National Review of the HIV/AIDS Response in Cambodia
April-June 1997

This review is a collaborative effort of the National AIDS Programme,
French Cooperation, European Union, USAID,
and NGOs
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FOREWORD

HIV/AIDS has become a major threat to the development of Cambodia. The Royal Government of Cambodia is aware of the seriousness of the problem, as shown by the First Prime Minister taking the leadership as the Honorary Chair of the National AIDS Committee.

I truly appreciate the efforts of the National HIV/AIDS Programme Review team members and all supporters who worked hard together to assist the National AIDS Programme to review and reflect on its progress in reducing the spread of HIV since 1993. It is remarkable that this review effort has brought collaboration across donor agencies and non-government organizations as well as across government sectors. This is be an important step for Cambodia to respond to the epidemic with solidarity across the nation.

The review results is a key step towards further development of the National Strategic Plan which will be used as a guide for the national response in the coming three years (1998-2000). This will be the plan of all agencies interested in assisting Cambodia to fight against the dreadful virus and help to improve the quality of life of Cambodians.

As the Minister of Health and Chairman of the National AIDS Committee, I take full responsibility for ensuring that the National AIDS Programme will strive to overcome many difficulties faced by the government of Cambodia to combat the spread of HIV and minimize the impact of AIDS on the society.

Finally, I wish to express my deep gratitude to all parties involved in supporting, organizing, executing and contributing to the review of the National Programme on HIV/AIDS/STD. I hope our solidarity and commitment will remain strong and bring success to this long term battle with HIV/AIDS in the years to come.

Dr. Chhea Thang
Minister of Health
Chairman of the National AIDS Committee
Cambodia
Acknowledgements

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We would like to thank all the NGOs, particularly Maryknoll, World Vision International, and Medicine Sans Frontier (France, Holland/Belgium/Swiss who represented HACC and MEDICAM, for actively participating and contributing throughout the process of the review.

Most importantly, the review team is extremely grateful for the valuable inputs and candid comments of all key informants from various ministries, IOs, NGOs and the private sectors interviewed during the review.

The review team hopes that the results of the review will serve as a ground work to develop the National Strategic Plan for 1998-2000, by the National AIDS Programme and with the participation from all partners and stakeholders involved in HIV/STDs/AIDS in Cambodia.

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Abbreviations

ADB    Asian Development Bank
AIDS   Acquired Immune Deficiency Syndrome
AIDSCAP AIDS Control and Prevention Project of Family Health International
USAID
AMCEK  A Cambodian Teachers Magazine
ARC    American Refugee Committee
AUSAID Australian Agency for International Development
BWAP   Battambang Women's AIDS Project
CARE   Care International in Cambodia
CARERS Cambodian Area Resettlement and Reintegration Program
CBO    Community-Based Organization
CDC    Centre for Disease Control
CMAC   Cambodia Mine Action Center
COCOM  Coordination Committee on Health
CPA    Country Programme Advisor
CRC    Cambodian Red Cross
CSWs   Commercial Sex Workers
CUHCA  Cambodia Urban Health Care Association
CWDA   Cambodian Women's Development Association
DHEdHy Department of Health Education, Hygiene
EU     European Union
FAC    France Cooperation in Cambodia
FPS/TB/HE Family Planning/ Tuberculosis/ Health education
GTZ    Deutsche Gesellschaft fur Technische Zusammenarbeit
HACC   HIV/AIDS Coordinating Committee
HCPs   Health Care Providers
HCWs   Health Care Workers
HIS    Health Information System
HIV    Human Immunodeficiency Virus
ICRC   International Committee of the Red Cross
IEC    Information, Education and Communication
IOs    International Organizations
IPC    Institute Pasteur Cambodge
IPH    Institute of Public Health
ITM    Institution of Tropical Medicine/Antwerp
MCH    Maternal and Child Health
MDM    Médecins du Monde
MEDICAM Medical Coordination Committee in Cambodia
MoAg   Ministry of Agriculture
MoEYS  Ministry of Education, Youth and Sport
MOH    Ministry of Health
MoINFO Ministry of Information
MoINT  Ministry of Interior
MoRD   Ministry of Rural Development
MoSALVA Ministry of Social Affairs, Labor and Veteran's Affairs
MoT    Ministry of Tourism
MoWA   Ministry of Women's Affairs
MPA    Minimum Package of Activities
MSF    Médecins Sans Frontières
NAC    National AIDS Committee
NAP    National AIDS Program
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<th>Abbreviation</th>
<th>Full Form</th>
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<td>National AIDS Program Office</td>
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<td>NBTC</td>
<td>National Blood Transfusion Center</td>
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<td>NSTDC</td>
<td>National Sexually Transmitted Diseases Center</td>
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<td>ODA</td>
<td>Overseas Development Administration</td>
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<td>PAC</td>
<td>Provincial AIDS Committee</td>
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<td>PAO</td>
<td>Provincial AIDS Offices</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PHD</td>
<td>Provincial Health Department</td>
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<td>PLWHA</td>
<td>People living with HIV/AIDS</td>
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<td>PPU</td>
<td>Project Preparation Unit</td>
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<td>PROCOCOM</td>
<td>Provincial Coordinating Committee on Health</td>
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<td>PSF</td>
<td>Pharmaciens Sans Frontieres</td>
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<td>PSI</td>
<td>Population Services International</td>
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<td>PTC</td>
<td>Provincial Transfusion Centers</td>
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<td>RGC</td>
<td>Royal Government of Cambodia</td>
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<td>RHAC</td>
<td>Reproductive Health Association-Cambodia</td>
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<td>SCF/UK</td>
<td>Save the Children Fund /UK</td>
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<td>ST</td>
<td>Secretary of State</td>
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<td>STD TWG</td>
<td>STD Technical Working Group</td>
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<td>STD</td>
<td>Sexually Transmitted Diseases</td>
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<td>TB DOTS</td>
<td>TB Direct Observed Therapy Short-term</td>
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<td>Tuberculosis</td>
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<td>TBA</td>
<td>Traditional Birth Attendants</td>
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<td>TPHA</td>
<td>Treponema Pallidum Haemagglutination Antibody</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nation Programme on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNESCO</td>
<td>United Nations Educational Scientific and Cultural Organization</td>
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<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>UST</td>
<td>Under-Secretary of State</td>
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<td>VDC</td>
<td>Village Development Committee</td>
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<td>VHV's</td>
<td>Village Health Volunteers</td>
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<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
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<td>WID</td>
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<td>WVI</td>
<td>World Vision International</td>
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Executive Summary

The Kingdom of Cambodia has the most serious HIV/AIDS epidemic in Asia with many contributing factors which suggest that the epidemic has the potential to cause Cambodia to become one of the worst affected countries in the world. The 1990s in Cambodia have been marked by an alarmingly rapid increase in the overall number of HIV infections and a rapid rise in the national HIV prevalence among several key populations. The first reported cases of HIV infection were in mid 1991 with unreported cases suggested to have begun in the late 1980s. A Comprehensive National Plan was developed in 1993 to guide the national response to the epidemic. Many significant achievements have occurred since 1993 which have laid the foundation for an improved national response to the HIV/STD/AIDS epidemic.

- There have been major advancements in developing a better understanding of the nature and factors effecting the epidemic through the implementation of nation wide HIV surveillance program and several critical behavioral research studies.
- Education and some service delivery have been offered through Government and Non-Governmental structures in many provinces across the country. These efforts have resulted in an improved general knowledge of HIV and the very beginning of change in risk taking behavior in some populations.
- Finally, improved capacity has been established within the National and Provincial Government sectors, Non-Government Organizations the UN and donors.

The epidemic has increased dramatically since the early 1990s. Between 70,000-120,000 people are now estimated to be infected with HIV. The major constraint has been that the country has been undergoing massive reconstruction after 20 years of war. Human, financial and technical resources across the country are severely limited. At the current level of leadership and commitment, technical, financial investment and collaboration in HIV/STD/AIDS, the Kingdom of Cambodia will not have a major impact on the spread of the epidemic in the next three years.

National leadership in tandem with increased human, technical and financial resources which are wisely managed are paramount. To reduce the further spread of the epidemic and prepare the country to care for people and families infected and affected by HIV/STD/AIDS the Nation of Cambodia should address the following critical recommendations.

Government Structure, Commitment and Policy
- Advisors to the 1st and 2nd Prime Ministers need to be approached and provided continual support to lead a national campaign to slow the spread of HIV and reduce the discrimination associated with being infected.
- The Council of Ministers must be made aware of the potential economic impact of HIV/AIDS on Cambodia and consider HIV/AIDS as a National Emergency. Secondly; the Council of Ministers should review the role, function and effectiveness of the National AIDS Committee.
- The National Government structures—the National AIDS Committee and the National AIDS Secretariat--designed to provide high level commitment, policy development and leadership need to be provided with more direct qualified technical and financial support from the donors to be able to undertake their role. Additionally, the Technical Working Groups under the National AIDS Programme must be provided with direct technical support and increased participation of other ministries and NGOs.
- The IOs and local NGOs need to be supported to take an active role on the National AIDS Committee and learn to provide better advocacy for change within the country.
- The new MoH structure needs to allow for optimal collaboration with other centres within the MoH and other ministries. The leadership should be chosen based upon proven program experience in HIV/AIDS.
Resources, Funding and Distribution

- Donors must realise and address the fact that unrealistic government salaries and donor product-based incentive systems have not resulted in a prioritization of activities which will have a national impact on the epidemic.
- Donors must increase the overall funding and managed support to improve the distribution of human, technical, financial resources at provincial and district levels in all western and southern provinces and in semi-urban and urban areas around the country.
- Funding priorities should be made for innovative STD/HIV education, care and services for men and women engaging in high-risk sexual behaviours. Current education efforts need to be improved to use approaches which support changes in behavior with a stronger focus on men.
- Priorities for education, health and social services for people in the general population should occur through the existing structures in the community e.g. Cluster schools, community groups, traditional and religious sectors.

Technical Assistance

- The UN and donors must realise that appropriately experienced technical assistance is needed in all aspects of HIV/STD/AIDS policy, planning, services and evaluation.
- Priority should be given to technical assistance from the region with knowledge and experience in developing culturally relevant and appropriate communication, services and in the mobilization of communities to respond to the epidemic.
- Priority should be given to technical assistance in preparing the country for the eventual challenge of HIV/AIDS related sickness and loss of human and family resources.

Coordination and Collaboration

- The MoH needs to establish and effectively run a Sub-Co-Com on HIV/STD/AIDS with the involvement of the technical level of other ministries, 10 and local NGO representatives, UN and donors. Technical working groups need to be developed with specific time-limited tasks to improve the quality of services and fill gaps in program leadership.
- Government, donors and NGOs must foster improved collaboration with the private sector to increase access and coverage in education and improve the quality and distribution of services (e.g., workplace programs, pharmacies).
- Priority should be given to regional collaboration which will impact on the human rights abuses associated with the trafficking of women and children and also for the improvement of services for migratory labour in the region.

The cumulative efforts of the Government, Non-Governmental sector, UN and donors over the next three years needs to prioritise a focused approach to reducing the spread of HIV among people at risk of infection through high quality education, care and services. Few efforts to date have prioritised mobilising men to change their behavior which puts them at risk of infection and increases the risk that they will transmit the virus. Increased efforts in this area could have a significant impact on the epidemic.

"AIDS does not have a face in Cambodia". In cooperation with a focused approach, efforts must be prioritised to reduce the discrimination associated with having HIV/STD/AIDS and to provide care and support for those already infected. Care for people living with MV/AIDS must be a priority. Communities need to be directly supported to reduce discrimination and fear, and to provide care and support for their members who are infected and affected by HIV/STD/AIDS.

With improved leadership and cooperation, and increased human, technical and wisely managed financial resources, Cambodia has strong potential to impact on the spread of the epidemic and mitigate the consequences of AIDS over the next few years.
Introduction

Context and Factors Affecting the HIV/AIDS Epidemic in Cambodia

A. Epidemiology

Cambodia has the most serious HIV epidemic in Asia with the cumulative number of people infected with HIV estimated to be between 70,000 -120,000 as of late 1996. Estimates from 1996 also suggest that approximately 17-25,000 new infections per year are occurring in the country. Close to 40% of all infections are occurring in people 20-29 years old and over 80% of infections in people 13-39 years old. Greater than 90% of infections are occurring through heterosexual transmission. It has now become clear that the HIV subtype in Cambodia is Type E, closely related to the subtype found in Thailand and most of Southeast Asian countries (Ryan and Gorbach, 1997).

HIV was first detected in Cambodia during serological screening in 1991. In late 1993 and early 1994, the first cases of AIDS were diagnosed. In 1995 and 1996 surveillance data, conducted by the NAP, has noted significant increases in several key populations. Sentinel groups in 1995 included eight different population groups in 9 provinces mainly on the Cambodia/Thailand border. In 1996, to increase efficiency and better assess national average prevalence rates, sentinel surveillance was limited to four population groups and the coverage was expanded to 18 provinces; these included brothel-based female commercial sex workers; military, police and female antenatal clinic attendees. Comparisons between the 1995 and 1996 data from the same provinces along the border provide data for analysis of trends across these populations for this region. In 1996, the mean prevalence of female CSWs increased from 37% to almost 50%. Antenatal clinic attendees’ sero-prevalence increased from 2.5% to 3.0%. The mean prevalence rates in the police and military were similar in 1995 and 1996 with 8.1 % to 9.4%.

Across the country the 1996 surveillance data suggests alarmingly high prevalence rates. The mean prevalence rate among CSWs was 40.88%, police 5.46%, military 5.95% and among pregnant women attending antenatal clinics 1.73%. The national MV prevalence rate in brothel-based CSW of 40.88% places Cambodia with the highest prevalence in Asia in this population of women. The national average of 1.73% for pregnant women places Cambodia second only to Thailand with a national average of 1.8%.

The surveillance data suggests that the epidemic has begun to affect both people who engage in high risk behavior and the more general population. The provinces which are most affected are along the Thai border to the west and ports to the south (Banteay Meanchey, Battambang, Pursat, Koh Kong and Sihanoukville) and the Vietnamese/Laos border to the east (Rattanakiri). The geographical maps in Annex I show prevalence rates by province.

B. Demographics/Ethnicity

The Kingdom of Cambodia is a territory of 181,035 sq. km placed in South East Asia nestled among neighbouring Thailand on its west and north, Laos to the north, Vietnam to the east and the Gulf of Thailand to the south. Cambodia has an estimated 10.5 million inhabitants. The birth rate is one of the highest in Asia estimated at 43 per 1000. The annual population growth rate is approximately 2.8%, and the population is estimated to reach 12 million by the year 2000. The people of Cambodia live across 20 provinces, 3 municipalities, 170 districts, over 1500 communes and close to 13,000 villages. Approximately 1 million people live in Phnom Penh. Only an estimated 15% of the total population live in urban areas and over 85% live rurally. Women in Cambodia account for approximately 52% of the population. In rural areas one in four households are headed by a woman, and in Phnom Penh one in three. Approximately 50% of the entire population is under the age of 17.
Statistics show that 96% of the people of Cambodia are ethnic Khmer. There are a number of Ethnic Vietnamese, Chinese and Cham Muslims (Khmer Islam) whose numbers are 100,000, over 50,000 and 200,000 respectively. Cambodia's ethno-linguistic minorities or 'hill tribes' known as Khmer Loeu are found primarily in the north-eastern provinces and they number between 60,000 to 70,000 people.

C. Health/STDs

The health status of the population in Cambodia is one of the lowest in Asia. The current infant mortality rate is estimated to be 115 per 1,000 live births and the under five mortality rate is about 181 per 1000 live births. The major causes of infant and child morbidity and mortality are malaria, diarrheas diseases, acute respiratory infection and more recently dengue hemorrhages fever. Most health surveys are hospital based and small in scale and therefore reliable morbidity and mortality rates which represent the population as a whole are needed.

A recent study by Ryan and Grouch, 1997, found 44% of the CSWs examined had at least one STD other than HIV and over 50% of those with an STD had no clinical signs of infection. In men examined 17% had the presence of at least one STD. The high level of asymptotic STD infections and the presence of resistant strains of gonorrhea invigorate the HIV epidemic and complicate the delivery of services for STD treatment.

Access to public health care and services is extremely limited. In two recent studies between 33-50% o of men went directly the pharmacies for treatment of STDs and a third of all CSWs reported having taken an antibiotic in the last month (Ryan and Gorbach, 1997; and Brown 1997). There is a growing concern that the preference for injections as a form for treatment for many illnesses couple with the lack of sterile syringes and means to sterilize is a potentially significant pathway of infection.

It is estimated that only 25% of the rural population access public health services - many rely on the traditional services of healers such as the Kru Khmer(18%) and private drug sellers (22%) (Brown, 1997). In urban areas 80% o of the population have access to some form of public health services. The lack of equipment, drugs and extremely low salaries for health care workers challenges an inadequate public health system.

During the last two years a major effort has begun to revitalizes primary health care services in parts of the country. A National Health Plan has been developed to provide first level primary health care services based upon population numbers and geographical access. The mho has established a Minimum Package of Activities which include a variety of services including vaccinations, nutrition management, antenatal, postnatal care and health promotion. The UN/WHO and ODA are funding a major program in health reform which will establish a "pay for service" in public system which aims to streamline the numbers of government health providers and overall improve the quality of public health services. The completion of this program is several years away.

D. Education

Formal

The Education system in Cambodia is re-establishing itself. Women and men over the age of 15 are respectively 48% and 22% illiterate. The rates of illiteracy in rural areas are higher than in urban areas with approximately 2-3 million women and 1 million men who cannot read and write. Men on average have 2.3 years of schooling and women 1.7 years (Cambodia Study, ADB 1996). During informant interviews the team was told that primary students spend on average 2-3.5 hours in school a day. The education system is also under constraint due the lack of adequate pay for teachers.

The Ministry of Education, Youth and Sport is in the process of redeveloping textbooks and the education system. Primary level school goes up to grade 6, grades 7-9 are lower secondary, and 10-12 upper secondary. Curriculum and textbooks are now being developed with teacher guides. Reform is trying to address in-service training so those teachers can be trained on how to use the newly developed textbooks in the classroom and within teacher training colleges.
The Department of Health Education and Hygiene within the Ministry of Education currently serves as a focal point for integrating HIV/AIDS prevention work into education system. However, there is still lack of clarity on role and functions of the unit to influence the integration of HIV/AIDS/STDs into the current education system.

**Non-formal Education**

Literacy programs occur through UN, NGOs, Ministries of Education and Women's Affairs programs. The current programs vary but are approximately 4 months in duration. Individuals in the community, many acting as volunteers, implement these programs in remote rural areas. The majority of students are between the ages of 15-35 years old. Many of the attendants of the literacy programs are women in both the urban and rural areas which offers a key contact for information to rural women.

**E. Gender Relations**

The HIV/AIDS epidemic in Cambodia is centrally linked to gender roles, inequity and the low social and economic status of women. Women are discouraged through cultural norms and peer pressure, from being knowledgeable about sexual matters. This directly affects male/female relationships and open discussions that would allow both women and men to protect themselves and one another from STD and HIV infections.

A study conducted by Care International in 1994, "Men are like gold, women are like cloth", suggests that gender inequity may contribute to their finding that men do not realise their vulnerability to HIV infection when having sex with a commercial sex worker without a condom, nor do men seem to realize that they can in turn give HIV to their wives.

A study conducted by Dr. Chou Meng Tarr (1996) provided Cambodia with social research concerning young adult sexuality. They suggest that an appreciation of a diverse set of influences and resources affects Cambodian culture, gender relations and sexuality, which in turn affects the HIV epidemic. They found that the cultural tradition of young women being chaste before marriage is changing. A significant number of teenage women in their study have boyfriends and many had engaged in sexual intercourse.

A recent clinical ethnographic study conducted by Dr. M. Eisenbruch (1997) lends further understanding of how traditional beliefs of disease process affects the way in which men and women respond to STD and HIV infection and their prevention. For example, women are seen as the giver or creator of syphilis, while men get syphilis. This in itself may offer some insight into reasons why women may not seek treatment of STDs. Further ethnographic understanding of gender relations and how they relate to STD/HIV and the disease process is needed in order to respond more effectively to gender issues.

**F. Culture, Language and Beliefs**

Most rural Cambodians maintain traditional beliefs and consult traditional healers in preference to formal health services. According; to the Eisenbruch study, syphilis and chancroid are known by the Khmer name 'Svayy' or mango. This study shows that 'mango' can evolve into 'svaay krapp' or 'crouching mango'. The advanced stages of svaay krapp are now known as AIDS. Since 1992, the Khmer language has absorbed the terms HIV (hiew) and AIDS (sida), but there is difficulty in accepting the concept of asymptotic HIV infection. This reflects the cultural view that a person is sick only when they have symptoms. Syphilis and AIDS are believed to be able to cross between people through bodily fluids including sweat, the steam of urine, breast milk and mosquito bites. Condoms are often believed to be useless against many kinds of exchange of body fluid exchange. These beliefs may present barriers to the implementation and adoption of condom use. Further exploration of how to harness local language and cultural beliefs to support AIDS education and campaigns instead of working against them are needed.
G. Economy, Migration and Prostitution

Following decades of civil strife, Cambodia today is one of the poorer countries in the region and in the world. The per capita Gross Domestic Product is currently estimated at $300. While the current GDP estimate represents a significant growth over the past six years (more than 7%), political in-fighting and insecurity may slow this economic growth. The majority of Cambodians are farmers with approximately 75% of the country's 11 million people working in the agricultural sector. Over the past five years however the agricultural sector has been stagnant due to declining crop yields. Employment options for the large number of unskilled people are extremely scarce especially in rural areas. Many men and some women leave their homes for better work prospects and income to support their families. Particularly during the dry season (November to March), many rural men migrate to construction projects in urban setting. Cambodia's coastline on the Gulf of Thailand also provides the country with commercial fishing, trade and tourist attractions. Porous borders with Vietnam make it easy for people moving back and forth. Migration within the region is one of the critical factors that fuelled the regional epidemic, and requires regional solutions. Cambodia needs to work in collaboration with its neighboring countries to tackle these issues more effectively.

The average household size in Cambodia is close to six persons while the average monthly expenditures amounts to $116. About 75% of all expenditures cover food and housing and an average of 80% on medical care. Women head One in four of all urban households and one in five in rural areas. Widows comprise 18% of all the women over 15 years of age. Many women faced with no income generation options rum to prostitution even though the income is not high enough to support their family. In Cambodia the price of sex is cheap ranking from 500 Rile (US$0.20) to over Rile 50,000 (US$20). When limited financial resources force families to support school costs for only some of their children - usually boys - the girls are pulled out of school. Some of the girls are sold into prostitution as a means to support their families with their parents receiving a lump-sum payment or loan which keeps the young girls working to repay the debts to the brothel owners. Numerous instances of trafficking of women and children into and out of Cambodia have been reported, but it is still unclear as to the number and the size and the extent of the trafficking syndicates. Legislation was passed in early 1996 on the "Suppression of Kidnapping and Trafficking/Sales of Human Persons and Exploitation of Human Persons" by the National Assembly. The issues are being addressed by a number of local and international NGOs.

The multitude of factors, reflected across the diversity of Cambodian society, can dramatically influence the spread of the epidemic and the response for people already infected or affected by HIV/STD/AIDS. The challenge is in creating an environment, which can flexibly and adequately respond to improve the health status and welfare of Cambodians.
Summary of Findings and Recommendations

Overview of Structure, Function, Priorities

National AIDS Committee and the National AIDS Secretariat
The Royal Government of Cambodia first established the National AIDS Committee (NAC) in 1993 which originally consisted of the Ministers or the Secretary of State from 12 Ministries and the Vice Governors of Provinces, cities and Phnom Penh Municipality. The role of the National AIDS Committee was to be responsible for preventative measures and guiding the Royal Government of Cambodia concerning AIDS issues. A Secretariat to the National Committee was also established which consisted of members of the Ministry of Health. The role of the Secretariat was to implement AIDS activities, plan for activities and cooperate with WHO and other international organizations for financial and technical support.

By 1995 several changes had occurred. Prince Norodom Ranariddh became the Honorary Chairman of the National Committee for HIV/AIDS/STDs, the Minister of Health the Chairman, Minister of Interior the Deputy Chairman, with members from the Ministry of Information, Education Youth and Sport, Women's Affairs, and Tourism, and Deputy Governors from the provinces and Phnom Penh. The Secretariat was chaired by the Under-secretary of Health and members from Interior, Women's Affairs, Education, and observers from Information and Tourism (See Annex IV). They have met once a year and now plan to meet twice a year. Attempts to strengthen or change these structures have occurred in the form of workshops and recommendations in cooperation with some donors. There have been few actions from these committees. The review is recommending that if the Government and Donors want these structures to function according to their original purpose then the donor community needs to support not only meetings but actual technical and financial assistance in undertaking their role. The Secretariat is better positioned to work on developing policies in cooperation with strategies that are being implemented within their ministries and work with the NAC to promote action from the top levels.

Ministry of Health (MOH) and the National AIDS Program (NAP) Office
During this review, structural changes within the MOH were approved by the Ministry and submitted to the Council of Ministers for formal approval (Annex V). The structural changes create a new Department of the Centre for Disease Control (CDC). Details of what programs will be under the CDC were not available to the review team. The role of the CDC would be three fold: 1) develop and direct policy and guidelines for programs across all areas; 2) Monitor and evaluate interventions research and surveillance of all communicable diseases; 3) Develop national plans for communicable diseases. The NAP has not historically had 'official' status within the MOH although they have received support from many donors. The current structural changes may serve to better support the NAP, however, at the moment it is uncertain.

The process of this review clearly defines that integration of HIV/STD services with other health centers is critical. In the past the NAP has not co-ordinates well with other centers in the Ministry of Health. Within the new designs of the MOH, it is crucial to the strengthening of the NAP that they are better placed to co-ordinate and integrate STD services with other health service partners including TB/Malaria/MCH. Secondly, it is important that the MOH/NAP are supported to take leadership in collaborating with other ministries which should occur through the National AIDS Secretariat.

Final decision on the structure, roles, responsibilities and means to accomplish it need to take into account the following situation. The donors must understand that low government salaries and the present product-based incentive system forces national programmers to prioritize efforts based upon donor prescribed financial incentives. The products which have been chosen to be financed become the prioritized role of the NAP. These may not always be the most effective roles for the NAP and may not always be the choices which will contribute to a national impact on the epidemic. Currently the staff of NAP office spends most of their time on training and workshops, translation, outreach
work, travel and surveillance. These activities have been well supported technically and financially. However, policy development, program management and provincial support, co-ordination with other partners, guideline development, national plan evaluation and dissemination of information have not been supported as well with technical and financial assistance. The latter however, should be a part of the prioritized role of a national AIDS program. The donors must either tip the balance to better support the latter set of priorities or development an agreement in salary supplementation, which will support the NAP to prioritize in accordance with their proper role.

Currently there is no donor who is funding a process of technical and financial assistance for co-ordination and policy development and therefore it can not be prioritized, except in its loose association with program implementation.

The issues of collaboration and co-ordination for the National AIDS Program are vital and difficult for several reasons. The NAP staff - currently ten technical staff (Annex VI) - is too few in number to implement large programs and therefore it is necessary for the program to integrate HIV/STD/AIDS education and services into a variety of other programs. This is not a simple task within a product-based incentive system.

Secondly, there have been many LTN and donor program or technical staff - soon they will total nine in all, almost the size of the National AIDS Program. Collaboration and co-ordination within the UN technical and program staff occurs through the UN technical working group. The bi-lateral donors do not currently have any forum for co-ordination. The lack of a forum for all players to collaborate and co-ordinate promotes an extremely disjointed national effort. The primary end response is for each organization to go its own way to accomplish their objectives, to be suspicious of one another and to create small factions which are extremely dysfunctional. This review represents the first effort of all parties at a national level to work as a large team. The National AIDS Program alone cannot possibly co-ordinate all of these technical and program staff. A system needs to be developed which will help support national level responses which will be effective. A MOH Sub-Co-Corn on HIV/STD/AIDS is recommended as a start so that IOs and local NGO representatives can participate with donors and government. Technical working groups with time-limited outcomes should be developed from the Sub-Co-Corn. (see recommendations on co-ordination).

The NAP needs both management and technical assistance. Certain UN/donor technical staff should take the lead in providing technical support or "backstopping" to the appropriate technical unit in the NAP. It is clear that program managers should not act as technical advisors. However, management support and backstopping needs to be identified and provided. Finally, consent should be reached to identify an agency which will support and backstop co-ordination: Clear priorities, roles and responsibilities for each of the NAP staff needs to be developed as does the roles, responsibilities and means for support of each of the UN/donor program and technical advisors.

**HIV/AIDS Coordinating Committee (RACC) and MEDICAM**

There are several co-ordination mechanisms for NGOs. The HACC is designed specifically for NGOs working on HIV/ADDS. NIEDICAM is a Coordinating forum for health related programs. HACC is a relatively new and a well-established forum for NGOs working in the field of AIDS. There also have been other efforts to co-ordinate and strengthen local NGOs through the International HIV/AIDS Alliance. As this review illustrates the Non-Governmental sector has thus far received the vast majority of funds coming into Cambodia to implement HIV/AIDS programs (SO%). With these funds the NGOs actually lead the responses across the country. The HACC needs to be strengthened with donor technical and financial assistance. Better collaboration with MEDICAM should be explored. The role of the HACC as the lead NGO committee in HIV/AIDS needs to be recognized as a critical component of the overall response. There needs to be H.ACC representation of both local NGOs and IOs on the NAC and a Sub-Co-Corn on HIV/AIDS.

The role of the NGOs vis a vis the Government program needs to be better defined. In some places around the country collaboration is working well and in other places there is a sense of competition between the NGOs and the Government. On the other hand the NGOs can choose to work in a small
geographical area to focus their efforts, while the Government with less resources are responsible for the country as a whole. Collaboration at a national and local level is needed to improve the quality and coverage of HIV/AIDS/STD education and services.

**Provincial AIDS Committees (PAC)**

Provincial AIDS Committees have been set up in many provinces but only in a few provinces they meet on a regular basis. The Deputy-Governor of the provinces chair the PACs. The purpose is primarily to guide the provincial HIV/AIDS responses and provide a forum for multisectoral collaboration at a high level. The review team found that some PACs are meeting on regular basis and that the forums are being used primarily as an informative session where the Director of Health provides information to the other sectors. In some places the Ministry of Women's Affairs, Rural Development and also Education are also providing information about their activities. There is potential for greater collaboration at a provincial level.

The review committee recommends that assistance is offered to a limited number of PACs to improve these forums to become more consultative and develop their purpose and plans. It is clear that the PACs felt that they could do more within each of the Ministries if they had increased financial, technical and human resources as well as direction from the central level of their individual ministries. The National Secretariat in collaboration with the NAC should be helping to guide policy and strategy development within individual ministries to better support the provincial level. Additionally, the PACs effectiveness could be improved by representation of IOs and NGOs on across the country.

**Provincial AIDS Offices (PAO)**

Provincial AIDS Offices have been set up in every province around the country. Their offices are within the Provincial Health Departments. They are staffed with dedicated individuals usually with a Program Manager, at least one Outreach worker and educators. Battambang has the largest number of staff at 15 members. Many PAOs are providing training and education to a wide variety of community members including: the outreach program to CSWs, health care workers, schools, the military and police. The review team feels that the PAOs are vital to the Government program, however, they are severely restricted by a lack of human, financial and technical resources. They are primarily dependant upon the IOs and NGOs working in their area for transportation, educational materials and most resources. There are little incentives for the staff which makes it very difficult to sustain the program activities. A final constraint is that from a central level there is no one who is assigned to give management support directly to the PAOs.

The review team suggests decentralization of financial and technical resources to the provincial level. Decentralization needs to occur in such a way as to properly support a national effort and to not overwhelm the PAOs. Co-operation within the provincial health departments is critical for success of an integrated strategy. The PAOs need to clearly define their goals so that integration of HIV/AIDS programs can occur and they are not implementing everything themselves. A way in which the PAOs may ease some of their work load is to work with the Health Educators who are part of the PHD, as well as other programs or departments. This is already occurring in some areas. The Department of Health Education, Hygiene and Primary Health Care (DHEdHy & PHC) can also be of assistance in this process as they have been actively involved in HIV/AIDS/-STD training at the national level. Collaboration in the provinces is critical. Within the health departments in some provinces, collaboration on a technical level is occurring through Pro-Co-Coin. The review committee suggests that for technical and implementation co-ordination that Pro-Co-Coin forums are set up to allow collaboration across Government, donor, IOs and local NGO efforts. The review team does not see that Pro-Co-Coin duplicate the efforts of the PACs. The role is differentiated through the ability to exchange technical information and collaborates in implementation of programs. In summary, the review team recommends that the PROs should be better supported to undertake the role of education and upgrading of services with a primary focus on provincial towns and their outlying areas and a secondary focus on Coordinating and advocating for integrating HIV/AIDS/STD education and services in existing government and NGO programs to reach district and commune
levels.

**Priorities and Coverage**

This review sets out an enormously long list of recommendations based upon findings over a six week process of data and information collection. The review team attempted to prioritize a list of findings and recommendations based upon this process. The process was limited by time, design, expertise and the difficulty of developing consensus across a variety of stakeholders. The process also was also limited by the lack of IO, local NGO, University as well as many other sectors, including the religious sector, involved in the core team. Nonetheless, the review process and outcomes attempt to focus the national response on issues and recommendations relating to improving the overall response in Cambodia to HIV/AIDS (Annex XIII).

The review team found overall that efforts are limited to urban areas and provincial towns in some parts of the country. The exceptions are where IOs or NGOs are working in rural areas. There are major gaps in the overall coverage and quality of programs in the semi-urban and urban settings. There are some key provinces with little activities, including Koh Kong and Sihanoukville, which have some of the highest prevalence rates in the country (Annex I). This review was limited by the inability at this time to completely map all the current efforts across the country, though a general outline is provided in Annex IX. Nonetheless, the primary finding was that there were no provinces that had enough human, financial or technical resource to completely cover the provincial towns and their immediate peripheral areas with education and services. Improving the quality and coverage of education and services in the western and southern semi-urban areas is a priority.

The review team was concerned that although urban and semi-urban epicenters primarily fuel the epidemic, frequent migration to and from these epicenters is spreading the epidemic into the rural areas. The review recommends that research is done very quickly to know how far into the rural communities this epidemic has spread and whether there are behaviors in the rural setting which are fuelling a "rural epidemic". With 85% of people living in rural areas and one in 4 households headed by women, it is important to know the elements of possible rural epidemic. If people are transmitting HIV to multiple partners in rural settings then national priorities need to address this information. Until this data is known priorities need to be focused on improving services in semi-urban and urban settings to address the epicenters of the epidemic. However, integration of education and services through existing mechanisms in rural settings was also identified as a priority.

It is critical that with the synthesis of findings in this review, a strategic vision for the next one to three years is developed which provides leadership and enhances the technical, financial and human resource commitment currently being invested in the national and provincial responses. The strength of the epidemic and the complexity of contextual factors in Cambodia has made it a national and international challenge to prioritize an effective and sustainable approach. During the review process a consensus was reached that strategies designed to have a short-term impact on the spread of the epidemic and a medium term impact on mitigating the effects of the large number of infections should be prioritized. The first stages of prioritization of those strategies occurred during the review process. the next stages will need to occur during the strategic planning process with a larger number of partners.

Section I: Policy, Management and Coordination

I. Monitoring, Quality Assurance, and Research

Achievements

1. Functioning high-quality HIV surveillance has been operating in Cambodia since 1995 and yields valuable information regarding HIV epidemic trends.
2. The first wave of a HIV risk behavioral surveillance system will be completed in July 1997, and will provide national-trend data on behavioral trends and indicators for use in
monitoring prevention success.

3. Numerous HIV, STD, and behavioral research projects have been conducted which have aided the development of prevention strategies, including surveys and qualitative studies conducted by the PPU/WH0, CRC/ARC, AIDSCAP, Care, SCF/UK, BWAP, CWDA and World Vision.

Constraints/Gaps

1. The zero-surveillance survey program has experienced some difficulty in maintaining proper procedures in sample selection within the Military and informed consent in other groups.
2. Social Research Studies have not been adequately supported to be translated into policy or operational tools for program improvement.
3. Evaluation of HIV and STD programs has been rare and thus adjustments and changes which could improve these programs has not occurred.
4. Research in several key areas which will significantly affect program design is needed. (See Annex II)
5. There are currently no indicators of success guiding the national response to the HIV epidemic.
6. The MOH Ethical sub-CoCom committee does not currently have the capacity to address the use of human subjects in HIV/STD/AIDS related research projects.

Recommendations

1. The NAP should review the performance and quality of the national-level HIV/STD serologic and behavioral surveillance program and provide national indicators to monitor success.
2. The NAP should continually review the performance of the HIV sero-surveillance system to maintain quality, particularly in the area of informed consent and sample selection.
3. The Ethical sub-CoCom committee must be supported to build their capacity to address research issues relating to human subjects and HIV/STD/AIDS.
4. The Sub-Co-Com on HIV/AIDS/STDs, when established, should identify gaps in key operations research, and social, behavioral and ethnographic research to mobilize donor funds to conduct this research and translate this research into program implementation (See Annex II)

MOH/NAP and Donor Community should ensure that research findings are disseminated across the interested organizations in Cambodia. Discussion of the significance of research findings should occur on a regular basis to inform program planning.

II. Resources, Co-ordination and Response Mobilization

Achievements

Several Mechanisms have been established with some examples of response mobilization
1. A National Committee of HIV/STD/AIDS was established with the 1st Prime Minister as Honorary Chairman, and the Minister of Health as Chairman whose purpose is multi-sectional co-ordination, resource and response mobilization. In addition, the establishment of Provincial AIDS Committees whose purpose is the same at a provincial level.
3. Ongoing NGO/IO co-ordination through MEDICAM and establishment of HACC with increased efforts in planning and programming.
5. World AIDS Day in most places represents a model for co-operation across all parties.

Financial Commitment: Completely accurate funding figures beginning from 1993 were not given in full from all the UN and donor agencies. However, based upon figures given the, following
estimates were derived (See Annex VII)

1. Approximately $US7.3 million have been allocated to respond to the epidemic since 1993 with approximately $US3.52 million in 1996.
2. 80% of all resources since 1993 have been for Non-governmental responses and 20% for Government programs.
3. UN Agencies (WHO, UNDP, UNFPA) were the first to contribute in the early 1990s with bilateral donors funding arriving in 1995/96.
4. There is currently a projected increase for HIV/AIDS expenditures to $US 6.6 million in the year 1997. (UN and World Bank: $US 3.29 million; Bi-/mulit-lateral: $US 2.3 million plus USAID’s new project proposal).

Constraints/Gaps

Commitment (Government/Donors/Others)
1. No National Spokesperson or Leadership to mobilize the country to understand how to respond to the epidemic.
2. The Council of Ministers does not see HIV/AIDS as a priority.
3. Lack of clear roles, responsibilities and plan of action for the National AIDS Committee and the Provincial AIDS Committees. A workshop held in 1995 by UNDP attempted to improve the role, structure and function of high level commitment to HIV/AIDS, however, no recommendation has been followed through by the government or donor community.
4. Donor funding has arrived relatively late in the course of the epidemic and has not been well managed from the donors standpoint to have a major impact on the epidemic.

Collaboration
1. No common forum for Government, NGOs, Donors and UN to exchange information, research findings, and develop policy, co-ordinates planning, implementation and evaluation.
2. In 1997 there will be a total of 13 UN and donors providing programmatic, technical and financial support without clear means of collaboration with the Government.
3. Many UN agencies have unrealistic expectations that the MOH/NAP will kick start programs within other ministries when NAP financial, technical and human resources are severely stretched.
4. The current level of collaboration may not contribute to impact on the epidemic in the coming three years.

Recommendations
Promote National and Provincial Leadership, Commitment and Action
1. The First and Second Prime Ministers need to be supported to become national spokes persons in HIV/STD/AIDS through the direct support of two advisors whose role it would be to inform and advise the Prime Ministers.
2. The private sector, NGO, traditional and religious sectors are capable of responding flexibly and quickly to reduce the spread of HIV/STD/AIDS and need to be provided more opportunity by donors and government for leadership in the response.
3. The Council of Ministers must be made aware of the potential economic impact of HIV/AIDS and consider it a National Emergency.
4. The Council of Ministers should, review the role, function and effectiveness of the National AIDS Committee.
5. The NACIPAC and secretariat need to define their role and the actions for which they are responsible and the donors need to better support them to undertake their role with technical and financial support.
6. The NAC needs to add at least one to two donor(s), and local and international NGO
Representatives to improve an alliance between all partners.

**Resource Mobilization**

1. Donors need to assure projected resources and consider increased investments in the western and southern provinces and in all semi-urban and urban areas.
2. Funding priorities should be made for innovative STD/HIV education, care and services for men and women engaging in high-risk sexual behavior.
3. Projected resources for the coming years may need to triple over 1995 resource levels to provide coverage across the country in education and STD service delivery. There is a caution that large amounts of funding may cause a distorted approach to education and services which will not be sustainable: however, increasing current levels from.30/per capita spent on education and care to.90/per capita over the next two years would allow a substantial improvement in quality, coverage and reach into the more rural populations. There the epidemic is beginning.
4. Resource mobilization needs to occur subsequent to the upcoming strategic planning exercise. Funding needs to be sought for the period of the strategic plan; three years, to ensure continuity of the plan, and commitment from the donors.

**Co-ordination**

**Short Term**

1. A "Sub-Co-Com" on HIV/STD/AIDS needs to be established to discuss the best means of co-ordination to address information and service delivery. Technical working groups should be developed from the Sub-Co-Com with time limited tasks to improve the quality of services and develop guidelines to improve program leadership.
2. Provincial Co-Coms (Pro-Co-Com) on HIV/STD/AIDS need to be established, wherever feasible, to include members of government, NGOs, the private sector and donors to address issues in technical implementation and quality improvement and increased coverage of provincial responses.

**III. Policy Development**

**Achievements**

1. A document entitled "National Policy on AIDS/STD prevention and control in the Kingdom of Cambodia" was adopted by the members of the National Committee for HIV/AIDS/STD Prevention and Control on 15 December 1997, and disseminated to central government offices and provincial AIDS offices throughout the country (Annex XIV).

**Constraints/Gaps**

1. Lack of actionable policies: The document entitled "National Policy on AIDS/STD Prevention and Control in the Kingdom of Cambodia" is a broad framework which lists some extremely important areas of HIV/AIDS policy. However, in its present form it cannot provide a framework for action for a national response to the epidemic in Cambodia.
2. There is no clear strategy or mechanism for making policies which are developed at a national level, have an impact on programmer implementation at the provincial and district levels.
3. There is a gap of expertise, finances and awareness of the current and potential impact of the HIV/AIDS epidemic at a policy level to mobilise strategies in responding to HIV/AIDS, as well as a lack of donor input.
Recommendations

1. Policy development and implementation can not be accomplished unless the UN/donors financially and technically support it to occur.
2. It is the role of the National AIDS Secretariat with the MOH NAP to lead and inform the development of policies that will improve the effectiveness of programmer in a national response to HIV/AIDS/STDs. It is the role of the NAC to adopt and ensure policy and program implementation.
3. Policies and strategies need to be directly linked to programmer implementation. Innovative policy development needs to occur to test the capacity for programs to incorporate policy changes in a realistic and non-discriminatory, fashion.
4. Required policies and strategies addressing prostitution should not reduce the capacity of public health and human rights programmers to access commercial sex workers with services.
5. Policy development should occur in partnership: e.g., with women's organizations, NGOs, CSWs where possible, Ministry of Women's Affairs, Ministry of Interior, Ministry of National Defense, brothel owners, and donors to develop a national strategy on prostitution and HIV/AIDS,STDs.

Immediate

1. The content of the document entitled the "National Policy on AIDS/STD Prevention and Control in the Kingdom of Cambodia" should be considered during the strategic planning process so that these policy issues can be discussed and made actionable in a "National HIV/AIDS/STD Strategic Plan for the next three years.

Longer Term

1. Financial and technical assistance to the National AIDS Secretariat and National AIDS Committee to initiate a policy development programmer is needed. A policy development programmer's role should be clearly defined and needs to address many key issues. Issues raised during the review include:
   a). Prostitution, human rights and HIV/UDS/STDs
   b). Discrimination of people living with HIV/AIDS/STDS (including isolation)
   c). Disclosure of HIV positive status
   d). Mandatory testing
   e). Condom promotion with youth

   (Please note that this is by no means a prioritized or exhaustive list of policy needs.)

IV. MOH/NAP/PAO Program and Financial Management

Achievements

1. The N:AP has attracted dedicated staff who have managed and implemented an impressive number of activities with minimal financial support.
2. The N:1P has established Provincial AIDS Offices (PAOs) in every province. The PAOs have developed programs with minimal resources under difficult working conditions.

Constraints/Gaps

Roles and Structure

1. It is unclear how the currently proposed structural changes within the Ministry of Health will affect program leadership, planning. Collaboration and implementation.
2. The appropriateness of the role of the NAKPAO as implementers of an outreach program directly to commercial sex workers has been questioned by most donors (including the donor that initially funded it) and many NGOs.
Resources: Financial, Personnel, Material

1. Low government salaries and the present product-based incentive system forces national programmers to prioritize efforts based upon donor prescribed financial incentives. This process may not represent the real priorities of the programmer, nor be the most effective role for the NAP and may not contribute to a national impact on the epidemic.

2. Relative to its mission to lead the country's response to the HIV epidemic, the NAP is severely under-staffed and under-funded. They currently only have 10 permanent technical staff (Annex VI).

3. Overall NAP program implementation budget over the last four years has been approximately 1.05 Million US$ (WHO, FAC, UNAIDS, UNDP, USAID, GTZ) which is approximately 20% of the estimated total expenditure on HIV/AIDS for the nation since 1993.

4. Provincial Level financial support for salaries, product based incentives, equipment and program implementation is severely low - in some provinces only $300US per year for the program.

5. The process to access the National Budget for HIV/AIDS is extremely lengthy with severe restrictions. In 1995 and 1996, only 2% and 6% of the Government HIV/AIDS Budget was released (totaling US$ 15,000).

Collaboration and Co-ordination

1. There is lack of collaboration and co-ordination between the NAP and other partners within and outside the Ministry of Health.

2. The numerous Technical Advisors and Program Managers (Annex 6) from the UN and donor community have no systematic way to support the MOH/NAP and other ministries.

3. The increasing number of donors contributing to HIV/AIDS in Cambodia has made it more difficult for donors to co-ordinate their planning with the MOH/NAP.

Management Capacity

1. Centralized planning and management in the NAP have led to implementation and management occurring "simultaneously".

2. There is a lack of management support to the Provincial AIDS Offices.

Recommendations

Roles and Structure

1. Considered within a new Center for Disease Control, the MoH needs to consider proven experience and commitment in the field of HIV/AIDS/STD in selecting the leadership.

2. In finalizing the structural changes, the MoH needs to consider establishing the NAP at a level which would give them more opportunity to collaborate technically across sectors.

3. Without expansion of Human, Financial and Technical Resources the MOH/NAP can not expand their current role and will have a difficult time maintaining their current level of work.

4. The NAP needs to prioritize their role and responsibility. The NAP may consider management assistance in determining roles and responsibilities at a national and provincial level.

5. The development of functional units within the NAP needs to be reconsidered. These functional units may be more effective if given authority to manage their individual programs leaving top managers able to oversee the program as a whole and to collaborate with key partners. (Annex X).

Resources: Financial, Personnel and Material

1. Donors must co-ordinate to develop an agreement which balances the current product-based
incentive system in favor of time and resources being spent on the role the lead
government organization should take in responding to the epidemic (e.g., leadership, co-
ordination, policy and guideline development).

2. Decentralization to Provincial AIDS Offices with donor funding for materials and
support is a priority.

3. The Donors, especially the World Bank, need to reconsider their programmatic planning
after the MOH/NAP defines their role and priorities.

4. High expectations of the NAP by donors must be matched by increased support.

Management Capacity and Collaboration

1. The role of the international advisors needs to be addressed. The NAP functional units
need support from advisors qualified within that technical area. In areas where there
are several donors contributing financially, one adviser needs to be delegated as a lead
support person.

2. More NAP staff qualified to oversee program and technical management are needed.
The exact number needs to be defined when the role and breath of responsibility for
the NAP is defined.

3. Clear job descriptions are needed for each position.
Section II   Health Services Relating to HIV/STD/AIDS

1. STD Services

Achievements

1. Guidelines for the syndromes management of STDs updated, flipcharts printed in Khmer and distributed to all Provincial AIDS Offices (PAOs).
2. Public sector STD services renovated and equipped with clinical material in all provincial capitals except two (Mondulkiri and Kampong Speu).
3. All PAO directors and many provincial STD managers trained in clinical diagnosis and treatment of STDs, some also trained in syndromic management. STD/HIV module included in curriculum of the National Nursing School in Phnom Penh since 1995.
4. Condoms distributed by the NAP to STD services; during special events; within CSW outreach; and by UNFPA to Mother and Child Health (MCH) clinics.

Constraints

1. Non-NGO supported STD services not functional due to chronic shortage of STD drugs and lack of staff training
2. Widespread implementation of STD syndromic management constrained by lack of adapted curriculum; inadequate distribution of protocols; relocation of 40% trained staff; lack of training at Health Center level; non-inclusion of private/traditional sectors.
3. Vertical services not in line with integrated health care.
4. Respective roles of National STD Center, Institute of Public Health and Pasteur Institute regarding research, training and reference level not clear.
5. Inadequate collection of STD data through health information system (HIS).

Recommendations

1. Assess public sector STD drug needs for the coming 3 years and seek financial support for drug procurement.
2. Develop an appropriate curriculum for STD syndromic management training. Provide on-site training to existing health services and disseminate guidelines and protocols to all levels, including private pharmacies.
3. Ensure the production of culturally relevant and acceptable messages on STD care. Include traditional healers in plans for STD management.
4. Define respective roles of NSTDC, IPH and IPC, and strengthen STD data collection through the HIS.

2. Special Interventions for High Risk Groups

Achievements

1. Set-up of a limited number of public and private-non-profit STD clinics focused on services for CSWs.
2. Outreach program for CSWs in Phnom Penh and 22 provinces since 1995.
3. Several studies conducted to document CSWs and clients' knowledge and behavior.

Constraints

1. Inadequate STD care for CSWs due to inaccessibility of public or private-non-profit health services, lack of standardised guidelines and an uncontrolled private sector.
2. Health services accessible to CSWs rarely offer services other than STD treatment and HIV
prevention, such as birth spacing, pediatric care and counseling.

3. Outreach interventions with CSWs focus on information-giving rather than behavior change, and fail to reach the male clients or brothel owners.

4. Chronic lack of STD interventions for military/police/de-miners (CMAC)

Recommendations
1. Develop and disseminate standardized guidelines for the management of STDs and related issues among CSWs.
2. Develop innovative interventions to increase accessibility and acceptability of health services for CSWs, e.g. mobile teams
3. Mobilize donor support for resources for STD/HIV prevention and care for military/police/CMAC
4. Improve coordination of outreach interventions and promote behavior change amongst clients.

3. Blood Safety

Achievements
1. Fifteen Blood Transfusion Centers set up, the majority under the supervision of the International Committee of the Red Cross (ICRC).
2. Blood units tested for syphilis, malaria, hepatitis B, and HIV, with testing for Hepatitis C beginning.
3. Sub cocoon on blood safety established.

Constraints
1. Chronic shortage of safe blood products due to lack of BTCs, and insufficient number of regular, low-risk, donors due to cultural barriers / lack of confidence in the service.
2. Lack of of financial and technical understanding to provide appropriate and timely supports from the government leading to insecurity over future of BTCs when ICRC withdraw.
3. HIV screening sometimes misused for diagnostic testing. Lack of confidentiality, follow-up or counseling.
4. No control of blood transfusion and/or blood products in private formal/informal sector.

Recommendations
1. Create joint collaboration between blood banks, hospital labs and Voluntary Testing Centers to provide reliable serological diagnosis of HIV
2. Promote understanding of blood safety through inclusion in medical and nursing training, and supervision at provincial level.
3. Undertake operational research to determine cultural barriers to blood donation and investigate ways to promote regular blood donation among the low risk population.
4. Ensure technical and financial support of national blood transfusion system.

4. Universal Precautions

Achievements
1. Two documents produced on Infection Control and Universal Precautions, distributed and explained to PAOs.
2. Training integrated into nursing and laboratory technician curricula
Constraints

1. Universal Precautions limited by inadequate means of waste disposal; shortage of single use material and sterilization equipment.
2. Overuse of injecting material due to excessive public demand for indictable medicines.

Recommendations

1. Mobilize support for safe decontamination and disposal of clinical/laboratory waste, and procurement of sterilization equipment and sterile consumables.
2. Rationalize use of single use material (gloves, needles,...) by setting priorities among services and activities and through educational messages.
3. Extend training of HCWs in universal precautions to community health care workers and particularly traditional birth attendants.

5. Testing & Counseling

Achievements

1. Policy on testing and counseling drawn up and distributed to provinces.
2. Six Voluntary Testing Centers set up, with staff trained in lab procedures, counseling and data collection.

Constraints

1. Testing Centers functioning inadequately due to limited distribution/understanding of policy document, irregular supervision and shortage of trained staff.
2. Lack of follow-up of HIV positive patients.
3. Reliability and conditions of testing in private (for-profit) sector uncontrolled.
4. Unknown validity (sensitivity and specificity) and reliability of self-tests available at private pharmacies.

Recommendations

1. Ensure that rules and recommendations regarding the 4 different types of testing are respected by the private and public sector.
2. Testing Centers should be fully equipped for diagnostic purposes
3. Set up appropriate structures to ensure that guidelines and minimal practice standards for testing and counseling are followed, e.g. through support for counselors.
4. Evaluate the entire testing centers system by end 1997 before setting up any new center.

6. Integration of Vertical Programs (MCH/TB/STD-HIV)

Achievements

1. Guidelines for STD/HIV/AIDS included in Minimal Package of Activities (MPA) for Health Centers, and Complementary Package of Activities (CPA) for Referral Hospitals.

Constraints

1. Lack of coordination between the 3 vertical programmers (MCH, TB, NAP).

Recommendations

1. NAP and MCH programmer to co-ordinate, particularly on syphilis screening and HIV management in pregnant women. NAP should participate in monthly MCH sub CoComs when appropriate.
quality assurance, gaps/overlaps, false and misleading information and promote best practices and assure culturally appropriate messages.

3. NAP and relevant partners to advocate for policy/national support for increasing free and prime air time for social messages.

III. Condoms

Achievements
1. Both government and NGOs distribute condoms through their HIV/AIDS/STD activities
2. Sales in Cambodia have increased greatly with the introduction of a socially marketed condom

Constraints
1. Widespread access to safe condoms is constrained by problems with consistent supply, distribution, particularly in rural area, and quality control
2. Promotional messages strongly associate condoms with commercial sex, do not emphasize consistent usage, and do not adequately consider cultural attitudes and beliefs nor the female perspective

Recommendations
1. Promotion of ‘100% condom use’ in brothels
2. Prioritize sensitization of policy makers and media personnel. ’Normalization’ of the condom image is urgently required and should address cultural factors that affect non-usage, with the aim of increasing condom use in the non-commercial sex context
3. Secure sufficient condom supply for Cambodia, and ensure distribution to district and community level
4. Establish a monitoring mechanism for effective distribution and quality assurance at central and outlet level

IV. Counseling/Psycho-Social Support

Summary
The majority of counseling related to HIV/AIDS occurs in conjunction with the six government testing centers. Both government staff and NGOs have been trained to carry out the pre- and post-test counseling that takes place in these centers. Non-specific psychosocial support is more traditional in Khmer culture and is offered on an informal basis by various individuals and groups in the community, e.g. monks, Kruu, VHV’s, Community Mental Health Educators. Professional counseling as a process to assist individuals to identify their own problems and solutions is rather new in Cambodia.

Achievements
1. HIV test-related counseling is available in all government testing centers
2. NGOs and community groups are working together to develop non-test related counseling and psycho-social support for people affected by HIV/AIDS

Constraints/Gaps
1. ’Formal’ counseling is strongly associated with the HIV test and is therefore not widely available. Training and service delivery are not standardized, there is no referral system and counselors have no network of support or supervision.
2. The potential benefits for people affected by AIDS of ’non-formal’ counseling or traditional methods of psycho-social support is not being fulfilled, due to lack of recognition and coordination
out in which a minimum package of awareness and messages are offered to teachers throughout the system, and relies on the coordination and collaboration of the MoIi/NAP and DHEdHy& PHC, donors, PAO and available NGO assistance at the provincial levels.

**Non-Formal:**
Non-Formal education refers to education programmers outside the primary, secondary and tertiary setting. For the most part it consists of literacy programmers but it also includes such groups and settings as out-of-school youth, men in the workplace, and the military. Youth organizations are few in number and tend to be tied to school activities.

**Achievements**
1. There is strong collaboration and coordination occurring between ministries, international agencies, and NGOs working in the literacy programmed from national to community levels, including efforts to integrate STD/HIV/AMS into curriculum and books.
2. Ad hoc activities have been taking place to raise awareness of young people and men in particular, through other learning channels and settings (workplace), as well as through pilot project activities.

**Constraints**
1. There is a lack of trained human resources and limited culturally appropriate material for literacy programmers to address STD/HIV/AIDS.
2. Other than educational channels, settings where men and youth may be reached for informational/educational purposes have not been widely explored.

**Recommendations**
1. Explore and expand alternative channels to reach men, particularly military, police and other men away from home, to influence socio-cultural norms which are favorable to reducing STD/HIV/AIDS risk behavior.
2. Maximize the use of the literacy programmer to reach women and female youth in rural areas with culturally appropriate messages about sexuality and reproductive health to become more pro-active in protecting themselves from STD/FIIIV/AIDS.
3. Promote innovative channels to reach out-of-school youth using peer education approaches (e.g. sports, clubs, language schools, etc.).

**II. Communication Strategies and Materials**

**Achievements**
1. Information about HIV/AIDS and its transmission has reached the general population and specific target groups.
2. Government and NGOs have used a variety of channels and innovative approaches.

**Constraints**
1. Existing messages are not sufficiently gender or culturally related to effectively influence attitudes and behavioral change, and fail to offer information about services.
2. Lack of expertise in communication strategies and execution of production.
3. Lack of policy support, resources and weak coordination results in insufficient diffusion of messages and material, particularly to rural populations.

**Recommendations**
1. Establish a sustained National Communication Strategy involving key ministries, NGOs and the private sector.
2. Create a multi-sectional Coordinating Body for HIV/AIDS/STD information, supported by technical assistance in human sexuality and behavioral change communication, to address
Annexes
Recommendations

1. Effective and quality HIV/AIDS/STD counseling must be expanded, ensuring counselor capacity is strengthened through the initial and in-service training; regular supervision, and support
2. Co-ordination within and between health and non-health services and traditional sectors providing `counseling' is needed in order to enlarge the scope and reach of psycho-social support available to people in Cambodia
3. Promote the establishment of non-test related `formal' counseling in other health services and in the community e.g. MCH clinics. Provincial Hospitals, within NGO programs

V. Community Activities

Achievements

1. NGOs have been actively involved in AIDS education at community level, mostly through their existing health/development programmes. Both NGOs and government are reaching certain groups such as CSWs in provincial towns on a regular basis.
2. There is recognition by both Government and NGOs working at community level that current community education efforts have limitations for affecting behavioral change and that capacity building is needed to enable them to mobilize effective community responses.

Constraints/Gap

1. Communities in general still lack understanding of HIV/AIDS/STDs and its impact to individuals and community. Community participation, mobilization and culturally appropriate approaches are not being utilised by most groups working on HIV/AIDS/STDs.
2. Existing coordination structures at provincial level have limitations in involving broader groups other than health, thus lack the ability to mobilize effective responses, particularly at district and commune level.
3. There is a lack of understanding of the continuum of HIV/STDs/AIDS prevention activities and provision of care (and other social services) for people affected by HIV/AIDS/STDs in the community from "formal" health services to "traditional" health services and to community.

Recommendations

1. Mobilize and support community structures at local level such as Village Development Committee, Cluster School Committee, to integrate HIV/AIDS/STDs prevention and care into community activities.
2. Encourage full community participation in assessing, planning, and monitoring ways to reduce risk of HIV/AIDS/STDs and provide care for people affected by AIDS within the community and cultural context.
3. Coordinating mechanism on HIV/AIDS/STDs at provincial and district level need to include non-health sector, community groups, NGOs, donors, and, when possible, private sector and be utilised to reach consensus on programme direction and management.
4. Promote understanding of the prevention and care continuum, ensuring that prevention activities, as well as traditional and non-traditional health and social services are linked.
Annex Ia  Estimates of Cumulative HIV Infections in Cambodia

Estimates of cumulative HIV infections in Cambodia 1990-2000
(Source: WHO/WPRO)

Annex Ib  HIV prevalence among Commercial Sex Workers

HIV PREVALENCE FROM SENTINEL SURVEILLANCE 1990 AMONG DIRECT COMMERCIAL SEX WORKER BY PROVINCE
Annex Ig  National HIV Prevalence in Pregnant Women

National HIV prevalence in pregnant women, 1996
Source: WHO/MOH in selected countries
Annex III  

**Representation on the National AIDS Committee and Secretariat**

National AIDS Committee
National AIDS Committee Members
HRH Prince Norodom Ranariddh, Honorary Chairman
HE Chhea Thang, Minister, Chairman, Ministry of Health
HE Em Sam An, ST, Deputy Chairman, Ministry of Interior
HE Prom Gnien Vicheth, UST, Member, Ministry of Information
HE Kea Sahorn, ST, Member, Ministry of Education, Youth and Sports
HE Keat Sokum, ST, Member, Ministry of Women's Affairs
HE Thong Khon, ST, Member, Ministry of Tourism

Deputy Governors
HE He Kan, Member, Phnom Penh Municipality
HE Nam Turn, Member, Battambang
HE Hoy Eang, Member, Ta Kev
HE Kun Kimteng, Member, Kampot
HE Vankirirat, Member, Koh Kong
HE Sun Heng, Member, Kampong Som
HE Uch Proung, Member, Kampong Speu
HE Chhun Siry, Member, Kandal
HE Leng Loeung, Member, Kampong Chhnang
HE Ros Sreng, Member, Pursat
HE Chhay Sareth, Member, Banteay Meancheay
HE Korn Heang, Member, Siem Reap
HE Third Deputy Governor, Member, Kampong Thom
HE So Nat, Member, Kampong Cham
HE Sa Phim, Member, Rattanakiri
HE Third Deputy Governor, Member, Mundulkiri
HE Third Deputy Governor, Member, Prea Vihear
HE Ngoun Pen, Member, Stung Treng
HE Net Houn, Member, Kep
HE Phok Samen, Member, Svay Rieng
HE Chey Sayoun, Member, Prey Veng
HE Dagn Ang, Member, Kratie

National AIDS Secretariat
National AIDS Secretariat Members
HE Nuth Sokhum, Chairman, UST, Ministry of Health
Dr. Hor Bun Leng, Member, Coordinator, NAP, Ministry of Health
Dr. Ken Phun, Member, Director, Health Department, Ministry of Interior
Dr. Kiev Serevyuthea, Member, Women's Health Department Director, Ministry of Women's Affairs
Dr. Slat Chhan, Member, School Hygiene Dept. Director, Ministry of Education, Youth & Sports (Open), Member, Ministry of Information
Mr. Sau Chhanna, Member, Director, Legislation & Coordination, Ministry of Tourism

ST = Secretary of State
UST = Under-secretary of State
Annex II   Key Research Areas Identified

The following areas were not detailed in order of priority and are not meant to be an exhaustive list of research priorities.

• Special Interventions for sex workers

Study self-perceptions of sex work by sex workers (Khmer and non-Khmer) and perceptions of sex workers by brothel owners and general population in order to improve STD/HIV prevention messages and health seeking behavior.

• Pharmacists' STD drug dispensing behaviours

• universal Precautions

Investigate use of injectable medicines in the private, formal/informal sector and assess safety in order to promote safe injections among the public and health care providers.

• Counselling and Testing

1. Investigate the extent of self-testing in Cambodia.
2. Assess the impact of self-testing on risk behavior change.

• AIDS Care

Identify the most prevalent opportunistic infections in Cambodia.

• Blood Safety

Based on available anthropological data, design and test promotional messages for volunteer blood donation.

• Cultural Beliefs and Practices Influence on Behavior

1. Cultural barriers against men adapting 100% condom usage.
2. Cultural beliefs among men and women which may be harnessed to increase use of condoms by men and CSWs with all sexual partners.
3. Methods by which non-harmful interventions of traditional healers can synergise with and improve existent health policies and strategies.

• HIV prevalence among Rural Populations and the Sexual Behaviour of Rural Men and Women

It was unclear during this review the extent to which the epidemic has spread into and is spreading through the rural communities. Because over 85% of people live rurally, it is important to know the extent of the rural epidemic. In rural areas women head one in four households. Poverty and lack of access to health care is common. The extent to which multiple wives or multiple sexual partners is occurring in rural areas is critical in designing program interventions.
Management and Technical
1. Dr. Tia Phalla - Program Director
2. Dr. Hor BunLeng - Program Manager
3. Dr. Lan VanSeng - Training Officer and Administrator
4. Dr. Seng Sopheap - STD Program Officer and AIDS Care
5. Dr. Heng Sopheap - Behavioral Surveillance and Outreach Program Officer
6. Dr. Mun Phalkun - Outreach Program Officer
7. Ms. Ek Someth - Behavioral Surveillance and Outreach Program Officer
8. Dr. Saphonn Vonthanak - HIV Surveillance Program Officer
9. Dr. Kol Vorhit - Training Officer
10. Ms. Chhour Peou - IEC Program Officer and Training (temporary)

On Leave now or soon
1. Dr. Seng Suthwantha - Deputy Program Manager
2. Dr. Chhoun Samrith - Surveillance Program Officer
3. Dr. Ly Peng Sun - IEC Program Officer
4. Dr. Sok Bunna - STD Program Officer

Administration and Support
1. Mr. Chhun Vanthy - Administrator
2. Ms. Uy Thy - Secretary
3. Ms. Hing Bonavy – Secretary
4. Ms. Ung Sokunthea. Secretary
5. Mr. Thuy Por - Driver
6. Mr. Som Vichit Dara – Driver
7. Mr. Chhe Chan - Driver

UN and Donor Program Managers and Technical Advisors
1. Ms. Pawana Wienrawee, UNAIDS Country Program Advisor
2. Mr. Michael Calabria, UNDP HIV/ADS Program Coordinator
3. Mr. Jim Meilke, UNICEF HIV/AIDS Program Manager
4. Dr. Annie Macarry, WHO HIV/AIDS Technical Advisor
5. Dr. Bernard Fabre-Test, French Cooperation Program Director and Technical Advisor
6. Ms. Henrietta Wells, ODA/WHO Technical Advisor

Soon to arrive:
1. Dr. Francois Crabbe, EU Program Manager and Technical Advisor
2. World Bank: 1 program manager/advisor and 1 IEC/media advisor

Part time assistance:
1. Mr. Steve Mills or Mr. Tony Bennet, AIDSCAP/USAID Technical Advisors
2. GTZ Regional Technical Consultant
Annex IV  National Committee for HIV/STD/AIDS Prevention and Control
Structure

Structure of National Committee for HIV/AIDS/STD Prevention and Control

Honoray chairman 1st Prime Minister
Chairman Ministry of Health
Member: Secretary of State
From Ministry Member

National Committee for HIV/AIDS/STD Prevention and Control

Minister of Health

Secretariat

National HIV/AIDS/STD Programme

Technical Working Group

Donor Agencies International Organisation International and Local NGO

Media Task Force

Provincial AIDS/STD Committee

Provincial Health Department

District Health Department

Provincial AIDS/STD Program

District AIDS/STD Program

District AIDS/STD Committee

District AIDS/STD Team

Annex V  Organogram of the Ministry of Health

ORGANOGRAM OF THE MINISTRY OF HEALTH

MINISTER

Under-secretary of State

Cabinet

Direction General of Inspection

Direction General of Health

Direction General of Administrative & Finance

Provincial Directorate

Department of Planning and HIV
Department of Prevention
Department of Medical Care
Department of Human Resource
Department of Drug & Medical Supply
Department of CTM
Department of Administration
Department of Tented
Department of Finance
Department of Inspection Industry
### Source of Funds for HIV/AIDS/STD Activities by Funding Agency in US$

**Date:** June 19, 1997

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N.B. Whenever possible please indicate the "recipient" of the funds i.e. NGOs, GOV. others. Also mark any problem or difficulty incurred in obtaining the data. It data concerning the Strategic Areas of Intervention and relevant implementing agency are available, please include.
Combined national and international funding for HIV in Cambodia 1993-1997 (in US$ million)
(Source: UNAIDS, MOH, Donors)
### AREAS OF HIV/AIDS INTERVENTION BY ORGANIZATIONS 1996-1997

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**Notes:**
- **NAP:** National Program
- **PAC:** Provincial AIDS Committee
- **Research**
- **Condom**
- **School**
- **Training**

**Legend:**
- **x** indicates involvement in the area.
- **-** indicates involvement in the area.

**Annex VIII Areas of HIV/AIDS Interventions Listed by Organization**
### Areas of HIV/AIDS Intervention by Provinces 1996-1997

**Date:** June 19, 1997

#### FUNDING AGENCY

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<tr>
<th>Geographic Area</th>
<th>Phnom Penh</th>
<th>Battambang</th>
<th>Pursat</th>
<th>Siem Reap</th>
<th>Kep</th>
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#### UN SYSTEM

- UNAIDS
- UNICEF
- UNDP/OPS-HIVD Project
- UNESCO
- UNFPA
- UNICEF
- WHO (All sources)
- WB

### BILATERALS

- USAID
- AIDSCAP/PPE
- ALLIANCE
- GTZ/CHASPA
- FRENCH/COOPERATION
- INDONESIA GOVT
- ODA/DFID
- AUSAID (see CRC/ARC)

### MULTILATERALS

- European Union
- ICRC

### NGOs

- MSF (Holland-Belgium-Switzerland)
- MSF (France)
- Saige Children UK
- CARE International
- WOF
- Work Vision International in Cambodia
- Australia Cambodia Red Cross
- CRS
- OHRB
- Maryknoll
- Oumker Service Australia
- Cambodia Women’s Development Association
- Save the Children
- Servar
- Redd Bante
- Health Unlimited
- FPA/HRAC
- International AIDS Alliance
- Pasteur Institute

### NATIONAL

- National AIDS Program (NAP)
- Ministry of Education
- Ministry of Defense
- Ministry of Woman Affairs
- Ministry of Social Affairs

### OTHERS

- Private Sector
- NAP: National AIDS Program
- PAC: Provincial AIDS Committee

**Source:** Annex IX Areas of HIV/AIDS Interventions by Province

**Note:** The table above provides an overview of the areas of HIV/AIDS intervention by provinces in Cambodia for the years 1996-1997. The table lists the funding agencies, geographic areas, and NGOs involved in these interventions. The information is organized to show which provinces have received assistance from different sources, indicating the collaborative nature of the response to HIV/AIDS in Cambodia during this period.
of being a stumbling block to integrate AIDS into the system easily
13. Shortage of teachers at the primary level which leads to overcrowding, double sessions and limits teaching-learning time in class
14. Overcrowding of classes, and at times a wide range of differing ages in the same class, make participatory teaching-learning methods and age appropriate lessons difficult
15. Low wages make the possibility of having teachers volunteer to work extra hours to assist in after-school STD/HIV/AIDS activities unrealistic
16. Donor commitment from within the MoEYS for assistance in FN/AIDS has been largely verbal with little demonstrated action
17. There have been delays in the UNICEF programmer of working with the MoEYS to integrate STD/HIV/AIDS into the system
18. Text books and teachers manuals which have already been written do not yet include STD-TUV/AIDS (exception of grade 6&7 science books)
19. There is an inadequate supply of teaching and learning materials available for subjects presently included in the curriculum, including country appropriate HIV/AIDS/STD material

Recommendations
Policy:
1. Policy statements to ensure non-discriminatory practices need to be developed, disseminated, explained and modeled
2. Guidelines for immediate action to integrate HIV/AIDS/STD messages into school activities must be written and communicated to the provincial level (see "Immediate Recommendations")
3. Policy to ensure that educational programmes are appropriate to local social and cultural contexts
4. The role and responsibilities of the Training Sub-Committee and the Department of Hygiene in responding to AIDS within the MoEYS needs to be clarified
5. Identify structures and process of where best to place STD/HIV/AIDS/Life Skills through formal discussions with concerned departments. Continuity and consistency across departments should be ensured in this process
6. Assess the UNICEF model in which the Department of Hygiene is used as a focal point to work with other MoEYS departments and MoH, to see if this can be used for integrating STD/HIV/AIDS Life Skills into the ministry

Strategies:
1. Use the ministerial structure's comparative advantage to ensure integration into the various activities carried out by departments and donors
2. Develop appropriate curriculum giving priority to end grades of a cycle (grade 6 of primary school, grade 9 of lower secondary and grade 12 of upper secondary)
3. Integrate HIV/AIDS sexuality into "General Hygiene" (Anamvsuksa) which addresses personal hygiene issues
4. Develop/adapt teaching-learning material. Integrates HIV/AIDS/STDs/Life Skills into the basic competencies (Khmer language, and math), syllabus (science and social sciences) and the curriculum imperatives (environment, human rights and health)
5. Integrate AIDS into text books where possible. Coverage of the diverse settings found in Cambodia must be included (e.g. urban and rural, ethnic & cultural groups)
6. Develop supplementary readers to compliment text books, these can be made culturally appropriate for the various settings in country
7. Pre-test all material developed or adapted for clarity and effectiveness on the targeted audiences (teachers/students)
8. Use cluster schools for training, pre-testing and centralizing material in the field
9. Establish a resource library. to centralize educational HIV/AIDS/STD material from within country and the region. Review material for possible adaptation in Cambodia.
### Areas of HIV/AIDS Intervention by Provinces 1996-1997

**Date:** June 19, 1997

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Place Annex IXb here: intervention by province code.
Comparisons of 1996 HIV prevalence in total population and per capita HIV budget ($US) in Cambodia and Thailand
(Source: UNAIDS/WHO)
Information, Education, Communication and Community Response

I. Education

Formal

The education system in Cambodia has been instituting education reform strategies while rebuilding a system that was devastated during the previous decades. The international donor community has been supporting the MoEYS in restructuring grade levels, setting up cluster schools, reviewing and rewriting curriculum and text books, and training teachers. It is important to realise the dimensions of this scenario in order to make realistic recommendations for HIV/AIDS/STD education activities to be integrated in the MoEYS.

Achievements

1. MoEYS is a member of the NAC, as well as of PAC
2. Educational Sub-committees within MoEYS established
3. Collaboration and coordination with NGOs, donors and the MoH to begin raising the capacity of some MoEYS personnel at both national and provincial levels (e.g. training, and study tours)
4. Ad hoc support from PAO and NGOs to incorporate HIV/AIDS education into school activities occurs at provincial levels and in Phnom Penh
5. Awareness raising integrated into in-service teacher training sessions on an ad hoc basis and select teacher training colleges with 10 and NGO assistance
6. STD and HIV integrated into "Population Education" in social sciences and sciences (biology) at secondary level
7. Some material specifically developed for use in schools, chapters on HIV/AIDS with condom messages included in Integrated Science Book grade 6 and Biology Book grade 7

Constraints

1. No existing policy to avoid discrimination of PLWHA from working in or attending school (teachers/students)
2. Lack of HIV/AIDS/STD policy direction from the national down to the provincial level
3. The two HIV/AIDS sub-committees within the MoEYS lack technical and financial resources to become pro-active in carrying out their technical roles
4. The two sub-committees have not met since their establishment
5. The sub-committee on "Training", headed by the Department of Hygiene, is unclear about its role and responsibilities, this reflects a general weakness of the department itself
6. Lack of time in the curriculum to add in another subject, other than integrating messages and information into other subjects (e.g. Khmer language, moral, science, etc.), creates the risk of having little impact on influencing attitudes and non-risk behaviour among the youth
7. Children are being treated as a homogenous group through generic strategies and textbooks, whereas their differing backgrounds (ethnicity, cultural, rurality, etc.) will forge the way in which they receive messages
8. Provincial level can only carryout AIDS education as an extra-curricula activity until formally integrated into the curriculum
9. Tertiary (university) education has not been addressed outside of ad hoc activities by NGOs
10. There is a limited number of well trained and experienced trainers in participatory teaching-learning methods, compounded by few MoEYS personnel trained in HIV/AIDS and sexuality to offer technical assistance within the ministry
11. The numerous activities occurring simultaneously within the education system is over-stretching the limited number of well trained, skilled and experienced personnel
12. The variety of educational approaches taken by donors assisting the ministry has the potential
PAO and NGOs offer awareness raising to workers in factories in some provinces

Constraints
1. The possibility of up-grading literacy teacher's skills and knowledge to include HIV/AIDS through in-service courses is limited to once per year
2. The level of basic literacy courses limits the possibility of messages
3. The majority of literacy classes are attended by women, making it difficult to reach men in rural settings
4. Literacy material is generic in nature and not made culturally appropriate for various groups (e.g. Chain, Chinese, Vietnamese, etc.) making it difficult to target messages for specific groups
5. Due to the lack of a system to organize language schools and monitor curriculum, integration of AIDS into language schools may be on an ad hoc basis
6. There is a gap of using sports and athletes as role models to promote prevention and non-risk behaviour among youth (especially among young males)
7. Other than working through community based responses (e.g. peer educators) reaching out of school youth remains a gap
8. There are limited means to reach men through non-formal systems

Recommendations
Policy:
1. Explore and expand alternative channels to reach men, particularly military, police and men away from home, to influence socio-cultural norms which are favourable to reducing STD/HIV/AIDS risk behaviour.
2. Maximise the use of the literacy programme to reach women and female youth in rural areas with culturally appropriate messages about sexuality and reproductive health to become more proactive in protecting themselves from STD/IUV/AIDS.
3. Promote innovative channels to reach out-of-school youth using peer education approaches (e.g. sports, clubs, language schools, etc.).

Strategies:
1. As there is a need for more post literacy readers, stories about issues relating to STD/HIV/AIDS should be written. These stories need to be written so that the reader would find a way to share the information with his/her partner
2. Identify resources among donors/NGOs working with ethnic groups to develop culturally appropriate readers which include sexuality and STD/AIDS
3. Utilisation of supervisor/teacher trainers should be mobilised and sensitised in order to integrate HIV/AIDS in teacher/student dialogues during literacy classes, to complement the basic messages, this may be done during monthly teacher meetings, monitoring visits or the yearly up date review
4. As the MoEYS sports section is in a beginning phase of developing a framework to organize sports activities it is the ideal time to take steps to promote HIV/AIDS modelling for youth and healthy lifestyles
5. Explore pilot projects to mobilize the private sector with the idea of targeting men in the workplace (factories, construction, logging companies, etc.) through businesses and appropriate government departments, e.g. labour at the MoSALVA, forestry at the MoAg
6. Sensitize and motivate managers/authorities to gain their support and commitment in ensuring HIV/AIDS/STD activities to workers
7. The pilot peer education project in the military, needs to be assessed for lessons learnt and to determine if it is replicable for other male groups, such as police, C-NLAC, or in the private sector.
8. Explore the need for separate male and female programmes in all non-formal activities
10. Explore ways to integrate AIDS into the various faculties of the university of Phnom Penh
11. Identify donor resources for technical assistance in development of curriculum, material and teacher training programmer
12. Train appropriate personnel on the use of curriculum, teacher's manuals, text books or other material developed

Immediate Recommendations
While the long term process is taking place, an emergency-like strategy needs to be carried out in which a minimum package of awareness and messages are offered to teachers throughout the system, and relies on the coordination and collaboration of the MoH/NAP and DHEdHy&PHC, donors, PAO and available NGO assistance at the provincial levels.

1. MoEYS must develop and disseminate Guidelines for immediate action to integrate HIV/AIDS/STD messages into school activities throughout the country
2. Generate commitment and involvement of schools directors and teachers
3. Mobilize the NAP & DHEdHy&PHC and the MoEYS to identify financial and logistical resources to conduct awareness and sensitisation sessions for teachers
   • during in-service training
   • in Teacher Training Colleges (for student teachers & teachers)
   • at the provincial and district levels
Possible resource people may be found in the PAO, other departments and NGOs
1. Identify 1-2 subjects and lessons into which STD/HIV/AIDS messages may be integrated
2. Develop key messages which maybe used in the identified subjects/lessons that are to be given to the teachers during the awareness and sensitisation sessions
3. Use other channels for reaching teachers, such as: the Distance Learning Course and the teacher magazine AMCEK and the teacher's newsletter
4. Continue to include HIV/AIDS awareness in on in-service training (1-2 days)
5. Encourage and support the development of complementary after-school programmes (e.g. Peer Education, Prevent AIDS Clubs, traditional theatre club, etc.)
6. Involve parents in HIV/AIDS prevention for their children through Parent/Teacher Associations

Non-Formal
"Non-Formal" education refers to education programmes outside the primary, secondary and tertiary setting. For the most part it consists of literacy programmes but it also includes such groups and settings as out-of-school youth, men in the workplace, and the military. Youth organisations are few in number and tend to be tied to school activities.

Achievements
1. The literacy programme which is carried out in 16 provinces, includes an HIV/AIDS lesson in the basic literacy course. This is being implemented by both government and NGOs using the same curriculum and books
2. Literacy curriculum writers and literacy supervisors from MoWA & MoEYS trained in HIV/AIDS
3. Expansion of STD/HIV/AIDS messages into other appropriate lessons of the literacy programme presently happening
4. Operational coordination of MoEYS, MoWA, UN and NGOs involved in literacy at the national and provincial levels
5. Youth and young adults in urban areas are being targeted through other educational channels, e.g. language schools to integrate STD/HIV/AIDS related issues into learning English as a second language
6. Men with high risk behaviour (e.g. police, military) are being targeted through ad hoc awareness sessions by PAO and NGOs, as well as pilot projects (military)
4. Develop effective messages that address the role of individuals in families and communities (e.g. the role of a concerned parent)
5. Conduct qualitative research to understand risk contexts and sexual lives of Cambodians
6. Use information from the traditional sector to formulate IEC messages to have the greatest impact on the local population
7. Produce guidelines for developing, pre-testing, evaluating HIV/AIDS/STD messages, focusing on communication for behavioral change through audience participation methods
8. Provide regular training, refresher courses and technical assistance to government personnel and NGOs involved in the production of HIV/AIDS/STD material and media
9. Promote understanding that STDs increase the risk for HIV infection and ensure proper promotion of STD treatment is integrated into messages
10. Assure consistency of messages and incorporate them into other programmes (e.g. Safe Motherhood, MCH, etc.)
11. Utilise existing community and government structures (e.g. VDC, MoRD, etc.) and traditional and religious ceremonies (bon prapeyni ciet) (e.g. Water Festival, Khmer New Year, etc.), as well as special events (e.g. World AIDS Day, etc.) to disseminate messages and materials

III Condoms

Achievements
1. PSI already very successful in distributing 800,000-1,000,000 condoms per month
2. NAP promotes condoms through its programme activities
3. NAP distributes free condoms to other ministries for training purposes e.g. Women Affairs and Social Action
4. NGOs have been very instrumental in getting No. I condoms out to rural areas and show a strong potential to expand their distribution
5. Condoms are also distributed through MCH programmes

Constraints
1. Both NAP and PSI condoms do not reach CSWs/condom outlets at district level
2. Brothel owners are not always supportive to CSWs using condoms
3. Condoms supplied through MCH programme are sometimes viewed by MCH staff to be exclusively for Family Planning
4. Condoms are viewed by the general population as for commercial sex only, and not for use in other relationships
5. There has been minimal monitoring of the effectiveness, appropriateness, relevance or acceptability of messages through the media with respect to condom promotion
6. Research results regarding condom use, attitudes and practices have not been utilised in IEC development
7. Traditional beliefs that may affect the use of condoms have not been utilised in condom messages
8. Consistent condom use remains a problem even in commercial sex
9. Unsafe condoms are found in markets and drugstores
10. AIDS education is sometimes constrained by donor/INGO religious/moral positions which are not fully supportive to condom promotion or use
11. Media personnel feel constrained in promotion of condoms by fear of offending high level authorities
12. There have been complaints that neither NAP nor No. 1 condoms have sufficient lubricant
II. Communication Strategies and IEC Materials

Achievements
1. Awareness of HIV and its transmission is high among the population in provincial towns and major districts.
2. Certain risk groups (e.g. CSWs, particularly at provincial level) have been targeted regularly, reflected in their high awareness of HIV/AIDS and to a lesser extent STDs.
3. Both health and non-health personnel are aware of HIV/AIDS problems and believe that they should be involved in HIV/AIDS activities.
4. PROs are given access to non-health sectors in order to educate their populations.
5. IEC materials produced by NAP are used by provincial level health staff, NGOs, some staff at district level and to a lesser extent, non-health sectors.
6. Electronic media (particularly television) has been used by NAP and NGOs to reach people in rural areas.
7. Innovative media approaches by both NGOs and the NAP exist.
8. Special events such as World AIDS Day have provoked multi-sectoral responses.

Constraints
1. Many EEC materials produced by various groups focus only on the virus and its transmission, the absence of a personal context limits its ability to impact on behaviour.
2. Most IEC material lacks audience research and pre-testing.
3. Messages concentrate on men and the commercial sex context; and are thus less effective in raising awareness amongst women. No messages specifically target women to empower them to feel that they can protect themselves.
4. Lack of linkage between HIV/AIDS and STDs in most messages.
5. The language used in messages is often too technical for layman's understanding and lacks a cultural context.
6. There is very little IEC material produced specifically for non-literate or non-Khmer speakers.
7. Many organisations (health and non-health) producing IEC materials and involved in communication approaches lack proper training in understanding communication aspects for behavioral change related to HIV/AIDS and human sexuality.
8. Non-health sectors lack technical understanding and resources to participate in HIV/AIDS/STD communication approaches.
9. TV, radio and IEC material often lack consistency, are limited in diffusion and receive insufficient air-time.

Recommendations
Policy:
1. Establish a sustained National Communication Strategy involving key ministries, NGOs and the private sector.
2. Create a multi-sectoral Coordinating Body for HIV/AIDS/STD information to address quality assurance, gaps/overlaps, false and misleading information and promote best practices.
3. NAP and relevant partners to advocate for policy/national support for free air time for social messages.

Strategies:
1. Communication approaches must move beyond HIV/AIDS/STD awareness and become more interactive in modeling behavioral options to avoid risk contexts and discrimination, and instead promote more positive messages about HIV/AIDS/STD and sex.
2. Normalize the condom image to embrace trusting relationships (use of condoms as both a Family Planning method and protection against STD/HIV).
3. Ensure IEC messages are developed for specific groups (e.g. women, non-literate Chimeras,
3. Pro-active role taken by NGOs in counseling training and service provision
4. Forum for NGO co-ordination of counseling activities exists
5. Many existing structures/organizations involved in counseling (e.g. merc-al heals organizations) plan to integrate HIV/AIDS into their counseling

Constraints
1. Guidelines and Policy are not fully disseminated or understood, some evidence of giving false negatives to avoid need for counseling
2. No co-ordination between the different sectors involved in aspects of HIV/AIDS counseling and psychosocial support (e.g. Health; Social Services; Traditional)
3. Counseling as a means of exploring behavioral and emotional aspects of HIV/AIDS is linked to Khmer culture, within which information is given in a directive manner
4. Concepts of counseling further confused by disagreements amongst various foreign influences e.g. donors, NGOs, religious organizations
5. There are not enough people with the capacity to offer counseling for HIV/AIDS
6. Development of wider uses of HIV/AIDS psychosocial support inhibited by association of counseling with the medical Procedure of HIV testing
7. Counseling training not standardized; no supervision or support network for counselors

Recommendations
Policy:
1. Effective and quality HIV/AIDS/STD counseling must be expanded, ensuring counselor capacity is strengthened through the initial and in-service training; regular supervision, and support
2. Co-ordination within and between health services and other sectors providing 'counseling' is needed in order to enlarge the scope and reach of psychosocial support available to people in Cambodia
3. Promote the establishment of non-test related 'formal' counseling in other health services and in the community e.g. MCH clinics, Provincial Hospitals, within NGO programmers

Strategies:
1. CBOs should be encouraged to provide psycho-social support to people affected by AIDS at the community level
2. Initiate co-ordination body on counseling, with the involvement of appropriate departments, such as:
   • Ministry of Health including sub-committee on mental health, NAP, Traditional Medicine Center
     • Ministry of Cult and Religious Affairs including Buddhist Institute,
     • Ministry of Education including relevant departments of Royal Phnom Penh University such as Department of Psychology,
     • Ministry of Women's Affairs
     • Ministry of Rural Development
     • NGOs/donors
3. Set out a minimal criteria for 'formal' counseling related to HIV/AIDS. Establish minimal standards for counseling, including a core curriculum, network of counseling support, and structure for counseling supervision
4. Seek to expand the role of 'non-formal' psycho-social support provided by VHV, monks Kruu Khmer etc., and provide a structure for support
5. Explore Potential for counseling service delivery and/or referral in the Private Health Sector and within Primary Health Care services
6. Promote and maximize use at national and provincial levels of the Testing and Counseling Policy and Guidelines that have been developed
Recommendations

Policy:

1. Promotion of `100% condom use' in brothels
2. Prioritize sensitization of policy makers and media personnel. `Normalization' of the condom image is urgently required and should address cultural factors that affect non-usage, with the aim of increasing condom use in the non-commercial sex context
3. Secure sufficient condom supply for Cambodia
4. Establish a monitoring mechanism for effective distribution and quality assurance at central and outlet level

Strategies:

1. Condom situation to be analyzed thoroughly and systematically to identify gaps in supply, distribution and quality control at the outlet
2. Increase condom outlets particularly in rural areas. Consider free distribution of condoms in certain high risk populations which may not be reached by the social marketing programmed (e.g. military) in order to increase familiarity
3. Promote different brands of condoms for non-commercial sex market/develop marketing strategy to reach non-commercial sex
4. Promote familiarity with and consistency of condom usage in all HIV/AIDS/STD programmers and messages
5. Prioritize rapid anthropological research of condom use by men in Cambodia, looking at message development in the context of critical cultural factors (such as the different perspectives of men and women, vulnerable times in the life-cycle (before marriage, before getting pregnant, pre- and post-birth etc.)
6. More active condom promotion and demonstration in MCH programmer and all STD services
7. Condom promotion needs to target women, including strategies to get partners to use condoms
8. Innovative channels for condom promotion should be explored e.g. places where sex occurs, places where pornographic movies are shown, places where traditional marriages are arranged
9. Specifically involve the `gatekeepers' of commercial sex work (brothel owners, police, client’s etc.) in order to facilitate 100% condom use
10. Target the gatekeepers in positive condom promotion
11. Inappropriate condoms in drugstores must be regulated and discouraging their use should be incorporated into condom education
12. Female condom promotion and marketing should be explored

IV. Counseling/psychosocial Support

Summary
The majority of counseling related to HIV/AIDS occurs in conjunction with the seven government-testing centers. Both government staff and NGOs have been trained to carry out the pre- and post- test counseling that takes place in these centers. Non-specific psychosocial support is more traditional in Khmer culture and is offered on an informal basis by various individuals and groups in the community, e.g. monks, Kruu, VHV’s, Community Mental Health Educators. Professional counseling as a process to assist individuals to identify their own problems and solutions is rather new in Cambodia.

Achievements

1. National Guidelines and Policy for Pre- and Post- test counseling developed and distributed
2. All government testing centers staffed by trained counselors
2. Encourage full community participation in assessing, planning, and monitoring ways to reduce risk of HIV/AIDS/STDs and provide care for people affected by AIDS within the community and cultural context.

3. Coordinating mechanism on HIV/AIDS/STDs at provincial and district level need to include non-health sector, community groups, NGOs, donors, and, when possible, private sector and be utilized to reach consensus on programmer direction and management activities and traditional and non-traditional health and social services are linked.

4. Promote understanding of the prevention and care continuum, ensuring that prevention activities and traditional and non-traditional health and social services are linked.

Strategies:
1. Utilize existing HIV/AIDS community activities to integrate issues of care and the Community Role along side prevention and non-discrimination messages aimed at the individuals, and their roles as community members.

2. Raise awareness of the donor community of the need to integrate HIV/AIDS into development activities. This should include capacity building of local NGOs currently/planning to be involved in HIV/AIDS activities at community level.

3. NGOs and community-based organizations should be encouraged and supported to create support groups for people affected by AIDS. These should be linked to existing community activities and with a referral system to health and other services, including traditional healers when appropriate.

4. Establish a pilot intervention utilizing various members of the traditional sector e.g. TBAs, Kruu Khmer, monks, mediums, fortune tellers etc. to evaluate their possible roles in assisting their communities with HIV/AIDS-related areas e.g. sexuality and relationships of men and women; STD education; support for family members who have AIDS etc.

5. Encourage expansion and coordination of the diverse VHV or equivalent initiatives (i.e. under NGOs, WID programmers, Rural Development, Health Education etc.) in regard to scope of work, remuneration and training needs.

6. Establish Home Care Programmers utilizing existing community resources i.e. involving liaison between Health Centers, NGOs, CBOs, TB DOTS programmers, VHV, and the traditional sector. NAP to take the lead with donor support.

7. Existing co-ordination mechanisms (such as pro-CoCom) should consider creating an HIV-specific forum involving both health and non-health sectors. Activities should include coordination of programs, on-going exchange of lessons learned, establishing consistency on working conditions etc.

8. CSW outreach programmers should expand its strategies to target the ‘gatekeepers' of commercial sex (brothel owners, clients, police) to promote 100% condom use in brothels and proper treatment and regular check-up on STDs.

9. Building capacity of organizations working on HIV/STDs/AIDS, both government and NGOs, to increase understanding of HIV/AIDS/STDs complexity, human sexuality, genderrelated issues and increase interpersonal communication skills.

Section III Health Services Related to HIV/STD/AIDS

I. STD Services

Achievements
1. Guidelines for the syndrome management of sexually transmitted diseases (STDs) (in Khmer) updated in 1996 with the latest World Health Organization (WHO) flowcharts and effective anti-biotherapy, by National AIDS Program (NAP) and various consultants; flipcharts printed in Khmer and distributed to all Provincial AIDS Offices (PAOs).

2. Public sector STD services renovated and equipped with clinical material a few health centers and all provincial capitals except in Mondulkiri and Kampong Speu.
V. Community Activities

Achievements

1. Many NGOs are actively promoting AIDS prevention and introducing condoms as a means of prevention.
2. There are many examples of innovative schemes integrating HIV into current development activities and expanding their reach to vulnerable groups. Community organizations are generally integrated HIV/AIDS into the reformed health structures e.g. VHV’s linked to Health Centers.
3. CSW outreach has been established in all provinces by the NAP and NGOs.
4. Networks of organizations working on HIV exist at provincial level and in Phnom Penh, and have potential to further expand.
5. Some efforts are being made by international groups to increase the capacity of local community-based NGOs to address the complexity of HIV issues.
6. Policy direction for establishing District AIDS Committees with multi-sectional and commune level participation has been issued and some districts are beginning to establish them.
7. The potential for the role of the traditional sector has been recognized by some groups.
8. There is some recognition of the need, particularly among NGOs, to move their intervention beyond awareness raising to mobilization of their communities towards behavioral change and community care.

Constraints

1. HIV/AIDS is not generally perceived by rural communities to be their problem.
2. Poverty, lack of understanding, discrimination and cultural factors contribute to a reluctance to care for people with AIDS in the community.
3. HIV/AIDS prevention and HIV/AIDS care are seen as separate, non-integrated activities.
4. There is a lack of prevention activities targeted at specific groups at risk (e.g. men away from home) and groups who are vulnerable (e.g. non-CSW women, ethnic minorities, orphans and rural communities).
5. The design and implementation of AIDS interventions in the community tend to be non participatory, particularly with the traditional sector.
6. The current involvement of monks and pagodas in HIV/AIDS is limited to prevention activities. The potential in providing care/support for people affected by AIDS has not yet been explored.
7. CSW outreach programmers do not target brothel owners and clients. CSWs are not usually empowered to make decisions about condom use.
8. Existing coordination structures tend to be limited to health organizations.
9. VHV (and equivalent) programmers under different organizations, which have been key agent at commune level to provide AIDS education, are inconsistent in terms of remuneration, training needs etc.
10. Some NAP and NGO outreach programmers are uncoordinated resolutions in redundant and less effective of intervention coverage. Both PAOs and NGOs are restricted in reaching out to their communities by lack of transport, security problems etc.
11. There is a lack of monitoring and evaluation of current responses due to insufficient technical expertise and resources.
12. Misleading claims on treating and curing HIV/AIDS is causing false hope and financial losses.

Recommendations

Policy

1. Mobilize and support community structures at local level such as Village Development Committee, Cluster School Committee, to integrate HIV/AIDS/STDs prevention and care into community activities.
V. Community Activities

Achievements

1. Many NGOs are actively promoting AIDS prevention and introducing condoms as a means of prevention.

2. There are many examples of innovative schemes integrating HIV into current development activities and expanding their reach to vulnerable groups. Community organizations are growing. Integrated health structures are being strengthened, linked to Health Centers.

3. CSW outreach has been established in all provinces by the NAP and NGOs, with networks of organizations working on HIV/AIDS at the provincial level in Phnom Penh, and have potential for further expansion.

4. Some efforts are being made by international groups to increase the visibility of local community-based NGOs to address the complexity of HIV/AIDS issues.

5. Policy direction for establishing District AIDS Committees with multi-sectoral and commune participatory level representation has been lessened and some initiatives are beginning to establish them.

6. The potential for the role of the traditional sector has been recognised by NGOs.

7. There is some recognition of the need, particularly among NGOs, to move their intervention beyond awareness raising to mobilization of their communities towards behavioral change and community care.

Constraints

1. HIV/AIDS is not generally perceived by rural communities as a major problem.

2. Poverty, lack of understanding, discrimination and cultural factors contribute to a reluctance to care for persons living with AIDS in the community.

3. HIV/AIDS prevention and care services are seen as separate, non-integrated activities.

4. There is a lack of prevention activities targeted at specific populations at risk (e.g., drug users, sex workers, public minorities, orphans and rural communities).

5. The design and implementation of interventions in the community tend to be non-participatory, particularly with traditional sector.

6. The current involvement of monks and nuns in HIV/AIDS is limited to existing health education activities. The potential role of these communities has not yet been explored.

7. CSW outreach programmes do not target brothel owners and clients. SVIs are not usually seen as a priority by government or international donors.

8. Existing coordination structures tend to be limited to health care providers, and they need to be strengthened.

9. HIV and equivalent programmes need to be integrated at commune level to ensure they are consistent in terms of remuneration, training needs etc.

10. Some NAP and NGO outreach programmes are uncoordinated resulting in redundant and less effective of intervention coverage. Both PAOs and NGOs are restricted in reaching out to their communities by lack of transport, security problems etc.

11. There is a lack of monitoring and evaluation of current responses due to insufficient technical expertise and resources.

12. Misleading claims on beating and curing HIV/AIDS is causing false hope and financial losses.

Recommendations

Policy:

1. Mobilize and support community structures at local level, such as AIDs Committees, Cluster School Committee, and the school. This will ensure a cohesive approach to HIV/AIDS prevention and care into community activities.
3. Establishment of STD services at the National STD Center, the Municipal Hospital, Toul Kork clinic, RHAC clinics and the CUHCA clinics in Svay Pak and Chrang Cham Res. NGO support to Batambong STD Clinic.
4. AL PAO directors and part of provincial STD managers trained in clinical diagnosis and treatment of STDs Some staff from PAOs and districts trained in syndrome management of STDs.
5. STD/HIV prevalence studies and first round of behavioral study conducted since 1994.
6. STD/HIV module included in curriculum of the National nursing school in Phnom Penh (PNP) since 1995.
7. Condoms distributed by the NAP to STD services, at special events such as World AIDS Day, and during outreach for commercial sex workers (CSWs). Mother and child health (MCH) clinics supplied mainly by United Nations Population Fund (UNFPA) project.
8. STD drugs purchased with Overseas Development Agency (ODA) grant or through Le Fonds d Aide et de Cooperation (FAC) soon to be distributed. Should meet needs of STD clinics up to end 1997. Drugs currently available in most Non Governmental Organizations (NTGO)supported services.

Constraints/Gaps
1. Flowchart on Vaginal Discharge with risk assessment not appropriate for Cambodia.
2. Late arrival of STD drugs has undermined credibility of public health sector. Current procurement unlikely to meet needs in 15 STD clinics beyond 6-12 months.
3. Non-NGO supported STD services are currently not functional, because of lack of drugs and most staff not trained in syndrome approach.
4. Contraceptive Service not in line with integrated health care.
5. Respective role of NSTDC, Institute of Public Health (IPH) and Institute Pasteur du Cambridge (TPC) regarding research, training and reference level not clarified. NSTDC currently not functioning as referral level.
6. On-site training: 1) 40% of trained staff removed. 2) Latest STD management protocols not distributed to all district level. 3) Few health care workers (HCWs) trained at district level; none at health center level.
7. Curriculum of nursing schools not yet updated with latest STD management protocols.
8. Private HCWs, traditional health sector, and pharmacies not enlisted in syndrome management of STDs.
9. Inadequate collection of STD data through health information system (HIS).

Recommendations
1. NAP/partners: 1') Assess drug needs in the public sector (integrated health services and STD clinics) for the coming 3 years; 2) seek financial support for drug procurement [SHORT TERM] _
2. MoH: fully integrate STD care in existing health services through on-site training [SHORT TERM] _
3. NAP: develop master plan for on-site training with all donors [SHORT TERM].
4. NAP/others: STD Technical Working Group (STD TWG) to evaluate role of 'vertical' STD clinics after 6 to 12 months of operation (drugs available in clinics) [SHORT TERM]. 5. NAP/partners: develop guidelines and training material on syndromes management of STDs for private pharmacies staff [SHORT/MEDIUM TERM]
6. NAP/partners: Disseminate and explain STD management guidelines among all HCWs at first encounter level (public sector/private sector, NGO/non-NGO) [SHORT TERM]. Enlist traditional healers sector for STD management [MEDIUM TERM].
7. NAP/MoH/partners: explore and pilot test cost-sharing schemes for STD care in the public health sector [MED UM/LONG TERM].
8. Identify donors for the procurement of condoms for promotional activities, STD clinics, schooling etc. [SHORT TERM].
4. Guidelines on blood safety and optimal use of blood not (yet) developed.
5. HIV screening sometimes misused for diagnostic testing, and confidentiality of HIV test results not always ensured.
6. Non-existence of structures for medical follow-up and/or counseling for HIV(+) donors at provincial level.
7. Syphilis screening based on TPHA. No quality control of tests at provincial level.
8. Supervision of PTC regular but superficial.
9. Although invited, the NAP has not attended sub-CoCom meetings.
10. Lack of commitment and financial support from Government of Cambodia to blood transfusion system (ICRC to withdraw from national blood transfusion system as soon as possible)
11. No control of blood transfusion and/or blood products in private formal/informal sector.
12. Reluctance to donate blood may be caused by cultural barriers and/or lack of confidence in transfusion services, creating an over dependence on the receipt of blood from "professional" donors.

Recommendations
1. NBTC/ICRC/NAP: Make clear that HIV screening in blood banks is inappropriate for the diagnosis of HIV infection [INNIEIDATE].
2. NBTC/ICRC/NAP: Create joint collaboration between blood banks, hospital labs and Voluntary Testing Centers to provide reliable serologic diagnosis of HIV [SHORT TERM].
3. NAP/ NBTC/ICRC/Partners: where blood banks do not exist, ensure HIV testing of blood products with reliable test kits. [SHORT TERM]
4. NAP: Take active participation in blood safety sub CoCom meetings when appropriate [INIIIEIDATE].
5. NBTC/ICRC: set up of coding system for blood products to ensure confidentiality of test results [SHORT TERM]
6. NBTC/ICRC: distribution and explanation of guidelines on blood transfusion to provinces [SHORT TERM].
7. NBTC/ICRC: Ensure inclusion of blood transfusion/safety module in curriculum of medical and nursing schools (including military), and post university refresher training. [SHORT TERM]
8. NBTC/ICRC: ensure quality control and supervision at provincial level [SHORT TER1]
9. NAP/partners: investigate use of blood and blood products in private formal/informal health sector [SHORT TERM].
10. NBTC/ICRC/NAP: Take advantage of blood transfusion system to inform/educate blooddonors on blood-borne infections (including HIV) [SHORT TERM].
11. NBTC/ICRC/CRC: promotion of blood donation among the low risk population; recruitment of regular and non-risk donors in provinces. Promote operational research to determine cultural barriers to blood donation and ways to overcome it [LONG TERM].
12. NBTC: Extend blood transfusion to referral hospital which perform surgery [LONG TERM].
13. NBTC/MoH: promote and ensure set-up of safe private blood banks. Ensure safety control by Sanitary Inspection Department [LONG TERM]
14. Govt. of Cambodia/donors: Ensure financial support of national blood transfusion system [LONG TERM].

IV. Universal Precautions

Achievements
2. Document on" Universal precautions" adapted from WHO manual and produced by NAP in 1994; distributed d explained to PAOs.
B) Frequent Users of Commercial Sex Work (military, police, etc.)

Achievements
1. Donors’ funding recently allocated for the training of military HCPs in syndrome management of STDs in the 5 military regions in Cambodia, and for the procurement of STD drugs for 1997-98, in collaboration with Ministry of Defense.
2. NGO assistance to establish STD services at the Military hospital in Phnom Penh and Stung Treng.

Constraints/Gaps
1. Chronic shortage of medical equipment, consumable and STD drugs in all military hospitals and health care facilities.
3. Difficulty to reach clients of CSWs not belonging to Military, Police or CMAC.

Recommendations
1. NAP/NAC: Advocate the urgent need and mobilize donors' resources for STD/HIV control interventions targeted at military/police/CMAC [SHORT TERM].
2. NAC/Ministry of National Defense (MoND) : Include Min Defense in NAC [SHORT TERM].
3. NAC/partners: Extend STD/HIV interventions to all levels of military/police/CMAC infrastructure and organization PEvIEDLATE/SHORT TERM].
4. Implementing Organizations: develop innovative interventions to target clients of CSWs (Military/Police/CMAC and others to be identified) [SHORT TERM],
5. NAP/MoND : include new protocols in curriculum of military medical school [SHORT TERM].

III-Blood Safety

Achievements
1. Thirteen blood transfusion centers in provinces and 2 in Phnom Penh, mainly with technical and financial support of International Committee of the Red Cross (ICRC).
2. Set up of a database of regular blood donors in Phnom Penh.
3. Pre/post HIV test counseling available at NBTC, with possible follow-up at Calmat or the National STD Center.
5. BTC staff trained and supervised by ICRC and National Blood Transfusion Center (NBTC) (including prevention of occupational exposure to HIV).
6. Sub CoCom on blood safety meets every month.
7. Training of one medical doctor and 1 pharmacist from NBTC (National Blood Transfusion Center) in France.

Constraints/Gaps
1. Chronic shortage of blood products due to insufficient number of regular (and low-risk behavior) blood donors.
2. Difficulty to select low-risk donors, although attempts have been made to avoid HIV high streaks groups. HIV prevalence among blood donors remains higher than in general population.
3. PTC currently missing in 7 provinces (5 should be set up with World Bank(WB)'s support). HIV testing of blood units by ICRC and/or NGOs in Ratanakiri, Preah Vihear and Stung Treng.
5. Irregular supervision of testing centers by NAP.
6. Lack of funding from Government of Cambodia for operational costs; dependence on external funding.
7. No follow-up of HIV(+)/AIDS patients to date, except in Phnom Penh (to some extent). Over 50% loss to follow-up of patients referred by IPC to Calmat.
8. No feedback from NAP on data report by testing centers.
9. Limited knowledge on availability and role of testing centers among HCPs and targeted risk groups.
10. Unknown validity (sensitivity and specificity) and reliability of self-tests available at private pharmacies.

Recommendations
1. NAP/PAOs: Ensure that rules and recommendations regarding the 4 different types of testing (a/ voluntary, b/ blood screening, c/ HIV diagnosis, d/ HIV surveillance) are understood and respected by HCPs in the public sector. [SHORT TERM]
2. NAP/TAOs: Disseminate acid explain policy document on testing and counseling to HCPs in the private sector [SHORT TERM].
3. NBTC/NTAP/PAOs/partners: Make testing center equipment available for diagnostic purposes or confirming results of blood screening, with the following conditions: 1) rules and conditions contained in policy document on testing are respected; 2) donors’ support is available for additional consumable and reagents; 3) testing centers’ guidelines are updated [SHORT TERM].
4. NAP: Revise contents and methodology of training in counseling [SHORT TERM].
5. NAP/PAOs: Set up minimal practice standards for testing and counseling and set up appropriate structures (such as support group for counselors) to ensure that these standards are maintained [SHORT TERM].
6. Ensure adequate functioning of the testing centers system by: 1) ensuring staffing of centers (SHORT TERM: NAP, Provincial Health Dept, PAOs); 2) procuring consumable and reagents (SHORT TERM: donors); 3) supervising the functioning of centers (management & data report) [SHORT TERM].
7. NAP: Evaluate the entire testing centers system by end 1997, before setting up any new center [SHORT TERM].
8. NAP/partners: 1) Investigate availability of self-tests in Cambodia; 2) review published literature on impact of self-testing on risk behavior change [SHORT TERM].

VI. Integration of Vertical Programs (MCHITB/STD-HIV)
Achievements
1. HEALTH REFORM:
   • Syndromes approach for selected STDs and guidelines for the management of HIV/AIDS included in Minimal Package of Activities (MPA) for "new" health centers.
   • STD care and HIV/AIDS guidelines included in Complementary Package of Activities (CPA) for referral hospitals at district and provincial level.
   • Phase I of establishment of health reform starting by end 1997.
   • Additional staff trained in use of MPA by Department of Human Resources by end 1997.
2. MOTHER & CHILD HEALTH (NICH) SERVICES:
   • Condoms available.
   • Training in integrated MCH/STD management should start by end 1997.
   • Integration of MCH/STD achieved by NGOs in some provinces.
3. Several training sessions conducted by NAP and PAOs in Phnom Penh and provinces.
4. Universal precautions module included in curriculum nursing schools and for laboratory technicians.

Constraints/Gaps
1. Universal precautions not adhered to because 1) adequate means of waste disposal unveil, 2) shortage of single use material, 3) sterilization equipment unavailable in many settings.
2. Incomplete training of HCWs.
3. Inadequate use and management of existing consumable.
4. Overuse of injecting material due to excessive Public demand for indictable medicines.

Recommendations
1. McH/partners: Provide the means for safe decontamination and disposal of clinica laboratory waste [SHORT TERM],
2. Mc H: Mobilize donors' support to Procure sterilization equipment and sterile consumable to health facilities [SHORT/MEDIUM TERM].
3. McH: Rational use of single use material (gloves, needles, etc.) by setting Priorities among serices and activities [SHORT TERM].
4. McH/partners: Explore feasibility/cost of assembling injectable STD drugs with single use needle/syringe in one package [SHORT TERM].
5. McH/partners: Promote operational research on the use of injectable medicines in the Private formal/Informal health sector, in order to improve educational messages [SHORT/MEDIUM].
6. MoH: Mentify the unit responsible for the prevention of blood-borne infections and clarify its role [MEDIUM TERM] Promote the Prevention of blood-borne infections [MEDIUM TERM].
7. MoH: Extend training of HCWs in universal precautions to community health care workers and Particularly traditional birth attendants [MEDIUM TERM],
8. Mo H/partners: Encourage behavioral change among HCPs (including traditional sector) and the pubic to ensure safe injections and reduce unnecessary ones [LONG TERM].

V. Testing & Counseling

Achievements
2. Six Voluntary Testing Centers Presently in operation (3 in Phnom Penh and 1 Battambang, Siam Reap and Kampong Cham).
3. Guidelines developed on testing and data collection, Setup of data reporting system from testing centers to NAP,
4. Testing centers' staff trained in lab Procedures, counseling and data collection. Supervision in collaboration with IPC.
5. Quality control of results set up with IPC.

Constraints/Gaps
1. Limited distribution of Policy document, not associated with explanation or training, Shortage of trained staff,
2. Counseling is generally Poor (compared with WHO guidelines), explained in part by inadequate/insufficient training,
3. Lack of confidentiality.
4. Lack of guidelines for testing blood brought in by a 3rd Party (regarding Pricing, counseling, confidentiality, follow-up),
4. Low level of knowledge of AIDS care among HCWs in spite of IPC workshop.
5. Slow progress of development of AIDS care guidelines and IEC/training material for HCWs and patients.
6. Lack of confidentiality and discrimination against AIDS patients on behalf on HCWs and family/community is still the rule rather than the exception.
7. AIDS care in private for-profit sector is uncontrolled and inappropriate (single-shot treatment of AIDS with anti-viral drugs!).

Recommendations
1. Collect available data on prevalence of opportunistic infections [IMMEDIATE].
2. NAP/partners: Set up technical working group to develop guidelines for AIDS care in Cambodia to address: 1) the follow-up of HIV positive persons and the prevention of opportunistic infections, 2) the treatment of opportunistic infections, 3) awareness raising about cost of effective of anti-viral multi-drug therapies, 4) palliative care for terminally ill patients at the hospital and in the community. [SHORT TERM]. Ensure that HIV/AIDS care is culturally appropriate, taking due account of patients' beliefs about the disease. Ensure that the traditional healing sector is engaged as appropriate [SHORT/MEDIUM TERM].
3. NAP/EDD/ donors/NGOs: a) Mobilize donors' support for AIDS care (hospital and home-based) including drugs for opportunistic infections [SHORT/TERM] b) Include drugs recommended by AIDS care technical working group on Essential Drug List [SHORT TERM].
4. NAP/PAOs/partners: Make testing centers' equipment available for diagnostic purposes in health settings, at the following conditions: 1) rules and conditions contained in policy document on testing must be strictly adhered to; 2) donors' funding is available to cover needs for additional consumable and reagents so that diagnosis would be free; 3) guidelines for testing centers are updated [SHORT TERM].
5. NAP/PAOs/partners: Disseminate and explain AIDS care guidelines among HCWs in both public (including military/police) and private sector [SHORT TERM].
6. NAP/PAOs: Supervise AIDS care in the public health sector [SHORT TERM].
7. NAP/MoH: Ensure confidentiality and non-discrimination against any category of AIDS patients in all public sector health care settings [SHORT TERM].
8. NAP/partners: Mobilize families and communities for the support of HIV positive persons and AIDS patients (especially terminally ill patients) [SHORT/MEDIUM TERM].
9. MoH: Take steps towards control of quality of AIDS care in the private sector by Sanitary Inspection department [LONG TERM]

Section III  Policy, Management and Co-ordination

1. Monitoring, Quality Assurance, and Research

Achievements

1. Functioning high-quality HIV surveillance has been operating in Cambodia since 1995 and yields valuable information regarding HIV epidemic trends.
2. The first wave of a HIV risk behavioral surveillance system will be completed in July 1997. This will provide national-trend data on behavioral trends and indicators for use in monitoring prevention success.
3. Numerous HIV, STD, and behavioral research projects have been conducted which have aided the development of prevention strategies. These include surveys and qualitative studies conducted by the PPU/WHO, CRC/ARC, AIDSCAP, Care, SCF/UK, BWAP, CWDA and World Vision.
3. TB PROGRAM:
  • Development of guidelines for HIV/AIDS care in Tuberculosis (TB) patients in progress.

Constraints/ Gaps
  1. lack of coordination between N A P and MCH.
  2. NAP not participating in monthly MCH sub CoComs.
  3. Low level of coordination between TB program and NAP, at central or provincial level.

Recommendations
  1. HEALTH REFORM:
     • NAP/Partners: Supervise development and production of IEC material for the training of HCPs throughout integrated services by the Department of Human Resources and NGOs (see also Group 1’s recommendations) [SHORT TERM].
  
  2. MCH:
     • NAP/MCH: Participation of NAP in monthly MCH sub CoComs when appropriate [SHORT TERM].
     • NAP: Recommend integration of syphilis screening for pregnant women where lab testing is feasible and treatment available [SHORT TERM].
     • NIAPAICH: Training materials for MCH have to be finalized.
     • 'NAPNICH: Ensure coordination between NAP and MCH to optimize HIV surveillance methodology in pregnant women [IMMEDIATE].
     
     • AP/MCH Parmers: Develop protocols for the management of HIV infection in pregnant women [SHORT/MEDIUM TERM].
     • MCH/NAP/ Parmers: Review literature on impact of family planning methods on HIV transmission [IMMEDIATE].
  
  3. TB PROGRAM:
     • TB Program /NAP: - Train health care workers from TB program in HIV counseling and AIDS care [SHORT TERM]. Extend TB program infrastructure to TB/HIV patients [SHORT ERM]- Integrate AIDS care in TB patients followed in the community [SHORT TERM].

VII Institutional AIDS Care

Achievements
  1- Four clinicians from 4 hospitals in Phnom Penh trained in France; 19 clinicians participated in 2week workshop on HIV/AIDS organized by MoH and Pasteur Institute.
  2- Upgrading of in acetous disease wards at Municipal and Sihanouk Hospitals in Phnom Penh to serve ADS patients
  3- Improvement of HCPs' attitude towards AIDS patients in PP.
  4- Hospťal-based and home-based care for AIDS patients has been initiated by NGOs, mainly in PP - (medicines d:a Monde[MDM], MSF-France, Maryknoll, Sisters of Charity).
  5- NGO's have peen working on the development of management protocols for AIDS patients.

Constraints/Gaps
  1- Very limited resources for AIDS care in health sector and in the community. Shortage of drugs for opportunistic infections.
  2- HIV diagnosis currently not available in hospitals.
  3- Unavailability of data on the prevalence of opportunistic infections.
Constraints/Gaps

1. There is a lack of actionable policies. The document entitled "National Policy on AIDS/STD Prevention and Control in the Kingdom of Cambodia" is a broad framework that lists some extremely important areas of HIV/AIDS policy. However, in its present form it cannot provide a framework for action for a national response to the epidemic in Cambodia.
2. There is a lack of high-level government support for and involvement in development of HIV/AIDS strategies and policies.
3. There is no clear strategy for developing policies at a national level to have an impact on programmer implementation at the provincial and district levels.
4. There is a lack of clarity of which government structure (National AIDS Committee or the Council of Ministers) is sanctioned to approve, disseminate and assure the implementation of policies which affect several ministries and the effectiveness of a national response to the HIV/AIDS epidemic.
5. There is a gap of expertise, finances and awareness of the current and potential impact of the HIV/AIDS epidemic at a policy level to mobilize strategies in responding to HIV/AIDS.
6. People living with HIV/AIDS/STDs are experiencing discrimination on many levels.
7. Young women are involuntarily being forced into prostitution leaving them at high risk of STD and HIV infection.
8. Men do not clearly understand their responsibility in slowing the spread of HIV/AIDS/STDS

Recommendations

"Policy on Policy Development"

1. It is the role of the MoH/NAP to lead and inform the development of policies that will improve the effectiveness of programmers in a national response to HIV/AIDS/STDS.
2. The process of policy development needs to include key partners active in HIV/AIDS from other ministries, the NGOs and donor community so as to ensure that policies are realistic and actionable.
3. Policy, strategy and action plan need to be directly linked to programmer implementation.
4. Required policies and strategies addressing prostitution should not reduce the capacity of public health programmer to access commercial sex workers with services.
5. Policies and strategies addressing men who engage in high risk behavior must be given a high priority.

Strategy

Immediate

1. The content of the document entitled the "National Policy on AIDS/STD Prevention and Control in the Kingdom of Cambodia" should be considered during the strategic planning process so that these policy issues can be discussed and made actionable in a "National HIV/AIDS/STD Policy and Action Plan" for the next three years.
2. Promote top level government offices and officials to become more involved in a National HIV/AIDS Policy and Action Plan 2000"
   a) Presentation to the Council of Ministers, the National Assembly and donors of the projections and growth of the HIV/AIDS epidemic relative to other Asian and African nations and a socio-economic impact analysis including sectional analyses
   b) Develop the National HIV/AIDS Policy and Action Plan 2000 and submit it to the Council of Ministers for approval and action.
   c) Discuss 100% condom use in brothels and other strategies with women's organizations, NGOs, commercial sex workers, where possible, Ministry of Women's Affairs, Ministry of Interior, Ministry of National Defense, brothel owners, and donors to develop a national strategy on prostitution and HIV/AIDS/STDS.
   d) Mobilise government and community leaders to establish a prioritised strategy for increasing understanding of the role of men in the spread of HIV in Cambodia.
Constraints/Gaps

1. The zero-surveillance survey program has experienced some difficulty in maintaining proper procedures in sample selection within the Military and informed consent in other groups.
2. Social Research Studies have not been adequately supported for translation into policy or operational tools for program improvement.
3. Evaluation of HIV and STD programs has been rare and thus adjustments and changes that could improve these programs has not occurred.
4. Research in several key areas that will significantly affect program design is needed. This includes: 1) sexual behavior of rural males; 2) men’s and CSW’s STD treatment seeking behavior; and 3) pharmacists' STD drug dispensing behaviors. Such research should include both quantitative and qualitative data collection.
5. These are currently no indicators of success guiding the national response to the HIV epidemic.
6. The COCOM ethical committee does not currently have the capacity to address the use of human subjects in HIV/STD/AIDS related research projects.

Recommendations

Policy-Immediate

1. It is the responsibility of the NAP to provide the country with national-level HIV/STD serologic and behavioral surveillance data and indicators to monitor success.
2. The Cocom Ethical committee must be supported build their capacity to address research issues relating to human subjects and HIV/STD/AIDS.

Strategy – Immediate

1. The NAP should continually review the performance of the HIV sero-surveillance system to maintain quality, particularly in the area of informed consent and sample selection.
2. National-level prevention indicators should be developed and tracked. In this regard, WHO Prevention Indicators are a model which could be adapted for the country. They include such indicators as percent of population with non-regular sex partners in the past year and last time condom use with a non-regular partner. These data can be provided by the behavioral surveillance system that will be completed in July 1997. Others may necessitate the collection of further data. This should be decided during the strategic planning process of the national plan.
3. The Sub-Co-Com on HIV/AIDS/STDs, when established, should identify gaps in key operations research, and social, behavioral and ethnographic research to mobilize donor funds to conduct this research and translate this research into program implementation.
4. MOH/NAP and Donor Community should ensure that research findings are disseminated across the immersed organizations in Cambodia. Discussion of the significance of research findings should occur on a regular basis to inform program planning.

II. Policy Development

Achievements

1. A document entitled "National Policy on AIDS/STD prevention and control in the Kingdom of Cambodia" was adopted by the members of the National Committee for HIV/AIDS/STD Prevention and Control on 15 December 1997, and disseminated to central government offices and Provincial AIDS offices throughout the country.
2. HIV `AIDS Counseling and Testing Guidelines have been developed and disseminated to the provincial level.
4. Most donors have unrealistic expectations that the MOH/NAP will kick start programs within other ministries when NAP staff and capacity is severely limited.

Recommendations

Policy: Short Term

Promote National and Provincial Leadership, Commitment and Action

1. The First and Second Prime visitors need to become national spokes-persons with clear messages to change the behavior of men to slow the spread of HIV/STD/AIDS and reduce the discrimination associated with having HIV/STD/AIDS.
   a) President Musevini in Uganda newer speaks publicly without discussing HIV/STD/AIDS.

2. The Government, Donors, Private Sector and NGOs must form alliances to use their existing structures to slow the spread of HIV/STD.

3. Other National, Provincial and District Leaders need to be supported to provide leadership to change the behavior of men to slow the spread of HIV/STD/AIDS and reduce discrimination associated with having HIV/STD/AIDS.

4. All government Ministers need to identify and assign full time personnel to take action within their ministries to better educate their staff and the communities they reach about HIV/STD/AIDS.

Strategy: Short Term

Promote National and Provincial Leadership, Commitment and Action

1. To become national spokes-persons and leaders of the national HIV/AIDS response, the First and Second Prime Ministers need to be supported by each having an adviser on HIV/STD/AIDS.

2. The private sector, NGO and traditional sectors are capable of responding flexibly and quickly to reduce the spread of HIV/STD/AIDS and need to be provided more opportunity for leadership in the response.

3. High-level review the role, performance of the NAC is needed, with alternative structures developed if deemed necessary to assure an effective response to the epidemic.

4. The NAC and secretariat need to define their role and the actions for which they are responsible.

5. The NAC needs to add at least one to two donor(s), and local and international NGO representatives to improve an alliance between all partners.

6. The NAC and secretariat need to decide how they are responsible for filling the following major gaps:
   a) Mobilizing a sustained commitment at the highest levels of the Government to responding to the Epidemic.
   b) Advising on policies that affect several ministries and the HIV epidemic.
   c) Overseeing the development of a "National Policy and Action Plan on HIV/AIDS" and submit the Action Plan to the Council of Ministers for ratification.
   d) Ensuring that each Ministry develops it own response to the HIV/AIDS Epidemic.
   e) Ensuring that Ministries identify at least one to two persons within their Ministry 'who are responsible full time for mobilizing their Ministry to respond to the epidemic.
   f) Ensuring that Provincial AIDS Committee members understand their role and responsibility.
   g) Ensuring that evaluation and monitoring of the national response to ensure its effectiveness.

7. The role of the PAC needs to be clarified.
   a) Ensuring provincial resource and response mobilization.
Longer Term
1. Assistance to the National AIDS Secretariat and National AIDS Committee to initiate a policy development programmer. A policy development programmer's role should be clearly defined and need to address many key issues. Some raised during the review include:
   a) Prostitution, human rights and HIV/AIDS/STDs
   b) Discrimination of people living with HIV/AIDS/STDs
   c) Disclosure of HIV positive status
   d) Mandatory testing
   e) Quarantining of HIV positive people
   f) Condom promotion with youth

III Co-ordination, Resource and Response Mobilization

Exchange of information and technical expertise, development of collaborative planning to achieve a more effective response with greater synergistic results.

Achievements
1. Establishment of a National Committee of HIV/STD/AIDS with the Prime Minister as Honorary Chairman and the Minister of Health as chairman whose purpose is multi-sectional co-ordination.
2. Establishment of Provincial AIDS Committees whose purpose is multi-sectional co-ordination.
4. Ongoing NGO/IO co-ordination through MEDICAM and establishment of HACC.
5. Establishment of UN Technical Working Group and UN Theme Group.
6. Increasing mobilization of resources and technical assistance by donors since 1993.
7. World AIDS Day in most places represents a model for co-operation across all parties.

Constraints/Gaps

Commitment (Government/Donors/Others)
1. National leadership of a sustained and strongly orchestrated response is lacking.
2. Sensitization of Government leaders has not been to the level that is promoting them to respond to the epidemic with enough commitment to make a national difference.
3. To date limited donor funding has been available to address HIV/STD/AIDS directly.
4. Lack of clear roles, responsibilities and representation for the National and Provincial Multi-sectoral Coordinating bodies.

Collaboration
1. Ministries collaborate minimally at a technical working level.
2. MOH/NAP are not Coordinating specifically on HIV/STD/AIDS across other health sectors.
3. No forum for Government, NGOs, Donors and UN to exchange information and research findings, and develop policy, coordinated planning, implementation and evaluation.
4. The current level of collaboration may not reduce the spread of HIV in the coming three years.

Finances/Capacity
1. A lack of technical expertise within Ministries prevents most from responding to the epidemic.
2. A lack of a commitment of finances and resources within Ministries constrains their ability to respond.
3. Few donors are supporting work with Ministries outside of the Ministry of Health.
outside the Ministry of Health.

2. There are numerous HIV/AIDS Technical Advisors and Program managers from the donor community to the government, each with varying degrees of HIV/AIDS program experience and priority focus. There is currently no systematic way for them all to support a National Response to HIV/AIDS and to interact with the MOH/NAP.

3. The increasing number of donors contributing to HIV/AIDS in Cambodia has made it more difficult for donors to co-ordinate their planning with the MOH/NAP.

Capacity
1. Centralized planning and management have led to implementation and management occurring "simultaneously".
2. Management training has been lost due to staff turn over.
3. There is a lack of management support to the Provincial AIDS Offices.

Resources: Financial, Personnel, Material
1. The government must address the unrealistic salaries for government staff and the donors must understand that the present product-based incentive system forces national programmers to prioritizes efforts based upon financial incentives which may not have national impact on the epidemic.
2. Leaders in policy and programmer implementation for the National AIDS Programmer need to be chosen according to proven capacity and experience in HIV/AIDS.
3. Relative to its mission to lead the country’s response to the HIV epidemic, the NAP is severely under-staffed and under-funded. They currently only have 10 permanent technical staff (see annex six)
4. Overall NAP program implementation budget over the last four years has been approximately 1.05 Million US$ (WHO, FAC, UNAIDS, UNDP, USAID, GTZ) which is approximately 20% of the estimated total expenditure on HIV/AIDS for the nation since 1993.
5. Low staff salary is severely impeding the implementation of an effective national response.
6. Provincial Level financial support for program implementation is severely low - in some provinces only S300US per year.
7. The process to access the National Budget for HIV/AIDS is extremely lengthy with severe restrictions. In 199 and 1996, only 2% and 6% of the Government HIV/AIDS Budget was released (totaling US$ 16,000).
8. The PAOs are severely restricted by a lack of vehicles, motorcycles, communication equipment, materials and operating funds.

Roles and Strategies
1. Most donors and NGOs have directly questioned the appropriateness of the role of the NAP/PAO as implementers of an outreach program.
2. The role of the NAP as implementers to the Municipality of Phnom Penh is inappropriate.
3. The role of the NAP should not be determined purely by donor's priorities.

Recommendations

Structure
1. In finalizing the structural changes, the MoH needs to consider proven experience and commitment in the field of HIV/AIDS/STD in selecting the leadership.
2. In finalizing the structural changes, the MoH needs to consider establishing the NAP at a level which would give them more opportunity to collaborate technically across sectors.
3. The NAP needs to prioritize their role and responsibility. The NAP may need to consider management assistance in determining roles and responsibilities at a national and provincial level.
b) Co-ordination of provincial responses.
c) Promoting donor and NGO involvement at a provincial level.
8. The role of the National AIDS Program and the Provincial AIDS Offices should be clarified (see Program and Financial Management, below).

Co-ordination

Immediate
1. Strategy development, co-ordination and resource mobilization over the short term should occur through the three advisory groups that have been developed to undertake this review.
2. During strategy development lead government, NGO, private sector and donor teams are defined for each strategic area of response. These teams will be responsible for facilitating co-ordination of implementation of all partners over the next year.

Short Term
1. A "Sub-Co-Com" on HIV/STD/AIDS needs to meet to discuss the best means of co-ordination to address information and service delivery.
2. Provincial Co-Coms (PROCOCOM) on HIV/STD/AIDS need to be established, wherever feasible, to include members of government, NGOs, the private sector and donors to address issues in implementation of provincial responses.
3. Decisions need to be made as to what is the best way to co-ordinate a focused response for people engaging in high-risk behavior and a general response. Members should include the NAP, other health programs, donors, UN and NGO representatives.
   a) Decide on the role of the NAP, other MoH programmers, donors, UN agencies and NGOs and how these roles can be achieved.
   b) Improve communication and exchange of information across sectors, to ensure integration of HIV/STD into other sectors;
   c) Provide an opportunity for informal co-operation and to provide a forum to raise and resolve issues across the different implementing arms of the national HIV/STD/AIDS response.
   d) A means to allow members of the "Sub-Co-Com" to support its ongoing functioning should be established at the first Sub-Co-Corn meeting on HIV/STD/AIDS.
4. Establish Provincial Pro-Co-Coms on HIV/STD/AIDS to address information and service delivery to men and women who engage in high risk behavior

IV. Program and Financial Management

Achievements
1. The NAP has attracted dedicated staff who have managed and implemented an impressive number of activities with minimal financial support.
2. The NAP has established Provincial AIDS Offices (PAOs) in every province. The PAOs have developed programs with minimal resources under difficult working conditions.

Constraints/Gaps

Structure
1. It is unclear how the currently proposed structural changes within the Ministry of Health will affect program leadership, planning, collaboration and implementation.

Collaboration and Co-ordination
1. There is lack of collaboration and co-ordination between the NAP and other partners within and
Annex XI  Documents Reviewed

Policy, Management and Coordination

21. Cambodia Demographic Profile, Ministry of Planning, July 1999
24. Declaration No. 01 on the Control of the Quality of Blood, Declaration by the Ministry of Health, Royal Government of Cambodia, Phnom Penh, 23 March 1994.
4. The NAP needs to consider revising their management strategy.

5. The development of functional units within the NAP needs to be reconsidered. These functional units may be more effective if given authority to manage their individual programs leaving top managers able to oversee the program as a whole and to collaborate with key partners. Possible functional areas for NAP may include the following:
   a) Management
   b) Donor/multi-sectoral/NGO collaboration/policy development
   c) Ministry of Health co-ordination and de-centralization: TB/i'v1CH/Health Care Reform/HIS
   d) Provincial management support
   e) Finance and administration

   Technical Leadership, Co-operation and Provincial Support (as separate functional units):
   a) STD Services
   b) Prevention Education and Campaign: IEC, outreach, and condom promotion
   c) Surveillance, monitoring, and research
   d) HIV counseling and testing
   e) Care
   f) Blood Safety/Infection Control and Universal Precautions

   Each functional unit would need to define their role and responsibility for: planning, training, integration and collaboration with other health centers, and in co-operation with provincial managers, transfer of technical assistance to provinces.

Commitment (Government/Donor/Others)
1. The Donors need to reconsider their programmatic planning after the MOH/NAP defines their role and their priorities.
2. The Donors need to realize that if they have large expectations of the NAP's role then they must better support them to fulfil that role.

Capacity
1. The role of the international advisors needs to be addressed. The NAP functional units need support from advisors qualified within that technical area. In areas where there are several donors contributing financially, one adviser needs to be delegated as a lead support person.
2. More MOH staff qualified to oversee program and technical management are needed. The exact number needs to be defined when the role and breadth of responsibility for the NAP is defined.
3. Clear job descriptions are needed for each position.

Resources: Financial, Manpower and Material
1. The MoH needs to consider paying salaries, possibly with donor co-operation, which will allow a national program in HIV/STD/AIDS to be implemented and sustained.
2. Analysis of financial needs to implement a national program needs to occur along side a strategy development.
3. Decentralization to Provincial AIDS Offices, with donor funding for materials and support is a priority.
Information, Communication, Education and Community Response

5. "HIV/AIDS and Youth Project", Annual Project Report (December 95-December 96), Save the Children/UK, January 1997
8. "Mid-Term Evaluation Contraceptive Social Marketing Project: Birth Spacing and AIDS Prevention in Cambodia", USAID Grant No. 442-0112-G-00-4505-00, February 8-26, 1996
9. "Review of Relevant HIV/AIDS/STDs Epidemiology, Research and Programmes for 15-20 Year Old Cambodians" (Attachment I), Save the Children Fund (UK), Cambodia, 1997
10. Alfred C. & Adam G., "HIV/AIDS in Cambodia, an Outline Strategy for IEC and Three Implementation Scenarios", Health Unlimited,
28. Field Trip Report to Cambodia to Assess HIV/AIDS/STD Activities, Overseas Development Agency, October 1995,
32. Klement J., Delay P., Bennett T., and Burkly M., "HIV/AIDS Assessment in Cambodia", USAID, October 7-27, 1995,
34. Mekong Sub-Region STD/HIV/AIDS Project, UNICEF/EAPRO, November, 1995
44. Pharmaceutical Management Law adopted by the Cambodian National Assembly, 9 May 1996.
45. Project Request From the Government of Cambodia to the United Nations Population FundCMB/97/P01, March 1997
52. UNAIDS theme Group and Technical Working Groups Meeting Minutes-June 1996-March 1997
53. UNAIDS/Cambodia Semi-Annual Report, July-December 1996
7. Fee N., STD Care/Prevention, Consultant Report, WHOAVPRO, November 1996
14. Project D'appui A La Lutte Contre Le Sida Et Les MST Au Cambodge
15. Projet De Reduction De La Transmission Du VIH, Medecins Du ivfonde Cambodia, Mars 1997
28. Ly S., O'Brien C. & Davis M. "Young People, HIWAIDS, STDs and Sexual Health Project", Save the Children Fund (UK), February 1997
30. Mid-Term Activities Report to UNICEF, Research and Pilot Programme Development on HIV/AIDS and Youth,
36. Munz M., Report on "Media Round Table on HIV/AIDS Prevention in Cambodia, Ministry of information, August 1995
38. Participative HIV/AIDS /STDs Youth Peer Education Programme ( Project Proposal 4 Reports )Prepared By Australian Red Cross, Funded By AIDAB
42. Report of the AIDS Study Tour to Thailand of II Siam Reap officials, UNICEF, October, 1996
44. Social Marketing of Condoms in Cambodia for AIDS/STD Prevention and Child Spacing (The First Year) PSI-Cambodia, 1994-1995
47. UNICEF-Cambodia STD/HIV/AIDS Project Summary, November 1995

Health Services
2. "NAP Outreach To CSWs, Project Document", WHO, July-December 1995
5. Convention De Financement No 9500' 3600 Entre Le Gouvernement De La Republique Francaise Et Le Gouvernement Royal Du Cambodge, Appui A La Lutte Contre Le Sida Et Les MST Au Cambodge
a) Dr. Zari John Gill, AIDS Project Manager  b) Ms. Francesca Steur (MSF/Holland/Belgium/Swiss.)
c) Mr. Oum Sopheap, Program Officer  d) Dr. Yves Coyette (MSF-France)
e) Mr. Sok Mao, Counsellor at National STD Center  17. Medicins Du Monde, Cambodia
f) Mrs. Son Samphos, Counsellor at National STD Center  a) Dr. Michel Caillouet, Head of Delegation

2. Maryknoll

a) Fr. James Noonan  b) Sr. Juana Encalada

3. Redd Barna

a) Dr. Nop Sotherea, AIDS Project Officer, d) Mr. Daniel Dravet, Information/Communication Officer
b) Mr. Heng Vibol, Outreach Officer

4. Friends

a) Mr. Sebastien Marot, Co-ordinator  b) Mr. Ly Solim, Assistant Project officer
c) Mr. Heng Vibol, Outreach Officer   5. Quaker Service Australia,
a) Ms. Terrie Cowley, Training Officer  e) Ms. Beth Deutsch, Consultant

6. Servants

a) Ms. Sonia Knobloch  a) Mr. Leo DeVos, Representative
b) Dr. James Mielke, HIV/AIDS Project Officer

7. Salvation Centre Cambodia, Representative

a) Mr. Mak Sovannhang, Director  2. UNICEF

8. Humanitarian Khmer Doctors Association

a) Dr. Chea Moneth, Director  a) Ms. Magdelena Dugenia, Technical Advisor

9. Indradevi Association

a) Mr. Piseth  b) Dr. Liz Goodburn, MCH Project Manager
b) Mr. Kong Villa  c) Dr. Vincent FaUveaU, Resident

10. Cambodia Red Cross

a) Mr. Sok Long, HIV/AIDS Project Manager  3. UNESCO

11. Cambodia Women's Development Association

a) Ms. Khiev Srey Phal, Director  a) Dr. Supote Praserti, Education Programme Specialist

12. International HIV/AIDS Alliance

a) Ms. Phak Choo Phuah, Technical Advisor  b) Mr. Bruno Lafevre, Representative

13. Population Services International

a) Ms. Cynde Robinson, Vice-director, PSI  4. UNDP

b) Ms. Maia Smith, Programme Assistant  a) Mr. Paul Matthews, Resident Co-ordinator, Resident Representative

c) Ms. Keb Sothany, Sales Representative  b) Mr. Jean-Louis Ballidier, Programme Manager, Public Administrative Reform Programme

14. Health Unlimited

a) Mr. Kong Udom, Communication Officer  c) Mr. Jean-Marie Commeau, Senior Programme Co-ordinator, Public Administrative Reform Programme

15. Centre of Hope

a) Dr. Gill Hall  d) Mr. Mike Calabria, HIV/AIDS Programme Co-ordinator

16. Medicins Sans Frontieres

a) Ms. Fabienne Lopez (MSF-France)  5. WHO

b) Dr. Julian Lob-Levyt, SHS Programme Manager
c) Dr. Annie Macarry, Medical Officer HIV/STDs/AIDS

6. World Bank

a) Ms. Sandii Lwin, Manager, Project Preparation Unit  7. UNCHR
b) Dr. Georg Peterson, Resident Representative

c) Mr. David Hawke, Officer in Charge
Annex XII  Interviews Held by the Review Team

Phnom Penh

Government

1. Ministry of Health
   a) HE Dr. Chhea Thang, Minister
   b) HE Dr. Mam Bun Heng, Under Secretary of State
   c) Dr. Tea Phalla, Director, National AIDS Program

2. Ministry of Women's Affairs
   a) HE Em Run, Under-secretary of State
   b) Dr. Khieu Srey Vuthea, Director, Women's Health Department
   c) Ms. Nit Mita, Training & AIDS Management

3. Ministry of Health
   a) HE Dr. Chhea Thang, Minister
   b) Dr. Khieu Srey Vuthea, Director
   c) HE Dr. Mam Bun Heng, Under Secretary of State
   d) Dr. Tea Phalla, Director, National AIDS Management

4. Ministry of Education Youth and Sports
   a) Mr. Sor Muy Keang, Director Research Institute
   b) Mr. Ly Sonnang, Vice-Director, Research Institute
   c) Mr. Kim Sanh, Hygiene Department

5. Ministry of National Defense
   a) BG Dr. Veng Bun Lay, Chief, Health Division
   b) Dr. Tan Sokhey, Chief, AIDS Prevention Unit

6. Ministry of Rural Development
   a) Dr. Ouk Rim, Deputy Director, Department of Rural Health Care & Community Health/ Education

7. Ministry of Women's Affairs
   a) HE Em Run, Under-secretary of State
   b) Dr. Khieu Srey Vuthea, Director, Women's Health Department

8. Ministry of Interior
   a) Dr. Ken Phon, Director, Monivong Hospital

9. National Assembly
   a) HE Kann Moen, Chair of Parliament
   b) Mun Phal Kun, BSS/ NAP Sub Committee for Women's Affairs, Social Affairs, Health and Education

10. Ministry of Foreign Affairs
    a) HE Pok Marina, Under Secretary of State

11. Council of Ministers,
    a) HE Sochua Lieper, Advisor on Women's Affairs to HE the First Prime Minister

12. Ministry of Information
    a) Mr. Saeng Laprese, Secretary of State, Ministry of Information, Bi-laterals:

4. USAID
   a) Ms. Michele Moloney-Kitts, Health Population, Nutrition

2. European Union
   a) Dr. Francois Crabbe,

3. French Co-operation
   a) Dr. Bernard Fabre-Teste
   b) Mr. Bernard Millet, Cultural Counsel in Charge of Scientific and Technical Co operation, French Embassy

4. AUSAID
   a) Maem Sheinkman
   b) Mr. Mark Wedd, Programme Officer

Non Government Organizations:

1. World Vision International
Kompong Thom
Government:
1. Dr. Chan Sam An, Deputy Governor and Chairman of PAC
   a) Dr. Va Loung Khon, Provincial Health Director
   b) Dr. Meas Sokha, Vice Director, Provincial Health
   c) Provincial MCH Director, Kompong Thom
1. Provincial Health Department
   a) Dr. Va Loung Khon, Provincial Health Director
   b) Dr. Son Yen, Deputy Director, Provincial Health
   c) Provincial MCH Director, Kompong Thom
1. Provincial AIDS Office
   a) Mr. You Piseth, Provincial AIDS Manager
   b) Ms. Chim Pue, Peer Educator, CSW Outreach Programme
1. Information Department
   a) Mr. Kiev Huol, Director
1. Provincial Education Department (General Ed)
   a) Mr. Sou Konthy, Deputy Director,
   b) Mr. Bin Thun, Provincial Education Supervisor
1. Provincial Women Affairs Office
   a) Ms. Nong Alay, Deputy Director
1. Provincial Police Department
   a) Mr. Kam An, Deputy Director
8. Provincial Military
   a) Chief Commander
9. Baray District Hospital
   a) Dr. Meak Chim, Director
10. Santok District Hospital
    a) Hospital Director
    Non-Government
1. ADRA
   a) Cheryle Quillin, ADRA Coordinator (MCH Training), Santok District
2. CARITAS
   a) Catherine and Michel
   b) Dumrop Sopaul
3. World Vision
   a) Field Director
4. Traditional Healer in Kompong Thom Provincial town
5. Five Drugstores in Kompong Thom market areas and in Barai district
Kampong Cham
Government:
1. HE. So Nath, 3rd Deputy Governor, Chairman of PAC
2. Provincial Health Department
   a) Dr. Nguon SimAn, Director
   b) Dr. Son Yen, Deputy Director
   c) Dr. Un Sok ROUd, Director, Provincial
   d) Ms Tran Cheng Krvi, Director, MCH Programme
3. Provincial AIDS Office
   a) Dr. Yum Chon Thon, Manager of Provincial STD/AIDS Program
   b) Mr. Kim Kon, Outreach Worker
   c) Ms. Seng Sopheatra, STD Officer
   d) Mr. See Viseang, Health Educator
   e) Mr. Tang Nuth, Health Educator
   f) Mr. Vong Chanvaha, Lab Technician
   g) Ms. Sin Sitha, Peer Educator, CSW outreach programme
4. Military Hospital
   a) Dr. Am Yin, Commander
   b) Dr. Heng
5. Ministry of Social Affairs, Labor and Veterans Affairs
   a) Mr. Chiem Chin, Dept. Director
6. Police Department
   a) Mr. Loan Som Nan
7. Department of Culture
   a) Mr. SomKim Chuot, Director
8. Women in Development
   a) Ms. Khang Sam Eng
9. Director of Provincial Tourism
   a) Mr. Chiem Ran, Director of Provincial Planning Unit
10. Chamkar Leu District Hospital
    a) Director
    b) Medical Staff
Battambang Government
1. Second Vice-Governor: H.E Nam Toum, Chairman of PAC
2. Mr. El Soy, Director, Provincial Rural Development Committee
3. Dr. Mel Young (dentist)
4. Provincial Hospital:
   a) Dr. Nhek Bun Chhup, Director
   b) You Sang (Med. Asst), Vice-director
   c) Mr Chea Lok, Administrator
   d) Dr. Youth Chhann, Physician at Paediatric Ward
   e) Dr. Sim Yuthasa, Physician at Emergency Ward.
   f) Dr. Kak Saila, Physician at TB Ward
   g) Ms. Tourt Sam Ang, Vice-director of MCH1.CARERE
5. Provincial AIDS Office:
   a) Dr. Ouk Vichea, MD., Manager of AIDS/STD
   b) Dr. Chum Sopheak, Physician for STD clinic
   c) Mr. Iem Sakhon, Med. Asst HIV/AIDS Advisor
   d) Ms. Oeur Kim Hoeum, (Secondary midwife), STD Clinic
   e) Ms. Sin Vathana, (Secondary midwife), Counselor.
   f) Mr. Tourn Sophal, (Secondary nurse), Health Educator.
   g) Mr. Ham Rithy (Secondary nurse), Outreach officer
   h) Mr. Sou Norath, (Primary nurse), Assistant of outreach
   i) Mr. Sok Neang, (Secondary nurse), Program Administrator
   j) Ms. Sin Sitha, Peer Educator, CSW outreach programmer
6. Police Medical Service
   a) Mr. Soeung Sean, Vice-director of Provincial Police
   b) Mr. Chuen Seng, Deputy Chief of Health Unit
   c) Ms. Lau Sin, Chief, General Health Consultant
   d) Mr. Ban Chien, Health Unit Staff
7. Military Hospital
   a) Dr. Koe Synith, Vice-director
8. Provincial Youth & Sport Educational Department
9. Provincial Pedagogy School (Teacher College):
   a) Mr. Leng Synith, Director
   b) Mr. Chab Sam Nang, Vice-director
   c) Vocational Training Center/ Battambang
   d) Mr. Prak Sotin, Director
   e) Mr. Hin Siphat, Vice-director
10. Ek Phnom district (TBAs, VHV's)
   a) Yin Yen (Med Asst.), Director of Ek Phnom district (and 2 village health volunteers and 2 traditional birth attenedants)
   b) Mr. Youth Sanan, Deputy Director of district Non-formal education.
   c) Mr. Sao Chantha, Deputy Director of district education
Non-Government Organizations:
5. Provincial AIDS Office: a) Mr. Lamhien Samreth, Provincial Programme Manager
   b) Mr. xxxx, Health Officer/BTB
   a) Ms. Chao Peak Norem, financial Officer
   b) Ms. Dol Samphan Training Officer
3. CHED:
   a) Sam Sareth, Artist
   b) Rick Neal, Health Education Advisor
   c) Pao Sorben, Health Education Manager
4. CSI
   a) Mr. Sen Chan Dara, Director
5. CMCD
   a) Miss Sok Borina
6. World Vision
   a) Ms. Katti Chetra
   b) Eoum Chettra,(Med. Asst) District AIDS officer
7. Medicins Sans Frontieres/France
   a) Dr. Raynaud Cyril
   b) Miss Valerie Pouget, nurse
8. Buddhism for Development
   a) Ven. Touch Yon
   b) Ven. Teap Ket
   c) Mr. Ping Dara, Administrator
9. Private Clinics & Pharmacies in Battambang town:
d) Ms, You Sokun, STD Assistant
e) Ms. Nong Nat, STD Assistant
f) Mr. Em Phalla, STD Assistant
5. Kampot Regional Nursing School
   a) Dr, Mak Bun Than, Director
   b) Mr. Chhun Samnang, Pharmacist, Vice-Director
6. Provincial District Administration
   a) Mr. Kuy Sien, District Chief

Non-Government Organizations:
1. UCC
   a) Ms, Linda McKinney, Director
   b) Mr. Chhem Sip, Deputy Director
2. Mimesa
   a) Mr, Khieu Sinoun, Administrator
   b) Mr. Khem Thamn, Training and Demographic Survey
c) Imelda Hutten, Medical Anthropologist
3. Cambodia/Australia Red Cross
   a) Mr. Prach Phon, Vice-Director
   b) Mr. Ouk Say, Administrator, AIDS Project Manager
4. CMAC
   a) Mr, Ouk Rathana, Deputy Manager
5. Owner of Phnom Khiev Pharmacy
6. Military Hospital
   a) Dr. Kao Vannaridh, Director
7. District Medical Clinic
   a) Dr. Tuon Bunnarith, Chief
Non-Government Organizations:
1. American Friend Service Committee
   a).Ms, Yvonne Dunton, Project Coordinator,
2. Assemblies of God
   a) Mark Bouman, Director
3. Cambodia Trust
   a) Mr, Jack O'Kane, Branch Manager
4. Medicines du Monde
   a) Dr, Charles Tourre
5. Owner of Ekareach Pharmacy, Sihanouk ville
6. Private Practitioner, Mr. Nuth Hoeun, Medical Assistant
7. Private Laboratory Technician, Mr Ken Sopha

Government:
1. Provincial Health Department
   a) Dr. Kham Sarun, Vice-Director
2. Provincial AIDS Office
   a) Mr. Kim Sitha, Manager
   b) Ty Vibolla, Outreach Worker
c) Ms, Chem Sumbo, Health Educator
d) Mr. Tu Chi, Counsellor and Administrator
e) Mr. Chea Mong, Surveillance Officer
f) Mr, Keo Try, Private Laboratory Technician
g) Ms, Chea Peou, Peer educator
Non-Government Organizations:
1. Cambodian Red Cross
   a) Mr. Ung Tat, Head
2. NCCDP/AICF/USA
   a) David Wright, Coordinator
   b) Mr. Sok Sophat
   c) Ms. Kara Page, Community Development Officer
3. YWAM
   a) Ms. Joy Scott, Midwife
   b) Phillip Scott, Coordinator
4. UNICEF
   a) Mr. Bumpen Saweangdee, Cluster School Program
5. Medicins Sans Frontieres
   a) Mr. Jean Phillip
6. Owners of 2 private pharmacies

Stung Treng Government:
1. Provincial Health Department
   a) Dr. Heng Nheu, Director
   b) Ms. Soeur Kea Reng, Chief of MCH Center
2. Provincial AIDS Office
   a) Dr. Meas Tha, Programmer Manager
   b) Ms. Uon Chantha, Outreach Worker
3. Provincial Hospital
   a) Vice-director
   b) Staff
4. Provincial AIDS Committee
   a) HE Nguon Pen, First Deputy Governor
   b) Dr. Heng Hheu, Director of Health Department
   c) Mr. Chuok Sitha, Finance Department
   d) Mr. Ruos Soeur, Information Department
   e) Mr. Suor Sopheap, Department of Social Affairs, Labour & Veterans Affairs
   f) Ms. Kong Saothun, Department of Women’s Affairs
   g) Mr. Seng Chhaung, Vice-Director, Department of Rural Development
2. Provincial Health Department
   a) Dr. Lim Kaing Eang, Director
   b) Dr. Oum Vannathary, Deputy Chief of MCH
3. Provincial
   a) Dr. Touch Sokha, Director
   b) Director of Kampot Blood Transfusion Center
   c) Dr. Ho Eang, Chief of Intensive Care Unit
4. Provincial AIDS
   a) Mr. Sok Sambo, Medical Assistant, Assistant Manager, STD Services
   b) Ms. Teng Rathida, Health Educator
   c) Ms. Lim Sovann, Outreach Worker

Kampot Government:
1. Provincial AIDS Committee
   a) HE Touch Narin, Deputy Governor
   b) Dr. Lim Kaing Eang, Director of Health Department
   c) Mr. Chuok Sitha, Finance Department
   d) Mr. Ruos Soeur, Information Department
   e) Mr. Suor Sopheap, Department of Social Affairs, Labour & Veterans Affairs
   f) Ms. Kong Saotuhn, Department of Women’s Affairs
   g) Mr. Seng Chhaung, Vice-Director, Department of Rural Development
2. Provincial Health Department
   a) Dr. Lim Kaing Eang, Director
   b) Dr. Oum Vannathary, Deputy Chief of MCH
3. Provincial
   a) Dr. Touch Sokha, Director
   b) Director of Kampot Blood Transfusion Center
   c) Dr. Ho Eang, Chief of Intensive Care Unit
4. Provincial AIDS
   a) Mr. Sok Sambo, Medical Assistant, Assistant Manager, STD Services
   b) Ms. Teng Rathida, Health Educator
   c) Ms. Lim Sovann, Outreach Worker
Advisory Review Committees

Three Advisory Review Committees for three key Strategic Areas were developed. The roles of the Advisory Committees are to:

1. Provide input the Methodology of the Review to the core review team.
2. Provide key informant interviews with the core review team.
3. Provide input into the final recommendations.

A) Advisory Group on Information Education Communication and Community Activities:

Dr. Khiev Srey Vuthea  Ministry of Women’s Affairs
Dr. Slat Cahn  Ministry of Education, Youth & Sports
Dr. Ouk Rim  Ministry of Rural Development
Dr. Tan Sokhay  Ministry of Defiance
Dr. Meak Kim Suan  Ministry of Information
Pak Chou Phua  Intentional HIV/AIDS Alliance
Dr. Jim Mielke  UNICEF
Daniel Dravet  UNICEF
Dr. Supote Prasertsri  UNESCO
Dr. Jim Mielke  UNICEF
Dr. Zari Gill  World Vision representing HACC
Juliet Fleichel  Primary Health Care Project/AUSAID
Susan Wong  CARERE

B) Advisory Group on Health Service related to IIIV/AIDS/STDs:

National STD Programmer Manager
National MCH Programmer Manager
National TB Programmer Manager
Planning Unit,  MOH
Dr. Annie Macarry  WHO
Dr. Tea Phauly  UNDP
Dr. Bernard Fabre-Teste  FAC
Dr. Liz Goodburn  UNFPA
Dr. Sally Stansfield  USAID
Dr. Jean Ahlberg  USAID
Dr. Francois Crabbe  EU
Dr. Yves Coyette  MSF-France representing MEDICAM
Ms. Francesca Stuer  MSF-Holland/Belgium/Swiss representing HACC

C) Advisory Group on Policy and Programmer Management/Coordination:

Planning Unit  Ministry of Health
Mr. Sau Channa  Ministry of Tourism
Dr. Khen Phun  Ministry of Interior
Ms. Em Sophon  Ministry of Social Affair, Labor and Veterans Affairs
HE Sochua Lieper  Advisor to the First Prime Minister
HE Pok Marina  Ministry of Foreign Affairs
Ms. Kiev Srey Phal1  CWDA
1997 Review of the National Response to HIV/AIDS in Cambodia,

I. Goal:
To Improve the National Response to HIV/AIDS in Cambodia

II. Purpose:
1. To conduct an assessment with the involvement of major stakeholders of the achievements, constraints and gaps in the overall Cambodian response to HIV/AIDS since the development of the Comprehensive National Plan for AIDS Prevention and Control in 1993,
2. To develop recommendations in critical areas to inform the development of a strategic plan for the Nation of Cambodia for 1998-2000,

III. Background:

In Cambodia, a Comprehensive National Plan for AIDS Prevention and Control in Cambodia was developed in 1993,
The Goals were:

1. To reduce HIV transmission and
2. To reduce the morbidity and mortality associated with HIV infection,

The following Objectives were identified as essential to achieve these Goals:
1. To coordinate policy.
2. To collect accurate surveillance data on HIV infection in selected populations.
3. To accurately diagnose HIV and STDs in populations at risk,
4. To reduce the incidence of sexual transmission of HIV and STDs.
5. To provide educational information to coincide with surveillance,
6. To prevent transmission through blood products.
7. To prevent the spread of HIV infection among drug injectors,
8. To prevent the spread of HIV infection by skin-piercing instruments,
9. To reduce the transmission of HIV from mother to child,
10. To minimize the personal suffering and social stigma associated with AIDS and to provide psychosocial support to those affected by HIV/AIDS.
11. To provide the best available medical care for people with AIDS,
12. To monitor and evaluate activities of the Medium Term Plan.

These objectives will serve as a general guideline for assessing the National Response to HIV/AIDS in Cambodia. It was decided by the major stakeholders to develop a scope of work for a review which would adequately address the Cambodian National Response to HIV/AIDS.

In 1997, a team of individuals from major stakeholders from Cambodia developed a plan for a review of the National Response. These major stakeholders included the National AIDS Program (NAP), members of the Provincial AIDS Committees (PAC), Multilateral Organisations, NGOs and Donors. A Core Review Team was developed from the major stakeholders including the NAP, PAC, Multi-laterals and Donors and though a process of consultation they developed critical Areas for Review,

IV. Review Team
Core Review Team:
1. Dr, Tia Phalla, Manager, NAP, Team Leader
2. Dr, Hor Bun Leu, Assistant Manager, NAP
3. Dr, Seng Sopheap, Medical Officer in Charge of STD and HIV/AIDS Care, NAP
4. Dr, Lan Van Seng, Training Officer, NAP
5. Dr, Ouk Vichea, Provincial AIDS Manager/Battambang
6. Dr, Lim Nari, Provincial AIDS Manager/Siem Reap
7. Dr, Annie Macarry, Medical/Health Services, WHO
8. Dr, Francois Crabbe, STD Specialist, EU/ITM
2. health Services Relating to HIV/AIDS
   A. Voluntary Testing and Counseling
   B. Blood Safety
   C. STD Services
   D. Institutional AIDS Care
   E. Health Reform Programs and HIV/AIDS
   F. Integration of MCH/FPS/PHC/TB/HE
Core Team Members Responsible: Dr. Seng Sopheap, Dr. Ouk Vichea, Dr, Annie Macarry, Dr, Bernard Fabre-Test, Dr, Francois Crabbe.

3. Policy, Programme Management, Monitoring and Coordination
   A. National Level Structures, Roles and Responsibilities - including Non Government
      1. Policy
      2. Program Management
      3. Surveillance
      4. Technical Support'
      5. Financial Management
   B. National to Provincial Level Support - including Non Government
   C. Provincial Structures, Roles and Responsibilities
   D. Donor Roles and Responsibilities
   E. Donor and Government Coordination
Core Team Members Responsible: Dr, Tia Phalla, Dr, Hor Bun Leng, Mr, Steve Mills, Mr, Michael Calabria, Dr. Jeanine Buzy

The Core Review Team agreed that there were cross-cutting issues which affect all areas of information, education, community responses, health service delivery, policy and management. A general guide to these issues were developed which would inform the review process. These areas are:

- Coverage and Access to Information and Services
- Quality Assurance, Monitoring, Evaluation and Research
- Policy, Law, Human Rights and Ethics
- Roles, Responsibilities, Communication and Coordination
- Capacity Building, Training and Sustainability

General Guide to Cross-Cutting Issues
This will be used as a general guide of critical issues to be addressed through the analysis of documentation, key informant interviews and consultations with the Advisory Committees, A. Policy, Law, Human Rights and Ethics

1. Are there policies that support the implementation of interventions?
2. Example: What policies exist which effect issues concerning, prostitution and trafficking, status of women, sexuality education and condom promotion in the media
3. Is Confidentiality ensured during testing, treatment, counseling, notification and employment?
4. Is Informed Consent offered? Is Voluntary testing and counseling available?
5. What is being done to decrease discrimination of people infected with HIV/AIDS?
6. How could people living with HIV/AIDS be better supported to promote their ability to access information and services?
V. Methodology For the Review:

A. Scope of the Review
The review team developed a list of strategies used in HIV/AIDS responses in Cambodia to be reviewed. It was agreed that the review would "take stock" of the activities currently going on in Cambodia which would provide a general outline or mapping of existing programs and services. Additionally, the review committee agreed to undertake an identification and analysis of the achievements, constraints and gaps for each of the strategies in the National response and finally to develop recommendations for the years 1998-2000,

- Major Achievements of the National Responses at Different Levels
- Major Constraints in Programmer Implementation
- Major Gaps in the Overall Response
- Development of Recommendations which would inform the development of a Strategic Plan for the Nation for 1998-2000,

B. Process of the Review

1. Identification of key areas to be reviewed.
2. The development of Critical Questions for the Review.
3. Overview of HIV/AIDS in Cambodia discussed with the NAP.
4. An analysis of background documentation.
5. Consultation with Three Advisory Review Committees.
6. Consultation with Key Informants in Phnom Penh,
7. Field visits: in Battambang, Sihanoukville, Kampong Cham, Kampot, Kampong Thorn, Stung Treng.,
8. Consolidate findings and writing,
9. Consultation with Three Advisory Review Committees,
10. Finalize Review,
11. Present Review Findings,

C. Key Cambodian HIV/AIDS Strategic Areas to be Reviewed:

1. HIV/AIDS Information, Education, Communication and Community Activities Responses.
   A. Education 1. Formal 2. Informal
   B. Community Responses l, Prevention education 2. Community-based care
   C. Communication Strategy and IEC Materials
   D. Counseling
   E. Condom Marketing, Distribution and Supplies

Core Team Members Responsible: Dr. Lan Van Sena. Dr. Lim Nary, Ms, Monique Munz, Ms, Pawana Wienrawee, Ms. Henrietta Wells,
I. POLICY ON THE STRUCTURE OF AIDS/STD MANAGEMENT

2. The Royal government officially declare that HIV/AIDS is the first priority among the others which seriously affects the health of our general population, and is required political and financial support from the top level of the government.

3. The AIDS/STD management must be multisectorial structure which involve ministries, secretariats, government and private sectors or institutions, IOs NGOs, religion institutions, people in communities,…etc.

4. To improve the capacity of AIDS/STD Prevention and Control), provincial level National Committee for AIDS/STD Prevention and Control), provincial level (Provincial AIDS Committee), and district level (District AIDS Committee) responding to the spread of HIV/AIDS.

5. Ministry of Health play an important role in coordination with government sectors IOs, NGOs, and private sectors for the implementation of AIDS/STD prevention and control programmer in accordance with the National plan and policy.
B. Roles, Responsibilities, Communication and Coordination

1. Are there clearly identified and understood roles and responsibilities vis-à-vis HIV/AIDS across Cambodia for the:
   - Levels and Sectors of Government?
   - NGOs: including Local and International?
   - Traditional Sector and Religious Sector?
   - Private Sector: including Health and Non-Health related?
   - Employers: including brothel owners, factories, etc.?
   - Scientific and Medical Organizations?
   - Donors: Bilateral and Multilateral?

2. Are the structures appropriate to accomplish their roles?

3. What is the perception at the highest levels of organizations about the AIDS epidemic?

4. Is there evidence of supportive Communication and Coordination within and among these sectors to improve the overall response to HIV/AIDS in Cambodia?

5. Do the organizations and members have the authority and adequate support to accomplish their roles?

C. Capacity Building, Training and Sustainability

1. What are the needs at a National Level in Cambodia in technical and managerial capacity development to improve the National response to HIV/AIDS?

2. What are the needs at a Provincial Level in technical and managerial capacity development to improve the Provincial responses to HIV/AIDS?

3. What are the assurances of program and financial sustainability to address the HIV epidemic?

D. Coverage and Access to Information and Services

1. How well are Programs reaching these populations with information and services?
   A. High Priority Groups:
      1. CSW and their Clients
      2. STD Patients
      3. People Living with HIV/AIDS
      4. Police/Military
   B. General Population:
      1. Youth: 13-24

2. What are the gaps in Coverage and Access in urban and rural settings?

E. Quality Assurance, Planning, Monitoring, Evaluation and Research

1. Have Khmer Cultural Practices and Beliefs been identified and taken into account in developing information, media, education and clinical services?

2. Have program designs been based upon formative social or scientific research and has pre-testing of information for effectiveness occurred?

3. Have Gender Issues and/or Literacy been taken into account in developing information, media, education and services?

4. Are interventions and services being monitored for their effectiveness?

5. What areas of formative, social or scientific research would improve program interventions and services?
1. All government sectors both national and provincial levee] with the authorities Must ensure all government officials, civil servants, and people are maximum informed about the risk and prevention of HIV / AIDS.

2. AIDS education programme must be integrated into other National Programmes which are under control of government or private sectors. For example, NAP of MoH must be integrated into the programme of Mother and Child Health; Primary Health Care, National Tuberculosis Center, National Malaria Center ... etc.

3. Ministry of Education Youth and Sport must integrate AIDS education with appropriate context into school curriculum. Ministry of Culture and Religion Affairs and other religion groups must include AIDS education for their followers.

4. The meaning of AIDS education message must be in accordance with the good: Khmer custom, tradition and living standard of our people, but not so conservative.
   All information which may lead our people to the misconception about HIV / AIDS are prohibited.
II. POLICY ON MANAGEMENT AND FINANCE

1. The Royal government must provide financial support for AIDS/STD prevention and control programme as a priority.

2. All government sectors both national and provincial level must make an effort to appeal for financial support to run the AIDS/STD prevention and control programme.

3. An appeal for financial support from bilateral donor, IOs, NGOs, and private sectors especially the entertainment places.
V. POLICE ON MANAGEMENT AND CARE FOR PEOPLE LIVING WITH HIV/AIDS

1. Avoiding discrimination, stigmatization, and isolation on people living with HIV/AIDS.

2. In health care facilities both public and private, people living with HIV/AIDS have equal right to medical care and treatment.

3. In public and private hospital, HIV testing without agreement from the patient are not allowed.

4. Health care professionals in hospital and community should take care, provide treatment, and maintain absolutely confidentiality for people living with HIV/AIDS.

5. All health workers have to apply the universal precaution.
IV. POLICY ON HIV TESTING

1. Mandatory testing - is prohibited

2. HIV/AIDS surveillance must be done only by Secretariat of NAC anonymous unlinked and informed consent system.

3. Public and private testing services should conform to the following standard:
   - Run by staff with proper skill and qualified.
   - Maintain strict confidentiality of the test result.
   - Possess good counseling system.
   - Possess confirmation test.
   - Possess proper and sufficient preventive equipment.
IX. POLICY ON HIGH-RISK GROUP

1. To set up the appropriate and effective measures of management and control

2. To set up the regular check-up programme for the high-risk group.

3. To promote outreach activity through peer educators to the high-risk groups.

4. To promote 100% condom use policy within the entertainment places
VI. POLICY ON BLOOD SAFETY

1. To ensure all blood donation are already tested for HIV prior to use. But if the blood transfusion centers are not available, it has to ensure that the blood donors are not expose to the high risk infection.

2. To minimize as possible the necessity of blood using

VII. POLICY ON HUMAN RIGHT

People living with HIV/AIDS, as the other people, have equal right to live, work, and freedom of involvement in politic, economic, social, science ...etc.

VIII. POLICY ON MEDIA SYSTEM

Public and private media system should have responsibility in promoting free of charge HIV/AIDS education message.