Review of the 100% Condom Use Programme in Cambodia

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A Report of Findings and Recommendations

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PREFACE

When the HIV prevalence in Cambodia among sex workers and clients became the highest in the region, there was a need to install a better approach to better circumscribe the infection and to protect as much as possible the general population. As a response to this demand, 100% Condom Use Program was adopted from proven success in Thailand with an intention to prevent the further spread of HIV/AIDS starting from Sihanoukville as pilot Project. Three years later the program is being implemented countrywide.

The innovative concept of the program is to gain the cooperation of the government authorities and owners of all sex establishments in order to instruct or require the sex workers to use condoms in all sexual encounters. If their customers refuse to use condoms, they are urged to withhold services and refund those customers’ money. The measures must be taken by all sex establishments so that customers will not be able to purchase sex services without using condoms. The intention of the program is to install a norm of “always use condom in the sex industry”.

As for the introduction to the review of 100% Condom Use Program in Cambodia, we would like to clarify someone important stand points amidst the controversies on the issues of HIV/AIDS and prostitution:

- The strategy of the program is aiming to use the same principle of health promotion where the “healthy behavior is an easiest choice”. Comparable to seat belt policy, the sanction is very much needed to compliment the self-motivated behavior of individual, brothels should be closed if there is enough evidence of non-cooperation with the norm. The development of life skills, self-esteem and empowerment especially for sex workers can be integrated into the development of individuals whereas the sanction can be considered as an intervention on external factor of the behavior.

- 100% Condom Use Program is aiming to protect the right of both sex workers and clients to creating a norm with a mechanism to closely follow up the implementation. The program urges people to be proactive and responsible for protective behavior as well as seeking relevant services.

- Although it is clear to everyone that prostitution is illegal in Cambodia, this approach is designed to enable local authority and health care workers to work closely starting from the admittance of the existence of sex industry in their respective locality which is an entry point to allow interventions to take place. This touch decision is made from painful experiences in the past in Cambodia and in other countries as well as where sex entertainment has never been successfully closed and STIs and HIV/AIDS services have not been made appropriately available and affordable for both sex workers and their clients. Though 100% Condom Use Program not only health care workers,
• local authority and the police but also brothel owners and sex workers can reach to a common understanding about sex workers and the potential loss due to HIV/AIDS and most importantly they can put down into practices working principles aiming to maximize the safety of sex services.

• To enable the norm to be installed, there is a need to introduce a public policy regarding the safety in sex services, to advocate for a public opinion to promote positive image of condom and greater involvement of other sectors (police, local authority, brothel owners and sex workers), to make a public good, condom as largely access able, available and affordable as possible and lastly to sustain appropriate public services namely STI services and outreach for health promotion.

• Each country may need to adapt their approach to the issues of sex industry and HIV/AIDS. Part of this matter, it very tough to make an appropriate decision between the intervention aiming just to guarantee safety of sex services and the comprehensive approach which seek to address underlying factors of prostitution and HIV/AIDS. The first option is certainly less costly and can be largely expanded whereas the second choice is opting for long-term response aiming to act on the root causes. So far, in Cambodia more efforts were made for the first purpose.

• From the recognition of the dynamic and the complex nature of the HIV/AIDS epidemic, Cambodia is opened to the opinions from partner agencies, experts, colleagues, brother owners and sex workers for a better approach to deal with HIV/AIDS and sex entertainment.

We strongly believe that together we will not fail to protect the vulnerable, voiceless, powerless and marginalized people because we clearly see the links from these groups to the general population. Moreover, we can no longer afford loose our beloved people. Through 100% Condom Use Program, we can avoid the pain, the sorrow and the loss from the past coming back to us.

Dr. Tia Phalla
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Review of the 100% CUP in Cambodia.

1.0. INTRODUCTION:

1.1. Epidemiology and the Response to HIV/AIDS in Cambodia

HIV infection was first identified in Cambodia in 1991, and the first AIDS case diagnosed in 1993. HIV prevalence among blood donors in Phnom Penh was 0.08% in 1991, and grew to 2.3% in 2001. A National AIDS Programme was established in 1991. In 1992, the National AIDS Program, with the support of WHO, conducted unlinked anonymous serologic survey of selected risk populations in Phnom Penh. A total of 1017 specimens were collected. 9.17% of commercial sex workers (CSW) and 4.16% of STD patients tested positive for HIV antibodies. In order to monitor the trend of both the HIV and STI epidemic as well as the trend of high-risk behaviour which contributes to HIV/STI transmission, the National Center for HIV/AIDS, Dermatology and STI (NCHADS) installed the first HIV Sentinel Surveillance (HSS) system in 1995, the first STI prevalence study in 1996, and the first Behavioural Surveillance Survey (BSS) in 1997. HIV prevalence in Cambodia is 2.6% among adults (HSS, 2002), a significant change from 3.3% in 1998, but still one of the highest in Asia.

There has been a strong national response, including the formation of the National AIDS Authority (NAA), a multi-sectoral body with 26 constituent Ministries. This has resulted in forward-looking policies and legislation as well as comprehensive programmes. The activities underway include prevention education and services for the general population as well as targeted interventions for selected sub-populations such as the military and police, mobile populations, sex workers and young people; the development of IEC materials; AIDS education in schools; voluntary counselling and testing services, and treatment of opportunistic infection and TB through clinics as well as through home-care teams, and some treatment with ARVs. The health sector response is largely implemented through the NCHADS, with the National Maternal and Child Health Centre looking after prevention of mother to child transmission and the National Blood Transfusion Centre. With strong government leadership, NGOs have also played an important role in the response, many with the support of international donors. Some have implemented activities for the government.

I.2. The Introduction of the 100% CUP

The 100% Condom Use Programme (CUP) in Cambodia has been in place since 1998. It was modelled on the original programme of the same name developed in Thailand and credited with great success in that country. In Thailand, the programme has been credited with helping the country change
the course of the epidemic. Strong evidence exists that the 100% CUP has contributed to a sharp decrease in STI and HIV prevalence among Thai sex workers and among young men. In Cambodia as well, the 100% CUP is believed to be contributing to control of the AIDS epidemic.

In 1998, sentinel surveillance in Cambodia revealed 42.6% HIV sero-prevalence among direct sex workers (brothel-based). WHO recommended that Cambodia develop the 100% CUP as a way to combat the rapid spread of HIV related to the commercial sex sector. In June 1998, the Cambodian National AIDS Committee endorsed the 100% CUP as a central element in the Cambodian National HIV/AIDS Strategy and a pilot programme was established in Sihanoukville in October 1998, under the NCHADS. Sihanoukville is a tourist and economic-production zone, with a large sea-port and a large and lively sexual-service provision network. In addition, the Provincial AIDS Committee, Provincial AIDS Secretariat, and Provincial Health Department all showed willingness and commitment to supporting the implementation of 100% CUP throughout the municipality.

The objective was to raise awareness about HIV transmission and the importance of condom use in the prevention of transmission of HIV/AIDS. Activities included regular mapping of sex establishments, HIV/AIDS education, free STI treatment, and monitoring the activities of sex workers and brothel owners. The project was monitored by the Condom Use Monitoring and Evaluation Committee or CUMEC, comprising municipal authorities and police, in conjunction with brothel owners.

1.3. The 100% CUP

In intent, the 100% CUP had two significant benefits. First, it focused attention where a large part of HIV transmission took place, in sex work settings. Second, it introduced the brothel management in the negotiation process with clients about condom use in sex work. Consistent condom use was thus established as a work-place norm, to be followed for all transactions rather than left to successful negotiation by motivated sex-workers. This was a very significant shift in the way in which condom use was viewed, and was particularly useful in the Cambodian setting. Owing to experiences in the past, it was recognized that Sex Workers (SWs), brothel owners and clients failed to understand clearly the necessity of consistent condom use. Out reach activities and the provision of STI services in the early 1980’s in Phnom Penh had yielded a limited result. The rate of consistent condom use was not enough to reduce the HIV infection rate between SWs and clients. The 100% CUP was designed to use the stand of authority to enforce compliance on one side while creating an atmosphere of understanding and empowerment on the other. This dual approach would strengthen widespread understanding of the need to consistently use condoms across all stakeholders and partners. People would then see the program as a necessity rather than a threat.
In Cambodia, the 100% CUP included five key elements:

1. Involvement and commitment of a wide range of stakeholders, including government authorities, and owners of sex work establishments;
2. Regular examination and treatment of STI in sex workers;
3. Availability and accessibility of condoms;
4. Effective information, education and communication (IEC) activities through a variety of channels to make condom use the social norm; and
5. Outreach activities to reinforce the messages of the programme.

In addition to these, the programme encouraged increased collaboration between government and non governmental organizations (NGOs) to strengthen STI services and increase “user-friendliness” of STI services for sex workers. Examples of this are the effort made by FHI through local NGOs in 13 Provinces (e.g CFDS in Sisophon and Khemara in Svay Pak) and by the Cambodian Prostitutes Union in Phnom Penh to empower SWs (through income earning, Vocational training).

On the monitoring side, four strategies are mentioned in documentation as used for the programme. These are:

1. Condom sales, as reported by PSI, the major social marketing agent in the country;
2. “Mystery clients”, or men posing as clients;
3. Information from sex workers on condom use, based on interviews; and
4. STI incidence from clinic data

To reinforce this system, registration cards for each sex worker were developed. The cards include information for identification as well as information on the establishment where the sex worker works.

After one year of implementation under the technical and financial support of both the Government and WHO, this pilot programme was evaluated. The evaluation revealed a substantial decrease in infectious diseases, especially STI and HIV, and an increase in consistent condom use among sex workers in brothels. The outcomes of the evaluation were used to advocate for higher political support, and in 2000 the Prime Minister declared a National Policy on 100% Condom Use for country-wide implementation. With this level of support from the Prime Minister, NCHADS developed a plan to scale up the 100% CUP as a nation-wide program. The implementation of the strategy in each province followed the same general approach and has included study tours to Sihanoukville, the model province. The 100% CUP has now been implemented in 21 out of the 24 provinces and is about to be formally implemented in one of the remaining 3 provinces (Battambang) (This was re-started in late 2003). The other two provinces have not been included as one was created very recently and the other reportedly does not have any brothels.

The programme is perceived to be very effective in increasing condom use in brothels. Both behavioural as well as HIV sero-surveillance have shown
dramatic increases in condom use and a steady decrease in HIV prevalence. The 2002 BSS, indicated 89.9% condom use in provinces where BSS was done, and HIV prevalence among direct sex workers has fallen to 28.8%.

2.0. A REVIEW OF THE 100%CUP:

2.1. Rationale

Since the programme was first introduced in Sihanoukville in October 1998, it had not been externally evaluated. The time seemed opportune for a comprehensive review to consolidate the learning of lessons, as well as indicate directions for improving the quality and effectiveness of the programme. There was increasing concern about the quality of services and care. There were questions about whether the programme was following global “gold standards” in various aspects of service provision such as STI care and treatment, record-keeping and confidentiality; and monitoring of the program. Recent reports, (Documenting the Experiences of Sex Workers – Perceptions of the Cambodian 100% Condom Use Program by David Lowe for the Policy Project) raised questions regarding the adequacy of coverage and uniformity of implementation. Finally, increasing evidence in other countries indicated engagement and empowerment of sex workers as an essential component of effective and sustainable safer sex programmes. It would be pertinent to examine how this element could be included in the strategy and operationalised, especially as this would ensure a more rights based approach. There are also ethical questions and fears that the attention that the programme drew to SW as well as the personal information maintained by public officials and accessed by the police resulted in an increase in stigma and coercion.

The HIV/AIDS situation in Cambodia had changed since 1998. So also, had patterns of sex-services, from largely brothel-based to street-based and indirect services. There was also an evolution in understanding some of the elements of an effective, rights-based and people-centred sustainable intervention. The first round of financial support to the 100%CUP ended in June 2003. The time seemed appropriate to reflect on both, the strategy of 100% Condom use, implemented through brothel-owners with the assistance of local authorities, as well as the implementation of this strategy, with a view to improving the programme.

Based on these reasons as well as on the recommendations from the 2002 HIV Sentinel Surveillance, NCHADS proposed an evaluation of the 100% CUP. This coincided with an initiative from UNAIDS Geneva to strengthen targeted condom promotion programmes from the point of view of building solidarity among stake-holders and their participation in all aspects of programme planning and implementation.

2.2. TORs for the Review
The UNAIDS Secretariat and WHO agreed to support the initiative of the National Center for HIV/AIDS, Dermatology and STI (NCHADS) of the Ministry of Health of Cambodia to review the implementation of the 100% condom use programme (CUP). The review was intended to recommend adjustments in the coverage, quality, and approaches of the programme, in the light of changing developments and needs in the Cambodian HIV/AIDS context.

Specific concerns identified for the review to address were:
- Service provision of STI care and treatment,
- Harmonization of programme implementation with the National Strategic Plan objectives and goals
- Programme monitoring and evaluation
- Barriers to consistent condom use, including client and partner resistance, violence, supply and cost of condoms

The review was coordinated by an informal National Committee, composed of representatives of Government, civil society, sex workers, donors, the UN system, and appropriate specialists under the chairmanship of the Director, NCHADS. Relevant stakeholders in the 100% CUP were engaged. Under this collaboration, the UNAIDS Secretariat, through the Country Programme Adviser, and WHO facilitated the provision of technical and financial support as well as coordination of the review.

The main output of the review was a set of programmatic recommendations for strengthening the different aspects of the programme to ensure its effectiveness in reducing STI/HIV incidence. These are included at the end of this document.

2.3. Methodology for the Review

2.3.1. Review

The review team, convened by UNAIDS and WHO, included Dr S Jana (CARE, Bangladesh), Dr Kevin O’Reilly (WHO, Geneva), Kien Serey Phal (Cambodian Women’s Development Agency) and Geeta Sethi (UNAIDS, Cambodia). Representing the government were Dr Ly Penh Sun and Dr Sau Kessana (NCHADS) and Dr Tia Phalla and Dr Ning Lina (NAA). Sorn Sotheariddh (UNV/GIPA) accompanied the team for the first week to assist with translation, Leng Bunlong (UNFPA) did so for the second.

The review took place between June 3 and June 13, 2003 starting with a briefing meeting with the Informal Committee, and including an initial debriefing conducted on June 16. In that time, 5 different sites were visited (details are included below). As the time for the review was short, available quantitative data that have been collected since the programme began was used and supplemented with qualitative data collected by the team. The goal was to assess the validity of the data presented, in addition to exploring the issues identified.
To accomplish this, a regular pattern of questions was developed and applied during visits to each site. Meetings were held with the CUMEC, the third deputy governor, representatives of the police and sometimes the military, the provincial health officer, the provincial AIDS officer, the CUWG and the provincial outreach team (POT). STI clinics where the services are provided to sex workers and the labs that support them were visited. NGO clinics, VCT centres and an abortion service in a hospital-based maternal health center were also visited. NGOs working with brothels and sex workers in each location were met. In each location, brothels were visited and brothel managers interviewed. Most importantly, the team met with and interviewed sex workers in all locations. In all, more than seventy sex workers were interviewed. Most interviews were conducted in Khmer with translation provided by Cambodian team members. A few interviews were conducted in Vietnamese.

2.3.2. Issues Explored

In interviews the officials of the programme were consistently asked about the local history and experience of the programme. The team probed to find evidence for the effectiveness of the programme. In interviews with brothel managers, information received from the provincial officials was cross-checked. They were also asked about bribes and abuse by police. Condom supplies in the brothels were checked, and questions about prices and procedures with clients, the process of negotiation about condom use, and who pays for condoms were asked. Sex workers were asked about their experience of the programme, and of sex work in general, how they entered sex work, and if and how they avoided unprotected sex with clients. They were also asked about STI services and information received about outreach activities was cross-checked with them. Issues related to brothel closings and other sanctions against brothel managers and sex workers were explored. Abuse of sex workers by police and military personnel was also explored.

2.3.3. Documents Reviewed

As mentioned, existing quantitative data was utilised for the assessment. An impressive amount of data has been collected on the HIV/AIDS epidemic and the 100% CUP in Cambodia. Monitoring data is collected at each province where the programme operates, and data are maintained at most of the provincial STI clinics as well. PSI, the major social marketing agent in the country, maintains monitoring data on condom sales nationwide. The outcome of the programme has been assessed over time by behavioural surveillance surveys, focused on high risk groups. The impact of the programme is measured in repeat HIV seroprevalence surveys among high risk groups, as well as periodic STI prevalence studies. A list of the documents reviewed is included in the Appendix.

2.3.4. Schedule Followed and Places Visited

The review began with a meeting of all interested parties at NCHADS in Phnom Penh on June 4. At this meeting, the history and details of the
programme were laid out, as well as the evidence for its success. The range of parties interested in meeting with the team was also compiled. Based on this level of interest, the original schedule was modified to include more time in Phnom Penh, both to meet the interested parties and also to visit sex work sites and sex workers there. Indirect sex workers were also included in the interviews. Though this was not a large component of the work, it did provide some useful contrast to the direct sex workers.

The places visited and dates for the review are as follows:
- June 5-7: Battambong, Battambong Province
- June 8: Sisophon, Banteay Mean Chey Province
- June 9: Poi Pet, Banteay Mean Chey Province
- June 9: Sisophon
- June 10-11: Phnom Penh
- June 12-13: Sihanouk Ville
- June 14-16: Phnom Penh

The review concluded with a debriefing at NCHADS on June 16. The materials prepared for that briefing, and the list of participants, are included in the Appendix.

3.0 OBSERVATIONS:

3.1. Observations on Sex Work in Cambodia

The review provided an opportunity to understand the context for the programme, brothel-based sex, and to assess the veracity of the data that are presented in evaluations of the programme. Some observations on sex work in general are presented below, followed by observations on the 100% CUP in Cambodia.

3.1.1. Mobility

Sex work in Cambodia is characterised by mobility. Many of the sex workers interviewed had worked in other parts of the country. Perhaps as a result, the social norm about condom use in commercial sex seems as strong in Battambang, where the programme was unable to continue as brothels were shut down, as it does where the programme has been in force for years. In addition, many of the sex workers interviewed had a relatively short tenure in the brothels where interviews were conducted. The impression gathered was that, in the provincial settings at least, sex workers change their location frequently.

An additional aspect of this mobility is the movement between direct and indirect sex work. One of the limitations of the 100% CUP is that it does not address indirect sex work where women are largely outside the regulatory aspects of the programme. However, the Team observed marked movement in both directions. Many of the women interviewed had previously worked in indirect sex work, both karaoke and beer promotion and were now based in a brothel. It may be that a brothel offers some opportunities that indirect sex
work does not, such as the opportunity to borrow money from the brothel owner. Also, in line with the mobility of sex workers around the country, a brothel may be the first point of entry in a city, as it offers easy access to clients and provides room and board as well. If the question of mobility in sex work is examined from the perspective of freelance sex workers, not brothel based, it is likely that a different impression could be gathered.

The safest conclusion at this point is that mobility in sex work is high in Cambodia and movement between direct and indirect sex work is bi-directional. It is not possible to validate statements about the 100% CUP driving sex workers from direct to indirect sex work based on the evidence seen. If this remains a serious concern, further research would be required.

3.1.2. Urban Location and Ethnicity

Sex work in the big cities (Phnom Penh and Sihanoukville) is better organised than it is in the provincial towns. The earnings of sex workers are higher and the general health and well-being of the sex workers seems to be better. Often in the provincial towns, sex workers seemed tired, perhaps not well nourished and sometimes had visible rashes or blemishes. In the cities, they were generally healthier looking, more interactive and animated. In addition, they seemed more confident and displayed greater self esteem, though in general the difference between the Vietnamese and Cambodian sex workers in this regard was even greater. Cambodian sex workers in the cities were more likely to be concerned about their rights and about abuses, while this topic did not always evoke much interest or reflection from the provincial sex workers.

As mentioned above, striking differences were noted between the Vietnamese and the Cambodian sex workers. (The Vietnamese sex workers met were in more prosperous, well-organised establishments) . In addition to being more articulate and more entrepreneurial, which are both discussed below in the section on Phnom Penh, the Vietnamese also in general had closer contact with their families. While both groups regularly send money home to support their families, it is less often the case that the families of the Cambodian sex workers are aware of the source of those earnings. This relates to the general feelings of self esteem as well, and to future plans. The Vietnamese sex workers were likely to anticipate returning to their village when they have earned a sufficient amount, settling down and marrying, with the full knowledge of their families. Such plans were not common among the Cambodian sex workers.

3.1.3. Indirect Sex Workers

Much has been made of the difference between direct and indirect sex workers in relation to this programme. Though the 100% CUP is intended to “instruct or require ALL sex workers to use condoms in ALL sex encounters”, this is certainly more easily accomplished in brothel based direct sex work than it is in other sex work venues such as massage parlours, karaoke or beer gardens. Concern has been raised that one result of the 100% CUP has been
to drive women from the more regulated environment of direct sex work into
the less regulated or even regulation free environment of indirect sex work.
(The observations above do not confirm this contention, however, as
movement in both directions was found to occur) Some important differences
between direct and indirect sex work were observed. First, women in direct
sex work were more under the control of others, especially brothel managers.
This is one reason why the 100% CUP can be made to work. In addition,
women in direct sex work were more likely to have a debt bond or outstanding
loan from the brothel owner which limits their mobility. Women in indirect sex
work were more likely to deny their involvement in sex work, received more
money per client, and had many fewer clients than women in direct sex work.
As many of the women in indirect sex work had previously been in direct sex
work, they and their clients seem to have been exposed to the new social
norm for condom use in sex work, one of the key elements of the 100% CUP.
Even though they missed some of the other elements of the programme,
condom use is still increasing among indirect sex workers. The role of NGOs
in this increase needs to be explored. With the lesser number of partners, the
risk of HIV infection among indirect sex workers is much less than it is among
direct sex workers. This fact, along with increasing condom use over time
within this group, is probably increasing prevention of HIV despite their not
being covered by the programme. Similar observations may apply to
freelance sex workers, though there was less information on this.

3.1.4. Violence

Violence against sex workers was another aspect commonly assumed to be
linked to the programme. In most societies where sex workers have low
social status and relatively high income compared to police and military,
abuse is likely to occur. This is true in Cambodia as well. It is not possible to
attribute this to the 100% CUP, however, since it appears to have existed
prior to that programme. In addition, there may be evidence indicating that
the 100% CUP is lessening abuse at least in Phnom Penh (see details
specified below). As discussed below, sex workers are becoming better
organised and this is certainly an important step toward lessening abuse. In
addition, the Cambodian Prostitutes Union explained that sex workers now
have improved access to the commanders of the police through the
committees which monitor the 100% CUP (CUMEC). With improved
communications has come better understanding of the problems sex workers
face and sex workers in Phnom Penh said they could alert police
commanders who could and did take action against local police. It would be
useful to explore whether the Peer education programmes with the military
and police also contribute to any change in attitude and behaviour regarding
violence.

3.1.5. Contextual Factors

Finally, some observations on sex work in general in Cambodia may help give
context to the remaining findings. Sex work is well organised in Cambodia.
According to observations and to BSS data, patronage of sex work is
common. Despite its prevalence, attitudes about sex work seem conflicted in
Cambodia. Sex workers report feeling stigmatised and shunned by neighbours and family if their profession is discovered or even suspected. The attitude of the government itself to sex work is conflicted, sometimes endorsing programmes to make sex work safe, sometimes closing sex work establishments. This inconsistent approach to sex work appears to make it difficult for sex workers and brothel owners and managers to understand and trust the government’s intentions and motivations. Furthermore, these periodic closings are often ineffective. Exploration of the closing of sex work establishments in Battambang and in the more recent closings in Svay Pak in Phnom Penh (see specifics below), indicated the reality seemed much less severe than the perception. In one case, the closings were short-lived. In another, trade was diminished but the establishments remained open. It is clear that these closures are a hardship for those employed in sex work to endure. The sex workers said they have to move to a new location but remain under the control of the original brothel owner. Also, since they have moved and business is supposed to be closed, they have fewer clients, and find it far more difficult to refuse sex without a condom.

3.2. Observations on the 100% Condom Use Programme

Observations will be grouped into 4 main sub-sections, in keeping with the terms of reference for the review:

- Service provision of STI care and treatment,
- Programme monitoring and evaluation
- Harmonization of programme implementation with the National Strategic Plan objectives and goals
- Barriers to consistent condom use, including client and partner resistance, violence, supply and cost of condoms

The 100% CUP in Cambodia must be viewed against the background of the recent history of the country. The team was repeatedly told that experience of the Pol Pot regime and the genocide that occurred had left a lasting impact on contemporary life in Cambodia. Among some quarters, there was a perceived need for strong government and strong policy to control life in Cambodia and prevent things from slipping out of control again. This was certainly difficult for those outside the country who push for individual rights to understand, having not experienced the horrors of the genocide. One important result of the genocide was the elimination of many of the intellectuals and the educated. Coupled with the years of civil war that followed, this had enfeebled the education system. School attendance is short, if at all, and literacy is very low, among sex workers. Given this as background, the challenges that Cambodia faces in addressing HIV/AIDS, an epidemic that has humbled many societies with stronger governanace, are great.

3.2.1. Services for STI Care and Treatment

3.2.1.1. Syndromic Management
The quality of the syndromic management of STIs seemed generally sufficient in most places and excellent in some. In Sihanoukville, the development of a refined syndromic algorithm for vaginal discharge in sex workers was especially noteworthy. This algorithm includes presumptive treatment for all new sex workers at the clinic, an idea worth considering elsewhere. The use of syndromic management of STI for sex workers is endorsed and considered the best strategy for STI management.

Evidence from a recent, still unreleased linked behavioural survey in Banteay Mean Chey province revealed relatively low levels of STI there among both direct and indirect sex workers. Undoubtedly, this is in part due of the increased use of condoms but it must also be due to the increased use of antibiotics for suspected infections among sex workers. With frequent examination and treatment, sex workers are experiencing fewer infections. Future activities should build in the benefit for sex workers from frequent examination and treatment, encouraging them to come to the clinic to address any and all health concerns, not just STI, and avoiding any appearance of coercion. The provision of free services and free condoms may be one way to encourage that continued participation.

3.2.1.2. Expansion of Services and Clientele

Though sex workers evidently received frequent examination and treatment for STI, this was less often the case for men. As noted, patronage of sex workers seems common in Cambodia (13% on average, 19% in urban areas, in the last year in the 2000 Cambodian Household Male Survey) and could be concentrated among certain occupational groups, such as police and military. These concentrations can allow for targeted interventions and some of these do exist for the uniformed services. However, targeted STI services for these groups should also be included, if not already available.

3.2.1.3. Laboratory Support

The team was informed that one donor (the CDC GAP program) intended to strengthen the system of STI laboratory support in Cambodia. This was welcome news and will be of great help in this programme. However, the standard for management of STIs among sex workers should remain syndromic management. Though this approach, especially the algorithms dealing with vaginal discharge, have been criticised in many places as being too expensive, too inexact, inappropriate for case finding and leading to over treatment, the approach is well suited to the task of STI management among sex workers. The evidence indicated that it was well used in the sites visited in Cambodia as well. Any shift to etiologic diagnosis should be resisted.

3.2.1.4. Sensitivity Studies

Syndromic diagnosis does use a large amount of antimicrobial agents, however. This has cost considerations and also concerns about the possibility of increasing resistance to these agents. The current regime of monthly examinations for sex workers may be too frequent, or it may be what is
needed. Operations research to determine the best interval for the regular examinations for sex workers should be carried out. Once this is known, the policy that guides the 100% CUP can be changed. In addition, Cambodia should monitor the development of any resistance to antimicrobial agents and participate in the Gonococcal Antimicrobial Susceptibility Programme (GASP) if it does not already do so.

### 3.2.1.5. Medical History Form

The key form “Standard Medical History for Sex Workers” used in the monthly STI examinations under the 100% CUP was reviewed. This form contains questions of a more social than medical nature. Some of these questions may be remotely related to a sex worker’s health but others are hard to justify. For example, two questions ask whether the sex worker entered sex work voluntarily and whether she is currently repaying a debt. That the 100% CUP could benefit from greater knowledge of sex workers’ lives and situations is clear but this is not the means to do so. These are sensitive and complicated questions that deserve special study. The inclusion of two questions in a form addressing other topics might provide an answer of sorts but without the opportunity to understand the context and meaning of the answers the opportunities for misinterpretation are too great.

### 3.2.2. Programme Monitoring and Evaluation

At the provincial level, the programme is reviewed by the CUMEC. This committee is comprised of the third Deputy Governor, a representative of the police and sometimes the military, and the provincial health officer, at a minimum. Other members (eg from the Ministry of Women's and Veterans Affairs; Ministry of Social Action, Labour, Vocational Education and Youth) have been added in some places. The principle purpose of this committee is to ensure the commitment of senior authorities and the smooth functioning of the programme.

In addition, the Condom Use Working Group (CUWG) is established in each province. This group is “the key element in supporting and monitoring operational activities” of the 100% CUP. An outreach team (Provincial Outreach team or POT) is responsible for visiting sex work establishments and reinforcing the message of the programme.

### 3.2.2.1. New Social Norm for Condom Use

One of the stated objectives of the 100% CUP is to create a new social norm about condom use in commercial sex. A strong sign that the 100% CUP, along with other efforts, has achieved this objective is the “contamination” of the effect from province to province. The programme is not yet implemented in all provinces, specifically it is not presently operating Battambang, one of the areas in Cambodia most heavily affected by HIV/AIDS. Yet the frequency of condom use for commercial sex in Battambang, as measured by BSS and as observed by our interviews, is not significantly different from other provinces where the programme has been in operation for nearly 5 years. A
new national social norm about condom use has clearly been established and
new programmes in Cambodia should build on this strength. Pressure to
continue to expand the 100% CUP should also continue, as each step helps
reinforce its importance and the importance of the new social norm.

3.2.2.2. Assessing Impact on Behaviour

Behavioural surveillance survey data, targeting high risk groups, is probably
the best measure of the outcome of the 100% CUP. Assisted by FHI,
NCHADS has conducted BSS in annual surveys of sentinel groups, starting in
1997, and a household survey of male sexual behaviour in 2000. Data from
surveys up to 2001 are included in this review. One striking feature of those
results is the rapid and marked increase in condom use in commercial sex,
both as measured from interviews with clients and from direct and indirect sex
workers themselves. It is difficult to imagine how this could have been
accomplished as quickly without the assistance of the 100% CUP, albeit
operating in conjunction with other interventions such as condom social
marketing. Though the frequency of condom use is not 100%, as the title of
the programme would suggest it should be, it is more than 90% in some
areas in recent years. This level of condom use is not sufficient to protect
every sex worker and every client from infection all the time, but it is sufficient
to diminish the spread of HIV in the population. Continued support for BSS is
essential for tracking this epidemic in Cambodia. If other surveys are to be
used, they should be added to, not replace, the BSS so that the ability to track
changes over time with the same questions will not be lost.

3.2.2.3. Composition and Functioning of CUMECC

The CUMECC is tasked with overseeing the implementation of the 100% CUP in the
Province. A striking feature of the 100% CUP is the presence of the police and
military in the committees that oversee the project, especially the CUMECC. To
some of the external observers and critics, their presence on the committees
is a clear indication of the coercive nature of the programme. To those within
Cambodia, however, the presence of the police and military is needed for a
number of reasons: because they represent a strong and important faction in
Cambodian life and government; and because policemen and soldiers are
frequent clients of sex workers and frequent victims of HIV/AIDS themselves.
In addition to assuring the cooperation of a key element of the government,
the police and military committee members help reinforce the 100% CUP
message with men who are frequently clients of sex workers. Though not
specified and perhaps not anticipated in the design of the programme, the
presence of police and military commanders on the committees has also
provided them with greater insights into the lives of sex workers and the
problems they face. As reported in Phnom Penh (see below), those sex
workers who have managed to organize have been able to take advantage of
this increased access and communication with the commanders and bring
complaints about mistreatment by local police to their attention. In one area at
least, this has reportedly resulted in an observed reduction in incidents of
mistreatment.
The unanticipated benefit of this informal communication between sex workers and police and military commanders on the CUMEC is good but this is not enough to curb mistreatment and harassment everywhere. Additional steps are required to increase the voice of sex workers in the guidance and oversight of the 100% CUP. Direct involvement of sex workers when this is possible, or the involvement of civil society, including human rights groups or lawyers, will more directly address some of the criticisms and improve the implementation of the 100% CUP.

The Condom Use Monitoring and Evaluation Committee (CUMEC) does not in fact do any monitoring and evaluation in the normal sense of the words. An alternative title for this committee should be considered.

3.2.2.4. Registration of Sex Workers

Another feature of the 100% CUP that attracts attention is the required registration of sex workers. There appear to be two parallel systems of Registration. The STI Clinic registers each sex worker, along with information details, including name and address of the brothel and brothel-owner,. Similar information, accompanied by a photograph is also maintained by the Statistical Police in the local office. Before the review began, we read of abuses that this system had led to, including the display of sex workers’ photos at an STI clinic so that men with STI could identify the source of their infection. In none of our visits was anything like that abuse visible. The need for registration with photographs was justified, we were told, because it was required to trace and identify underage/runaway girls who had been trafficked or were reported missing from home. The need for photos was justified because names and all other identifying information can be changed. We were even shown a benefit of the photo identification system. Families searching for their lost daughters can visit some red light districts and see, in one book, all the sex workers employed in the area. This has apparently led to some tearful family reunions.

3.2.2.5. Monitoring and What it Means in the 100% CUP

Part of the justification for the identity-linked registration system is related to the concept of monitoring used in the programme. This monitoring focuses on the individual sex worker, not on the programme as a whole. The Programme may consider alternative concepts of monitoring, such as monitoring the number of sex workers seen at STI clinics for regular examination, monitoring the number of condoms sold or distributed to each brothel each month, or the prevalence of STI in sex workers by annual national survey. These data do not require the elaborate registration system for sex workers, provide what we feel is sufficient programme monitoring for the 100% CUP and pose less risk of abuse than the system currently in place. In addition, we discovered that the statistics police maintain a registry of all Cambodian citizens, without photos. With universal registration already in place, the need for additional registration for sex workers is even more debatable.
Especially notable was the lack of adequate monitoring of condoms in most provinces. Only Sihanoukville had an adequate condom monitoring system in place. While condoms were in evidence in every brothel, and in what seemed to be sufficient supply, brothel managers could not always tell us how they had gotten there nor when. Apart from Sihanoukville, neither the Condom Use Working Group nor the Provincial Outreach Team seemed to play a role in condom distribution nor in condom monitoring. We felt strongly that the programme should be paying more attention to the monitoring of condoms, starting at the brothel level, and that clear roles and responsibilities for condom promotion, distribution and monitoring need to be established in those provinces where it is not already in place.

Another mechanism that could be developed to allow for sharing of experiences with the programme, including complaints, is a drop-in centre. We visited one drop in centre operated by Cambodian Women for Peace and Development and were impressed by the activities. Drop in centres require either that sex workers not have debt bonds, so that they can move around more freely, or that the drop in centre work closely with brothel owners and managers to develop trust. They provide an opportunity not only to share information but also to develop ways to address common concerns and issues. Organising a community response among sex workers requires a community and drop in centres that allow sex workers to meet and share experiences are a good first step.

3.2.3. Harmonisation of the 100%CUP and National Plans

In 2002 Cambodia passed a Law on HIV/AIDS which calls for a rights- based approach aimed at addressing gender inequality and vulnerability. Similarly, the National Strategic Plan for HIV/AIDS was drafted after the 100%CUP was initiated, and calls for broad-based development-oriented implementation in partnership with a spectrum of Ministries, and civil society.

3.2.3.1. NGO Collaboration

Though the 100% CUP is a government programme, it does include NGOs in the effort. This is clear in many of the provinces where NGOs provide some of the essential services for sex workers. The quality of the services provided by these NGOs was generally very good and this seemed to be appreciated by the sex workers interviewed. (A list of the NGOs met is included in the Appendix.) However, two areas where co-ordination could be improved were: between NGOs working with sex workers and between NGOs and the government. The fluorescence of NGOs in recent years and the amount of funding they have been able to attract has made them important actors in prevention and care for HIV/AIDS in Cambodia. A more formal inclusion of NGOs in the committees established by the programme would help capitalise on their strengths for the benefit of the 100% CUP and the sex workers.

3.2.3.2. Policy Versus Programme Implementation
A certain tendency to view the HIV/AIDS situation as being solved because a policy for condom use exists may be present. The review of the 100% CUP showed that the 100% CUP was an essential element in the Cambodian response to a rapidly spreading epidemic. Equally, it was not a sufficient response, nor was it at the time it was instituted. With evidence that the epidemic is generalising and moving outside the context of sex work more and more, the need for additional interventions is clear. To develop these, the thinking must shift from a “policy” perspective to a “programme” perspective. Programmes that focus on clients of sex workers, men in general, and try to address the increasing transmission taking place outside the context of sex work are needed. Programmes that increase the general well-being and social position of sex workers, secure their position in society and afford them greater rights are also needed. Limiting thinking to a government established policy alone will limit the range of possible responses that Cambodia needs to address the HIV/AIDS epidemic and associated social problems.

3.2.3.3. Programmes for Indirect Sex Workers

Programmes as well as policy are also needed for indirect sex workers. Indirect sex work is not well covered by the 100% CUP, despite the intent to cover “all sex workers”. Efforts to protect indirect sex workers and their clients are needed. These will have to take a different, more programmatic approach than that of the 100% CUP. The Provincial Outreach Teams, for example, are currently focused on direct sex work only. In addition to increasing the frequency of their outreach, it would also be useful to develop a separate team that conducts frequent outreach with indirect sex workers. Services for STI treatment, condom access, etc. also need to expand and diversify to include indirect sex workers and their special requirements.

3.2.3.4. Differences in How 100% CUP is Written and How it is Implemented

Another important distinction was observed between the 100% CUP as it is written (the policy that establishes it) and the 100% CUP as it is implemented. Some of these differences appeared to be uniform across sites while others varied by province. In all the provinces visited, for example, STI in sex workers was dealt with differently than the written policy directs. According to the 100% CUP, STI in a sex worker was to be taken as evidence that condoms were not being used. The incident case was to be recorded and treated and the brothel manager warned. If additional cases were found from the same brothel over a period of time, the brothel should be closed. In all of Cambodia, only a small number of brothels (2) had ever been closed for non-compliance, all in Sihanoukville, while the programme was being initiated. Usually, STI in a sex worker was treated and she was counselled about correct and consistent condom use again. No punitive action was taken because the management of STI was by syndromic diagnosis, which was not sufficiently precise to differentiate whether a sex worker with a vaginal discharge had a sexually transmitted infection or not. Even if the existence of an infection could be confirmed, it would still not be possible to determine how she got the infection. Sex workers had sweethearts as well, and unprotected
sex with these men was common. For these and other reasons, the potentially punitive aspects of the 100% CUP that could follow the diagnosis of STI in sex workers were overlooked.

Local variations in the implementation of the 100% CUP also existed. Perhaps most striking were the differences between Sihanoukville and the other sites visited. In Sihanoukville, outreach to sex workers was more frequent and broader in topics covered than it was elsewhere. Condom monitoring at the brothel level was actually in place. Abortion services for sex workers were offered by the local hospital. These and many other aspects of the programme in Sihanoukville were especially good but were not apparent in the other provinces visited.

### 3.2.4. Barriers to Consistent Condom Use and other Issues

Various factors appear to limit the expansion of or pose barriers to consistent condom use.

#### 3.2.4.1. Outreach

The frequency and quality of outreach to brothels and sex workers is insufficient. Even in Sihanoukville, where this component is more developed than elsewhere, not enough effort is spent on outreach. Outreach efforts do not systematically reach indirect sex workers.

#### 3.2.4.2. Peer Education

Similarly, though peer educators have been identified and trained in some brothels, they were not supervised and reinforced in their efforts. Given the high degree of mobility among sex workers, the existence of a peer educator in all brothels is important. Through lack of attention to this component, a possibly important opportunity for timely intervention with new recruits to a brothel was often lost. This was particularly significant given that a large proportion of infections among sex workers occurred in the first year of work (HSS, 2002).

#### 3.2.4.3. Condom Quality

Sex workers highlighted the variations in condom quality and their comfort. At times clients bring their own condoms. They complained that these condoms are often not adequately lubricated, or are of varieties and textures that they find uncomfortable or painful.

#### 3.2.4.4. Confidentiality

It was reported by some sex workers that they were tested for HIV antibody from time to time. It appeared that the results were given to them and shared with the brothel manager. When explored with VCT centers and provincial health officials, there were assurances that government test centers did not share results and maintained strict confidentiality. No evidence to the contrary
was observed. It was possible that private practitioners and clinics may be testing sex workers for brothel managers. This should be investigated and if true, ways to protect the confidentiality of test results and protect sex workers from undue harm should be explored.

4.0. Recommendations:

The following recommendations are offered based on the review of the 100% CUP. They are grouped and ordered to reflect the sequence of observations in the text.

Continuation and expansion of the 100% CUP is recommended.


The policy to close down a brothel (as a regulatory measure) to enforce compliance to condom use should be changed.

The use of STIs diagnosed on the basis of a Syndromic approach, as a tool to monitor compliance to consistent condom use should be omitted.

The present system of registration of sex workers, as advocated in the document, should be removed.

4.2. Changes Suggested in Administrative System

4.2.1. CUMEC (Condom use Monitoring and Evaluation Committee)

A. Given its present functions, the Committee could possibly be renamed – for example, it could be called the “District Program Steering Committee”. The TOR needs to be re-framed. The role of the committee would be to oversee the programmatic goal, strategies including compliance to policies, and the co-ordination of different intervention activities in the province. It will also play the role of arbitrator in connection to any dispute.

B. To make the committee democratic and more participatory the following recommendations are made:

1. Incorporation of two elected members from the civil society, one representing the organizations engaged in prevention programs, the second representing the care and support organizations.

2. Inclusion of a representative from Human Rights Commission/organization.

3. To create space for future involvement of 1) Representative from the sex workers organization 2) From the positive people’s organization.

4.2.2. POT (Provincial Outreach Team)

A. The coordinator of the team should be a full time employee with proper remuneration.
B. There needs to be at least one representative from the sex workers community and one from the brothel owners (who would be remunerated accordingly) on the team
C. TOR of the committee, including the specification of performance measurement tools for the POT, need to be established and monitored regularly.

4.2.3. Re-Organise the Present CUMG

Reconstitute from among the peer and non-peer sex-workers representing every brothel in the area and supported by a Co-ordinator.
Proper remuneration to members functioning in the group
Develop and implement user-friendly monitoring tools that could be handled by the sex-workers

4.3. Changes Suggested in the Programming:

4.3.1. Outreach Component

A. All efforts should to be made to strengthen the outreach activities through peer based approach. Numbers of peers to be recruited will depend on the size of the brothel. Each brothel should have at least one peer. All peers should be remunerated for their designated work. They will constitute the backbone of CUMG. Recruitment of peers should follow some criteria and guidelines.
B. A team of peers will make regular visits to brothels, will sit with colleagues, and deliberate on issues related to HIV and safer sex practices [not only condom use]. They will be assisted to develop and use appropriate monitoring tools. They could learn the use of audio-visual media and should focus on issues of stigma, care and support to HIV positive persons in addition to preventive measures and practices. Building Peer’s capacity should be a continuous process which includes regular training, exposure visits etc.
C. The opening of Drop-in centers as part of the intervention strategy, which could be implemented in a phased manner, is also recommended. Drop in centers could create a social space where sex-workers can come and discuss on issues of interest among themselves. The Drop-in center could introduce different issues and activities over the period eg, non formal education, lessons on spoken English, micro credit, vocational training etc depending on the interest of the sex-workers. To begin with it could be started in a couple of provinces and could gradually be expanded to other areas.

4.3.2. Changes Suggested in STI Management

A. Continue with the Syndrome based management of STIs. The present system of STI check up which is done on a monthly basis could be modified to increase the time interval between two successive testing (at two/three months interval), based on the findings of appropriate operational research.
B. Introduction of presumptive treatment to all new sex-workers who are attending the clinic (as practiced in Sihanoukville) should be followed in all intervention areas, preceded by its incorporation in the treatment algorithm.

C. Simple microscopic examination should be introduced in clinics in all other areas (as practiced in Sihanoukville) to distinguish between cervical and vaginal discharge. This will essentially reduce the possible over-consumption of antibiotics.

D. Should take initiative and participate in the Gonococci Antimicrobial Susceptibility program [GASP] to monitor resistance to antimicrobial agent.

E. Medical history form should delete social questions unrelated to treatment and case management.

F. Syndromic management of STI of clients of sex workers is a neglected area what should receive due priority. An appropriate strategy needs to be developed to address the issue of clients and their treatment.

4.3.3. Changes Suggested in Monitoring

There is a need to make a paradigm shift in the present monitoring mechanism. The program should take the initiative to shift its focus from individual sex workers to the program. At this juncture the monitoring tool should focus on group norms and impact at the national level.

Few examples, [% of sex workers attending clinics. % of safer sex including condom use etc. Annual national survey on STDs etc]

A. Development of a system to monitor procurement, distribution and use of condoms starting from brothel level to higher up is urgently needed. This was found to be the most neglected part of the program. The system should identify persons at each and every level with clear-cut role and responsibility and a system of accountability.

B. Ongoing Behavioral survey and sentinel surveillance should be the yardstick of program monitoring.

4.3.4. Issues of Respect and Confidentiality

A. Development of a code of conduct on behaviour and practices of program implementers is urgently required which will include the issues of respect and confidentiality. The issue of confidentiality should be embedded in a broad based framework of rights and dignity and its incorporation at all levels of program functioning is highly recommended. There should be a system with requisite tools to monitor ethical aspects of the program implementation. All institutions/organizations engaged in prevention, care or similar other activities, irrespective of their involvement in testing and counseling, should come under the purview of ethical screening. Constituting a high level national ethical committee with branches at the provincial level could be a solution.

4.3.5. Intervention among the Non-Brothel Based Sex-Workers
A This should be a separate program.
B The program should be designed with the active participation of the community. Experience from Bangladesh and also from other countries suggests that a strong Peer based outreach component and provision of STI management services could be a starting point.

4.3.6. Capacity Building of Project Staff

There is an urgent need to make several changes to the 100% CUP to address the changing scenario of the epidemic and meet newer challenges. It is also important to equip and prepare human resources so that they can adequately respond to the changed program and program environment. The country should prepare a strategy and plan of action to develop capacity in line with the requirements.

4.3.7. Research Components

The epidemic is a dynamic process and to address this epidemic with appropriate interventions, programs and strategies need to be even more dynamic. There is a constant need to feed the program implementers with deeper and better understanding of issues in their full complexity. This is not possible without getting engaged into research activities. We suggest constituting a research body under NCHADS to look into existing and available data, with proper analysis and critical reflection. They would also conduct some operations research on the nature and context of different modes of sex transactions and the implications on the epidemic through active involvement of the sex workers community.

5.0. NOTE ON FUTURE DIRECTIONS:

5.1. Social Interventions for Sex Workers and for Men

The team agreed that, while 100% CUP is an important component of the Cambodian response to HIV/AIDS and should be maintained. Additional interventions are also needed. First, the programme as it now exists was developed to address a problem that was observed five years ago. That situation has changed, in part because of the programme itself. The development of new interventions to address clients of sex workers and men in general and to target the transmission of HIV within more established couples now seems warranted.

It is also time to develop additional programmes for sex workers, that focus on the social problems that sex workers encounter and helps them address these. An example of this approach is the Sonagachi project in Kolkata, which has been generating political action; building social capital and otherwise helping sex workers take greater control and improve their lives and community. The result has been continued low HIV prevalence, even in densely populated red light districts with many clients nightly. The Sonagachi
Intervention includes some of the same elements seen in the 100% CUP (STI treatment, condom promotion through outreach), set in a broader matrix of activities clearly designed to benefit sex workers.

The sex workers we met could clearly benefit from interventions like these. They encounter many problems in their lives and seem to have little recourse for help. Their situations are often made more complicated by taking loans and bad management of money and by sweethearts. Their futures are often limited by their lack of education and the stigma attached to their current profession. Interventions that are based on sex workers expressed needs and designed to address those are clearly needed as an adjunct to what Cambodia already has in place. The opportunity to improve the 100% CUP with more input from sex workers would also be more easily accomplished with these interventions in place.

5.2. Next Steps

The draft Report was circulated to stakeholders and comments received were discussed in a meeting of the informal committee and stake-holders, on 12 September. The decisions are:

1) A Steering Committee for the 100% CUP will be established, under the NAA.
2) Working Groups on Condoms, STIs, and Outreach will be set up/re-energised with NCHADS taking the lead.
3) The Recommendations will be worked out in greater detail. As several comments received relate to revision in implementation, interested stake-holders will be involved in this process.
4) An intervention for street-based sex workers will be developed.
Appendix I

Documents Reviewed and References Cited


BSS V: Sexual behaviour among urban sentinel groups, Cambodia 2001. NCHADS ;Final Report, January 2003

Cambodia’s behavioral surveillance survey 1997-1999 NCHADS 2001

Report on HIV sentinel surveillance in Cambodia 2000. NCHADS

Sweetheart relationships in Cambodia: Love, sex and condoms in the time of HIV. PSI Cambodia 2002

Strategy and guidelines for implementation of 100% condom use in Cambodia

Perceptions of the Cambodian 100% Condom use program: documenting the experiences of sex workers. David Lowe, Policy Project March 2003-07-04


Guidelines for scaling-up the 100% condom use programme. Regional Office for the Western Pacific, WHO. 2003.


Monitoring and evaluation of the 100% condom use program in entertainment establishments. Regional Office for the Western Pacific, WHO 2002.

STI/HIV: 100% condom use programme in entertainment establishments. Regional Office for the Western Pacific, WHO 2000.

Training course for the 100% condom use programme. Regional Office for the Western Pacific, WHO 2002.


Appendix II

Participants at Debriefing June 16, 2003, NCHADS

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<tr>
<th>Name</th>
<th>Organization</th>
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<td>Ning Lina</td>
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<td>UNAIDS</td>
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Appendix III

NGOs, Agencies and Key People Visited

Cambodian Family Development Services, Sisophon
Cambodian Prostitutes Union
Cambodian Women for Peace and Development
Carol Jenkins
Khemara
Oxfam
Pharmaciens sans frontieres
Policy Project
PSI/Cambodia
Reproductive Health Alliance Cambodia, Battambang
USAID
U:S: Centers for Disease Control and Prevention
Womyn’s Network for Unity

Appendix iv

Specific Observations on Each Site Visited

1. Battambong: This is one of the provinces that is only now about to implement that 100% CUP. Previously, as preparations were made in the province, the Prime Minister took note of increased violence in karaoke establishments and encouraged action against this. In Battambong, this was reported to have led to the closure of all sex work establishments. As a result, the 100% CUP was never endorsed and implemented there, since sex work was illegal and in theory, not functioning. The province is often described as one of the problem areas for the programme and it was a good sign that the government representatives wanted us to see it.

Based on our discussions in brothels, it is not clear what “closed” means. The brothels we visited were in fact open and had been for a long time. The same is true for the karaoke establishments we visited. In discussing this with brothel managers, they recounted that the brothels had been closed but for a very short period of time, a month or less. Their re-opening was not especially surreptitious but was in fact quasi-official. Brothel managers told us they had been taken to the provincial health office where they were told how to run a clean and safe establishment, including handling of garbage, etc, and told that if they failed to do so they would be closed again. Since that time, no interferences with their business had been reported.

Nonetheless, the 100% CUP had only been approved the week before our visit and was soon to be implemented. One official we interviewed expressed doubts that the programme would begin before the elections on July 27,
however. The committees and working groups have already been formed and the province is ready for implementation.

Despite the lack of a 100% CUP in the province, condom use in commercial sex is common, as seen in survey data and as we observed in the sex work establishments we visited. Condoms were readily available, as were PSI posters. Sex workers claimed to use condoms “always” and brothel managers indicated that they helped with negotiation when necessary. According to data reviewed, condom use in sex work in Battambong is no less frequent than that reported in other provinces where the programme is already in place. This could suggest that the 100% CUP is not driving the large increase in condom use in commercial sex in that province and, by extension, lead to questioning of its role in other provinces as well. However, key elements of the programme are in place in Battambong, most notably the availability and accessibility of condoms and the regular STI examination and treatment for sex workers. Condoms appear to have achieved the status of a social norm in Battambang, even without the active participation of the 100% CUP. However, the high mobility of both sex workers and clients, with frequent movement from other provinces where the 100% CUP is fully implemented, has probably helped the norm for condom use in sex work to diffuse to places even where the programme has not been implemented.

2. Sisophon and Poi Pet, Banteay Mean Chey Province: This province has been the recipient of intensive financial and technical support from the CDC GAP project. A general improvement in the facilities is immediately observable, extending from the provincial health offices to the STI clinic to the AIDS treatment clinic. Sisophon is a small provincial capital but Poi Pet is something very different. Nestled on the Thai border, it offers immediate access to Thailand and its markets and economy. This has attracted many Cambodians to the area, which results in increased sex work opportunities. In addition, a small strip just on the border has been developed with casinos for visitors to Cambodia. This strip of luxurious facilities seems out of place against the backdrop of the rest of the area. It as well has attracted many young Cambodians to provide the various services needed to run and maintain such an entertainment centre.

While we were in Poi Pet, we were exploring the issue of police abuse of sex workers. These were largely denied as an issue but one nurse did disclose that assisting sex workers who had been beaten or attacked by police was not uncommon in her work. Her testimony was not welcomed by our local hosts, however, and we were immediately hurried off to our next meetings, with local brothel owners.

When we arrived at the local red light district and pulled up in front of a brothel, we immediately encountered a uniformed police man. After some discussion, it became clear what sort of event was transpiring. A young sex worker had just joined the brothel two days earlier, having come from Battambang. The owner of the previous brothel in Battambang had arrived that morning with two military police to collect the young woman, claiming that
she had borrowed $300 and fled without repaying, which the young woman denied. The owner of the Poi Pet brothel had then summoned her own local police to come defend her interests. We had landed in the middle of a tense situation that made clear how risky sex work is and how potentially violent life can be in Cambodia. The young woman in question was taken to a group offering protective services for women until the truth could be determined and a resolution found.

3. Phnom Penh: The 100% CUP in the capitol is thought to be more plagued with difficulties and less consistent that elsewhere. This is in part explained by the greater presence of police and military in the city and by the higher volume and higher prices for sex work there. Opportunities for abuse and mistreatment are that much more common and the higher concentration of NGOs dealing with sex work in Phnom Penh results in greater chances of the detection and reporting of any such incidents.

While in Phnom Penh, we met with the Cambodian Prostitutes Union, a group supported by CWDA. This group was started to provide peer education to sex workers but shifted its attention to protecting the rights of sex workers and increasing their self esteem. Though a small group, around 330 members, they have representation in a number of red light districts, though all the women we met came from the same district. They reported that the level of harassment of sex workers by police has reduced in recent times. This reduction is the result of their continued political action and advocacy for sex workers rights and of their greater ability to communicate with the higher echelons of the police department, through the CUMEC, for example. Though this was only one example, it did highlight the possibility that the presence of high ranking police officials on the CUMEC and other committees related to the 100% CUP results in greater control of local police officers, not just sex workers. This point would benefit from more exploration than we had the time to do.

The city has a concentration of Vietnamese sex workers and presented us with our first opportunity to compare these with their Cambodian counterparts. The contrast was striking. The Vietnamese seemed better educated, a testimony to the less troubled recent history in that country. Most came from the border region with Cambodia where the language spoken is similar. Most had the same story to tell on how they had come to Phnom Penh. The oldest daughter in a large and very poor farming family, they were sent there to earn money for the entire family. Often their mothers came to visit them in Phnom Penh and carried money home for the family. The sex workers themselves visited their homes and families, usually once a year, and then returned to work in the city. They were much less likely to borrow money from the brothel owner or to have any debt and were in general more entrepreneurial in their profession. They were better groomed and more interactive than the Cambodian sex workers we had met up in the provincial settings. Their rates were somewhat higher than their Cambodian counterparts in Phnom Penh and they were more likely to serve a foreign clientele. They were often looked down on by Cambodian sex workers because they would provide a wider range of sexual services than simple vaginal sex. Other sex practices were
usually considered disgusting by the Cambodians and they refused to perform them.

Cambodian sex workers in Phnom Penh brothels were also more sophisticated than their provincial counterparts and better organised, though less so than the Vietnamese. Contact between sex workers from different brothels was more common here than it was in the provinces, though only in the absence of debt bonds. Brothel owners fear that women who had borrowed money would flee without repaying limited many sex workers’ mobility.

While in Phnom Penh, we met with Khemara. This NGO has taken over from a former MSF project in Svay Pak where mostly, if not exclusively, Vietnamese sex workers practice. The intervention is entirely social and not medical or clinical at all. It includes a very comfortable drop-in center in the red light district above an STD clinic run with support for the European Union. Skills training is included, as is language instruction.

A recent police raid in Svay Pak had led to another publicised “closing” of the brothels there. In the previous month, police had raided a brothel that was reputed to house two underage girls, who were taken away. As a result, all brothels in Svay Pa were ordered shut. In practice, this meant that clients had to enter through the back door, not the front. But for foreign clients, with whom the red district is well known and popular, the closing had discouraged business substantially. We discussed this with two Vietnamese sex workers in one session. Both were working there to send money home to their families and both now had debts to the owners, $300 and $500. One admitted that business had been so bad since the closing that she had resorted to sex without condoms rather than turn away clients. The second sex worker did not admit the same and seemed surprised at that admission.

4. Sihanoukville: The 100% CUP in this city is indeed different. One key difference is regular quarterly meetings of the outreach team with local sex workers. These meetings cover a variety of topics, not all of them directly related to the 100% CUP. In the most recent meeting, a discussion of the advantages and disadvantages of “sweethearts” and strategies for good money management were included. The meetings were described to us both by the outreach team and by the sex workers we met who had attended them. The descriptions for the most recent meeting, held a few weeks before our visit, matched well.

The clinical services available at the local STI clinic were also different in Sihanoukville. Though it may have been a matter of timing, we saw many more sex workers in the clinic in Sihanoukville than we did elsewhere. The quality of the services provided seemed good as well, with syndromic algorithms, developed in collaboration with the ITM project, that made good sense in the setting. On interview, sex workers denied that they felt coerced into attending the clinic each month. Some mentioned that they welcomed the opportunity to address other health complaints and concerns. Some of these
features of the Sihanoukville programme have not been copied in the provinces we visited, or at least not in ways that were obvious to us.

The programme in Sihanoukville has also formed links with the MCH programme there and has begun offering abortion services to sex workers. The facility in which this is provided is clean, comfortable and modern. Though still a small service, a quick review of the data they maintain revealed that demand for abortion is growing. The data also revealed that relatively few of all clients of the service, sex workers included, left with a post-abortion method of contraception selected and provided. While the service is a good addition for sex workers, the post abortion counselling should be enhanced.

Though the model programme for the country, Sihanoukville's 100% CUP is no longer funded. Efforts are underway to identify a donor who can assume the responsibility for funding this site.