-January, 2004. FHI/Impact has agreed to provide funding support to Phase One of the project. Conditional to the availability of funds, FHI and Homelands will discuss possible continued funding. It should be noted that UNICEF has already committed to providing financial support to the project after Phase One.

VI.  Capacity building by FHI/IMPACT for projects focusing on children affected by HIV/AIDS:

FHI/IMPACT works with projects that focus on children affected by HIV/AIDS through project design, implementation, and evaluation. Technical assistance is provided, beginning during initial design. The following are examples of assistance provided to the five projects currently being supported to focus on children affected by HIV/AIDS:

- Research on street children and their risk for HIV was conducted by Anne Gullou in September-November 1999 and a report was written, edited and distributed by FHI/Impact. (FHI/impact progress report to USAID/C Q3-Fy00) A summary document of the research has been developed for IEC purposes and to inform HIV/AIDS prevention strategies with street children.

- FHI/Impact facilitated a field trip to Thailand with NYEMO staff and NCHAD to visit programs focusing on children affected by HIV/AIDS. A document containing results of the field trip and lessons learned from these visits was produced and widely disseminated.

- For the two Battambang projects that are currently in the initiation stage, FHI/Impact developed a technical working group that includes representatives from the two projects, as well as provincial AIDS officers and Military Corps trainers. The latter bring to the group their experience in HIV/AIDS awareness and prevention activities. They will be involved in providing training and supervision to the new projects. The technical group will work with the projects to develop the curricula to be utilized in the project regarding HIV/AIDS prevention and care, including a focus on children affected by HIV/AIDS. They will also provide support in terms of training and supervising implementation of the curricula.

- Plans are underway for FHI/Impact, together with NYEMO, UNICEF, MOSALVY, and IOM to conduct a study on issues related to grief among children in Cambodia. Findings will be used to guide development of psychosocial support within projects focusing on children affected by HIV/AIDS.

- An assessment of lessons learned will be conducted in August among the projects. The focus will be on how to strengthen community coping mechanisms to support children affected by HIV/AIDS. (interview)
FHI/IMPACT has adapted and piloted a participatory qualitative evaluation methodology called Qualitative Participatory Evaluation (QPE). The objectives of the QPE are to evaluate the process and outcomes of ongoing interventions and is meant to be utilized on a yearly basis. (FHI mid-term review) Friends project has received training in QPE, but has not yet implemented the evaluation. The other projects are either undergoing training or will receive the training within the year. (interview)

Impact of scaling down funding for projects that focus on children affected by HIV/AIDS:

The first, and only, USAID projects focusing on Children affected by HIV/AIDS have been supported with FY1999 supplemental funds, but the funds were not received by projects until late in 2000. Therefore, these projects have just begun; some are still in the design phase. Those that have already begun and seem to be on their way to implementing a potentially effective program include NYEMO and KHANA. Those that have only just begun are Homeland, Kien Kes Volunteer network, and Children in Distress. These represent different models of identifying and working with children affected by HIV/AIDS and there is much to be learned from their various programming models. It would be a loss to allow them to die without: 1) maximizing their potential to continue through a concerted effort to work with them toward sustainability within the transition period; and 2) analyzing and documenting lessons that can be learned from these various models to inform future interventions focusing on children affected by HIV/AIDS in Cambodia (and in other parts of Asia). However, in order to assure both of these objectives, more than just additional funding would be necessary. It would also be necessary to assure that appropriate technical assistance is available and committed to accomplishing these objectives and regular progress toward achieving those goals is monitored to assure that they are reached in the short transitional period that would be available.

Issues/Challenges

In communities where HIV/AIDS prevalence is very high, as in some countries in Africa where prevalence is 10-30 percent, children affected by HIV/AIDS make up a large proportion of the most vulnerable. When developing interventions in those areas, lessons learned from Africa have led to the recommendation that communities themselves identify those children who are most vulnerable within the community. Generally, a large proportion of the most vulnerable children identified will likely be orphans, living with ill parents, living in households where increased number of dependents have drained the resources – both financial and psychosocial – of the adults in the household, or otherwise severely affected by HIV/AIDS. However, in a country like Cambodia, where HIV/AIDS prevalence is much lower and child morbidity and mortality are, in general, high (add the statistics), the most vulnerable children in a community will include only a small proportion who are affected by HIV/AIDS. Therefore, the most direct way of identifying children affected by HIV/AIDS will be to link with interventions that already identify adults who are chronically ill, and thereby, their families. In Cambodia, where home based care is beginning to expand, linking with home based care workers and hospital referral systems is a direct method of identifying children affected by HIV/AIDS.
In fact, home based care workers and others implementing HIV/AIDS prevention and care activities are increasingly identifying the needs of children affected by HIV/AIDS as a gap in the current interventions. Integrating programs that focus on children affected by HIV/AIDS with home based care activities may, therefore, be the most efficient way of identifying and implementing interventions related to children affected by HIV/AIDS. Another possibility of reaching children affected by HIV/AIDS may be the integration of those activities with other child survival interventions. This has not yet been a model that USAID HIV/AIDS activities have yet employed and might be an area that is further explored by the strategy team.

- Fear/stigma and discrimination against PLWHA and their families was repeatedly described throughout the interviews with implementing partners and has been identified through assessments conducted in Cambodia in 2000. In addition, changes resulting from care and support activities were also reported. NYEMO, for example, reports that HIV/AIDS education and daily association among women at the center have led to an environment at the Center where seropositivity has been normalized and there is no longer stigma or fear associated with those who are HIV+. One of the KHANA partner NGOs, conducting home based care in a squatter area of Phnom Penh reports a great deal of stigma toward PLWHA. However, the observation was made that the stigma seems to be a result of fear of becoming infected and that it decreases when the project begins its work to provide care and support. The workers attribute the change in attitude to be a result of the community members’ observation of the close contact between HBC workers and their patients. In this way, the community learns fear of becoming infected by the PLWHA is unfounded.

- Linking prevention and care and support activities: Many of the activities visited and discussed are currently linking prevention and care and support activities. Some have begun as prevention projects and, by necessity, have begun to expand to include care and support. Others are primarily focused on care and support but have recognized that prevention is of utmost importance in their work. There are many models in which prevention and care and support are integrated. Whatever model is used, it is important to consider the provision of both prevention and care and support in an integrated program design.

VII. Potential partners with whom USAID might consider collaborating on activities related to children affected by HIV/AIDS:

- World Food Program: The lack of food is a consistent problem identified through the activities focusing on PLWHA and their families. During a few of the interviews, mention was made of food received from World Food Program. These include SFODA (a KHANA partner NGO), the children’s centers through the Dept of Social Welfare, Friends, and others. Types of food provided have been canned fish, rice, oil, and a small amount of flour. Also mentioned was that the food provided from WFP must be supplemented because it does not provide a nutritious diet. There are potential benefits and potential drawbacks for incorporating food into care and support programs, including those that include a focus on children affected by HIV/AIDS. The FANTA Project,
supported by the USAID Global Bureau has received funding to address some of the issues related to coordination between food provision and HIV/AIDS. Though USAID programs have been recently initiated to combine Title II food distribution and HIV/AIDS activities in Rwanda and Malawi, there remains little information about optimal models of integrating these activities.

- **UNICEF:** The Government of Cambodia and UNICEF identified a set of priority problems affecting children and women. These include MTCT; HIV+ children and AIDS orphans; discrimination, including against PLWHA; unprotected sex among adolescents; and HIV/AIDS/STDs. Related priorities include: street children; child labor; access to basic services such as health, education, water, sanitation, household food security; TB; child abuse; neglect; exploitation; trafficking, etc. UNICEF supported the CASD program as an integrative approach to child survival, care, growth and development in 6 of the poorest provinces in the country. Through Village Development Committees, 600 villages prepared village action plans centered on the rights and needs of children and women. A stand-alone HIV/AIDS project was established after 1998. The following are targets for the year 2005:
  - PMTCT in all national hospitals with maternity wards and 50 percent of provincial hospitals
  - Availability of VCT in all national hospitals and 70 percent of provincial referral hospitals
  - Widespread awareness of HIV/AIDS, general knowledge in its modes of transmission, and adoption of protective behavior by 60 percent of the sexually active population and by 80 percent of adolescent and high risk groups
  - Access to recovery, health care, and psychosocial support for 70 percent of children affected by HIV/AIDS and development of family and community care practices for PLWHA

UNICEF supports HIV/AIDS activities through two sets of activities: 1) the Children in Need of Special Protection (CNSP) program includes a focus on children affected by HIV/AIDS; and 2) the HIV/AIDS program, which also includes a component that includes a focus on children affected by HIV/AIDS.

UNICEF/Cambodia plans to support MOSALVY to conduct an assessment on institutional and non-institutional approaches to vulnerable children. The analysis will identify problems and define potential options of care, including community care. There are currently no guidelines for institutions, and they remain unregulated. This assessment can thus be used to support the development of policies and regulations regarding institutions.

A couple of the projects currently being funded by USAID to support efforts focused on children affected by HIV/AIDS are also funded by UNICEF. There is a great deal of potential for further collaboration in the future on this issue and on others, as well. During a meeting with the UNICEF/Cambodia Program Coordinator and the HIV/AIDS coordinator, interest in collaboration between USAID and UNICEF was reaffirmed and plans to follow-up were made.
The meeting also included a representative from the Regional UNICEF office in Bangkok who was interested in pursuing discussion about collaboration at the regional and/or global level. For example, the possibility of collaborating on support of sessions focusing on children affected by HIV/AIDS at the upcoming regional meeting on HIV/AIDS in Australia was discussed as a possibility.

VIII. Recommendations to Strategy Design Team:

- Linkage between HBC, OVC, and VCT (including antenatal testing in MTCT) must be explicitly acknowledged and planned for. Linked programs will contribute to the effectiveness of these activities through identification and referral of project recipients. More than that, however, are the ethical considerations of, for example, providing patients with information that they are seropositive and a post-test counseling session in an area where there may be no on-going support for the PLWHA and their families (as well as the possibility of heightened stigmatization and fear surrounding the disease).

- KHANA has discussed with UNICEF and with Save the Children/UK the possibility of conducting a quantitative assessment of children affected by HIV/AIDS, to follow-up on the qualitative assessment conducted by KHANA in 2000. USAID/Cambodia might want to consider supporting a collaborative effort among a broad array of government, donors, NGOs and other stakeholders to conduct a national assessment similar to the joint effort of UNICEF, USAID and other stakeholders in Zambia. The joint assessment on the needs, resources, and gaps in a response to children affected by HIV/AIDS in Zambia was the beginning of an ongoing process of collaboration. The assessment provided information to guide a collaborative response. In addition, this type of collaborative effort has the potential to initiate a process that can maximize the effectiveness and the efficiency of follow-on activities through continued coordination among stakeholders.

Policy related information:

MOSALVY: NYEMO is working with MOSALVY to identify ways to provide foster care for orphans. For example, MOSALVY has social workers (funded through UNICEF) who may be able to provide follow-up support to women who return to their rural areas. NYEMO and other NGOs are signing an MOU with MOSALVY and MOH.

The Social Welfare Department of MOSALVY supports 20 children’s centers located in Phnom Penh and the provinces. The statistics for these centers is unclear, but the deputy director of the Department mentioned that there may be over 2,000 children being cared for. The Department operates a Children’s Center, located near Calmette Hospital in Phnom Penh that cares for
babies abandoned in the hospital. Babies are tested after one year. Those who are HIV- are adopted and those who are HIV+ are cared for at the Center until they die. MOSALVY provides 15,000 riel per month per child. This amount is also all that would be available under current policies for other children for whom the government may be responsible, such as orphans.

NCHADS: NCHADS supports home based care in Phnom Penh and in other provinces. HBC workers consist of health personnel, NGOs, and volunteers. PLWHA are in need of more than medical care. Psychosocial support is needed by the PLWHA and by the family. In addition, HBC reaches very poor households and there is often a need for material support such as food or transport to the hospital. These are not currently part of the HBC package, though NGOs are sometimes providing these through their own budgets. There is a potential niche for USAID in funding the expansion of social support, including support to children affected by HIV/AIDS, to supplement the medical care provided by home based care activities. (interview NCHEDA)

National AIDS Authority (NAA): NAA was created two years ago to serve as the HIV/AIDS umbrella organization tasked with coordinating the national HIV/AIDS response for the government ministries. However, few financial and human resources make it extremely challenging for NAA to fulfill its official legal directive. The NAA policy on HIV/AIDS is in need of revision, necessitating further consultations. The National Assembly, the Ministry of Women’s affairs, and the Ministry of Health have draft policies on HIV/AIDS. The latter does not include mention of children affected by HIV/AIDS, though the first two do mention children. In addition to NGOs, efforts to address the needs of children might include MOSALVY, Ministry of Women Affairs, Ministry of Health, and Ministry of Cult and Religion. There are many barriers facing inter-sectoral work on HIV/AIDS. Except for NCHADS, the ministries are greatly lacking in human and financial resources. An example of one of the barriers is that documents are frequently not translated into Khmer, and this makes them inaccessible to some Ministry personnel.

A personal thought about continued support of the Speak Out project, working with a network of NGOs and sex workers which is currently supported by FHI/IMPACT:

There are a number of reasons to consider continuation of funding for the project, at least until it can be evaluated:

- The project modifies a successful model of intervention among sex workers that was implemented in Calcutta, India, and has been attributed to reduction of HIV/AIDS and STDs among sex workers, among many other benefits to the sex workers.
- The intervention model in Cambodia is a more realistic and reproducible model in Cambodia and in other countries that do not have the extensive brothel areas found in Calcutta. The lessons learned from this activity – whether it is found to be successful or whether it fails – could provide valuable input into future efforts among sex workers in Cambodia and in other countries.
- USAID is the sole funder of this activity. Unless it is given a reasonable amount of time and support to seek alternative funding, the project is unlikely to continue. Therefore, the potential that this project represents will be lost, in addition to the loss of the time, energy, expectations, and hope that have been invested in the project by the sex workers and their partners.
ANNEX D: HEALTH SECTOR FINANCING FOR HIV/AIDS

Health Care Utilization Patterns and Household Expenses

The sequence of basic health service utilization in Cambodia is first, managing illness at home with home remedies, then accessing traditional medicine, purchasing medicines from pharmacies and drug sellers, and finally accessing trained health professionals.

Formal public and private health systems are involved in providing HIV prevention and care services through government health workers, centers, and facilities and through for-profit and non-governmental organizations (NGOs) which directly deliver behavior change, STD management, HIV care, and condom social marketing services. In addition, networks across public and private providers of care are essential components in forming referral networks for the provision of STD services and home care.

Household Expenditure

Accessing health services and HIV prevention and care services are often a burden on household expenses. Over 10 percent of household expenditures in Cambodia are for health services – in some instances up to 50 percent in poorer households. (Economic Costs of AIDS In Cambodia: Some Preliminary Estimates, Myers) Various health professionals and NGO representatives state that many clients and beneficiaries often go into debt to access health services due to fees and voluntary contributions. Expenditures for care are due to the cost of treatment and drugs, the cost of charges for in-patient care, travel costs, food while away from home in clinical setting, and opportunity costs of time spent accessing health services. Daily accommodation costs at provincial hospitals are reported to be $2.56. Given these costs from the clients’ perspective, traditional medicine is perceived to be less expensive because accommodation costs are not needed and treatments can seem shorter. For example, charges for STD treatment when accessing traditional medicine range from $1.28 to $3.80. (Integrating Care and Support into HIV/AIDS Prevention Projects – Report on Participatory Project Reviews - KHANA Partner NGOs)

Government Funding for HIV/AIDS

Local resources available for HIV programming from NCHADS to Provinces in 2001 totaled $1.2 million where provinces received what each requested. Provincial HIV budgets ranged from $30,000 – 107,000, averaging between $40,000 - $50,000 per province. Representatives from NCHADS stated that second to USAID projected increases in funding, the public sector are likely to be the largest source of NGO funds if ADB and World Bank loans are provided to the government. The current MOH Strategy for AIDS for 2001-2005 which covers HIV prevention and care services will require at least $9 million per year to finance. To put this level of funding in context, if Cambodia were to invest at the same level as Thailand, where $1.90 were spent per capita on prevention services, we’d find that the $9 million needed to fund the MOH strategy could fund prevention for 4 million Cambodians. (Economic Costs of AIDS In Cambodia: Some Preliminary Estimates, Myers) (Economic Costs of AIDS In Cambodia: Some Preliminary Estimates, Myers) If one were to look at investments in care alone, it is clear that $9 million
would not be enough resources to finance the home care needs in Cambodia today. Therefore, it is clear that the appropriate strategic focus of funding areas is critical, as resources administered by the Ministry is scarce.

NGO Sector and HIV

Globally, the delivery of HIV services is linked with the strength of NGOs and their relationships with populations vulnerable to becoming infected and affected by HIV – particularly since many of these populations are outside the reach of government. Table I highlights the number of prominent NGOs, primarily international NGOs and local NGOs, working in HIV and related areas as of January 2000. There are over 100 NGOs explicitly working in HIV related areas – over 60 percent working in HIV prevention related areas of IEC and STD management. These NGOs provide technical, material, and financial support. As Table I presents, the majority of services that NGOs provide are in technical areas or in all three areas combined. Therefore, technical services and the means to transfer technical skills by the NGO sector is important to understand. To date local NGOs are not yet able to fully reach populations vulnerable to HIV, therefore given the importance of NGOs in the delivery of HIV services, it is essential that growth in the NGO sector be nurtured.

Table I: Number of NGOs working in HIV related areas in Cambodia (Jan 2000)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>STDs</td>
<td>34</td>
<td>14</td>
<td>8</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>HIV prevention (IEC)</td>
<td>40</td>
<td>14</td>
<td>19</td>
<td></td>
<td></td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>HIV care</td>
<td>19</td>
<td>9</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Tb</td>
<td>22</td>
<td>11</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td><strong>115</strong></td>
<td><strong>48</strong></td>
<td><strong>41</strong></td>
<td><strong>2</strong></td>
<td><strong>13</strong></td>
<td><strong>5</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

(Source: Medicam Database: NGO Health Projects in Cambodia Jan 2000)

The Costs of Providing HIV Related Services in Health

Many health facilities, particularly the national hospital are already experiencing increased pressure of bed occupancy among people living with AIDS. The current costs to provide care are extreme. The average cost to deliver inpatient services is $20 per inpatient day in a health facility while outpatient services cost $4 per visit. When compared with the average budget for the health, it is clear that the public health system will not have enough resources to care for all of the projected needs for PLWHA accessing the system. (Economic Costs of AIDS In Cambodia: Some Preliminary Estimates, Myers)

In addition to the costs borne and estimated to impact the formal health system, NGO representatives report high spending on treatments and health care by People Living with
HIV/AIDS (PLWHA) and their families. The average cost for medicine per episode is $4.65. An initial visit to the hospital is $17.30. $7.30 for the first contact with a health provider. Given that the average monthly household income in Cambodia is $100, many families cannot afford to finance their care directly from discretionary income. (Cambodia Poverty Report, 1998) The cost of illness is also the costs borne by decreased income to the household by those who are infected and unable to work. As HIV related disease advances for individuals, household income decreases by over 25 percent of household income or $7 – 10 per week or $28 - $40 per month. (Evaluation of Home Based Care Program – KHANA 2000) Given these pressures of health care financing for HIV related illness on household income, health care is funded through partial or total sales of assets including land and livestock, and other productive assets. In addition, many households access credit through money- lenders to finance care when they have little to no savings or assets. (Integration of Care and Support with Prevention Programs – Participatory Review with KHANA NGOs draft report)

As a result of these constraints home care for the management of HIV related illness is an important component of a care strategy. An evaluation of home care reveals that the principal needs for PLWHAs are the appropriate use of traditional health systems, timely referral to government facilities and social services, and welfare for food and transport costs. (Evaluation of Home Based Care Program – KHANA 2000)

**Cost of Providing Home-based care to PLWA**

An evaluation of the pilot Home-Based Care program conducted in 2000 found that the program provides a diverse range of services including basic health services and social services to chronically ill adults and their families. In addition, it found that while the program has met many of the needs of the beneficiary population, reaching scale for this program will require many more resources. The costs of providing home care in rural area, areas where its most likely to be most needed, was at least 50 percent higher due to high transportation costs.

Over the program period of 1998 – 2000 up to 700 patients were reached per month at a cost of nearly $2000 per month. (Evaluation of Home Based Care Program – KHANA 2000)

Per the suggestion of the Evaluation to increase the efficiency of home care services to reach rural populations, it was estimated that 1500 patients per operational district could be reached for $70,000 per year. Using this estimate and the estimated cumulative number of HIV positives in 1999 at 250,000, approximately $12 million per year would be required to meet the home care needs of those likely to be positive.  

---

3 Given Evaluation’s recommendation on efficiency of home care program – it was suggested that 1500 patients per month could be reached for $70,000 per year. The parameters for scale and coverage were based on this assumed cost and the intention to at least reach the 250,000 HIV positives assumed in 1999.
ANNEX E: PERSONS CONTACTED

**AUSAID**
Christine Hansen, Project Development & Management Officer

**Cambodian Red Cross (CRC)**
Va Sopeak, HIV/AIDS Acting Program Manager

**Cambodian Women For Peace and Development (CWPD)**
Meah Sotheary, Advisor
Kim Sokunthea, AIDS Prevention Office

**CARE**
Neil Hawkins, Country Director
Dymphna Kenny, Reproductive Health Manager
Deng Lang, Midwife, Kampong Chhnang
So Pheap, Pursat Provincial Field Assistant
Muong Sopha, Project Manager, Sisophon
Sieng Sovann, Pursat Provincial Field Assistant
Yim Sovann, Kompong Chhnang Provincial Project Manager
Sok Thy, Pursat Provincial Field Assistant
Bun Thoeut, Pursat Provincial MCH Officer

**CIDA**
Suanne Wise, Coordinator, Health and Nutrition

**DFID**
Dr Delna Ghandhi, Health & Population Adviser

**EC/UNFPA Youth Reproductive Health Program**
Sarah Knibbs, Project Officer

**European Commission**
Joseph Piazza d’Olmo, Coordinator
Roberto Garcia, Malaria Program
Elisabeth Piernet, Health Program

**Family Health International (FHI)**
Jeanine M. Buzy Bardon, Ph.D, Associate Director, Asia Regional Office
Gill Fletcher, Information & Publications Officer
Soch Kunthea, STD Project Officer
Dr. Peter R. Lamptey, Executive Vice President, Chief Operation Officer
HIV/AIDS Prevention and Care Programs
Phan Nora, STD Care Training Officer
Tess Prombuth, Health Program Development Consultant, Asia Regional Office
Francesca Stuer, Cambodia Country Director
French AID
Bernard Faber-Teste, HIV/ AIDS Project Manager

The Futures Group
Harry Cross
Kevin Osborne

GTZ
Dr. Danielle Arnaud, Provincial Health Advisor
Dr. Gertrud Schmidt-Ehry, Team leader

Helen Keller International
Dora Panagides, Country Director
Mr. Hou Kroeum, Agriculture Officer

Indradevi Association
Uy Soung Chhan Sothy, Program Coordinator and Project Development

Institute Pasteur Du Cambodge (IPDC)
Dr. Philippe Glaziou, Epidemiologist
Dr. Mail Saman, Co-Investigator, Perikam Study

JICA
Noriko Fujita, Chief Advisor for MCH
Okajima Katsuki, Project Formulation Advisor on Japan- Asian Collaboration
Katsuki Okajima, Project Formulation Advisor on Japan-Asian Collaboration
Ikushi Onozaki, Chief Advisor
Yusa Tsuyosi, Assistant Resident Representative

KHANA
Pok Panhavichetr, Executive Director
Tilly Sellers, AIDS Alliance Technical Advisor
Dr. Chhim Sarath, Programme Officer

MEDICAM
Jean- François Frys, Executive Director

Medicines Sans Frontiers Holland/Belgium
Lydia Ettema, STD/HIV/AIDS Program Coordinator
Katkrina Kober, Nurse, Siem Reap
Pich Hatha, Health Center Supervisor, Siem Reap
Lyn Maysan, Technical Advisor HIV/AIDS and Substance Use
Sébastien Marot, Coordinator
Dr. Johan Von Schreeb, Regional Representative Siem Reap
**Ministry Of Health (MOH)**

**ADB/Basic Health Services Project**
Dr. Char Meng Chuor, PCU Manager  
Krang Sun Lorn MA.,MPH, ADB Project Manager  
Dr. Khoun vibol, MD, Health Management Monitor

**Bakan Operational District, Pursat Province**
Dr. Mery Buntha, Vice Director for Referral Hospital  
Sary Ka, Head of Supervision  
Oum Sokhom, Chief, Metik Health Center  
Tuth Sakorn, Chief, Rumlech Health Center  
Kiry Vuth, Chief, Administration and Finance

**Batambang Provincial Health Office**
Chou Seuth, Deputy of Technical Office  
Chea Sambo, Director  
Lay Vithiea, Deputy of Provincial AIDS Program

**Directorate For Health**
Prof. Eng Huot, Director General For Health

**Kampong Chhnang Provincial Health Department**
Leng Siv Npeng, Director, KC Operational District  
Noeu Soeun, Chief, Peum Chhouk HC  
Dr. Tek Saroeun, Provincial Health Director  
Dr. Bun Samnang, Chief of International Relations

**National Center for Tuberculosis and Leprosy Control (CENAT)**
Dr. Mao Tan Eang, Director

**National Center for HIV/AIDS, Dermatology and STD (NCHADs)**
Dr. Hor Bunleng, Deputy Director  
Peter Godwin, Adviser  
Dr. Mean Chhi Vun, Director  
Dr. Francois Crabbé, Project Technical Advisor

**National Maternal & Child Health Center (NMCHC)**
Prof. Koum Kanal, Director  
Dr Chhunn Long, National RH Programme Manager  
Dr. Chhun Poirot, Deputy Director

**Pursat Provincial Health Department**
Pal La Ine, Director, MCH  
Dr. Ky Kien Hong, Hospital Director
Siem Reap Operational District, Siem Reap Province  
Ith Sakteon, Deputy Director

Sampor Meas Operational District, Pursat Province  
Dr. Sieng Kim Seng, Director

Sotnithkhom Operational District, Siem Reap Province  
Nay Pol Lin, Director  
Kong Sarith, Vice Director for Health Center  
Seng Sophea, Chief, Samrong Heath Center  
Dr. Lim Tong, Vice Director for Referral Hospital

World Bank Project  
Dr. Veng Ky, World Bank Unit Chief

Ministry of Social Affairs (MOSALY)  
Mr Heng Kong Meng, Assistant to Deputy  
Mrs Em Sophon, Deputy Director of Social Welfare Department

Ministry of National Defense (MOND)  
Dr. Veng Bun Lay MD. MPH, Deputy Of National Director Logistic- Finance

Mith Samlanh/ Friends  
Sebastien Marot, Coordinator  
Lyn Maysom, Technical Advisor

National AIDS Authority (NNA)  
Dr. Tia Phalla, Secretary-General

NYEMO  
Simone Herault, Coordinatrice  
Fabienne Lopez, Medical Advisor

Partners For Development (PFD)  
Michael Chommie, Country Representative  
Peter Feldman, Water Resources Program Manager  
Michelle M. Lang, Health Program Officer  
Dok Sophanna, Program Officer
Population Services International (PSI)
   Om Chhen, Sales and Marketing Manager
   John M. Deidrick, Country Representative
   Denise Harrison, Deputy Country Representative
   Dr Meach Phakan, Training Coordinator
   Dr. Nop Sotheara, Communications Manager

Reproductive and Health Association of Cambodia (RHAC)
   Heng Kheng, Program Coordinator
   Var Chivorn, MPH, Associate Executive Director
   Vong Davy, Clinic Manager

Reproductive and Child Health Alliance (RACHA)
   Eva Blaza, Finance/Administration Officer
   Suon Bophea, Provincial Coordinator
   Hen Sokun Charya, Assistant Provincial Coordinator
   Judy Carlson, SM Advisor
   May Chanbolen, Home Birth kit Monitor
   Ping Chutema, M.D, Director of Clinical Services
   Chris Heriuamn, Program Development and Services
   Chhim Keahing, Home Birth Kit Monitor
   Thach Lykhann, Provincial Coordinator
   Sun Nasy, Provincial Program Team Leader
   Lim Nury, Community Program Coordinator
   Pek Nimol, Home Birth Kil Montor
   Chap Meng Seang, Program Clerk
   Hou Hem Munmary M.D, Clinic Manager
   Sou Penh, Home Birth Kit monitor
   Marcel Reyner, Reproductive Health Adviser
   Chao Sophea, Home Birth Kit Monitor
   Hor Sinang, Community Program Facilitator
   Chim Sovanny, Community Work Assistant
   Maria Smith, IEC Advisor
   Tep Savacry, Breastfeeding/CDD Health Promotion
   Dr. Richard B. Sturgis, Program Manager
   Neou Vongsa, HIS Coordinator

SFODA
   Pen Sophan, Director

SHARE
   Ung Malineat, Program Assistant

UNAIDS
   Steven J Kraus, Programme and External Relations Advisor
   Asia-Pacific Inter Country Team, Bamgkok
UND
Margaret Atkin, HIV/AIDS Coordinator, Bantheay Meanchey Province

UNFPA
Yoshiko Zenda, Representative

UNICEF
Dr. Guido Cornale, Programme Coordinator
Daniel Dravet, Information/ Communication Officer
Dr. Maurice Hours, Project Officer Health
Dr. Kieng Navy, National Officer/ Siem Reap
Dr. Rob Overtoom, Provincial Health Adviser/Siem Reap
Etienne P. Poirot, Project Officer HIV/AIDS
Brigitte Sonnoit, Project Officer, Vulnerable Children

USAID
Lois E. Bradshaw, Program Officer
Clifton J. Cortez, Jr, Policy Advisor HIV/AIDS, Global Bursar
Caroline F. Connolly, Director, PHN Office
Lisa Chiles, Mission Director
Dr. Kevin A. Rushing, Chief, Office of General Development

WHO
Dr. Henk Bekedam, Team Leader, Health Sector Reform Group
Dr. Nancy Fronczak, Consultant
Dr. Stefan Hoyer, Malaria Advisor
Dr. Hun Chhun Ly, Provincial Health Advisor/ Pursat
Dr. Andre Reiffer, Provincial Health Advisor/ Bantheay Meanchey

World Relief Cambodia
Neal L. Youngquist, Microfinance Advisor

Other:
Elizabeth Hoban, PHD Candidate University of Melbourne
Dr. Susanne Von Schreeb, Obstetrician
ANNEX F: DOCUMENTS REVIEWED


Care International, Pharmacists and Their STD Clients in Bauvet and Svay Rieng Towns (Svay Ring Province, Cambodia), November 1999.


Care International, Sexual Health Quantitative Survey Results Svay Rieng and Koh Kong, Cambodia.
Care International, _When the Stars are Up: Life and Work of Sex Workers in Koh Kong_, June 2000.


Cooperation Committee For Cambodia, _Directory of International Development Assistance in Cambodia_, June 2000.

Cooperation Committee For Cambodia, _Directory of Cambodian NGOs 2000-2001_.

Department for International Development, _Project Memorandum and Logical Framework: Support to PSI Cambodia for Social Marketing of Condoms, Phase 2, January 2000_.

Family Health International, _FHI’s Interventions in Cambodia: Evaluation._

Family Health International, _FHI’s Private Sector HIV/AIDS Strategy in Cambodia._

Family Health International, _FHI’s Work on Male Sexual Health in Cambodia._

Family Health International, _FHI’s Work on Supporting the Implementation of Cambodia’s 100% Condom Use Policy._

Family Health International, _FHI’s Work with the Uniformed Services in Cambodia._

Family Health International, _FHI’s Work on Upgrading STD Diagnosis and Treatment Capacity in Cambodia._

Family Health International, _FHI’s Work with Street Children in Cambodia._

Family Health International, _FHI’s Work on TB and HIV in Urban Phnom Penh._

Family Health International, _FHI’s Work on Women’s Empowerment in Cambodia._

Family Health International, _FHI’s Work With Children Affected by AIDS in Cambodia._

Family Health International/ Impact- Cambodia, _Cambodia 5- year Action Plan summary._

Family Health International/ Impact- Cambodia, _Detailed FY01 Implementation Plan, 1 October 2000- 30 September 2001._
Family Health International/ Impact- Cambodia, Implementation and Detailed 2-Year Work Plan

Family Health International/ Impact- Cambodia, Mid Term Review Scope of Work.

Family Health International /Impact- Cambodia, Mid Term Review, March 20001

Family Health International /Impact- Cambodia, Men Who Have Sex With Men (MSM)


Family Health International/Impact-Cambodia, Q4-FYOO FHI/ Impact Progress Report to USAID/C, 10 January 2000.


Family Health International/Impact- Cambodia, Sub Agreement Between Family Health International (FHI) and Meahto Phum Ko’Mah (Homeland), 15 February 2001.


Guillou ,Anne, Perceptions Regarding Cough And Tuberculosis in the Bassac Area Phnom Penh, Cambodia, November 1999.

Helen Keller International, ASIA-PACIFIC Regional Portfolio.


Hicks, Jane and Mammen, Priya, Strengthening Reproductive Health Service Delivery in Cambodia, January 2000.


Japan International Cooperation Agency and World Health Organization, TB Control Concern For All, 98.

Khmer HIV/AIDS NGO Alliance, Appraisal of Needs and Resources in Cambodia.


Khmer HIV/AIDS NGO Alliance, Summary Update on Khana Local NOG Partners, August 2000.


Medicam, Database of NGO Health Projects in Cambodia, January 2000.


Ministry of Planning, *Cambodia Poverty Assessment*.


Ministry of Health, *Cambodia’s Health Sector Performance Report 2000*.


Partners For Development, Malaria Control Program 1999 Kratie Province.


Reproductive and Child Health Alliance, *Deaths Among Women of Reproductive Age*, July 2000.


Reproductive Health Association of Cambodia, *Semi- annual Progress Report to USAID/Cambodia*.


Reproductive and Child Health Alliance, *Cambodia Midwives Association’s Continuing Education Program*, August 1999.


Sim, Kheng, *The Experience of the National Malaria Control Programme in the Use of Antigen Dipsticks for the Diagnosis of Malaria in Cambodia*.


UNAIDS and World Health Organization, *Epidemiological Fact Sheet onHIV/AIDS and Sexually Transmitted Infections in Cambodia 2000*.


United States Agency for International Development, *Grant No. 442-0112-G-00-5514-00 (Care)*, 1 July 1995.


United States Agency for International Development, *Grant Agreement With RHAC*, 1 April 1999.


United States Agency for International Development/ Cambodia, Results Review and Resource Request, April 2000.

United States Agency for International Development /Cambodia, Scope of Work for AVSC, BASICS and SEATS, July 1996.


White, Patrice, Family Management of Acute Respiratory Infections Kean Svey District, Kandal Province Kingdom of Cambodia, April 1998.


World Vision Cambodia, The Right to Sight.