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CAMBODIA

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Current State and Future Projection of the Spread of HIV/AIDS

Cambodia's experience with HIV/AIDS has been inextricably linked to that of its neighboring countries. The first cases of HIV detected in the Southeast Asian region were found in 1984 among men who have sex with men (MSM) in Thailand. Early on, injecting drug users (IDUs)—particularly in Bangkok—and sex workers were also found to have high rates of HIV infection. By 1989, the virus had spread from groups that practice high-risk behaviors to the general population, primarily through heterosexual contact. Thailand's HIV infections and AIDS cases are concentrated more in the northern part of the country but have been found in all 76 provinces. Estimates suggest that HIV prevalence at the national level and among some subgroups peaked during the mid- to late-1990s before starting to decline during the past few years (Policy Project 2003).

By the early 1990s, HIV/AIDS had reached Cambodia, and by the middle of that decade, the epidemic had exploded. Screening of blood donors revealed the country's first HIV infection in 1991, although HIV was detected in Cambodian refugees in Thailand two years earlier. Due to decades of conflict, Cambodia has witnessed a high degree of population migration, both within the country and between countries. During the first few years, most of Cambodia's people living with HIV/AIDS (PLWHA)

were residents of the Thai-Cambodia border region or of the southern and central provinces of Cambodia. Sex workers and males seeking treatment for sexually transmitted infections (STIs) (often assumed to be clients of sex workers or those engaging in reckless sexual behavior) were among the first groups to report high levels of HIV infection. By late 1993 and early 1994, the first cases of AIDS were diagnosed, and between 1995 and 1998, surveillance data from the National Center for HIV/AIDS, Dermatology and STD (NCHADS) showed rapid transmission of HIV in several key populations, predominantly through heterosexual transmission. Recent estimates of HIV and AIDS prevalence are shown in table 1.

Table 1. Country HIV and AIDS estimates, end 2003 (range given in parentheses)

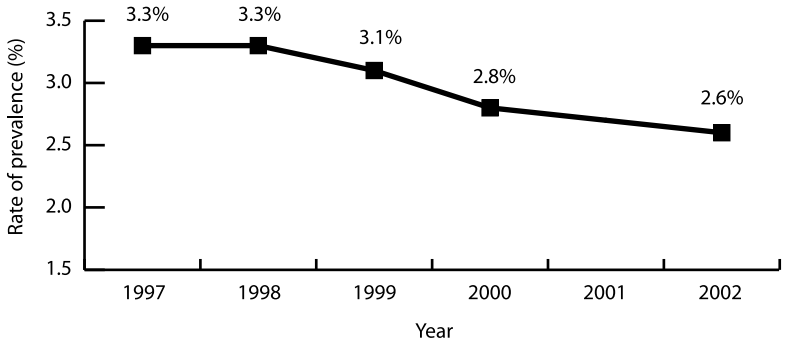
Adults (15–49)	
HIV prevalence rate	2.6% (1.5% –4.4%)
Living with HIV	170,000 (100,000–290,000)
Adults and children (0–49) living with HIV	170,0000 (99, 000–280,000)
Women (15–49) living with HIV	51,000 (31,000–86,000)
AIDS deaths (adults and children) in 2003	15,000 (9,100–25000)

Source: UNAIDS (2004).

While Cambodia is still experiencing a high level of HIV/AIDS prevalence nationally among adults (15–49 years old), that level appears to have declined somewhat in recent years (see fig. 1). The reduction in risky behavior among key target subpopulations has contributed to these declines, as has the increase in AIDS-related deaths.

According to the U.S. Centers for Disease Control and Prevention's Global AIDS Program in Cambodia, data from the 2002 HIV Sentinel Surveillance Survey revealed that the HIV prevalence rates were between 15% and 29% among female sex workers, 8.4% among tuberculosis (TB) patients, 3.9% among police, and 2.8% among antenatal clinic patients. To date, HIV in Cambodia has been overwhelmingly transmitted through heterosexual contact.

Figure 1. HIV prevalence rates in Cambodia, 1997–2002



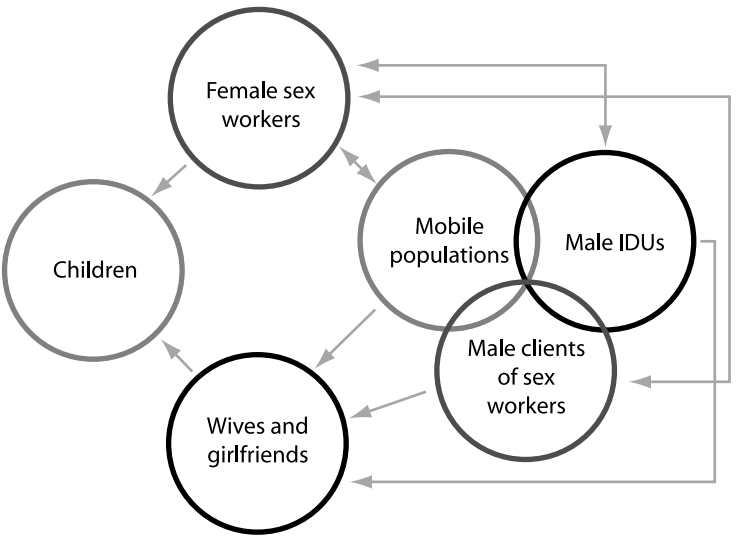
Source: NCHADS (2002).

There are efforts to address other potential high-risk behaviors as well. In May 2003, the first national drug conference was conducted with a substantial emphasis on the role of drug abuse in HIV infections; however, to date, there are very few documented cases of IDU transmission of HIV in Cambodia (CDC 2005).

Poverty and reckless sex appear to be the primary contributing factors that have led to the pervasiveness of the disease. Poverty often leads individuals to seek employment in the entertainment industry, such as brothels and massage parlors, where high-risk sex occurs between clients and workers. In addition, poverty is at the root of labor migration, and migrant workers—especially those near the Thai-Cambodia border—appear to have the highest rates of infection in the country. In short, HIV/AIDS is widespread because the pursuit of economic stability often leads to high-risk behaviors that compromise individuals' health security.

This is also reflected in the Asian Epidemic Model developed by the East-West Center at the University of Hawaii, a computer simulation model of the HIV/AIDS epidemic in Asia that shows how population mobility, compounded by reckless or unprotected sexual behavior, allows epidemics to proliferate across different groups in the region. Figure 2 illustrates the spread of HIV from vulnerable groups to the general population. Female sex workers; MSM; mobile populations such as truck drivers, migrant workers, tourists, and uniformed military/police personnel; male IDUs; and male clients of sex workers are more likely to practice risky behavior,

Figure 2. The spread of HIV from vulnerable groups to the general population



Source: Policy Project (2003).

including unprotected sex, and that in turn makes the general population vulnerable—especially children who are infected through mother-to-child transmission.

In response, Cambodia's HIV/AIDS prevention campaign incorporates a multisectoral approach that involves extensive coordination, networking, and service provision by the state, domestic and international nongovernmental organizations (NGOs), and community-based organizations (CBOs). This strategy delivers the responses needed to succeed in combating HIV/AIDS (Ministry of Health 2001).

Social and Economic Impact of HIV/AIDS

The social and economic impact on national development due to increases in health costs continues to negatively affect the national labor pool and social capital. Expenditures for healthcare are a major cause of debt, landlessness, and poverty. Cambodians spend a considerable fraction of their earnings on healthcare services provided by traditional healers, drug sellers, and unregistered or untrained pharmacists. A recent study prepared for the

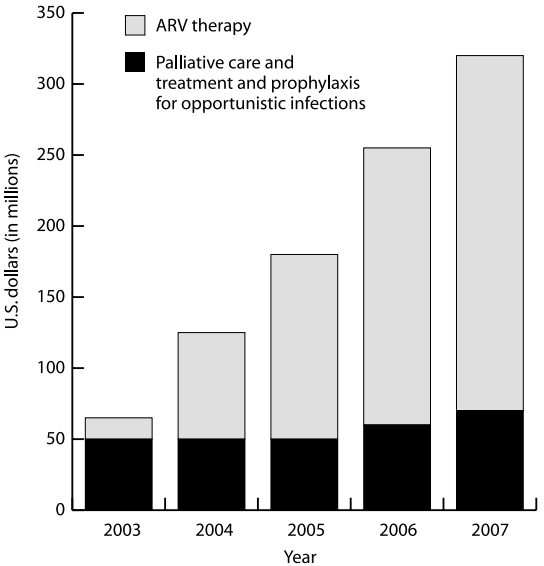
Joint United Nations Programme on HIV/AIDS (UNAIDS) examined the costs of scaling up prevention and care programs in low- and middle-income countries. That study estimated that for the four countries in the Lower Mekong Region (Cambodia, Lao PDR, Thailand, and Vietnam), the cost of palliative care, treatment of opportunistic infections (e.g., TB), and prophylaxis for opportunistic infections for all who need it totals approximately US$60 million per year (see fig. 3). The cost of providing antiretroviral (ARV) therapy to all PLWHA who need it and have access to adequate health facilities is expected to rise to about US$250 million by 2007. Women tend to bear the heaviest burden when it comes to the cost of caring for those infected with HIV/AIDS because they have to accept household and economic responsibilities and become the primary care providers for PLWHA. The lack of women's rights to property and inheritance following the death of a loved one further threatens the survival of families, as households lose resources. They are left even less able to respond when the woman is also diagnosed with HIV/AIDS.

Future Projections

In the 1990s, national adult HIV prevalence increased rapidly in Cambodia. Compared with other countries in Southeast Asia, evidence from surveillance data suggests that the prevalence is still high but has started to decline in recent years. Adult HIV prevalence is low but slowly rising in Lao PDR and Vietnam. Some research has suggested that the experiences of Thailand and Cambodia, where significant behavior change in both countries contributed to the gradual decline of HIV/AIDS levels, show that the prevalence will not rise above 3% in Asia. However, according to the East-West Center's Asian Epidemic Model, if high-risk sexual behavior had not changed in Thailand and Cambodia, HIV prevalence in those countries would have continued to rise rapidly in the early 1990s and could have reached 10–15% before stabilizing. The most relevant lesson from this may be that, with good programs and strong political support, populations can respond to rapidly emerging epidemics and change behavior quickly enough to reduce prevalence.

At the same time, the fact that HIV prevalence is currently low in Lao PDR and Vietnam does not ensure that it will remain low forever. Although the overall risk is lower in these countries than it was in Thailand and

Figure 3. Estimated costs for care and treatment of PLWHA in the Lower Mekong Region, 2003–2007



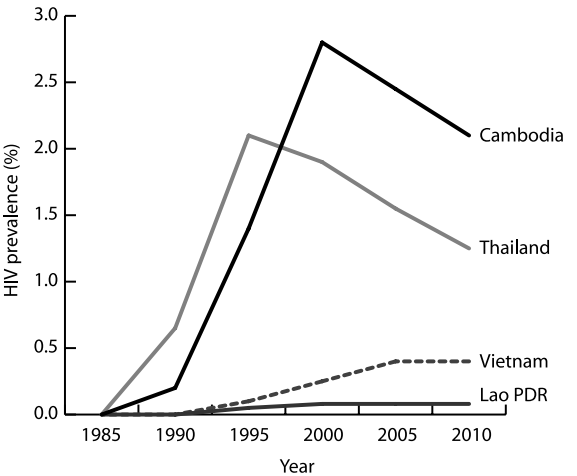
Source: Report presented to the UNAIDS Programme Coordinating Board, as quoted in Policy Project (2003).

Cambodia in the early 1990s, there is still enough risky behavior to sustain a growing epidemic. Simulations using the Asian Epidemic Model show that it may take longer, but prevalence could still reach 3–5% in countries that currently have low prevalence. The presence of an epidemic among IDUs in Vietnam makes it particularly susceptible to a rapid rise in prevalence in the future. For the purpose of projecting the future trends in HIV/AIDS prevalence, it has been conservatively assumed that the recent trends will continue in the immediate future, as shown in figures 4 and 5.

Population Groups Most Vulnerable to the Disease

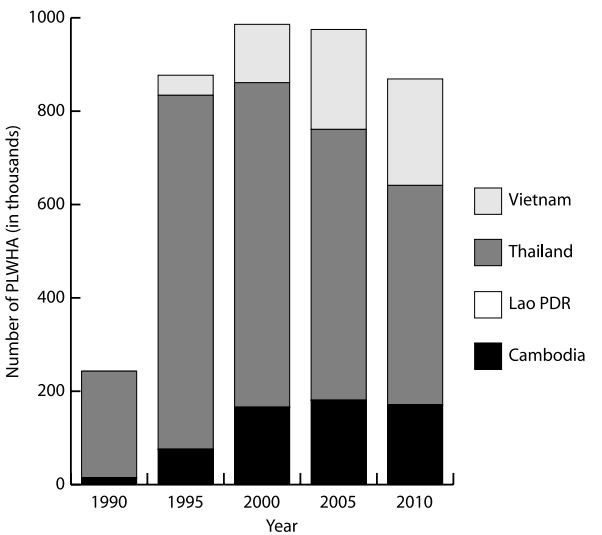
In Cambodia, the geographic patterns of the epidemic reveal a good deal about the groups most vulnerable to the disease (see fig. 6). It appears that the HIV epidemic in Cambodia has spread to all provinces even though the majority of people infected with HIV live in urban areas and in border provinces, especially those bordering Thailand. Specifically, those who are

Figure 4. Estimated and projected adult (age 15–49) HIV prevalence in the countries of the Lower Mekong Region, 1985–2010



Source: Policy Project (2003).

Figure 5. Estimated and projected number of PLWHA in the countries of the Lower Mekong Region, 1990–2010

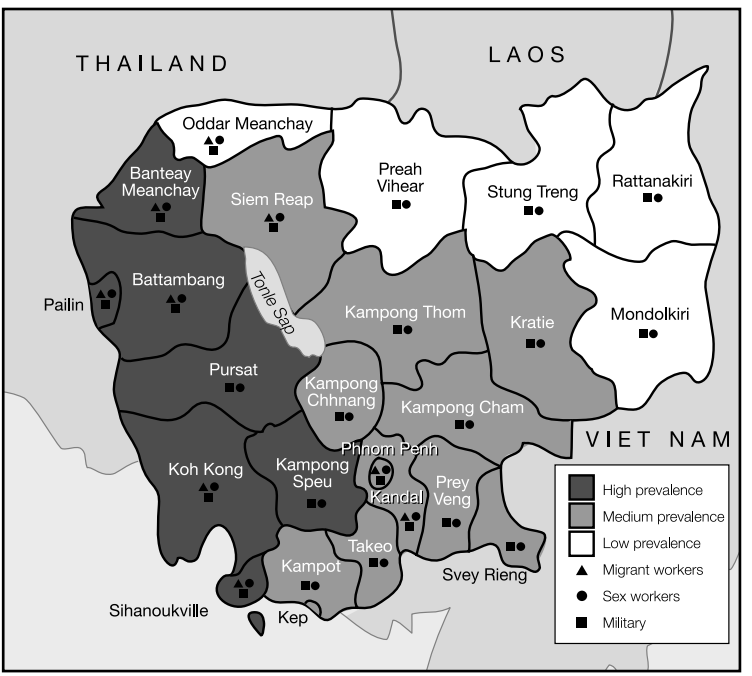


Source: Policy Project (2003).
Note: The number of PLWHA in Lao PDR is <2,000 in each projected year.

employed in the commercial sex industry face the highest peril of HIV/AIDS infection. In Cambodia, commercial sex workers can be found in brothel areas, karaoke lounges, massage houses, restaurants, and casinos. Commercial sex is stimulated by poverty and compounded by the low levels of literacy and a limited formal employment sector. Many young women turn to work in brothels or entertainment facilities where they can find employment opportunities, but then they face the high risk of HIV transmission and infection linked to this occupation.

Cambodia's grim economic situation has contributed to the spread of the virus. Results from the 2001 Behavioral Surveillance Survey show an increasing proportion of beer promotion girls and other girls working in the recreation and entertainment industry reportedly selling sex in the last year. Moreover, sketchy reports from the United States Agency for International Development (USAID) implementing partners and NCHADS indicate

Figure 6. HIV prevalence in Cambodia by geographic location and high-risk populations, January 2003



Source: USAID (2004).

that more commercial sex work is going "underground," with greater numbers of women moving from brothels into more clandestine, indirect forms of sex work, which places them at even greater risk.

Men are vulnerable to HIV/AIDS when they engage in risky sexual behavior, and they in turn victimize their families by making them vulnerable to HIV/AIDS, both in terms of health security and financial security. A 2001 UNAIDS estimate revealed that there was an almost even male-to-female ratio among PLWHA in Cambodia. As the epidemic becomes more mature, more women are likely to be affected by HIV/AIDS, and therefore community-based and national strategies must address the burden of care. HIV/AIDS programs must address women as individuals—for example, improving women's access to services for their own health needs—but must also recognize their roles within families and communities.

Government Response

Domestic Context

Given the complexity of the social, financial, and institutional burden in formulating and carrying out responses to HIV/AIDS, the government of Cambodia enacted anti-HIV/AIDS legislation in 2002 that called for the implementation of a holistic approach to the problem. As a result, the government's national response to HIV/AIDS has been carried out through extensive cooperation with bilateral donors, domestic and international NGOs, United Nations (UN) agencies, and a wide range of other organizations that specialize in HIV/AIDS prevention and care activities. Its current priorities include interministerial cooperation, prevention of mother-to-child transmission, school-based HIV and family health education, behavior change communication (BCC) programs for populations considered to be at high risk of HIV infection and transmission, capacity building at the provincial level to respond to the HIV epidemic, and community-based prevention and care programs. The government recently finished its National Strategic Plan (NSP) for a Comprehensive and Multisectoral Response to HIV/AIDS 2001–2005. That plan put into practice two complementary approaches to reduce vulnerabilities to HIV/AIDS at the individual, community, and societal levels. The first approach concentrated

on the causes of certain behaviors at the individual level, while the second approach focused on changing aspects of the socioeconomic, legal, and political environment.

In the context of the NSP, a number of provincial and ministerial strategic plans were developed, some of which include the following:

Ministry of Health (MoH) Strategic Plan for HIV/AIDS and STI Prevention and Care, 2001–2005—The MoH strategic plan is aimed at reducing transmission in high-risk situations through condom promotion, STI treatment promotion, awareness raising, and improved access to voluntary counseling and testing (VCT) services, as well as through efforts designed to equip the health system to cope with an increased demand for health services related to HIV/AIDS. NCHADS, an agency under the MoH, plays a leading role in implementing and overseeing the national health response to HIV/AIDS and provides technical support to other governmental agencies and national partners.

Ministry of National Defense (MoND) HIV/AIDS Strategic Plan, 2002–2006—The MoND has called for the implementation of a peer education project for STI/HIV/AIDS prevention and is working with Family Health International on its Implementing AIDS Prevention and Care Project to develop BCC messages for HIV/AIDS prevention and care targeted at military personnel and their families.

Ministry of Social Affairs, Labor, Vocational Training and Youth Rehabilitation (MoSALVY) Strategic Plan for a Comprehensive Response to HIV/AIDS, 2002–2006—The MoSALVY strategic plan includes the development of multiple interventions designed to decrease the social vulnerabilities of children and youth to HIV/AIDS, the promotion of workplace interventions to prevent transmission of HIV and increase access to services, and the enhancement of programs preventing human trafficking. The ministry also strives to protect those who are involved in illegal situations due to human trafficking, including sex workers, domestic helpers, and illegal immigrant workers.

The Ministry of Rural Development (MRD) Strategic Plan for a Comprehensive Response to HIV/AIDS, 2002–2006—The MRD aims to integrate

HIV/AIDS prevention into all rural infrastructure programs. Current funding from the United Nations Children's Fund (UNICEF) enables project implementation in the provinces of Kampong Chhnang and Kampong Speu, establishing youth volunteer groups and working with the village development committees.

According to a report entitled, "Hand-in-Hand: Government and NGOs Respond to the Epidemic in Cambodia—The Khana Experience," these plans recognize that individual risk is compounded by the real limitations on individual choices and options for risk reduction, including illiteracy; gender power imbalances; ignorance about HIV/AIDS; discrimination and marginalization of population groups (e.g., trafficked women and children, sex workers, and PLWHA); the legal environment; a lack of policy capacity; and insufficient government commitment and capacity to mount effective responses and to protect and promote political, economic, and social human rights (Goodwin 2003).

The effectiveness of the NSP in fighting HIV/AIDS remains to be seen, but there are clearly a number of barriers to accessing public services that must be addressed:

- Financial barriers—high opportunity cost, unpredictable informal charges, no system of deferred payments, a general failure of the exemption system to protect the poor
- Physical barriers—distance/time to reach the closest health facility, lack of transport, restricted hours of operation of health facilities
- Sociocultural barriers—preference of home-based healthcare, general reluctance to travel from home, lack of ability and willingness to attend and pay for healthcare
- Cognitive barriers—lack of information on services, user fees, and exemption schemes; little understanding of consumer rights; lack of confidence in public health facilities
- Organizational barriers—real and perceived poor quality of healthcare, unprofessional staff attitudes, unethical treatment of patients, ineffective referral mechanism, services that are not customer oriented

The impact of these factors is still unknown, but they may exacerbate operational issues of the NSP (J. Wilkinson 2001).

Issues in coordination, funding, and service delivery are the key factors for determining the success or failure of domestic HIV/AIDS policy. For example, to improve efficiency and service delivery, the MoH has been contracting NGOs and CBOs to carry out certain aspects of its programs at the provincial level. Nevertheless, there are fundamental problems in this scenario in terms of disbursement, trust, and spheres of control between the MoH and the contracted organizations. For instance, the MoH is concerned with being accountable to its donor (i.e., the World Bank), the Ministry of Economics and Finance, its clients (PLWHA), and Cambodian taxpayers for money borrowed from the World Bank, and it therefore maintains the right to retain control over the activities of the contracted NGOs. The Khmer HIV/AIDS NGO Alliance (KHANA) entered into a contractual agreement with the MoH that provides KHANA with the jurisdiction to collaborate "under the overall direction of the Ministry of Health" and to manage the disbursement of grant funds provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), which KHANA then provides to the government agencies' HIV/AIDS programs. But in practice, the lack of trust and competition for control affects the flow of funds, disbursements, and resources for care support, service delivery, and technical assistance programs. This in many ways undermines successful implementation of the policy objectives. As a result, there is essentially a lack of coordination between NCHADS and KHANA. What this means is that contractual arrangements for delivery and implementation of care support, if not handled more effectively, could undermine the effectiveness of the NSP (D. Wilkinson 2005).

In terms of political leadership, the commitment at the highest levels of the Cambodian government, strong political will, and evidence-based interventions have together contributed to the decline of HIV prevalence among some of the sentinel populations (see table 2). The decline in prevalence among sex workers since 1998 has been dramatic, especially among direct (i.e., brothel-based) female sex workers, while the decline among the police has seemingly plateaued since 2000. Prevalence rates among women who obtain antenatal care (ANC) services have remained fairly constant at approximately 3%, but are as high as 8% in some provinces, suggesting increasing transmission in the general population.

Table 2. HIV prevalence among sentinel groups

	1998	2000	2002
Adult population (age 15–49)[a]	3.3%	2.8%	2.6%
Direct female sex workers	42.6%	31.1%	28.8%
Indirect female sex workers	19.2%	18.8%	14.8%
Urban police	6.2%	3.8%	3.9%
Blood donors	4.2%	2.7%	2.3%[b]
ANC attendees (crude)	3.2%[c]	2.3%	2.8%
TB patients	3.9%[d]	6.7%	8.4%

Source: NCHADS (2002).
[a] Estimate based on sentinel data. [b] 2001 data. [c] 1997 data. [d]1999 data.

On June 14, 2002, the government of Cambodia adopted its first national laws to combat HIV/AIDS. The legislation provides police with the authority to prosecute people who deliberately spread the disease with up to one year in jail and a fine of up to one million riels (US$250). The legislation also provides for fines and punishment for those who sell fake drugs that claim to cure AIDS, while at the same time promotes dissemination of accurate information about the disease.

International Context

Cambodia is dependent on the international community for funds to finance the NSP. International assistance continues to play a vital role in national development. Although Cambodia's gross domestic product (GDP) grew at an average of 4% per year over the period 1996–2000 and progress was made in mobilizing government revenues, external assistance was still equivalent to an average of 15% of GDP from 1998 to 2000 and 138% of the national budget during those years. External assistance in the year 2000 was equivalent to approximately US$40 per capita. Moreover, the overall deficit in this period was almost completely financed (96%) from foreign sources and 73% of capital expenditures were foreign financed (USAID 2004).

Bilateral assistance comes from a number of countries. Chinese assistance is unofficially reported to be some US$30 million a year. China is also a source of substantial foreign direct investment. For the past two years, Australia and France have each contributed around US$20 million per year, while the United States is the largest donor in the health

sector, contributing US$23 million in FY2002 out of a total aid package of US$40 million. Sweden, Germany, the United Kingdom (UK), and the Netherlands are other important bilateral donors that contributed in the range of US$8–16 million per year in 2003 and 2004. Japan, France, and Germany all implement projects directly with the government, while Sweden, the UK, and the Netherlands direct significant portions of their assistance through UN agencies, and Australia uses both approaches. Nearly all of the major donors channel a portion of their assistance to donor-country NGOs and/or domestic NGOs (USAID 2004).

Coordination mechanisms among the government, donor countries, and NGOs have been put into place in the health and education sectors. The Health Sector Reform Program came out of a collaborative process among those actors, and the MoH has worked with its partners to develop a sector-wide approach for managing future assistance and to articulate an MoH strategy for 2002–2007. Other bilateral and multilateral donors are very interested in establishing close partnerships with those state and nonstate actors in the health field working on HIV/AIDS prevention.

Japan International Cooperation Agency—The Japan International Cooperation Agency (JICA) is currently providing technical assistance to a program for the prevention of mother-to-child transmission through a project at the National Mother and Child Health Center. JICA also provides support to KHANA, as does USAID. Support from these donors to KHANA is complementary, enabling the organization to reach greater numbers of the population affected by HIV/AIDS. Additionally, JICA provides support to the National Center for Tuberculosis and Leprosy (CENAT), which, together with NCHADS, has developed an HIV/TB co-infection strategy.

The Global Fund to Fight AIDS, Tuberculosis and Malaria—The Global Fund has approved funding for Cambodia in two of its grant rounds, totaling US$47.41 million, of which US$30.77 million has been awarded for HIV/AIDS. The focus of the grant in the first round is on reducing the burden of HIV/AIDS by mitigating the impact of AIDS on specific population groups, such as sex workers; the military, police, and other commercial sex clients; youth; garment factory workers; PLWHA; and pregnant and vulnerable women and their children. The second-round grant emphasizes

care and support, including possibly ARV therapy and ARV pharmaceutical management. The program will be implemented by 11 subrecipients, of which two—KHANA and Population Services International (PSI)—are also USAID partners. USAID is extremely active as the bilateral donor representative on the Cambodian Country Coordination Mechanism and a member of the Technical Review Panel for the Global Fund. USAID has taken the lead in helping the Principal Recipient establish its structure, hire staff, and create policies and protocols through direct financial as well as technical assistance. It is foreseen that USAID will continue to be actively involved in providing similar assistance and remain flexible to meet the needs of the changing donor environment.

Department for International Development—In the spring of 2003, the UK Department for International Development (DFID) initiated a new three-year HIV/AIDS strategy in Cambodia that includes budgetary support for NCHADS; technical assistance and capacity building for the National AIDS Authority and its constituent ministries; an ambitious, national-level media effort; and support for the development of HIV/AIDS education activities by the Ministry of Education, Youth and Sports. USAID and DFID will coordinate closely on the implementation of the media activities and on support to NCHADS and the National AIDS Authority. Moreover, DFID officials have indicated that they might consider targeting a portion of their support for a small number of operational districts, and would welcome USAID's assistance in identifying the sites for complementary programs in the provinces. DFID also plans to continue providing condoms for the USAID-supported "Number One" condom social marketing program.

Other donors providing funds for HIV/AIDS in Cambodia include the Australian Agency for International Development, which is focusing its investments in a few selected provinces and operational districts; the Canadian International Development Agency; the European Union; France Coopération Internationale; Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ); Kreditanstalt für Wiederaufbau (KfW); the UN Population Fund (UNFPA); UNAIDS; the UN Educational, Social and Cultural Organization (UNESCO); the World Health Organization (WHO); and the World Bank.

In this way, the international community has been working cooperatively with the MoH, providing funds to implement its national policy on HIV/AIDS. Cambodia is very fortunate to receive substantial funding and international resources for technical assistance. The challenge is not so much in securing funding but in effectively utilizing these funds to support national programs. To be specific, as mentioned above, the fundamental problems are delays in the disbursement of funds to the NGOs and CBOs, inefficiencies in contractual agreements between the MoH and NGOs/CBOs, and the existing tension and competition between government and CBOs, causing unnecessary delays and inevitably undermining coordination and policy implementation (D. Wilkinson 2005). Donors provide funds based on a specific expected outcome and therefore set conditions that may limit the scope and cost of an operation to achieve that desired outcome. Moreover, NGOs and CBOs must be accountable to their donors, whose ideas and approaches regarding HIV/AIDS may be very different from that of the government. Therefore, financial assistance would be most effectively disbursed and its objectives served if the MoH and contracted organizations were more flexible about their spheres of control and jurisdiction in operations.

Civil Society Response

In Cambodia, there are two well-known NGOs that work with CBOs involved in the fight against HIV/AIDS—KHANA and PSI. The scope of their activities includes technical assistance, project planning, policy advocacy, social awareness raising, campaign and promotion support, and care and service delivery. KHANA is technically and financially supported by several international donors, namely the International HIV/AIDS Alliance, the Global Fund, and USAID. Its primary function is to provide support to CBOs with technical and financial support from the International HIV/AIDS Alliance and bilateral donors such as USAID and JICA. Moreover, because KHANA is a country-based organization with extensive international support, the MoH works with this organization to implement components of the NSP. By having access to state institutions and support, KHANA has an advantage in carrying out policy advocacy and intervention

(Global Fund 2005). The scope of its work therefore extends to community health services, technical assistance, financial coordination, and referral.

PSI, on the other hand, has a different operational plan. PSI educates the public by using mass media to change the behavior and mindset of the public on HIV/AIDS and its prevention, family planning, and nutrition. The specific strategy used by PSI is the promotion of condom use because education on HIV/AIDS must be accompanied by behavior change to prevent HIV infection and transmission. PSI uses a balanced approach, including the promotion of abstinence, mutual fidelity, and correct and consistent condom use, and implements programs of VCT and prevention of mother-to-child transmission. It also operates a variety of educational and BCC campaigns that discourage harmful cultural norms such as cross-generational sex, unprotected sex, and stigma and prejudice against PLWHA. By providing education through communication and counseling, population groups gain knowledge about what to do and the necessary skills to do it, and condoms provide the tools needed to take action (PSI 2005). In 2002, PSI launched the United Health Network, a network of NGOs throughout the country, which is expanding into rural areas as much as possible to market condoms to the general public and to enable access to those who have had no prior access to condoms for protection.

The success and proliferation of health NGOs is partly due to their good relationship with and support from the government. In essence, the MoH recognizes that while its leadership is the foundation upon which an effective response to AIDS, TB, and malaria can be made, civil society is a critical implementer of support, prevention, and care programs, particularly for the most vulnerable and hard-to-reach communities. Yet the daunting challenge in terms of civil society involvement in fighting the disease is capacity and coordination. Competition among NGOs and inadequate trust between NGOs and state agencies are problematic, complicating implementation and operation. There must be a culture of joint cooperation, where state employees work with NGO staff without professional or political prejudice.

Corporate Response

An important element of the corporate response to HIV/AIDS is the response of the private healthcare system. One of the great dangers of Cambodia's private healthcare system is the absence of a professional work ethic and the prevalence of unqualified and irresponsible health service providers who not only lack the knowledge to provide accurate diagnoses, but recklessly issue prescriptions that often intensify symptoms. These health service providers are missing opportunities in linking TB to HIV, hence undermining early detection of HIV/AIDS. This in turn means that both the government and NGOs are missing opportunities to make TB and VCT services more client focused. Essentially, the government and NGOs must focus on establishing a one-stop approach, providing incorporated services where the focus is on addressing client needs rather than on provider convenience. This will help improve access, demand, and quality. There is a need for legislation demanding more accountability and stricter standards of qualification for health service providers.

Looking at the corporate sector more broadly, there appears to be no workplace policy on HIV/AIDS in effect as of yet for employees, their families, and the local community. The National AIDS Authority has a mandate to coordinate the implementation of government policy, but the private sector has not yet taken the initiative in making policies related to HIV/AIDS for employee families and the local community, and there is very weak enforcement or monitoring to ensure that the private sector is in compliance with the government's policy.

Local corporate philanthropic contributions for combating HIV/AIDS are rare, if they exist at all. There have, however, been some contributions from the international corporate world. For example, the Bill and Melinda Gates Foundation funds KHANA through the International HIV/AIDS Alliance, and the Pfizer Foundation is providing funds through Engender Health to the Reproductive and Child Health Alliance, a local NGO that provides assistance to HIV-infected persons among rural populations. But it is the Global Fund that has been the major direct source of financial and technical support for the implementation of NSP programs.

Media Response

Given that broadcasting reaches a wider audience than can the targeted outreach programs in the priority provinces, mass media is a critical communication medium for awareness raising and HIV/AIDS education. The government and NGOs have been using mass media, namely television, to broadcast dramas that try to eliminate stigmatization of and discrimination against PLWHA, promote prevention and voluntary testing, and encourage people to avoid high-risk sexual behavior. PSI, for example, has been promoting the use of condoms in its anti-HIV/AIDS campaigns on television spots, billboard advertisements, newspapers, and popular magazines. Local celebrities appear in HIV/AIDS education campaign activities and rallies, while the media also airs snippets and segments of conferences on healthcare and HIV/AIDS prevention education.

Regional and International Cooperation

Current assessments of regional responses to HIV/AIDS are positive, but cooperation must continue as we have witnessed positive results from international and regional cooperation in the fight against HIV/AIDS. For instance, Cambodia has greatly benefited from regional and international cooperation, particularly in terms of MoH national policy formulation and HIV/AIDS prevention planning. Human resource development—including education on HIV/AIDS—technical assistance, and multilateral research and collaboration with NGOs, CBOs, and regional organizations are necessary to achieve the NSP objectives. This cooperation enables technical capacity, care, support, and services and helps to change the mindset of high-risk groups on risky sexual behavior that makes the entire country vulnerable to infection by HIV/AIDS. As a member of the Association of Southeast Asian Nations (ASEAN) Disease Surveillance Network, the government is benefiting from collaborative research among member countries and with the participation of the U.S. Naval Medical Research Unit No. 2 (NAMRU), the U.S. Centers for Disease Control and Prevention, and USAID. This functional cooperation facilitates ASEAN regional collaboration on improving infectious disease outbreak detection

and response capabilities. NAMRU promotes outbreak response training workshops and also the development of laboratory diagnostic capabilities in identifying the pattern of HIV/AIDS spread (ASEAN Disease Surveillance Network 2005).

Table 3. Collaborating institutions in the ASEAN Disease Surveillance Network

Brunei • Regional Veterinary Laboratory, Dept. of Veterinary Services • Dept. of Health Services, Ministry of Health	**Malaysia** • Regional Veterinary Laboratory, Dept. of Veterinary Services • Army Field Command Headquarters
Cambodia • MoH • National Institute of Public Health • MoND • US NAMRU-2/NIPH Lab • USAID, Cambodian Office	**Nepal** • Vector Borne Disease Research and Training Center, Environmental Health Project/USAID, Ministry of Health
Laos • Centre for National Laboratory and Epidemiology • National Tourism Authority of Lao PDR • Champassak Provincial Health Department • Military Institute of Hygiene and Epidemiology • Luang Prabang Provincial Health Department	**Vietnam** • International Collaboration Dept., Ministry of Health • National Institute of Hygiene and Epidemiology • Hematology Center, Bech Mai Hospital • Pasteur Institute • Cho Quan Hospital • Pediatric Hospital • An Giang Province Health Authority • Vietnamese Red Cross Society

Note: For a current, comprehensive list, see http://www.asean-disease-surveillance.net/ASNCoIns_List.asp.

Yet regional cooperation is important not only because of functional cooperation but because it constitutes the political commitment that is vital for tackling transnational issues associated with HIV/AIDS. One such issue better addressed through concerted regional efforts than by individual countries is human trafficking. The sex industry in the region fuels the trafficking of women, children, and men—generally by coercion or deception—for the purpose of exploitative labor in a new location.

Under the pretense of economic and employment opportunities, the exploitation of this labor can take on a variety of forms, such as agricultural

"Cambodia," Fighting a Rising Tide: The Response to AIDS in East Asia; (eds. Tadashi Yamamoto and Satoko Itoh). Tokyo: Japan Center for International Exchange, 2006, pp. 53-75

labor, domestic servitude, and sex work. Undeniably, extreme poverty in the Mekong Region contributes to the problem of human trafficking as families, under pressure to repay debts, may sell their children to traffickers, while other individuals are lured away by the promise of high-paying jobs. Because of its illegal and underground nature, determining the exact number of people trafficked each year is extremely difficult. In 2003, UNICEF estimated that about one-third of international trafficking in women and children occurs within or from Southeast Asia alone. UNICEF also estimates that about one million children between the ages of 12 and 17 are involved in the sex industry throughout Asia—the largest number in the world. Those who are forced into the sex industry are particularly at risk for STIs, HIV infection, and physical and sexual abuse. Some female sex workers in Cambodia, many of whom have been trafficked against their will, have turned to sex work due to economic or other hardships. Many Vietnamese are being trafficked into Cambodia either to find economic opportunity or individual freedom; many end up being employed by the sex industry in karaoke clubs, massage parlors, and sex houses. Because of their role in spreading HIV/AIDS in the region, population migration and human trafficking pose real problems to regional health security and thus require a concerted political effort by the regional community (Mahathir 2004).

Conclusion

Whether population mobility is driven by human exploitation or political circumstances, it accelerates the proliferation and spread of HIV/AIDS in the region, thus increasing the level of HIV prevalence. To stop the proliferation of HIV/AIDS, it is critical that political commitment and institutional coordination are brought to bear on such transnational issues as migration, population mobility, and human trafficking.

Undoubtedly, the size and diversity of Southeast Asia presents challenges for functional and political coordination as it encompasses 8.5% of the world's population. The vast differences in demographic, socioeconomic, and political systems present substantial challenges for regional planning, coordination, and implementation, specifically when identifying feasible multicountry collaborative projects.

These are fundamental and real challenges to creating an enabling environment for the promotion of regional and international cooperation. And yet, the failure of the regional community to exercise the political commitment and leadership necessary to combat the transnational issues that fuel the spread of HIV/AIDS would unquestionably undermine the effectiveness of each individual country's national responses to HIV/AIDS. It is therefore critical that these challenges be overcome, and that it be done through transparent political implementation and cooperation.

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