HIV/AIDS IN Cambodia -
An Assessment of Prevention and Coordination

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### Glossary

The following is a complete list of acronyms and abbreviations and issue-specific terms used later in the text. With all but a few common exceptions (eg. "AIDS", "HIV", "GDP". and "US"), all are rendered in full at their first point of use.

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
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<tbody>
<tr>
<td>AIDAB</td>
<td>Australian International Development Assistance Bureau (Australian Government)</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>Bounded</td>
<td>A policy-making theory, that takes a long term view, bounded only in the sense of Rationality not being able to consider an infinite number of rational options.</td>
</tr>
<tr>
<td>CARE</td>
<td>CARE International (A'GO)</td>
</tr>
<tr>
<td>CCC</td>
<td>Cooperation Committee for Cambodia</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>CO</td>
<td>Christian Outreach (VGO)</td>
</tr>
<tr>
<td>CPP</td>
<td>Cambodian People's Party</td>
</tr>
<tr>
<td>CSW</td>
<td>Commercial Sex Worker</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health (Provincial level)</td>
</tr>
<tr>
<td>FUNCINPEC</td>
<td>United National Front for an Independent, Neutral, Peaceful and Cooperative Cambodia</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune deficiency virus</td>
</tr>
<tr>
<td>HIV+</td>
<td>Someone who carries HIV, but has not developed the symptoms of AIDS</td>
</tr>
<tr>
<td>ICORC</td>
<td>International Committee on Reconstructing Cambodia</td>
</tr>
<tr>
<td>ICRC</td>
<td>International Committee of the Red Cross</td>
</tr>
<tr>
<td>IDU(s)</td>
<td>Intravenous Drug User(s)</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labor Organization (a UV agency)</td>
</tr>
<tr>
<td>Incrementalism</td>
<td>A term used to describe 5711011 police changes over a period of time</td>
</tr>
<tr>
<td>INGO(s)</td>
<td>International Von Governmental Organization(s)</td>
</tr>
<tr>
<td>IO(s)</td>
<td>Intergovernmental Organization(s)</td>
</tr>
<tr>
<td>KAP (survey)</td>
<td>Knowledge, Attitude and Practice</td>
</tr>
<tr>
<td>MEDICAM</td>
<td>Medical cooperation meeting, (established by ihe.11oH)</td>
</tr>
<tr>
<td>Moll</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NAC</td>
<td>National AIDS Committee</td>
</tr>
</tbody>
</table>
NAP  National AIDS Program
NGO(s)  Non Governmental Organization(s)
("NGO" incorporates "INGOs" and indigenous organizations, although the latter are normally referred to as "local NGOs")
ODA  Overseas Development Administration (UK Government)
PA  Per Annum (per year)
PSI  Population Services International (a social marketing not for-profit organization)
SCF (UK)  Save the Children Fund (United Kingdom) (VGO)
Seropositive  A medical term for a positive response to an HIV test
STD  Sexually Transmitted Disease
Taxi-girl  A commercial sex worker
TB  Tuberculosis
UNCHR  United Nations Center for Human Rights
UNDP  United Nations Development Program
CAREERE  Cambodian Resettlement and Reintegration
UNESCO  United Nations Educational, Scientific, and Cultural Organization
UNICEF  United Nations Children's Fund
UNTAC  United Nations Transitional Authority in Cambodia
USAID  United States Agency for International Development (US Government)
\~TP  World Food Program (a U.V agency)
WHO/GPA  World Health Organization (UN) "Global Program on AIDS
WVI  World Vision International (NGO)
Abstract

Despite the danger of a potential HIV/AIDS epidemic, Cambodia opted to procrastinate, believing international isolation would act as a shield, thus postponing the inevitable. As a result, since the first diagnosis of HIV in 1991, the infection rate has accelerated to one of the fastest growing in the world.

Three key themes run through the chapters, looking at aspects of coordination, incremental policy-making, and the perception of AIDS as a health issue rather than a social problem. This latter focus has meant that the cost of the AIDS epidemic will be a burden increasingly carried by women, their children and will be borne disproportionately by the poor.

One area largely ignored in Cambodia, yet pointed to in many international studies, involves the role of migrant workers. Whilst acknowledging the dangers of identifying "high-risk" groups, the dissertation assesses information on migrant workers and their families, and the impact they may have on the future spread of the virus. Material used within the penultimate chapter draws heavily on research, funded by the Dutch government, designed and implemented by the author during his course placement in Cambodia.
To o Ruth

whom I have had the privilege of
working alongside,
in times of calm and through frustration,
as she has cried and cared,
laughed and loved.
Chapter I - Introduction

Cambodia has one of the fastest growing HIV rates in the world. Its first case was only diagnosed in 1951. Combining the impact of these two statements justifies alarm and prompts the question "how is the prevention of AIDS being tackled in Cambodia?" Central to the response are three distinct contributing factors, which consider the lack of coordination in Cambodia, the style of policy-making, and the lack of focus on certain key issues. In addressing these three factors, this dissertation documents the shape of the problem, its causes, and considers how best to deal with the epidemic and its social implications. This assessment draws upon several theories and concepts in AIDS prevention, although these should not be regarded as constituting the main framework for this study.

Coordination by the government happens at several levels. Although aware of a need to take a regional perspective, I argue that little has been done for coordination at international levels. At the second stage, of inter-ministerial coordination, despite lip-service being paid to a multi-sector approach, AIDS is still treated very much as a "health" rather than a "social" issue. In essence there will only be a limited effect from any form of intervention, unless wider root causes are considered.

Despite there being coordination at the stage of implementation between Non Governmental Organizations (NGOs), UN agencies and the National AIDS Committee (NAC) in Cambodia, it barely exists at the more critical point of planning. Instead widespread organizational individualism has led to many attempting to carry out their own agenda. In the absence of a clear direction being taken by the NAC combined with poor consultation with other International Organizations; NGO efforts produce a fragmented and partial solution.

The second theme draws on the style of police-making which considers the theoretical models of bounded rationality and incrementalism. Early awareness of the pandemic in policy-making is conspicuously absent, appearing only in 1991 with a certain degree of hesitancy. Initial policy appeared rational, although quickly relapsed into taking smaller incremental steps, despite the many years of lessons and experience available to policy-makers particularly from other countries such as Thailand, India; and those in sub-Saharan Africa.
Thirdly, a lack of focus on several issues has proved detrimental to the success of government policy. Most notably are issues of sustainability; empowerment of women; discrimination; HIV testing; program evaluation; counseling and palliative care. In addition, whilst the initial cause of transmission of HIV is likely to be sexual, entire families are at risk of cross infection through sharing of syringes. Most efforts thus far have focused on the former, but relatively little appears to have gone into preventing the latter. Cross infection is therefore likely to increase largely unchecked. The cost of such a failure will be felt by nation and individuals, both financially and socially.

The penultimate chapter - a case study of a high risk group - addresses a second question that so far has received little attention from those involved - "how important are migrant workers to the spread of the AIDS virus?" Experience from other developing nations strongly suggests they play an important role. In the absence of any prior research, the author designed and conducted a study of HIV/AIDS knowledge among migrant workers, (see Appendix B). The results form an integral part of the assessment of this question in the Cambodian context.

Initially however, the analysis looks at various political, economic, and social factors that have shaped Cambodia into the position the country finds itself in today. Ironically, civil war and international isolation had shielded Cambodia from a significant spread of the AIDS virus for many years. Lamentably political inter-party rivalry continues to hamper efforts aimed at provincial and central cooperation.

**History**

Modern Cambodia borders Thailand to the north west, Laos to the north east, and Vietnam to the south and east. Khmer people can trace the origins of their state back to 3 AD. The Angkorian era (802-1431), illustrated Cambodia's former economic and political power covering, at its peak; most of mainland South-east Asia. Towards the end of the 15th century sudden losses in labor, led to the disuse and lack of repair of a vast and intricate canal system. Khmer peasants focussed their villages around Buddhist temples ("wats") and carne to rely on subsistence farming - a situation largely unchanged even today. By the mid 19th century, fearful of Siam and Vietnam's intentions, King Norodom signed a treaty with France. French colonial rule continued until 1953, interrupted briefly by the Japanese during the Second World War.
Prince Sihanouk managed to stay neutral for much of the Vietnam war, despite giving his approval for the Ho Chi Minh trail to pass through parts of north, and eastern Cambodia. Eventually the tightrope of neutrality proved too slippery and a parliamentary vote in 1970 abolished the monarchy. General Lon Nol’s regime, backed by the United States government, immediately faced civil war. Prince Sihanouk had taken sides with the Communist Party of Kampuchea (Khmer Rouge), who fought their way to power in 1975, with popular peasant support.

"Year Zero" as it became known, saw the emptying of all cities, and the destruction of almost all Cambodia’s infrastructure. Three years later in 1978, the Khmer Rouge attacked the Vietnamese. Now fearing the increasing Chinese influence in Cambodia, the Vietnamese retaliated by invading Cambodia in early 1979. Despite ending the genocidal reign of the Khmer Rouge, they stood condemned by the United Nations for the invasion: fuelled in part by western fears of "creeping communism". This resulted in international isolation for their puppet regime, and for a desperately beleaguered Cambodia.

Civil war resumed between four opposing sides, the Vietnamese backed government in the form of the Cambodia People’s Party, (led by Hun Sen); the Khmer Rouge’s Party of Democratic Kampuchea; FUNCINPEC (loyal to Prince Sihanouk), and the Khmer People’s National Liberation Front. Rival interests prevented the UN Security Council from imposing an international arms embargo for many years. When it was eventually agreed the four sides conceded the futility of their fight, giving rise to the Paris Peace Accord. latter signed in October 1991. Shortly afterwards. the UN Transitional Authority in Cambodia (UN TAC) arrived to oversee democratic elections in May 1993. Sixteen thousand troops, and eight thousand civilian stiff inadvertently then went on to become the biggest catalyst to the spread of HIV in Cambodia.

Politics

In May 1993, the UN sponsored elections were won by the royalist FUNCINPEC party (45 per cent), although they were quickly forced into a coalition with the CPP (38 per cent), and two other smaller parties. While FUNCINPEC initially held much sway in the capital, CPP tended to control the Provincial authorities.

Staunch part) loyalty within government ministries continues to hamper policy implementation. Many government ministries are far from being apolitical, and come under direct and open control of party officials.
Sociocultural Issues

Cambodia lost most of its educated classes through the Khmer Rouge genocide. By 1988 there were fewer than 800 doctors for Cambodia's nine million population. Since then others have returned, trained in the Thai border camps, or from overseas.

The disproportionate death rate between men and women, has created further inequality and poverty. For many married women, their husbands can earn additional income in the "dry" season, by leaving home and gaining temporary migrant-work. "Many women who leave their villages to find work in the city, especially those without a formal education, find themselves alienated without the extended family and village community support, and resort to prostitution for economic survival". This clearly holds implications for putting an increasing number of women at risk of HIV.

Where HIV is spread predominantly through sexual intercourse, it follows that the sectors of the population most likely to be affected are those most sexually active. With just under half the population in the 15-64 age group, (an unusually skewed distribution of ages in itself), that implies many fall into such a category, (see Table 1, Page 5). With a further quarter of the population potentially becoming sexually active in the next decade, much must be done to limit the impact of HIV.

Table 1: Age and gender structure of population, end 1992

<table>
<thead>
<tr>
<th>Age group</th>
<th>Total Population (m)</th>
<th>Males per 100 females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5 years</td>
<td>2.0</td>
<td>100.5</td>
</tr>
<tr>
<td>5-14</td>
<td>2.8</td>
<td>100.0</td>
</tr>
<tr>
<td>15-64</td>
<td>4.6</td>
<td>82.0</td>
</tr>
<tr>
<td>65+</td>
<td>0.3</td>
<td>50.0</td>
</tr>
<tr>
<td>Total</td>
<td>9.7</td>
<td>90.5</td>
</tr>
</tbody>
</table>

Source: LWTAC, Office of Rehabilitation and Economic Affairs; Economic and Social Commission for Asia and the Pacific

[1]
Buddhism and Fate

As a result of the Khmer Rouge's destructive reign, Cambodia lost much of its heritage and tradition; some of it is now being revived with re-established links to Thailand. Buddhism, which Pol Pot attempted to eradicate from society, has been revived as the State religion, (albeit accepted in a mix with Animism and Brahmic belief). Whilst outwardly practiced less rigorously, it is still considered a social doctrine. It plays an important role in Cambodian society, and to ignore its significance is folly.

"As it is practiced in Cambodia, Buddhism does not foster a strong collective social responsibility. ... Only through one's individual efforts can prospects in the next life be improved. The focus on the past and future gives little incentive to take action which might improve one's immediate circumstances or better social condition." (Italics mine)

The lack of fear of death; combined with a belief in fate and reincarnation, are obstacles to AIDS education in Cambodia. Many in the population could die of malaria or tuberculosis (TB) next month: which prompts the question why then should they Worry about something that might kill them in five years time?

The culture also suffers from major contradictions and denial,

"Cambodian culture places great importance on upholding rigorously determined standards of behavior for members of society yet simultaneously tolerates deviant behavior by those who violate the social norms without serious consequence"\cite{4,3}

The point is well illustrated by a westerner who noticed a Buddhist monk in a sexually transmitted diseases (STD) clinic waiting for treatment. When questioning local people about the monk's supposed purity, they categorically denied that the monk could have been there. Therefore, it can mean that starting from an illogical premise (denial); a logical train of thought can be followed. Responses collected in a recent qualitative survey illustrate the point,
"I like to have sex with Vietnamese [commercial sex workers] because many men have sex with them but no one gets any disease from them"... "When the UN were here there was no AIDS because there were many doctors".5

Dr Tia Phalla, former head of the National AIDS Committee quotes a prostitute from Siem Reap as saying "I have rich powerful men coming here; and they never use condoms. I have nothing, no possessions. They have everything to lose and they don't use condoms. So why should I?"16

One aspect of Khmer culture that must be understood is the male attitude towards sex. A wife is considered to be there to produce children. Khmer culture accepts he will visit a brothel "for fun". Far from the secrecy found in western culture, such places are where men often go in groups. Frequently brothels have a bar or karioke club at the front. The wife may or may not be aware of such visits; either way they normally continue. A husband is only considered unfaithful if he has a girlfriend, or visits the same "taxi-girl" (commercial sex worker) regularly. Any attempt at stemming the spread of HIV in Cambodia must recognize that such conduct has been part of Khmer society for centuries, and will not change overnight.17 As Bit points out (1991) "well meaning efforts by outside benefactors will fail once again unless they are based on insightful understanding of the people and culture they are intended to assist."18

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Chapter 2 - Cambodia's Delay and the Asian Pandemic

The cost of ignoring HIV until it struck, is likely to haunt the country for many years to come. Had the government taken note of what was happening in neighboring Thailand, then perhaps an AIDS prevention program could have had more impact. In fairness, many countries appear to have taken a similar wait-and-see attitude, although many were forced into a rude awakening of the scale of HIV several years before Cambodia. Even now valuable lessons need to be learned from countries such as Thailand, and those in sub Saharan Africa if policy makers wish to avoid "reinventing the wheel".

Rates of Transmission

In mid-1991, Cambodia's National Blood Transfusion Service started collecting the data from their blood screening program, (which was limited to Phnom Penh). Their figures show a dramatic rise in HIV infection among donors, (see Figure 1).

![Figure 1: Percent HIV+ Amongst Blood Donors in Cambodia 1991-95](image)

Some have argued that the sample size of only a few hundred donors per month is too small to be statistically significant (Cunningham 1993). Not to be overlooked either is that 85 per cent of donors are males between
the ages of 18-40, and that the blood transfusion center is the only source of a free HIV test. Despite being called a "national" service; few provinces have any sizeable blood bank, with most hospitals still relying on emergency unscreened donations at the point of need.

Other sources of information, beside a national register of identifiable cases, are less accurate. These include the inevitable estimates of HIV infection. This estimate increased three fold overnight in September 1995, to 30,000, when the WHO recalculated their predictions based on new survey results. At the time the WHO's Global AIDS Program representative in Phnom Penh stated "the new estimates indicate that AIDS is spreading faster in Cambodia than in any other Asian country".

During UNTAC's time in Cambodia, one medical unit attached to the Indian battalion in the north eastern province of Stung Treng, tested 37 local "taxi-girls". Even in this remote part of the country, they discovered a 25 per cent HIV+ rate. On informing the World Health Organization (WHO), they were reportedly told to stop testing, because they did not have the training or resources to counsel those they tested.

Already two adults and a child are known to have died of AIDS related conditions. However until people start dying in the villages, it is unlikely that many people will take much notice. Dr Tia Phalla lamented that "at the Calamette hospital [in Phnom Penh] many people with full-blown AIDS are treated temporarily, but after they leave the hospital, we do not know how many die." Unfortunately many of these will be acknowledged as dying from tuberculosis or similar diseases. Once again this will hide the specter of AIDS from the sight of many, although for some it may be a "face-saving" measure for the remaining family.

Until 1995 there had been no attempt at a nationwide survey, with most predictions relying on snapshot samples. One such survey (see Figure 2, Page 10) in 1994 shocked all concerned when it discovered rates of up to 92.1 per cent HIV+ amongst commercial sex workers close to the Thai border in Sisophon, Banteay Meanchey province, (see map, Appendix C, page 55). The lowest level of the three sites recorded was 39.4 per cent HIV+ in the country's principal sea port of Kompong Som. Whilst they collected data on several other groups, such as TB patients, and army and police units (not measured in Kompong Som), no attempt was made to measure the general population. With more than 80 percent of the population not living in urban
areas, extrapolations from such figures must therefore be treated with caution. Furthermore, although they are "official" figures; there has been some discussion as to their validity by, among others, WHO themselves.

![Figure 2: Source National AIDS Committee/WHO Epidemiologic Survey 1994](image)

**The UN Transitional Authority in Cambodia - A Source of Transmission?**

UNTAC at times has been blamed for introducing HIV into Cambodia. This has been dismissed by several experts. "UNTAC is a nice excuse, but it does not get to the main problem ... The biggest risk comes from unprotected heterosexual activity, particularly among Cambodian men ..." argues Dr Tia Phalla. The presence of UNTAC did increase transmission. One Danish report went as far as to suggest the UN's presence was responsible for an estimated increase from 6,000 to 20,000 in the number of women and children involved in prostitution in Phnom Penh. During their tour of duty, the report claimed, 3,000 peacekeepers caught a sexually transmitted disease. Miss Kien Serey Phal, Vice President of the Phnom Penh Municipal Women's Association believes the figures to be lower; and suggests the increase took total figures to around 10,000.

Susan Cunningham, (writing in the *Bangkok Post*) believes that prostitution will proliferate "now that a few people have money to spend and so many women are so desperately poor." This view was echoed by William Shawcross. However to argue that the increase in prostitution is mainly attributable to UNTAC ignores the fact that even after the peacekeeping forces' departure, many brothels were able to stay in business.
Little more than a month after UNTAC finished its mission, the UN's chief medical officer (CMO) stated that "some 150 men had contracted the virus that leads to AIDS during their mission in Cambodia". The official record shows 467 cases were diagnosed, although that excluded those diagnosed after returning home, (forty-nine), and some former Eastern Bloc countries that refused to reveal figures. The UN CMO called for mandatory testing before assignment, to prevent "soldiers coming from these countries contributing to contamination in the area".30 Such a call was considered worthy of "more thought" according to the t N Research Institute for Social Development, although Sue Montgomery of the PANOS Institute points out that "there are no plans to implement the recommendations".31

**Methods of Transmission**

In Cambodia the principal source of transmission is heterosexual contact, normally between men and taxi-girls. "Clients" come from all walks of life, from cyclo [rickshaw] drivers, through to rich foreign businessmen, and prices vary considerably. Anecdotal evidence from those working amongst commercial sex workers in Phnom Penh's largest red light district, suggests that the poorer a woman is, the less influence she can exert over whether her clients wear condoms. It is also thought that more highly paid women are in a better position to purchase the necessary antibiotics to fight existing sexually transmitted diseases.32 Figures for 1993 from Thailand suggest that 28 per cent of all those recorded as HIV+ were classified as "lower priced" commercial sex workers, against only 7.5 per cent classified as "higher priced".

Most commercial sex workers are ethnic Cambodian and Vietnamese, although some are Thai. Many are forced into it through poverty, or particularly for highly-valued young virgins, they are abducted by relatives who sell them to brothel owners. In consequence they often have little or no control over whom they have sex with, frequently being forced into unprotected sex. Some of those using a condom, found that men sometimes used various pills to maintain an erection "all night". Lubricants often then proved insufficient, and condoms would rub. This led to soreness, and an unwillingness to use them, while creating thousands of tiny abrasions, thus making infection even more likely.

Of particular concern though was a similarly high incidence of non-fatal STD's between prostitutes and monogamous women, according to Dr Liz Anderson, (formerly with Voluntary Service Overseas) 33 This suggests many STD's are being transmitted by married men. She is not alone in her fear.

PAGE 11
"An unwittingly exposed group of women are single partner married women exposed to the risk of infection from their husbands who also have sexual relations with other women who have multiple male partners" 34 (The Jakarta Declaration for the Advancement of Women in Asia and the Pacific, para. 12)

The second source of transmission is from reused syringes. Conventional intravenous drug abuse is not a cause of concern yet, but there is a general tendency by Khmers to believe that something injected is more effective than medication taken orally. Injections would typically range from antibiotics through to vitamins. Administration of intravenous infusions are common place for tiredness. According to Lars Meyer, head of ICRC’s National Blood Transfusion Program, needle sharing’ is common in pharmacies, and in small provincial hospitals. "If you go into the local pharmacy at the market and he gives you an injection he uses the same needle for very many people and that’s one way it is spreading here 35

Particularly in the villages, one person may own a syringe, which is shared around the whole family, often with no, or inadequate, sterilization. Clearly this could, and probably will make the epidemic potentially explosive, as husbands take the virus home and subsequently pass it on to their entire families.

Peri-natal infection is currently believed to be relatively low. No figures are available, although a number of infants have been reported as HIV+ (at birth). Universally mother-to-child transmission of HIV is by far the greatest source of infection for children, and there is no reason to believe Cambodia will be any different. 36

Most of Cambodia’s blood supply remains unscreened, due to donations often occurring on a "pint for pint" ad hoc basis for friends or relatives. The true picture will be reduced by lower post-operation survival rates because of limited resources, late detection of complications, and inappropriate interventions. Conversely though, transmission could be higher due to the considerable numbers of landmine victims; (currently around 3-400 per month), who require large amounts of blood following amputations. 37 In contrast with western countries other sources, such as homosexual infection, are not considered a major cause of transmission.
AIDS - an Asian Pandemic

The WHO estimates that `3.5 million people in Asia have already been infected with HIV. About 750,000 those are in Thailand, but the disease is spreading like wildfire across Burma and Cambodia.\footnote{38} What happens in neighboring Thailand is bound to affect Cambodia.

Rapid economic growth in the region has had two main effects on the spread of HIV. The first is increased international travel, both for business and tourism. In Asia this can often mean frequenting "massage parlors" or for others it may involve activity illegal in their own country, \textit{(see also page 19)}. The second implication relates to economic migration of those who see scope for increased earnings in neighboring countries. Cambodia attracts both types of visitors, including specifically Thai and Malaysian businessmen, as well as Vietnamese commercial sex workers.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure3.png}
\caption{Some of the Principal Routes of Regional HIV Transmission in South-East Asia}
\end{figure}

Some principal channels of HIV transmission affecting Cambodia are illustrated in Figure 4, (above). Most of the countries mentioned also suffer from HIV transmission through intravenous drug abuse, although the evidence does not appear to suggest international travel for drug users in the same way as for commercial sex. The exception to this would be westerners, who find certain "soft" drugs easily obtainable, and often much cheaper than in their home countries. Most of these however tend to be non-injected drugs.
By 1993 three Thais were dying of AIDS every two days. Another report in 199 estimates that 46,000 Thais will have died of AIDS that year alone, bringing the total to 120,000. Thailand, considered to be running "the most aggressive campaign in Asia", still appears "to be fighting a losing battle". Origins of the epidemic in Thailand are traced back to homosexual activity in 1984. Infection then spread to intravenous drug users, before becoming a significant danger to the heterosexual community around 1988. In Myanmar (Burma), an estimated 400,000 are infected already. Most of these (75 per cent) are due to heterosexual activity, whilst around 74 per cent of Myanmar's intravenous drug users (IDUs) are thought to be HIV+. Vietnam's problem is thought to be with IDUs, who are said to account for 87 per cent of HIV+ cases.

Since Thailand has suffered more than any other similar nation in the region, Cambodia must learn from their mistakes, (see box below). In talks with Cambodia's National AIDS Committee in March 1994, the chairman of Thailand's Population and Community Development Association said they had spent "three of the most important early years just thing to convince the government that AIDS was a potential problem". Since they launched their aggressive program in 1990, attention has focussed on the use of condoms. The Ministry of Public Health started distributing free condoms to brothels; and now gives away 60 million per year. Condom consumption is now up to 170 million per year (for a population of 59 million).

"We share our culture with Cambodia and now we share our diseases. Don't wait too long to work on this problem and don't make the same mistakes we did. Educate people in the rural areas, not just in the city, and help people to understand that AIDS patients should be given understanding, not isolated and condemned".

(Thai Professor speaking to Cambodian delegates at an AIDS workshop).

Social stigma denoting lack of trust prevents many Khmer wives from insisting on condom use. Ironically the perceived indiscretion would be considered to lie with wives should women persist in requesting condom use. Until very recently the availability of quality condoms in Cambodia has also been an issue, along with the relatively high cost, (a third of a day's pay for a 400 Riel condom ($0.14)), which has previously been a factor for low use. One of WHO's first attempts at importing condoms in 1993 proved a farce when they realized they
had spent their condom budget on European size, rather than Asian. Overall condom use in Cambodia is still exceptionally low.

Vietnam's publicity on AIDS takes a negative approach, focusing on fear. Despite some suggestions to the contrary; Cambodia's many posters and leaflets rarely feature "scan monsters". Instead they would typically focus on advocating practical methods of prevention, illustrated for example by a man and woman in bed together, underlined with a message bordered within a condom. 43 Myanmar meanwhile is still grappling with a conservative social structure that makes AIDS education difficult, despite having a vast propaganda machine at its disposal.44

Lao, Malaysia and Singapore

Laos is behind Cambodia in both the impact of HIV and the methods used to tackle it. Three years ago a UN official tallied about Laos having "a window of opportunity". Such possibilities for early intervention are rapidly evaporating. Government leaders, including Dr Sithat Insisienghmay, secretary of the National Committee for the control of AIDS, prefer to ignore their neighbors' experiences and still proclaim that promiscuity is not acceptable in Lao society and goes against the good values of Lao culture.45 Whilst Malaysia and Singapore are part of the region geographically, they differ significantly in culture, and in their ability to test for, and promote prevention of HIV. Both established AIDS prevention program two years before either one's first recorded case.46 By 1994 Malaysia had reported around 105 cases of AIDS, and 7,500 cases of HIV. Singapore's program appears to have worked more effectively; with only 60 cases of AIDS, and 90 reported incidences of HIV. Both countries found the HIV/AIDS epidemic started with higher rates of infection amongst homosexuals, although more recently most new cases have been caused by heterosexual transmission. Malaysia does not officially restrict entry to the country, although those found to be HIV and likely to spread the virus may be asked to leave. In Singapore, foreign workers earning less than $1,500/month (around £750), are required to take an HIV test, and those that fail will be repatriated. International travellers, mainly businessmen, from Malaysia and Singapore with contract, and then spread the virus to other nations, mainly through contact with commercial sex workers. Cambodia's most effective course of action to counter such risks remains the regulation and oversight of brothels and "massage parlous", thus giving women a greater chance of refusing unprotected intercourse.
One concern expressed by human rights groups is the trafficking of women for prostitution. Women have been kidnapped and forced into such roles. Others, whilst attempting to support families, are taken across borders under false pretences. Such economic international migration, whether forced or otherwise, will greatly increase HIV rates in areas such as rural villages, that might otherwise remain relatively HIV free.

**Under Reporting**

HIV rates remain significantly under reported; causing a wide discrepancy between actual diagnoses and estimated cases. Several factors cause problems: incorrect/missed diagnosis; migration of people with inadequate coordination of reporting and recording death of those HIV+ by another cause before the onset of AIDS. This may, in part, be the cause of apathy or denial on government's behalf.

Out of the above countries, Thailand appears the only one with similarities to Cambodia's situation, which achieving any success in a government-led program. In other countries; non-government organizations may succeeding at a local level, although until the problem is adopted as a priority at a national level, such measures are best, stopgaps.
Chapter 3 - The Cost of AIDS

Cambodia has paid dearly for the Pol Pot tears. In the eighties, society continued to suffer, albeit to a lesser extent, under the Vietnamese backed government. By the turn of the century, the country could be starting to suffer again - this time - from AIDS. The cost will be felt in many areas. Economic and health costs are likely only to be limited by the inability of the country to pay the price. Socially, AIDS is likely further to widen the gulf between rich and poor. The most vulnerable, notably women, are likely to suffer the most. Knock-on effects will include decreased labor for food production, and increased medical costs while caring for the sick and dying.

Economic Costs

According to the PANGS institute, "The indirect costs of AIDS in Third World countries cannot yet be forecast accurately, but the impact of the epidemic on social and economic development may be critical"48 That was in 1988, and may seem dated, yet even now according to the Far Eastern Economic Review two different studies of the impact of AIDS in Asia have recently been published with startling variation. The first by the firm DRI/McGraw Hill suggested AIDS could cost Asian countries between US$38 billion and US$52 billion by the year 2000. Bloom and Mahal on the other hand looked at "the effect on per-capita GDP growth in 51 countries, and found it negligible". 49 In an earlier study, Viravaidya estimated that for Thailand the cumulative cost of health care plus the value of lost income, is projected to be between US$7.2 billion and US$8.5 billion by the year 2000.50 Whilst Cambodia may be likened to Thailand in many ways with regard to AIDS, its economic situation is markedly different.

Agriculture and Forestry

At present Cambodia is an importer of rice, although pre-Pol Pot the country was not only self sufficient but realized a net export. If as surmised later in Chapter 6, migrant workers are likely to suffer disproportionately from the impact of AIDS, then it follows that their original trades will bear this cost. The vast majority of workers come from rice farming, and therefore it is here that repercussions would be felt the most. Supply and demand dictates that in a free market when rice production falls the price will rise. Since rice is the staple food in Cambodia, that price would have to be paid, or imports will have to increase. In turn this would result in
an adverse impact on the country's balance of trade. In years when the harvest suffered from severe flooding or drought, this would be particularly noticeable. For example, in 1994 a combination of flooding followed by drought, caused crop failures in excess of 50 percent in some areas, such as Prey Veng, and Kompong Speu.

Families of subsistence farmers are also at risk in a number of ways. Firstly, village credit schemes may be jeopardized through those with AIDS either dying or defaulting through the lack of income and increased cost of care. However, refusing a person a loan based on their HIV status will harm them when they are vulnerable. One possible way of preventing this would be for loans to be made to the family, and not to the individual. Yet this may only compound problems for the remaining family. Deprived of a source of income, the family will already be under strain. Children may be withdrawn from school to work from a younger age, thus denying the next generation of an education without which they stand little chance of breaking out from their spiral of poverty.

Yet this may only compound problems for the remaining family. Deprived of a source of income, the family will already be under strain. Children may be withdrawn from school to work from a younger age, thus denying the next generation of an education without which they stand little chance of breaking out from their spiral of poverty.

Forestry is unlikely to suffer significantly. Whilst it may lose part of its workforce, the cash income individuals receive probably remain an important inducement for recruitment to the industry. Already many people in the sector work in malarial areas, which is likely to continue to have a greater impact than AIDS on morbidity and mortality rates, for quite a few years. The same is true of the rubber trade. Whilst there is an international demand, the companies will continue to pay salaries. Since the jobs are unskilled, the replacement of absentees should remain straightforward.

Tourism

In the late eighties, countries such as Kenya and Zambia became worried about the impact of the disease, when negative publicity about AIDS rates contributed to tourism revenue dropping by as much as 25 percent. In some countries, such as Thailand, an open sex trade, whether through direct services that may not be available in the tourists home country, or indirectly in the guise of bars and massage parlours- will inevitably result in a long term negative impact. Short term, it will continue to bring in foreign currency, yet long term it will cost the country in increased health care, and loss of earnings/tax revenue.

Cambodia's fledgling tourism trade currently focuses on Phnom Penh and Angkor Wat. Plans have been made, and contracts signed; to turn parts of Kompong Som into a major coastal attraction, including a large and
exclusive casino on one of the islands. Beyond that, at present there is little to see except for those willing to leave the beaten track. Tourism is likely to remain more susceptible to the impact of kidnapping of tourists (January, April and July 1994), and shootings (January 1995), whether by Khmer Rouge or renegade soldiers, for the foreseeable future.

The sex industry in Phnom Penh, in its capacity of catering for foreigners, mainly serves visiting Asian businessmen. In the short term, if anything, it is likely to grow in size, as a result over concerns about HIV rates in neighboring Thailand.

Concerns have been raised by some agencies, including the UN Center for Human Rights, over alleged child abuse. Allegations were made in the Australian parliament about impropriety by their citizens in Cambodia, and in 1995, a British [male] doctor was convicted of having sex with under age children in Phnom Penh. However the numbers involved, whilst significant enough to cause concern, are probably not high enough to indicate Cambodia has a tourist sex industry based upon pedophilia. For those involved in providing such services, the human cost, ranging from economic to psychological, is likely to become more apparent and increase in the coming years.

Broadly speaking, tourism is likely to be more affected by concerns stemming from continuing civil war; poor infrastructure and services; and little choice of destinations. While AIDS may become a factor, it is unlikely to be significant in the next few years.

Health Sector

The direct economic cost of AIDS to the health sector is likely to be significant. Some have argued that this may not be the case for two reasons. Martin Foreman notes that "within many developing countries some patients do not necessarily incur higher hospital costs than other patients ... This is largely because [hospitals are not] ... adequately equipped to diagnose and treat HIV-related disease". The second reason being that where high levels of HIV are reported, hospitals may find they can access additional funding.

Other studies however showed that HIV+ patients also suffering from TB, are likely to remain in a hospital for the length of time of HIV negative patients with TB. This is a significant cause for concern because
in 1994, WHO stated that Cambodia had the highest rate of new TB cases in the world. Officials warned that "the destruction of the immune system caused by the AIDS virus will increase the spread of the already prevalent TB." One physician from the National Tuberculosis Center suggested that by the turn of the century 50 percent of those with HIV in Cambodia would also have tuberculosis. Other opportunistic infections are likely to become more prevalent, due to a person's poor state of health and nutrition, with increasing risk of the more infectious likely also to be passed to sero-negative infants and the elderly.

At present where facilities do exist, for example at provincial or district hospitals; patients are charged for treatment. Many families spend up to a quarter of their total income on medication, which often involve multiple injections of vitamins, and poor use of antibiotics, with highly questionable benefit. Hospital staff rarely work nights or weekends, and consequently one or more family members must stay to look after sick relatives, often many miles from home. Besides medicine and doctor's fees, patients may be charged for the room, and responsibility for provision of food lies with their relatives. The indirect cost of this, while the patient is generating no income, and the carer is unlikely to do much work, produces further strain on the family.

Social Costs

Before developing any signs or symptoms of AIDS, a person may become stigmatized and rejected by their community. In Thailand, whole families have been ostracized, forced into leaving their place of work and moving house, when it became known one member of the family was HIV positive. In Britain to help counteract this, high profile personalities including royalty were seen to be visiting people with AIDS, and making body contact through the shaking of hands. In Cambodian culture, such body contact is uncommon, even taboo. Greetings instead consist of raising one's hands together in front of one's face, with the level signifying the degree of respect. Touching of the head, even by the dignitary, would be considered inappropriate. However, the King in the past has handed out traditional check scarves - "kramas" - to the public, which could provide dignitaries the opportunity of personal contact with those already infected. Nonetheless, such high profile meetings may prove counter productive if it was not clear that body contact has been made, especially if they identified specific individuals.
Increased Poverty

The poorest in society are already disadvantaged in three ways with respect to AIDS, according to the PANOS dossier, "The Hidden Cost of AIDS". Firstly, it is suggested that they are less likely to be literate, and therefore will probably have less access to information. This however may not be true in Cambodia. Wide use of radio and television appears to have countered the imbalance, according to Penfold (1995), who found that there was no direct correlation between migrant workers’ literacy and their knowledge of AIDS. Secondly, a low income will tend to limit access to reasonable health care. Thirdly, they start their sex life with little access to education, thus increasing the likelihood of pregnancy or contracting a STD.59

Once a person has started to develop AIDS, their health will deteriorate. Depending on whether they are self-employed, or not, may determine whether they lose their job. In the absence of sickness benefit, the worker will immediately feel the loss of income, whilst facing increased outgoing to pay for medication resulting in debt.

Women

Cambodian society is only just beginning to recover from a gender imbalance. If HIV rates were notably higher in men than women, this could signal a return to such a state. This would mean that more women were used for heavy laboring jobs, but there is no indication that they would be as well rewarded as their male counterparts. Widows of those who died from AIDS - whether infected or not - are likely to find it harder to remarry, and thus will face further stigma.60 Another consequence would be that with fewer men, a possible ratio of four:ix), one in three women would have little choice but to remain single.

If wives contract HIV from their infected husbands, this then creates an even greater socioeconomic risk. Couples have large families in Cambodia. As increasing numbers of children are orphaned, an excessive burden will be placed on the extended family. Again, the issue of stigma becomes paramount: would relatives want to cope? If the child is likely to bring a stigma to their adopters, then the answer is probably "no". This will have a significant impact on the ability of society to accept and care for children.

In the long term, even if a child is orphaned, and found to be HIV negative, then their problems may not be over. Either through stigma, or simply because the adopted parents may not have the means to provide for the
"additional" child's need, whether day-to-day, or looking ahead to elaborate and costly weddings. In these cases, particularly for women, marriage may then prove elusive.

Compassion will be the biggest way of reducing the "cost" of AIDS, according to the Chairman of the US Presidential Commission on the HIV epidemic (June 1988):

"Although we tend to view compassion as a feeling between individuals, in fact, it is a much broader concept... In societal terms, compassion must be seen as the collective will and political acts that bring about resources, structures, institutions; behaviors, and norms directed at the care of the sick, the prevention of illness, and the promotion of health."\(^6\)
Chapter 4 - Government Policy

'As the doctors say of a wasting disease, to start with it is easy to cure but difficult to diagnose; after a time, unless it has been diagnosed and treated at the outset, it becomes easy to diagnose but difficult to cure. So it is in politics

Machiavelli "The Prince"

Modern writers have stated that due to the long period of incubation, effective interventions need to be made while the threat of an AIDS epidemic remains theoretical - which is only possible by allocating resources disproportionate to the current scale of the epidemic." With this in mind, government policy is assessed to determine how it came about and whether it is efficient, effective and equitable.

The Policy Making Process

Despite AIDS having been known about since 1983, and becoming a source of concern in neighboring Thailand in the late eighties, there is no documented evidence to suggest that the Cambodian government considered policy before the first case of HIV being discovered in 1991. By then the UN were again taking an active interest in assisting Cambodia, and with them, the World Health Organization's (WHO) epidemiologists.

In May 1991 a short term plan was established. The objective appears to have been to "gain knowledge about prevention and control in the Cambodian setting". With the prospect of a peace settlement, and the uncertainty that would bring to government, delaying longer term planning at this stage might have been seen as the most credible option. Alternatively the government could be seen as stalling in the hope of assurances of international financial assistance before deciding how and when they might act.

AIDS presents policy-makers with a rare opportunity - to start from scratch. All areas from whom the policy is aimed at, through to the size of budget and resources require examination. Herbert Simon (1940 explained that this provides the opportunity for rational choice, based on a "comprehensive analysis of alternatives and their consequences." For developing countries with International Organizations and NGOs, it allows the
government to set the agenda. Particularly in Cambodia's case when NGOs were just beginning to arrive after the signing of the Peace Accord, this is an opportunity that should have been capitalized upon. Instead, the government, with WHO assistance, opted for a more conservative and detached approach based around their short-term assessment. This resulted in the birth of an AIDS Prevention Control Program, supported by a group of technical specialists. In November 1992, the need for a multi-sectional approach was acknowledged through the establishment of a National AIDS Committee. Members included senior officials from twelve ministries, and vice governors from all municipal and provincial authorities.

With the influx of large numbers of NGOs arriving in the wake of the Paris Peace Accord, the need to coordinate NGO activity became apparent. The early NGO community established the Cooperation Committee on Cambodia, which in turn created meetings for different sectors, such as forestry, hydrology and AIDS. Sectional meetings were primarily for NGOs to meet with each other, although they provided a natural forum for meeting with UN agencies and government ministries.

Around the same time, the Ministry of Health created MEDICAM, a monthly meeting in which government, UN and NGO could come together. Within MEDICAM sub-sectors were also formed, covering areas such as TB, maternal and child health, and again AIDS. Despite numerous requests for meetings, NGO members of the MEDICAM AIDS committee were ignored; and the sub-committee failed to function. This meant in practice that the only dedicated meeting to coordinate AIDS programs was the NGO-led CCC/AIDS sectional meeting.

While the initial stages of policy-making show signs of Herbert Simon's "limited rational choice" model, there are specific points that indicate a more "incrementalist" approach (Lindblom, 1959). Even "limited" rational choice requires a solid diet of reliable information and cannot realistically be based on estimates. For a country that does not even have a working system to record births and deaths, any attempt at numerical accuracy regarding population needs will inevitably represent flawed guesswork. The specific delay in formulating policy until 1991 tends to point towards a "seat of pants" approach in government commitment to policy. From the point after a policy direction was eventually set in 1991; decision making became incremental. The result, an approach Etzioni (1967) termed "mixed scanning."
Outline of the Five Year Plan (1993-98)

The plan has been summarized as having three broad spheres of work:

I. Promoting general public awareness through mass communication,
II. Improving the capacity of health workers, centrally and locally through training, which includes sex education and infection control;
3. Direct involvement with sex workers, which would also incorporate training of local NGOs.

Promoting Awareness through Mass Communication

Few would dispute the need to educate the public at large about the dangers of HIV, and the methods of transmission. Leaflets, posters, roadside advertisements and T-shirts have appeared in abundance in recent years. Radio and television stations have provided airtime ranging from free advertising time through to weekly public health slots; (the appropriateness of different forms of media is discussed later in Chapter 6, page 44).

One serious flaw in the plan is that while it can be shown that "effective" campaigns reach their intended audience, there is not necessarily a resulting change in behavior.

"Many people persist in unhealthy activities ... even when they are aware of the need to change and have the ability to do so. There is often a highly subjective element in people's attitude to risk-taking ... but many people continue to put themselves at risk of HIV/AIDS because their social and economic circumstances make it hard not to." (Italics mine)

Discussion, particularly through peer education, has proved one way of avoiding the "it won't happen to me" mentality. 69 For others, notably those in abject poverty and particularly women, their environment currently means they have little choice in the matter.
Improving the Capacity of Health Workers

One of the greatest hindrances to NAC policy lies in poverty among its own health staff. "In Cambodia, a qualified surgeon makes only US$30 a month, even less in the community health sector where most AIDS prevention work takes place" comments Dr Tia Phalla, who himself had to work as a surgeon, whilst heading the NAC, simply to make ends meet. In practice this means that it is "almost impossible for staff to go out from the cities and towns, away from the possibility of earning extra income, to provide services to the rural poor families".

A further restraint on their plans, is that the National AIDS Program (NAP) only has a relatively small budget of US$360,000 (1994). Dr Phalla once nervously explained the difficulty he and his staff had while attempting to access these funds. His comments were picked up immediately by the Undersecretary of State for Health, who pointed out that "80% of the Ministry's budget goes directly on salaries, leaving only 20% for educational programs, rehabilitation, and medical equipment." After three years of existence, it seems incredulous that the Head of the NAC had not been told this before.

Direct Involvement with Sex Workers

According to the World Bank "reducing transmission in the section of the population at highest risk is likely to have a far greater effect than reducing transmission among those who change their partners infrequently." While this may sound straightforward, identifying those considered at highest risk can prove to be quite the reverse. These include non-commercial sexual relationships (Pramualratana, 1995), as well as those working in indirect services such as massage, or cigarette and beer promotion.

An unforeseen setback to the NAC's came in August 1994 when the Mayor of Phnom Penh announced he had ordered the closure of all brothels in the capital. At a public meeting prior to implementation, direct questioning of the Mayor by Rick Renas (WHO) and Joan Anderson (SCF (UK)) speaking on the behalf of the Cooperation Committee for Cambodia (CCC)/NGO AIDS committee, failed to convince him to reverse his decision. He argued "we must stop AIDS - by closing the brothels [sic]."

When the order was carried out, most known brothels closed. Some reopened shortly afterwards posing as karaoke bars, and others as hair dressing/massage saloons, while others scattered around Phnom Penh.
establishing "underground brothels". Nevertheless Phnom Penh's main red-light district, home to more than 1,500 "taxi-girls" became distinctly quieter. This was a specific blow to the NAC who had piloted a STD clinic in the middle of the area, in conjunction with WHO, staffed by a Khmer medical team and supervised by a VSO community health worker. Attendance at the clinic dropped significantly. Even when women started returning to work, many were afraid to attend the clinic for fear of being arrested or harassed by municipal police, whose main objective appeared to be to extort bribes or sexual favours, in return for turning a blind eye. Whilst some Vietnamese women returned home; others moved into provincial towns, such as Prey Veng, thus exacerbating further the potential spread of STDs.

Implementation

Much of the implementation appears to be delegated to International Organizations (IOs), International NGOs (INGOs) and local NGOs. This however may be too simplistic an assessment. In practice most IOs, (inc. WHO) and NGOs will bring programs into the country that they are using elsewhere. Whilst they are necessarily adapted, to a greater or lesser extent, they are nonetheless "outside" initiatives. They may appear to slot into the broad lines of the government's plan, but ultimately the NAC has little control on the implementation, or modification of these programs (this is discussed further in the following chapter).

Whilst most NGOs are required to account for sustainability when submitting proposals, the issue is unclear from the NAC plan. The economy may be expanding, (around 7 per cent annual growth at present), but much business is being enticed to Cambodia with the promise of tax-holidays, (ref. Cambodian Development Corporation advertisements). Thus whilst tax revenue is expected to increase over the years, the levels of international aid are likely to fall. Dependence on international funding in the interim is dangerous. A change in US foreign policy has led to efforts to cut the aid budget by one third. Out of twenty-one activities listed in Cambodia's 1994 register of HIV/AIDS activities, four are solely funded by US Agency for International Development (USAID), and one is jointly funded. s This excludes UN-funded programs. Likewise with Japan's economy currently in a downward trend, pressure will exist to cut their overseas budget.

The British Overseas Development Administration (ODA), whilst not a major funding agency in Cambodia; froze funding to fifteen NGOs in early 1995, due to apparent concerns over security of British subjects.
working in "dangerous" areas. Whilst this was successfully contested by the London-based NGO Forum, it is indicative of problems that could arise again with very little warning, thus putting in jeopardy parts of the Cambodia governments' plans. Indeed at the time of writing, the ODA has announced their intention to cease funding activities in South-east Asia.76

Lack of Policy

What is missing from the plan, is any significant attempt to look beyond the immediate situation. Despite an appropriate focus on prevention, the emphasis is on medical and educational interventions. Both could be seen as coming under a normal health remit. Yet AIDS is a social problem, and not merely a medical one. This is recognized by some of those working on the NAC, although there is still no evidence to suggest any change in their response to the problem." A sense of equity is surely missing unless discrimination is addressed along with the root causes for those HIV affects the most, namely women and the poor.

Women

Women are likely to suffer more than men as the epidemic spreads. In the PANOS dossier "Triple Jeopardy' three distinct threats are identified. Firstly, in heterosexual intercourse, "men are twice as likely to infect their female partners as vice versa'.78 Some might argue that the distribution of condoms, and education regarding their effectiveness is the solution. However this negates the basic problem that women have little power to say "no".9 Condom promotion in itself is problematic. As highlighted earlier, the cost, as with any family planning measure, can sometimes prove prohibitive, particularly after a bad harvest." In addition the latex is susceptible to disintegration if exposed to long periods of heat, and furthermore, poor use accounts for most condom failures.81

Secondly "safer sex" - whether non penetrative or condom protected - presupposes sex without conception. A woman is then left with the dilemma of denying any maternal instincts, or putting herself, and any future children at risk. Childless women may suffer social stigma, which "may result in desertion or divorce".82

A third threat arises from a distinct lack of policy on ways of caring. Society's traditional carriers will again be in demand for both husbands contracting the disease, and orphaned children from seropositive mothers. Many
would point to the cost of cane, and say that it is better to put the limited available resources into prevention. Whilst this is a valid argument to some extent, it obscures the fact that considerable numbers of working age people will start to die in coming years. The traditional safety net provided by the nuclear and extended family, will become stretched beyond capacity, particularly in communities that have members involved in high-risk activity. It is negligent to take an "ostrich approach" to this problem. hoping that it will go away. A lack of pro-active planning has already caught Cambodia out, and may do so again. Such planning whilst eventually requiring financial resources, could in the interim be directing the Government, and outside donors, to be considering ways of re-prioritizing resources in the future.

**Discrimination**

Specific policy to counter discrimination needs urgent attention. Most countries who have experienced the AIDS epidemic have been through the "rubber gloves" phase. Ignorance among health workers is likely to quickly rub off on the public. Whilst most countries appear to rely on broad education on how HIV can and cannot be contracted, some countries (eg. Germany) have had specific campaigns aimed at promoting tolerance, and more importantly understanding.

**HIV Testing, Commerce, Program Coordination, and Evaluation**

Four final areas lacking policy are worth highlighting. Whilst a stated aim is to earn out surveillance in Phnom Penh and the provinces, in practice there appears little allocation of funds to meet such an aim. To date, the availability of testing in Cambodia is limited to that conducted by the National Blood Transfusion service, (externally funded), and the Pasteur Institute, who charge a 'moderate', and apparently variable, fee for their service.

In a number of countries various National AIDS Programs have helped business realize the cost of ignoring AIDS, through legislation on voluntarily. Although Cambodia has little established industry, significant numbers of multinational companies are now entering the country. These, probably more so than existing business, are better placed to be involved in educating their staff, and could assist the NAC if committed to doing so.
Part of Cambodia's problems on coordination stems from the delay in taking action until HIV was discovered in the country. Even so had they acted promptly they could have mobilized incoming NGOs and UN agencies more effectively, thus ensuring that areas that posed a potential problem were adequately covered. These should have included instigating a wide range of programs amongst, for example, commercial sex workers in the capital in Battambang, and the port of Kompong Som. Two other areas, Sisophon, close to the principal border crossing into Thailand, and Koh Kong's port, would have been advisable, although security, especially for expatriates, may have been problematic. Nevertheless, training programs could have been instigated and teams dispatched to work in these areas, where necessary funded through UN agencies.

Finally, much has been written on the need for effective evaluation of AIDS interventions, (e.g. Mertens et al. 83) Results from all programs, whether government, UN or NGO, should be fed back in a form easily comparable by the NAC. Failure to do so represents a potentially ineffective use of existing resources, and does nothing to help the NAC in planning for the future.
Chapter 5 - The Role of NGOs and UN agencies

Without international assistance through UN agencies and the NGO community, it is questionable whether the Cambodian government would have had the inclination, motivation and resources to launch a National AIDS Program. It is important therefore to question to what extent are the UN and NGOs acting as a substitute for government action?

Several specific points are addressed in this chapter. The first section looks at the inherent differences between the UN, NGOs, and the State, insisting that NGOs should have the freedom and flexibility to experiment with alternative approaches. Indigenous NGOs are already emerging, although so far there still appears to be a distinct lack of local support groups. These have proved invaluable in countries such as Thailand, although they will initially need nurturing by NGOs and government. Secondly, the HIV epidemic, unlike other preventable disease "has the capacity for relentless growth", which means any interventions must be able to sustain increasing need. In the NGO sector two approaches are considered; the "medical model", and second a "people-center" technique, both of which are examined for their effectiveness, catchment, and potential sustainability. In addition and pertinent in its own right is social marketing, which is a growing force, although not welcomed by all. The third area looks at the idea of an "implementation deficit" - why plans rarely work out as intended. Finally, the issue of cooperation and coordination between NGO, Government and UN agencies is assessed, outlining how corporate individualism is hindering the effectiveness of an agreed objective.

The Role of the United Nations

For UN agencies such as WHO, UN Development Program (UNDP), UN Children's Fund (UNICEF), their role is one of working in conjunction with the NAP, and government initiatives. Looking at the (somewhat incomplete) register of HIV/AIDS activities in Cambodia for 1994, UN agencies are almost without exception involved in supporting government departments. (See Table 2, Appendix A, page 52). This shows the role of the UN agencies is currently directly linked to aspects of the NAP. Indeed WHO have had a technical officer working within the NAC for several years, and UNDP recently appointed a AIDS coordinator in 1994.
Current limited financial and human resources generated by the Cambodian government, make it appropriate for the UN to provide such assistance for the moment. With a vast wealth of technical and financial resources at their disposal, UN agencies are well placed to advise the government on policies that have proved successful elsewhere. Countries such as those in sub-Saharan Africa, and more local neighbors including Thailand, have much to offer in terms of lessons already learned.

Non Government Organizations

Unlike the UN, which is essentially an International body, non government organizations, are inherently different by definition. Lacking the resources of the UN, and the formal authority of the National Government, NGOs' strengths lie in reaching communities at grass roots level. With them, they bring a combination of technical skills, several decades of project experience. flexibility, mobility and innovation. "Voluntary action can be more spontaneous" points out James Douglas, unlike state action which "has to fit a pattern of rules". Douglas also argues that

"Governments, perhaps more by convention than by strict democratic theory, have to adopt the convinced approach of acting on certainties rather than the tentative approach of the experimentalists ... If the approach has already been tried by a voluntary body and proved viable, government can then follow using the experience gained by the voluntary organization." 88

Storck and Brown (I992) accept this is the case. "In Rwanda, Kenya, Uganda and Tanzania, for example, NGOs have helped review national Medium Term Plans to combat the pandemic". At present however, such a formal role for NGOs appears absent from Cambodia's National AIDS Committee agenda.

The Emergence of Local NGOs

A number of groups have emerged acknowledging the need to respond to the potential AIDS crisis. Students' groups have actively supported AIDS prevention work. Others include- the Khmer Youth Development organization, that started life in the refugee camps on the Thai border. The Christian Response to AIDS, initiated by Christian INGOs, was to provide a channel for the indigenous church to respond to AIDS in their
local community. Within twelve months it was run entirely by Khmer. As with many local NGOs, they still rely heavily on INGOs for funding.

Various women's groups, such as the Battambang Women's Association, have become prominent in the search for ways of applying the brakes to the epidemic. Many of these tie their activities in with issues of human rights. Participants are almost exclusively "middle class" - few if any "working class" women could afford the time required to get involved in such groups.90

INGOs have already learned many lessons that can be passed on to their local counterparts. Poor styles of approach and presentation can lead to local NGOs alienating their fellow nationals. The negative use of fear is one example, according to Dr Homans (ODA), which resulted in the AIDS virus being characterized as a "hairy monster". That said, INGOs sometimes still use such characters themselves.

Local NGOs do have several advantages over other agencies. For instance, they can reach sections of the community that INGOs would traditionally find difficult, such as students on a university campus. They are also likely to be the ones who could care for those dying most appropriately. In Thailand, for instance, people dying from AIDS/Aids Related Complex, were frequently stigmatized. Therefore an INGO chose Thai staff to visit people at home, thus reducing the rumors likely to spread if a "fearing" (Thai for "foreigner") were seen to visit. This reinforces the need for international and national NGOs to work less in isolation and more in partnership with each other.

In the coming years, AIDS orphans will increase in number. If patterns in Africa are followed, then there will come a point where the extended family will no longer be able to manage. 91 In the absence of any foreseeable government program, the early encouragement of local support groups may help in enabling families to learn how to take the strain, and whom to turn to when eventually they can take no more. In the early stages, such groups could be taught counseling techniques, for those who discover they are HIV positive. At present there are no established counseling services. Such groups could perform a dual task: assisting a family in planning for the loss of a member, and the income that they bring home: and ensuring the family is aware how
HIV can, and cannot be spread. This latter part could hold the key to containing what otherwise could be an exponential growth in HIV rates, should entire families become infected.

**NGO Approaches**

Currently within NGO circles there are two main schools of thought regarding HIV prevention. The first relies on the "medical model", (sometimes called the "vertical" approach’), which also acknowledges AIDS is a social problem. It is thus tackled in its own right by AIDS organizations, or those with an AIDS program. In practice it involves condom promotion, frequently integrated into STD or birth spacing programs. Health workers are trained in sterilization techniques, and may even be provided with the equipment to facilitate this in their working environment. Campaigns reach wide audiences through video, radio, posters and leaflets that explain how it is, and is not, possible to contract the AIDS virus. Stated aims might include the limitation of the spread of HIV, and the promotion of behavioral change - although the latter often proves distinctly elusive, or at best only produces modest results, (eg. Swaddiwudhipong et al., "Condom promotion and behavioral change"93). This is particularly the case in short-term public communication campaigns, which usually require a long term commitment to have an effect. 94 This approach on its own should therefore been seen as primarily raising awareness, rather than necessarily inducing behavioral change. 95 The approach is dependant on external input, either from government, NGO, or another recognized source. It therefore has limited sustainability.

The second approach is using a "people-centered" approach, (the "horizontal" approach). Organizations applying this method, tend to use it without singling out AIDS as an inherent "problem". Baseline studies; (eg WVI Rapid Appraisal Survey, Oudong district, March 1990), have shown that most communities do not list health as high on their agendas. Other factors higher on the village agenda might include water resource management: drinking water and sanitation; school buildings; and credit programs.96 Even when health is raised, issues normally relate to treatment rather than prevention. Such problems often have a more fundamental root, (see Box 4 below), and tackling them individually is seen as relatively futile.

By mid morning a large crowd had gathered to watch an AIDS video from a television balanced on pickup truck's roof. Onlookers were handed leaflets by the NGO's staff. Strips of four condoms were given to small groups of taxi-drivers, and laborers watching from the periphery.

In Pre Cla village, a similar scene developed late afternoon, outside the family planning clinic. Men chuckled as they saw the condoms. Asked if they knew how to use one, a young man with s. amusement said "no". Sareth unpacked the condom, and then she demonstrated, by rolling it down the handgrip on the man's motorcycle.

To Christian Outreach's (CO) community development team, the distribution of posters and condoms in itself was an unusual exercise in mass-communication. It rode on the back of support. International AIDS Day, although it was otherwise unconnected with their "people center" approach.

In the coming days and months, discussions started during walkabouts, and village meetings. Common issues from domestic violence, to the poor harvest; and a shortage of money for birth spacing supplies all brought AIDS back into peoples' minds. How to negotiate with a violent husband. How to prioritize with what little money is available. To the villagers these are all real issues, which inadvertently hold answers to AIDS prevention.

Box 4: Source: Personal anecdote from my time with Co-Cambodia (August 1993-Junly 1995)

This approach is different to using HIV community workers, who "often face the challenge of addressing issue which communities rarely want to discuss, let alone prioritise". One benefit of a people cent approach is sustainability - coming about through development of choices which people are empowered make for themselves. Inherently this requires less external intervention. Probably the greatest weakness of this approach; is the time involved in building relationships; and the very limited catchment of such programs.

In a climate where an epidemic is dawning at an alarming rate; the question remains - is this intrinsically small scale and time-consuming method a viable approach?

It would be wrong to suggest that only one approach is right. The question is therefore one of balance. The second approach benefits from public awareness campaigns. Martin Foreman (PANGS) explains that, with peer education from trusted individuals and the provision of counseling services, the first approach, which appears to make all the right noises, «ill generally fail to effect behavior significantly."
The Role of Social Marketing

Social marketing serves a number of purposes. The first and most obvious being that such organizations have a product; which is considered of benefit to the community. Selling it cheaply, rather than giving it away free has two main purposes. Firstly it attaches value to the product. Secondly, it uses the existing commercial channels of distribution, by attaching profit to their product. Consequently with an active sales back up, and financial incentive, thousands of pharmacies, rather than a limited number of clinics, provide a national outlet for the product.

The second role of the marketers, is to change attitude. By "redefining HIV/AIDS as a 'lifestyle' rather than a venereal disease" they bring the notion of choice back into peoples' perception.' In a country where late is seen as part of living, this potentially represents an important break with current perception.

Condoms have yet to gain acceptance in Cambodia. In a nationwide survey, (Save the Children Fund 1995 Knowledge Attitude and Practice (KAP) survey), less than 1 per cent of women used a condom as a means of birth control. Despite this, Population Services International (PSI) succeeded in selling 1.6 million condoms between their launch in December 1994, and June 1995. Some of these however, have been purchased by to supply their own AIDS prevention programs, and existing birth spacing initiatives.

Concern was recently expressed in India, where free condoms are being phased out by the government. Opponents claimed that a conspiracy between donors, social marketing companies, and "subservient national policies" were leaving potential users with nothing. The head of India's NAP responded by saving that `once people realize it's a life saving device; the price tag will not be a problem". The difficulty therefore appears to be in the interim, between the end of free supplies, and the point where the benefits of condoms are widely appreciated.

One idea yet to be tried by marketers, is the 'Femidom', (a female condom). At a recent conference on "AIDS in Asia", Dr Hilary Homans (ODA) reported that trials looking at acceptability, had taken place in Papua New Guinea. As in Cambodia, women there are not considered equal with their husbands. Nonetheless responses were encouraging with 95 per cent of women saying they would use one again. They reported feeling "safer and more in control". Men also said they preferred it, as less restrictive than a male condom, and it absolved
them of responsibility for unwanted pregnancies, or their wives contracting STDs. Anecdotal evidence indicates that health workers and CSWs in Cambodia would be interested in such an idea." Dr Homans stated that WHO are currently negotiating with manufacturers in an attempt to bring the price down to a practical level - the principal reason it is not yet being tried in Cambodia.

Cooperation and Coordination

Within Cambodia there are more than sixty registered INGOs. Of these around fifteen are actively involved in AIDS prevention programs. In addition there are five UN agencies, either funding, or working directly on AIDS programs. Add to this, a small, but increasing number of local NGOs, and it quickly becomes apparent that cooperation would be desirable, and coordination would be wise. To date the principal forum for this has come about in the NGO-led Cooperation Committee for Cambodia, which runs an AIDS Cooperation Committee meeting in Phnom Penh, once a month. Coordination remains limited and voluntary, with the degree of involvement resting with individual organizations.

Restructuring of CCC's AIDS committee took place in April 1995, which led to the formation of a Steering Committee. This in turn would oversee three working groups on: training; mass media; and behavioral research. In practice, the committee tended to be reactive, embracing new ideas, or planning events such as AIDS day. It also provides a good forum for the presentation and discussion of research, and conference reports. Most NGO activity was focussed around agencies such as Redd Barna, CARE, World Vision, and Save the Children Fund (UK), although none have sought a coordinating role. Each had their own AIDS experts, who more often than not, came with experience from other countries. Their broad agendas were set, each quite rightly in one sense, having a long term strategy for AIDS prevention.

Yet this inherently hinders cooperation, and leads to a fragmented and disjointed approach. In August 1993 Dr Tia Phalla (NAC) and Rick Renas (WHO) specifically requested that NGOs plans were discussed with them. Collaboration and proactive planning cannot really be said to exist if the National AIDS Committee is only consulted when locations of work, and types of program are not included in the agenda for
discussion. It would be true, and not entirely unjust, to say that lip service is paid to coordination. This is true of NGOs, UN agencies, and the NAC, (and equally applicable to other sectors other than AIDS, and is almost certainly true in many similar situations in developing nations.)

If the analogy of building a road from A to B were to be used, the amount of coordination which NGOs (etc.) currently exercise would result in disaster. One might say they are working in A and B, but not in between, and their specialty is surveys and engineering. Another may be good at signposting, and lighting. Still another works in an area just outside A. and with its moderate budget, can build a stretch of road two lanes wide, with reasonable foundations. A fourth is good with maintenance, but only works in town B. The UN enters the scene; and has already done the surveying, and would like to do a different route, via C, having devised plans with a four-lane width, and deep foundations. They are working with the government, who have also been approached by country X that wishes to fund a couple of high-profile bridges.

Unless pro-active planning is implemented, across all the agencies concerned, then differing sized pockets of AIDS prevention, will be all that result from the millions of dollars and time devoted to the task. There is still much to gain from greater planning and coordination.

The Implementation Gap

Whilst not negating the need for greater pro-active planning, efforts will inevitably suffer from the "implementation deficit", due to the increased stages and inter-organizational linkages involved. Indeed such coordination may in fact exacerbate the deficit. One area where the analogy falls down, is that road building is normally done by one organization, which subcontracts to other companies. In the autonomous world of NGOs and UN agencies, this would be difficult to achieve. However, this should not negate the responsibility of those involved to seek to optimize coordination at each stage.

Hogwood and Gunn compiled a list of ten preconditions for successful implementation, which included "external" factors such as implementing a program that does not have a proven link between cause and effect, thereby failing in meeting its objectives. "Internal constraints involve the availability of the required resources, whether financial, material, or human. This latter category is particularly pertinent for countries
considered "dangerous", and agencies do sometimes experience difficulty in recruiting appropriate expatriate staff. (particularly true after the Khmer Rouge kidnapped foreigners in 1994).

Specific areas that may cause difficulties, within Hogwood and Gunn's criteria, include the volatility of security, which for Cambodia means that an area may be deemed "safe [enough]" one week, and then be subject to attack. The main arterial Route 4 from Phnom Penh to Kompong Som is a classic example. Used frequently by UN and NGOs after the elections until the kidnapping of three expatriates from a taxi in April 1994 by Khmer Rouge guerillas resulted in travel restrictions being imposed by Embassies, and voluntarily by NGOs themselves.

It is likely that a failure to locate identifiable groups, such as seasonal migrant workers, would fall into the trap of being a "crippling constraint ... external to the implementing agency". Another example, mentioned in an earlier chapter, involved a lack of agreement among the players, which led to the undermining of the NAC's authority by the Mayor of Phnom Penh. His decision to close all the brothels, impeded the AIDS prevention program with commercial sex workers at Toul Kork's STD clinic.

One of Hogwood and Gunn's first criteria states that adequate time and resources must be available. Changes in development aid policy by the US and British governments implicitly endanger programs designed to run for longer than current funding allows. Particularly when entering a new country, organizations face several unknown factors, such as the time needed to establish protocol agreements with various Ministries, and difficulties in communication in the absence of adequate telephone and postal coverage. Time is also pressured by Cambodia's 25+ national holidays, originally instituted to ensure adequate holidays, in the absence of annual leave provided by benevolent employers. When the two are combined, sore organizations realize they are only working 10/2 months of the year. In addition, agricultural demands mean few meetings are possible during the rainy season, due to villagers rice planting, transplanting, and later harvesting.

The penultimate precondition for perfect implementation on Hogwood and Gunn's list, refers to "perfect communication and coordination of the various elements in the program". As the previous section demonstrates, while having made some progress, Cambodia still has some way to go.
Chapter 6 - The Role of Migrant Workers in Spreading HIV

Migration may become not only a contributing factor to the spread of the [AFDS] epidemic, but also a consequence, as deaths within a family, loss of land or unemployment force surotoors to seek a livelihood elsewhere.

Despite both posing a risk, and simultaneously being at risk, migrant workers in Cambodia have largely been ignored. They have fallen into the gap of not been "at home" for organizations working in the villages, and they are also not a static entity long enough to be the focus of attention in their place of work. This chapter examines why migrant workers are relevant, and is based on existing uncoordinated approaches and policies.

The effectiveness of current methods of outreach through mass communication is assessed, in the light of recent research among the migrant population in Cambodia. Poor cooperation between NGO, UN and government has resulted in too many small media campaigns having too little reinforcement. This, it is claimed, is leading towards tiredness among the intended audience. On a regional level, international government cooperation barely exists, and recent proposals for cross-border efforts are weak and require further thought. Finally, reasons for migration are considered alongside ways of reducing the rural exodus.

The Relevance of the Migrant Worker

It was in I993 that UNDP, in publishing the results of a Survey, reported that "Available data suggests that the main risk groups are commercial sex workers, their clients, and their spouses. Another high risk group may be itinerant group [sic] such as fishermen and traders" (italics mine). Later in 1993, a report was published by Chulalongkom University and the Thai Ministry of Health, which stated that "except in the case of Bangkok, at least 98 per cent of all AIDS-infected Thais live in rural areas" and went on to say that this could be a case of migrant workers transmitting the virus.111
In India, as in other developing nations, "... HIV is known as the poverty virus, because it hits the poor the hardest. One of the segments most vulnerable to the AIDS virus today is migrant labor. Work patterns that bring rural labor into the cities for employment put the rural population at a very high risk."

In recent years a number of studies in Cambodia have looked at commercial sex workers, either as the sole focus, or partial focus of their research. Evidence from those working among such groups suggests that these women often only stay in one location for a matter of months. They are frequently forced into their work. Some are kidnapped and later escape. Others are paying off debts they built up, often unwittingly, from money lent indirectly from pimps. How much involves national migration, or indeed international migration, is still a subject for study. At this stage though, it would be fair to postulate that some will become infected in centers such as Phnom Penh, taking the virus back to their village or home town. This however excludes their clients from the equation.

In the capital, interviews with health workers and commercial sex workers; indicate "taxi-girls" would have intercourse with up to ten partners per night. It would be logical to assume therefore that whilst sex-workers are the principal point of transmission, they are not necessarily the main carriers. In other words for every commercial sex worker, there will be an unknown, but presumably considerably larger quantity of male clients. If all these clients came from the same city, then planning for increased demand on the health infrastructure, would be that much easier. If Thailand's lead is followed, then this will not be the case.

In an attempt to work among commercial sex workers, a program of integrating, STD clinics into known "red-light" districts is already underway in some areas. This follows the successful pilot of the MoH/WHO clinic on Tuol Kork's dike, (which would draw CSWs from as far away as Kompong Som and Siem Reap). It is because of this that attention is turned to migrant workers as a case study; who appear to be generating legitimate concerns about their potential role in spreading HIV.
Group versus Behavior Theory

In the past there has been much talk of "high risk" groups. Recent moves have shifted thinking towards behavior and away from targeting specific groups, (ref. Ramah and Cassidy in Sepulveda et al.; Phan and Patterson). This has stemmed from an understanding that "hidden" groups are also major recipients of infection from so-called "high risk" groups. Partners of those who have indiscriminate unprotected sex are one obvious example. As mentioned in Chapter 2, children are also at risk; due to the sharing of syringes for nility medication.

A second problem with talking about "high risk" groups, is that it tends to imply a high percentage are at specific risk of infection. Yet even in these groups there will be anomalies. Commercial sex workers are an obvious category for being labeled high-risk. In practice those who serve the lower priced end of the market are less likely to use a condom, and are therefore at a higher risk than those who charge more. That said, Jacques Dunn points out that more expensive "higher class" sex workers are perceived as "cleaner", and therefore clients are less inclined to wear a condom.113

In a survey of migrant workers, 26 percent admitted having slept with a taxi-girl at least once in the last Near. Sixty-six percent of these men said they used a condom at least some of the time. Of those who said they did use a condom sometimes, only 29 percent thought a condom could reduce the risk of infection from HIV. In essence that means that two thirds of migrant workers who admitted sleeping with taxi-girls, are unaware of the benefits of a condom, or chose to ignore such benefits. Since fewer than 2 per cent of married couples use a condom, this inevitably puts women at risk.114

There is a third area of difficulty when tackling "high risk" groups -generally they are part of the community. Any cyclo riders are not migrants, although numerous migrant workers do ride cyclos. Commercial sex workers may be active for under a year, before escaping, or returning to their families. Fishermen, while turning to the same port on a regular basis, may be away for weeks or months at a time. Therefore finding such groups proves difficult.

A fourth, and significant reason for rejecting the "high risk" label, is naming such groups has in past led to discrimination. In the West, AIDS was initially labeled as "the gay plague" due to the initial high incidence.
among homosexual men. This in turn led to calls from the gay community of "homophobia" against sections of the heterosexual community. Far from helping the situation, it led to an increase in the existing contempt between such groups. In Britain identification of the gay community as the principal "high risk" group proved detrimental.

"Had there been no identifiable community to which the disease could be attributed (by those so inclined), there might have been less inclination to look for life style causes of the disease. By the same token, the exclusion of gay groups in the UK may have left less excuse for prejudice and delay within government."

The result has been to emphasize behavior. In Cambodia this focuses on safer sex practices, although it has been backed up by other recommendations such as "use a clean needle every time" - one of the slogans used in the 1994 National AIDS day. Known brothels have been targeted with posters, although these are occasionally met with resistance, with owners claiming that they are "a defamation of their reputation".

Naming high risk groups also reinforces the "It won't happen to me" idea that pervades most peoples' minds, with perhaps the obvious exception of those in such categories. In Britain this was innovatively tackled through advertisements in fashionable magazines that contained a mirror with the slogan "Now you know what a typical AIDS carrier looks like."

If behavior is to be targeted, when practiced by much of the population, then the effect of individual organizations running isolated campaigns might be likened to throwing a solitary bucket of water on a large fire. Although there is scope for broad national campaigns, targeting an audience would appear more sensible, when tackling specific behavior. For commercial sex workers this means shifting emphasis away from mentioning them in campaigns, whilst working with them to increase the numbers practicing safer sex.
Use of Media Resources

Various forms of media have been used by the government, and NGOs. The widest reaching are radio and television. The United Nations proved the use of radios as an effective means of communication, through their innovative use of 'Radio UNTAC' in the run up to the 1993 elections. Inexpensive radios are widely available, even in the more remote provinces. Radio campaigns have featured on the four stations based in Phnom Penh. Public health messages have been supplemented by AIDS songs.

Messages have also been broadcast on national television. Dr Sam Ouem (NAC) said that requests had been made to the three television stations to broadcast various themes including: discrimination and misconceptions: how to use a condom correctly; running "Susy's story" (an Australian AIDS story), and showing a short Khmer drama. However airtime is precious even in Cambodia, and broadcasters are under pressure to dedicate more time to business campaigns, because it generates more income.

Even in remote villages seeing televisions is common. Despite the lack of mains electricity, many are run from car batteries. In restaurants they are frequently connected to videos, which tend to show popular martial-arts and "Rambo" style films. However several AIDS videos have been made, and circulated to a number of such venues. CARE commissioned a popular video, using one of Cambodia's better known actors. In a Khmer quasi "Chaplin" style, the video is highly watchable; although possibly extends beyond most people's span of attention. Other sources of media include messages in newspapers; leaflets and booklets: posters, and road side hoarding (billboards). As part of training health workers, NGOs have used a number of the above resources. Training may vary from simple lessons in the dangers of AIDS, through to sterilization techniques for syringes.

Despite a variety of methods having been used, the only two consistently acknowledged forms are radio and television. Newspapers, available in Phnom Penh and certain larger towns. have "not provided quality information about HIV/AIDS and serve only a limited section of the population' (Phan and Patterson, 1994). Radio however, was thought to be a "good source of information". This was echoed in a survey of migrant workers and their families (Penfold, 1995), which found that 54 per cent of respondents had heard about AIDS through the radio." The same survey found that equal numbers had heard through the television, which suggests a change from Phan and Patterson's.
Are These Methods Effective?

Knowledge

The "migrant workers" study found regional variations in which media mentioned, with radio being the most common source in the port of Kompong Som, while television was mentioned more frequently by those in the capital Phnom Penh. There also seemed to be a split between male and female, with most men only stating one source, while women tended to mention both the radio and television. Around 22 per cent of women said they had also heard through their friends, which might suggest they discussed what they heard.

When "how people heard", was cross tabulated with their "score", (based on their knowledge of methods of transmission), it was discovered that a combination of radio and television produced the best knowledge. Second most effective was radio on its own, with television being the least efficient of the three options; (other sources such as leaflets, posters, and "from a health worker" were mentioned infrequently and became statistically insignificant.) Furthermore, when asked if respondents felt they had received enough information about AIDS, of those who heard by "television [only]", 95 per cent said they felt they knew enough, (although such belief was not reflected in their actual knowledge). This dropped to 87½ per cent for both "radio [only]" and "radio and television [combined]" respondents.

When their score was modified to look at their knowledge of behavior that carried intrinsic "risk factors", the results justified some concern. Of those saying they had heard enough about AIDS, nearly two thirds answered three out of five questions incorrectly. The study concluded that despite sustained campaigns in the national media, the audience was in danger of becoming tired of listening to repeated messages. Analysis of the "scores" showed that such messages had failed to communicate effectively that body fluids are the only source of infection, and that condoms can reduce the risk of infection.

Practice

Statistics on people's knowledge about HIV/AIDS are useless unless they translate into a change in practice. Condom usage among migrant workers appeared to be lower than might be expected when measured against a recent nationwide KAP survey. This was supported by findings in Pramualratana's survey of cross border movements along the Thai-Cambodia border, who found that "condom use in commercial sex establishments
by Cambodian and Thai fishermen is extremely low” Not surprisingly perhaps, he also found that women have "no bargaining power with their husbands with regard to condom use”.

Pramualratana makes a number of recommendations, which address issues raised. Several of his recommendations involve a combined Thai-Cambodian approach, with counseling and campaigns to be conducted trilingual (including Vietnamese). Whilst the recommendations appear valid, the recommendations overall fail to address three issues.

The first is that whilst they advocate a cross border approach, it resembles a micro-level solution that falls short of any attempt at significant regional cooperation, despite his acknowledging the need for this in the report's summary. Secondly, excepting one area where he states Thai health personnel and volunteers are available, he fails to explain where the additional resources should come from to implement such a program. One of the recommendations includes free condom distribution. This is not only costly, but works in direct contradiction of the social marketing efforts of PSI, who are currently making successful inroads into promoting condom use within Cambodia. Thirdly, whilst explaining the need of audience segmentation, the reason for focussing on Koh Kong, (see map, Appendix C, page 55), and the surrounding area, is far from clear. Cambodia is currently seeing rises in HIV rates across a number of principal towns and cities. Koh Kong is undoubtedly one of them. Yet the highest rates recorded so far, have been in north western Cambodia, in Sisophon, (see Figure 2, page 10), which is situated close to the main Thai-Cambodian border crossing. The study has clearly identified areas of need, but the solutions are weak in terms of their feasibility.

The "Environment Model" and Causal Factors

Another school of thought moves away from the "medical model" of tackling the spread of AIDS. Instead it takes a causal look at why primary-infection groups become "high risk". Concentrating on Cambodia, such groups would include commercial sex workers; migrant workers (including fishermen and wood cutters); and the military. Of the first two, many are often forced or lured into their occupations for economic reasons. Migrant workers often leave home because there is only one harvest per year, and have either few or no alternative sources of income during the dry season. The military are frequently away, due to continued fighting with the Khmer Rouge; particularly in the dry season, when the government takes the opportunity of easy vehicular access to launch offensives.
While this latter approach takes steps to consider cause, the resulting initial prescription is flawed. Economic migration exists in most societies, although there are normally more alternatives in more developed environments. Secondly while there is scope for reducing numbers, the trades mentioned are all part of society. The "taxi-girl" is a member of the oldest profession in the world: the wood cutter, will do so for personal use, even if not for profit, and the military will be a necessity in most countries for the foreseeable future.

**Applied to Migrant Workers**

Most migrant workers are only seasonal, and the majority are traditional subsistence farmers. During the rainy season, rice becomes scarce and consequently the cost of living increases. In order to assist during this time, members of the family (predominantly men), will leave during the preceding dry season and work in centers that provide a greater diversity of employment. They could stay on in these centers during the rainy season, but this would create too great workload for the remaining family. One way to overcome this is for the family to hire oxen to plough the fields, or to hire additional labor for manual ploughing. With the limited income from migrant work, neither option is sustainable. As a result, the migrant worker returns.

There are two approaches to tackling the HIV spread with migrant workers, although it applies equally to commercial sex workers. The first involves looking for ways of removing them from the situation. This would embrace the "environment" model, as mentioned earlier. This can be done through creating an advantage in staying in their community environment, or alternatively by penalizing them by making migrant work uneconomical. This latter one may take the form, for example, of increased fees for licenses for cyclos, or motos, or by ensuring fines are collected. In practice, it would prove open to widespread corruption, and would only prove vaguely workable for selected trades or professions.

The former solution involves providing incentives for the worker to stay within daily commuting distance of his village; (other than CSWs, women rarely migrate). Schemes such as World Food Program's (WFP) "Food for Work" have sought to involve entire members of communities; in building local irrigation canals, roads, or dams. These have taken place in the dry season, while rice prices are high, and before work begins on ploughing, sowing and planting the land. Despite WFPs aim of getting away from the notion of "handouts", such schemes are in effect still reliant on support from donor nations. They therefore should only be considered as representing a limited and short term solution.
A second way of enticing villagers to remain in the village, is to provide alternative employment. Most farmers presume that the dry season cannot be used for growing rice, unless they are near a plentiful source of water, such as a river. Recently some community development programs have looked at ways of tackling this, by introducing alternative sources of income generation.

One program has seen the introduction of "treadle pumps". (suction pumps suitable for small scale co-op production). The pump is now produced in country by a small number of blacksmiths. These are bought by farmers who in turn draw from water from a few meters down, thus providing irrigation for small scale crops. One farmer started growing mushrooms, which had previously been in very short supply. He paid for his pump from only two seasons' profits. The same organization has also promoted the manufacture of low technology solar dryers, for food preservation; again these are now manufactured locally.

Village credit schemes allow villagers the ability to borrow money to establish their own businesses. In giving people the ability to make choices about their economic future; such schemes inadvertently contribute to the reduction in those villagers contracting HIV, through reducing the necessity for migration. Once established, a revolving tillage credit scheme should be managed by a village committee, who are responsible for ensuring collection of payments, whilst levying a manageable level of interest. The initial capital injection is given to the committee; and the scheme "belongs" to the villagers, therefore making it more likely to be sustainable.

Etherington, in his analysis of [principally migrant] cyclo riders, specified three main reasons that prevented respondents from leaving their work:

Lack of skill polarized them into certain types of employment;
Lack of income to satisfy subsistence needs meant that there was little venture capital available;
There are few viable forms of alternative income generation in rural areas.

These criteria would generally be applicable to most forms of migrant work; and do not appear unique to cyclo riding.

In his conclusion he went beyond the economic implications. and stated that "migration caused problems in respect to the cost of travelling, and increased burden on the respondents' wives and families'. Returning to AIDS, the problem is inherently social and economic. Despite the apparent lip-service paid to it being a multi
sectoral approach, unless the government and cooperating organizations recognize that this is a social problem in its truest sense; then efforts will continue to fall short of the mark.

Summary

Public health workers need to be aware of the role migrant workers may be playing in the spread of HIV in Cambodia. Attention is required in planning media campaigns, promoting STD, specifically HIV, testing, and considering ways of caring for the families of those who may soon begin to show signs, and will eventually die as a result of AIDS. This should all be done at a policy stage, and without reference to them as a "high risk" group.

At the same time, and with no less zeal, those involved on sectors such as rural and community development; irrigation; those involved in promoting alternative sources of employment, such as NGOs and the UN's International Labour Organization (ILO), must consider their part. Apart from reducing the need for migration, the active use of discussion groups in villages as discussed in Chapter 5, needs to be implemented. It is vital that if the husband contracts HIV, wives are empowered to limit the spread as much as possible. Where condom use is nonnegotiable at present, ways of promoting it should be advocated; particularly in the presence of a STD. Failing that, women should at least be aware of the danger of passing HIV through unsterile syringes, and ways of reducing such risk.
Chapter 7 - Conclusion

The AIDS epidemic has arrived in Cambodia and the cost is going to be high. Even while writing, new estimates from WHO have been released suggesting that "between 50,000 and 90,000... are HIV positive".\textsuperscript{130} In one sense the figures cease to hold relevance. There are actions required to be taken by government, UN, NGOs and individuals - whether there are 7,000 or 70,000 already infected.

Despite the good intentions of those involved, AIDS prevention can be summarized as uncoordinated, unnecessarily incremental, and failing to shift perception of the issue from primarily being one of health to one equiring a wider social response. As a result of this perception, and a lack of significant thought towards the future, the focus of current attention is too narrow. Migrant workers, whose movement poses a significant threat to the spread of HIV, are one of the groups ignored and disadvantaged by the limited view of current interventions.

In practice behavioral change is proving extremely slow and has failed to halt the first stage of the epidemic. The second wave of infection, which is "a more slowly developing but larger epidemic" must be planned for without delay."\textsuperscript{131} Limited resources mean efforts need a clear focus, particularly in public awareness campaigns, increasing peer group discussion among commercial sex workers, and establishing a network of support groups. These should aim at limiting infection among the families of those known to be HIV positive interventions in Tanzania suggest that reducing STDs can also have a dramatic effect on HIV prevalence. Therefore replication of Toul Kork's STD clinic inside other red-light districts should be a priority. In rural areas, interventions must aim to integrate a pro-active STD service into the existing health service infrastructure, thus creating fewer problems in finding those far whom preventive counseling would be appropriate.
Meanwhile, the deficits in government policy must be addressed. Whilst it is laudable that Cambodia so quickly decided to take a multi sectored approach to the epidemic, evidence of action by other Ministries has yet to be forthcoming. Unless each Ministry involved reflects upon how it can assist, occasional prodding by the NAC will have little effect.

UN agencies should take a look at how they are attempting to coordinate their actions with government and NGOs alike. In the past, for example, UNICEF has successfully brought the Ministry of Health, Provincial and District Health Committees, and NGOs together for *National Immunization Days*. Whilst limited to the field of health, such coordination would be invaluable for more coordinated HIV prevention campaigns.

NGOs' staff are better positioned than most to advise on problems of implementation facing policy-makers. However unless they are more involved with the NAC and their efforts better coordinated, then little will change.

People do not face the AIDS epidemic in isolation from their personal circumstances. It is within the confines of such circumstances that choice has to be made. A key for policy-makers and individuals rests in promoting informed discussion on interrelated issues covering: health, agriculture; poverty; empowering people with greater choice; domestic violence, and AIDS. Longer term solutions should draw on the lessons of others, and will require application and cooperation. Wisdom and humility will need to walk hand in hand.
### Appendix A - Funding Organizations and Executing Agencies

Table 2: Funding Organizations and Executing Agencies

<table>
<thead>
<tr>
<th>Funding Organization</th>
<th>Executing Agency</th>
<th>Budget (US$)</th>
<th>Activity Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redd Barna, Cambodian Oxfam (Hong Kong), Women's Education and training program.</td>
<td>Cambodian Women's Development Assoc.</td>
<td>20,000</td>
<td>HIV/AIDS working group formulation. Education and training program.</td>
</tr>
<tr>
<td>UNDP (Carere) Siem Reap Dept. Of Health</td>
<td>Siem Reap Dept. Of Health</td>
<td>13,000</td>
<td>Materials, equipment and budgetary support for DoH's education awareness program.</td>
</tr>
<tr>
<td>UNDP Min. Of Health, UNESCO Min. Of Education</td>
<td>Min. Of Education</td>
<td>35,988</td>
<td>Assistance in policy planning and strengthening of human resources, including coordination mechanisms</td>
</tr>
<tr>
<td>(UN Educational, Scientific and Cultural Organization) and UNESCO specialists for primary and secondary level science, inc. HIV/AIDS awareness.</td>
<td></td>
<td>5,000</td>
<td>Training for curriculum development</td>
</tr>
<tr>
<td>UNICEF</td>
<td>UNICEF</td>
<td>10,630</td>
<td>Consultancy to formulate project proposal</td>
</tr>
<tr>
<td>VSO, ODA Municipality Health</td>
<td>Municipality Health</td>
<td>40,500</td>
<td>Prof. Support to clinical and educational staff</td>
</tr>
<tr>
<td>WHO/GPA Service and VSO</td>
<td>Service and VSO</td>
<td>at Toul Kork Dike community clinic.</td>
<td></td>
</tr>
<tr>
<td>WHOIGPA Min. Of Health</td>
<td>Min. Of Health</td>
<td>203,757</td>
<td>Support to NAP, with an emphasis on multi sectoral planning and provision of technical support.</td>
</tr>
</tbody>
</table>

Extracts detailing UN agency's HIV/AIDS activities, from WHO's "Register of HIV/AIDS Activities in Cambodia for 1994."

NB. Some of the programs span several years, and the budget may reflect the overall amount allocated rather than that specifically for 1994. Different "accounting Years" also account for possible variations.
Appendix B - Executive Summary from the "Migrant Worker"

Executive Summary

Christian Outreach conducted an interviewer based survey of male migrant workers in Phnom Penh and Kompong Som, along with wives of migrant workers in Kampot and Prey Veng. The survey, which took four weeks in May, collected responses from a sample of 160 people. The aims of the survey were to assess: the effectiveness of different forms of HIV-prevention material; the likelihood of... and frequency of extra-marital relationships amongst male migrant workers; and to assess the usefulness of leaflets in the light of literacy.

How did people hear about AIDS?

Equal numbers of respondents had heard through the radio and television. Others said they had heard through friends, and a small number mentioned they had learned about AIDS through a poster, leaflet or health worker. Of these latter groups, relatively few had heard through these methods, which made measuring their effectiveness statistically almost irrelevant.

There did not appear to be one single method which was most effective at communicating the AIDS message. However there were specific trends in how people heard, eg. men in Phnom Penh were more likely to hear by television, whilst women in Kampot more often heard by radio. Radio tended to convey messages slightly better than television, although a combination of the two appeared to be the most effective.

One warming factor, was that 82% responded that they felt they had enough information about AIDS, yet of these 64% displayed a poor knowledge when answering questions regarding high risks normally associated with HIV infection. This would suggest "AIDS fatigue" may already be setting in, thus requiring more sparing and careful targeting of campaigns in future.

How much do people already know?

Knowledge varied quite considerably. Few seemed to have grasped the "body fluids" concept. There also seemed some confusion between AIDS and other diseases, such as malaria, or TB. Women's knowledge about how You can, and cannot, contract the AIDS virus was generally better than men's; although when it came to specifics of how not to contract AIDS, men were more aware.

Whilst the survey showed some popular misconceptions about AIDS, it is encouraging to see how much certain themes have been accepted. Over 90% of respondents knew that AIDS cannot be cured, you can die from AIDS; and over 95% knew they could pass HIV between husband and wife, and from mother to the un-burn child.

When asked to estimate the percentage of HIV+ taxi-girls (commercial sex workers) in Phnom Penh, 50% thought there were under 10%. Over 75% thought the figure was under 30%.
Extra-marital relationships and condom use

Only 25% of respondents thought a condom could help prevent infection. Condom use between husband and wife was around 2%, although 24% of men said they used a condom with either taxi-girls or girlfriends. Women were generally unaware whether their husbands were sleeping with someone else.

When asked if they felt at risk, 69% of respondents said "Yes"; 28% said they did not think they were at risk.

When asked how often they visited taxi-girls, only 26% of men said they went more than once a year. This figure is lower than expected, and lower than other surveys have suggested. One possible explanation for this could be due to the lack of "disposable income".

When asked who they would talk to if they were worried about AIDS, most said their spouse, although half also said they would talk to a doctor. Only two people said they would talk to a commune nurse.

Literacy

Around 71% of respondents showed a basic level of literacy. Of these men tended to have a higher rate than women. Comparing their overall knowledge of AIDS, to literacy, showed little connection. This is probably due to most hearing through the television or radio.

Conclusion

- Campaigns need better cooperation and greater coordination between the government's National AIDS Committee (NAC), UN agencies, and both International and Local Non-Governmental Organizations;
- They need to be behavior orientated,
- Campaigns need a single theme, to ensure the clarity of the message;
- They need planning, implementing and strategic reinforcement, in conjunction with local women's groups, INGOs and NGOs.
- The running of individual campaigns may already be causing "AIDS fatigue" through an information-overload amongst the population. Each agency needs to assess the effectiveness of the message they are using.

(Executive Summary, taken from Penfold 1995)
Appendix C - Map of Cambodia

Figure 5: Sketch Map of Cambodia

(Not to scale)
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