Key Messages on HIV and AIDS from Cambodian Civil Society Organisations

Asia-Pacific Regional Consultation on Universal Access to HIV Prevention, Treatment, Care and Support: 'Getting to Zero', Bangkok, Thailand, 30th & 31st March, 2011

The Purpose of the Key Messages

Even though Cambodia has achieved much in its HIV response, there are still persistently high infection rates among most-at-risk population groups (MARP), which include sex workers (SW; known as entertainment workers [EW]), men who have sex with men (MSM), transgender people (TG) and injecting drug users (IDU). Furthermore, people living with HIV (PLHIV) continue to face huge barriers to adequate treatment, care and support. Therefore, achieving Universal Access to prevention, treatment, care and support remains a fundamental priority for Cambodia[1].

The efforts of civil society are fundamental to the national and international HIV response and its meaningful involvement will be a crucial component of this Regional Consultation and the upcoming UN General Assembly High Level Meeting on AIDS, to highlight the existing gaps and potential solutions. Through this **Key Messages** document, civil society in Cambodia wishes to explicitly state the immediate priorities of the HIV response from their perspective. These **Key Messages** were generated through a working group consisting of representatives of civil society organisations and from referencing recent key documents such as the *Joint Statement from Cambodian HIV/AIDS Networks*[2] and the National AIDS Authority's (NAA) *Country Aide Memoir on Universal Access*[1].

The **Key Messages** are structured in a way that reflects the major theme of the Regional Consultation – "*Getting to Zero*". This document presents the harsh realities of the numerous challenges that PLHIV and MARP currently face on a daily basis, not least of which is widespread discrimination and regular human rights violations perpetrated by local authorities and health services. There are severe restrictions placed on PLHIV and MARP on their access to prevention and treatment services, restrictions that are imposed by the state of the legal and social environments. In addition, the document draws attention to the growing HIV vulnerability of most-at-risk young people, a group that is often overlooked in any HIV intervention.

In light of these key issues, specific recommendations were made in a way which can be realistically implemented within the next 2 years. These include advocating political leaders and local authorities to escalate their efforts to provide an enabling environment; and the empowerment of community networks through increasing awareness and protection of their various rights, active participation in existing frameworks that place emphasis on best-practice preventative and treatment services, and forming strategic partnerships with networks and organisations that can help in impact mitigation and social protection.

Through this Regional Consultation, these **Key Messages** aim play a part in guiding the future direction of the national HIV response in Cambodia. These **Key Messages** form a clarion call for strong commitment to action at the policy, organisational and community level to achieve Universal Access to prevention, treatment, access and care.

1. Violations of Rights – Getting to Zero Discrimination

High levels of stigma and discrimination surround HIV/AIDS and the lifestyle and occupational choices of MARP[1,2]. PLHIV and MARP feel discriminated against not only by the general public, but also by their family, friends and colleagues. Violations of the rights of PLHIV and MARP also occur on a regular basis. Intentional or unintentional misinterpretation of the *Law on Suppression on Human Trafficking and Sexual Exploitation (2008)* has led to unfair targeted harassment and arrests of EW by local authorities. The law is intended to curb sexual exploitation associated with human trafficking, but in reality, police officers often do not know the difference between those who voluntarily sell sex and those who are trafficked and exploited, making far higher numbers of EW arrests compared to human traffickers[3].

Police officers have often misinterpreted article 25 of the Human-Trafficking Law in such a way that the mere possession of condoms can be used as evidence of sex work, leading to numerous arrests of EW, MSM and TG. IDU attempting to access HIV prevention mobile services have reported being tracked by police officers and were arrested as soon as the service provider moves on[4]. Once detained by the police, MARP members are regularly reported to be subjected to extortion, beatings, sexual harassment and rape[6,7]. Such treatments have also been perpetrated by security guards and other local authorities, and even by staff members of government-run rehabilitation centers[6]. Many detained MARP members have been extorted for bribes, even worse, forced to have sex with police officers, in exchange for their release[8,9].

The reproductive rights of PLHIV are often violated when attempting to access sexual and reproductive health and family planning. Because of their HIV status, a large proportion of PLHIV are coerced to terminate their pregnancy (19%) and/or undergo sterilization procedures (6%) by medical professionals[10]. An astoundingly high proportion of PLHIV respondents were advised not to have any children (79%). An HIV positive woman died during childbirth because health workers at a referral hospital refused to provide her with the necessary care to address birth complications once her status was known[11].

There is currently no mechanism for referral, or any stipulated legal remedies, in response to the violations of rights of MARPs and PLHIV. In the absence of such mechanisms, PLHIV and MARP struggle to protect their rights and access to justice, and are therefore more vulnerable to HIV transmission.

Recommendations

Empower Individuals and Networks – There are currently very few, if any, national networks for EW, IDU, MSM and TG. The number of networks and the capacity of current networks need to increase significantly. The organisational and leadership structures of existing MARPs and PLHIV networks need to be significantly improved so that they are able to provide "safe" spaces for their members to discuss issues openly, share experiences and to learn about their rights. By raising awareness and knowledge of their legal rights and rights to access of treatment and services without discrimination, PLHIV and MARP are empowered to report violations of rights and instances of discrimination. Peer-educators, self-help groups and support groups should all be used as platforms for awareness raising and education.

Documentation of Rights Violations – Strengthen the capacity of PLHIV and MARP networks to document rights violations, especially those committed by police officers and health services. The technical capacity to collect data and documentation procedures will be raised through training

conducted by capable and experienced human rights organisations. Proper documentation will then facilitate the effective reporting of rights violations.

Referral Mechanism and Legal Service – Develop a comprehensive, efficient and effective referral mechanism that includes the provision of adequate legal support specifically for PLHIV and MARP, and ensures close follow-up of reported cases of rights violations. Such a referral mechanism should be linked to the *MARP Community Partnership Initiative* (MCPI) that is currently being established by the NAA. By forming a partnership with the MCPI, PLHIV and MARP networks will be able to participate in the coordination of local health services, human rights organisations, and the legal and law enforcement authorities.

Accountability –It is very important to make close follow-up of major cases of rights violations. Human rights partnership forums such as *Daiku Kampuchea* (DK) should be utilised for the reporting and monitoring of rights violations. DK allows PLHIV and MARP networks to freely express their opinions, share reports and update on cases of rights violation, and act as a key advocate on issues related to human rights and HIV. Such a forum needs to meet regularly and requires the active and meaningful participation of PLHIV and MARP networks.

Advocate and Educate – Stigma and discrimination are perpetuated by the lack of awareness and understanding about PLHIV and MARP issues in the general population, in particular among social and political leaders. PLHIV and MARP networks, along with their development partners, need to scale-up the public awareness campaign through engaging with media and other public forums. Continuous dialogue with parliamentarians needs to be established to advocate for a "safe" space to discuss human rights issues and their underlying social issues among key opinion makers, decision makers, PLHIV, MARP and the general public.

2. Prevention – Getting to Zero New Infections

Harm Reduction Services for IDU

The HIV prevalence in the IDU population is an exorbitant 24.4%[12], but is coupled with low coverage of HIV prevention interventions (40%)[1]. The availability and quality of treatment and rehabilitation services for IDU are significantly lacking at the moment. Only 1 NGO has been granted a license by the *National Authority on Combating Drugs* (NACD) to deliver harm reduction programmes. The *Law on Drug Control (1997*) does not favour harm reduction programmes and criminalises drug users (DU), especially when they are in relapse[4]. Furthermore, there is a distinct lack of political commitment among senior government officials and local authorities in supporting the harm reduction programmes. In fact, the recent introduction of the *Village Safety Policy (2010)* has viewed these services as part of the drug problem. This policy has resulted in the tracking and raiding of harm reduction service points by police and the unfair targeting and incarceration of IDU who voluntarily seek out HIV prevention programmes[2, 4].

Hard-to-Reach Groups

The unfair targeting of MARP under the Drug and Human Trafficking Laws has caused the loss of trust in HIV prevention services and has made these population groups harder to reach. The criminalisation of drug use and sex work has made SW/EW and DU/IDU into highly mobile population groups. The promulgation of the Human Trafficking Law has forced SW/EW to be based in non-traditional entertainment venues, such as karaoke bars, beer gardens and snooker halls. There has been a 46% increase in street-based sex work since the Human Trafficking Law was

enacted[3]. This dispersal has made EW much harder to reach, shown by a 26% reduction in coverage of HIV intervention services.

The high level of stigma surrounding MSM and TG results in discrimination from family, friends and colleagues, and a loss of social support, discontinuation of formal education and loss of employment. Furthermore, discriminatory practices by health professionals have led to the loss of trust and confidence in health services. Because of this, MSM and TG tend to hide their sexual behaviour, and are unwilling to access a range of prevention service[4]. This is one of the reasons why HIV infection among MSM (8.1% in parts of Cambodia) and TG (9.8%) remains high[14].

Reduction in Condom Use

The forced mobility of EW has neutralised the impact of the highly successful *100% Condom Use Policy* because sex work now occurs in unregulated venues. Street-based sex work is associated with increased rates of gender-based violence and increased HIV vulnerability because the coerced sex is associated with physical trauma and EW are less empowered to negotiate condom use[3]. Police officers have on many occasions cited the mere possession of a condom as evidence of sex work under article 25 of the Human-Trafficking Law[2,4]. This has resulted in a large number of arrests of EW, MSM and TG, and a major disincentive for them and EW clients to carry condoms. MSM and TG have also had condoms confiscated as evidence of sex work under article 25[13].

Recommendations

Form Partnerships – Strong MARP networks are required to ensure meaningful involvement and active participation in policy development, through better linking mechanisms within and between civil society and with relevant non-government and government organizations. MARP networks must participate in the development and implementation of the MCPI and utilize it as a national mechanism to reduce the negative impact of the *Village Safety Policy*. For instance, there must be a community-based approach to treatment and rehabilitation of IDU and regular communication with, and training of, local authorities about their role on how to support harm reduction and the 100% *Condom Use Policy*.

Advocate – MARP networks need to advocate for: an enabling environment and "safe" space to allow for public discussion on the effectiveness of relevant laws and for genuine and meaningful participation by MARP members; inclusion of the decriminalisation of voluntary access to harm reduction programmes as part of the revision of the Drug Law currently taking place; NACD to increase the licensing of harm reduction service providers to improve accessibility to these programmes; dialogue with parliamentarians, local authorities and the general population, through community forums, the media and the MCPI, to raise awareness and understanding of the benefits of harm reduction and its intended outcomes; entertainment establishment owners to establish a clear policy mandating effective implementation of the *100% Condom Use Policy*.

Most-at-Risk Young People

Cambodia has the youngest population in Southeast Asia – 35% is aged 10-24 years old – many of whom are just beginning their sexually active lives. Furthermore, a large number of young people in various 'hotspots' around the country are deemed to be most-at-risk because they take part in numerous risky behaviours that increase their vulnerability to HIV infection, such as drug use, low levels of condom use, multiple concurrent sex partners and low rates of HIV testing. Therefore, most-at-risk young people (MARYP) can potentially form the next wave of the Cambodian HIV epidemic in 5-10 years' time[15].

There is a lack of specific knowledge about health services or how to correctly use contraception amongst MARYP. Among those who reported developing STI symptoms, more than a third did not seek any treatment. Furthermore, a similar proportion of young girls who were pregnant underwent an abortion. Currently, there is no youth-friendly, targeted programme for MARYP on sexual and reproductive health. MARYP are extremely reluctant to use public clinics due to shyness, concerns for confidentiality, non-same sex health providers and transport or service fees[15].

A particularly at-risk group of young people are garment factory workers[4]. The global financial crisis led to the shut down of many factories. Because of their lack of education and vocational skills, many young women factory workers move into sex work. Many of these young women are illiterate and are highly vulnerable to HIV infection because of their lack of awareness and knowledge of, and of where to get information associated with, HIV. Young people within MSM and TG populations are also a particularly marginalised group. Widespread stigma and discrimination targeted at MSM and TG can invoke confusion and denial in young people about their sexuality, resulting in their reluctance to access support and information services[4].

Recommendations:

Empower and Educate – Establish networks of MARYP to create a social support structure and solidarity among young people. Empower young people and increase their capacity for leadership and to exercise their rights to information and services. Facilitate the delivery of HIV education that is based around improving life-skills and risk reduction skills to help them negotiate safer sex practices with their sex partners. To reach this population group, mobilize peers to act as agents of change around social norms that govern sexuality, condom use, and the consumption of drugs and alcohol.

Form Partnerships – There is a need for strong collaboration and coordination between civil society and government stakeholders to ensure that all the programs for young people respond appropriately to the needs of young people, and to ensure the sustainability of these programs; Create protective environments and support responsible behaviour by engaging school staff, local authorities, police, social workers and parents; Form strategic partnerships with relevant NGOs to deliver HIV appropriate intervention programmes to young people.

Advocacy – MARYP networks and partner organisations will advocate for: policy and legislative changes that reflect the unique risks of young people and interventions that specifically target young people; the Ministry of Education to improve sexual and reproductive health and drug education in schools; the introduction of new initiatives like *model youth* or *real youth*, where low-risk behaviour is modelled and championed by a role model.

3. Treatment, Care and Support – Getting to Zero AIDS-related Deaths

Livelihood and Poverty

HIV-related illness and discrimination reduce the opportunities for income generation, employment and formal education. Furthermore, PLHIV are discriminated against when attempting to apply for loans from a commercial bank, and may have to resort to money lenders who charge unsustainably high interest rates[4]. Alternatively, many sell their land and property to pay for treatment and testing services. Such harsh financial circumstance leads to a vicious cycle of debt and poverty for many

PLHIV and their households. Therefore, HIV affected households tend to be poorer, have lower incomes and health outcomes, but higher healthcare expenditure[16].

The cost of testing and treatment services remains a barrier to access, especially for PLHIV living in the provinces. Transportation costs to attend regular consultations or obtain medication are often beyond what many PLHIV in the provinces can afford. The Equity Fund set up by the government is only able to cover 30% of the poorest PLHIV[4]. Even though the *Law on Prevention and Control of HIV/AIDS (2002)* clearly mandates the government to ensure free primary health services to PLHIV, the problem of inaccessability is exacerbated by the introduction of autonomous hospitals that charge unaffordable fees, as well as referral hospitals that extort money, for essential treatment and testing. Such practices discourage adequate treatment adherence and follow-up by patients. Poverty, unemployment and landlessness have displaced many PLHIV because they have had to sell their homes and to look for work. This increased mobility has led to reduced access to, and discontinuation of, treatment and have resulted in several deaths of PLHIV[4].

Treatment and Testing Services

Although antiretroviral treatment (ART) coverage has improved dramatically in recent times, many PLHIV still have inadequate access to ART. For instance, there are currently over 5000 children in need of ART but only 68% of them are able to access it[17]. There are also concerning reports about expired medication being sold, due in part to the relatively high cost of non-expired medication and the low economic circumstance of many PLHIV[4].

Another concern is the limited range of laboratory and diagnostic tests, including liver and kidney function tests, even at large hospitals which often only offer CD4 antibody count[4]. There is also low access of opportunistic infection treatment (OIT). The unavailability of services and OIT is especially prevalent in provincial hospitals and is concerning because many PLHIV are now becoming resistant to the 1st and 2nd lines of ART[4].

The last few years have seen a decreasing trend of the level of funding for HIV-related interventions, possibly because of the decreasing national HIV prevalence rate and the extent of the recent global financial crisis[18]. As a result, there is growing concern of the willingness of international donors to sustain the funding for ART services so that current 1st line ART is maintained, as well as up-scaling of the 2nd and 3rd line ART.

Recommendations:

Strengthen PLHIV networks – Better coordination between PLHIV networks is required to enhance their meaningful contribution to national and sub-national policy development, particularly policies relating to issues of poverty and access to affordable treatment; increase the capacity for networks to document and report the instances when the access to affordable treatment is hampered.

Advocate – PLHIV networks will advocate for: comprehensive and integrated approach to impact mitigation programmes that includes addressing issues associated with unemployment, landlessness and homelessness; enforcement of the HIV Law to ensure safe, easy and free access to treatment and testing services; establishment of a set of standard operating procedures to ensure that user fees are standardized and health services adequately funded; strengthening the capacity of referral hospitals to ensure comprehensive high-level healthcare services, including consultation, hospitalization, laboratory testing, psychosocial support, nutritional screening and palliative care to better detect and care for any treatment failures and associated complications; scaling up the

coverage of OIT and 2nd and 3rd line ART by securing long-term sustainable funding source for these treatments;

Mobilise Resources – PLHIV networks must assist their members to effectively and efficiently access the Equity Fund, and advocate for its expansion, so that treatment and testing are affordable, or even free, for those who are poor. With shrinking operating funds for HIV intervention programmes, PLHIV networks must guide development partners, UN agencies and government on where to best target limited resources for optimal impact; this includes the need for programmes to focus on delivering sustainable access to all medications and more community-based care integrated into existing health systems. There should also be a focus on mobilising sustainable domestic funding sources to finance the national response, rather than allow the current heavy reliance on international donors to continue.

Microfinance – Form partnerships with microfinance institutions to establish a microfinance framework specifically for PLHIV. Alternatively, establish a non-profit microfinance project in partnership with experienced and capable NGOs. Microfinance can stimulate income generation by starting up or expanding an enterprise or help meet immediate household needs, enabling many PLHIV to break their cycle of poverty and debt.

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