

**Cambodia: Family Planning Programs  
and HIV/AIDS Services,  
Results of Focus Group Discussions**

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## **Executive Summary**

As part of the POLICY Project's investigations into the delivery of family planning (FP) services in the context of high HIV prevalence, six focus group discussions were held in Cambodia in December 2004. The aim of these discussions was to document the views of FP users, service providers, and HIV-positive (HIV+) women on the accessibility and quality of FP services, particularly in light of the HIV/AIDS epidemic in Cambodia.

These focus group discussions suggest the following:

- Male involvement must be encouraged to readdress the current attitudes toward condoms.
- The capacity and resources of services providers, particularly in the rural areas and in the private sector, must be developed. This is essential to readdress the current environment in which FP and HIV/AIDS services are managed and to reduce discrimination and misconceptions about HIV/AIDS, which prevent the adoption of adequate protection and FP methods.
- Information, education, and communication (IEC) campaigns, through multimedia, must be developed to reinforce all these changes and help turn the stigma felt toward those with HIV/AIDS into compassion and understanding.
- At the local level, there is little or no attempt to integrate HIV/AIDS and FP services. The resources and the knowledge to do this are severely lacking.

From these discussions it was clear that understanding of and demand for family planning is growing in Cambodia, particularly in light of the HIV/AIDS epidemic. However, until the prevailing attitudes toward condoms, particularly among men, can be changed, and until the fear of discrimination and stigma associated with HIV/AIDS can be diminished, people in Cambodia are not going to take all the precautions and access all the services available to them. This situation must change if transmission of HIV to married women and children is to be prevented, and if those with HIV/AIDS are to receive essential counseling and care.

## Abbreviations

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ARV	antiretroviral
FGD	focus group discussion
FP	family planning
HIV	human immunodeficiency virus
IEC	information, education, and communication
MCH	maternal and child health
MOH	Ministry of Health
NMCHC	National Maternal and Child Health Center
OD	operational district
PLHA	person living with HIV or AIDS
PMTCT	prevention of mother-to-child transmission
RHAC	Reproductive Health Association of Cambodia
STI	sexually transmitted infection
TB	tuberculosis
VCCT	voluntary confidential counseling and testing

## Introduction

As part of the POLICY Project's investigations into the delivery of family planning (FP) services in the context of high HIV prevalence, six focus group discussions (FGDs) were held in Cambodia in December 2004. The aim of these discussions was to document the views of FP users, service providers, and HIV+ women on the accessibility and quality of FP services, particularly in light of the HIV/AIDS epidemic in Cambodia.

Two FGDs with each target group were held. Staff at RACHA-supported (Reproductive and Child Health Alliance) health centers helped to convene three groups—two of clients and one of service providers.<sup>1</sup> These discussions were held in Kampot Province, approximately 80km southwest of Phnom Penh. The second service provider group was convened through the operational district (OD) health services of Ksach Kandal, Kandal Province, approximately 20km northwest of Phnom Penh.<sup>2</sup> The two groups of HIV+ women were assembled with the help of the Antiretroviral (ARV) User Association.<sup>3</sup> These two FGDs were held in Phnom Penh, but the participants in both groups came from Phnom Penh and Kandal Province.

It was deemed appropriate for men to be included in the service provider group because in Cambodia, FP service providers are both male and female. This is particularly true of the private sector, where most service providers are men, except in very intimate circumstances, such as for IUD insertions. There are also male FP clients, although their numbers are limited. It also seemed appropriate to include men given the nature of the research—i.e., the integration of FP and HIV services. However, only a few men attended the FGDs (two in the service provider groups and five in the client groups). This can be taken as a partial reflection of the limited involvement of men in family planning, both as users and as providers.

In Cambodia, it is considered appropriate for male or female moderators to be used for FGD of this nature. For this research, a male FGD moderator was used who was highly experienced in conducting FGDs with participants of both sexes.

The questions asked of these groups can be found in Annexes 1, 2, and 3. A Cambodian researcher who is trained in and has extensive experience convening FGDs led each group. He was assisted by a Cambodian note-taker. The note-taker wrote down all the responses in the Khmer language, and each session was tape recorded in its entirety. Immediately following each focus group session, the researcher and note-taker met with the lead consultant to relate and discuss the responses to each question. The results of these discussions are presented in detail below.

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<sup>1</sup> In Cambodia, most health centers are able to function because they have the support of an NGO. It would probably not have been possible to convene any focus group with the service providers and clients of a health center that does not have this kind of support, as staff and client attendance and opening times are usually so erratic.

<sup>2</sup> After consultation with POLICY/Cambodia, it was decided that time would not allow focus group discussions to be conducted further afield than Phnom Penh, Kandal, and Kampot.

<sup>3</sup> It is acknowledged that it is not wholly representative to talk to only HIV+ women on ARV. However, in the time frame allotted to the study, it was not possible to convene a second focus group of HIV+ women through another challenge. Therefore, after consultation with POLICY/Cambodia, it was decided that the ARV User Association should help to convene both focus groups.

## Discussion of Major Trends and Findings

### 1. Family Planning Clients

Two group discussions with FP clients were held in Banteay Meas and Angkor Cheas districts in Kampot Province. Group A consisted of 10 people, two of whom were men. All the participants had children, and all were currently using modern birthspacing methods. Group B also had 10 participants, three of whom were men. Nine of the participants already had children. The tenth, a woman, had no children. She was newly married and currently using a modern birthspacing method.

#### *The Need for FP Services*

Not surprisingly, there was universal approval of family planning among the participants of both groups. All participants agreed that family planning was still important, especially because of, and not in spite of, the HIV/AIDS epidemic.

#### *The Use of Condoms as a Contraceptive Method*

Generally, condoms were viewed by both groups as a contraceptive only in exceptional circumstances, such as the use of condoms by HIV+ persons. One woman in Group B said that because her husband works away from home (he is a policeman) and probably has other sexual partners, she insists on using a condom with him to protect herself from sexually transmitted infections (STIs), and she uses the pill as her contraceptive method. The men in this group confirmed that if they were to have sex outside of their marriage, then they would use a condom, but when they had sex with their wives, they did not like to use condoms as condoms were uncomfortable and left men feeling unsatisfied. The participants of Group A were also in agreement that using condoms inside a marriage implied a lack of trust.

*If my husband wanted to use a condom with me, I would think that he had had sex with someone else. (Woman, Group A)*

One man said that men will use condoms when their wives are not using another contraceptive method (e.g., during pill-free days), but all participants agreed that married men and women preferred not to use condoms all the time as they were associated with extra-marital sex. Only a couple of women, such as the one whose husband was a policeman, wanted their husbands to use a condom when having sex with their wives.

Neither group thought that dual methods were being promoted through their health centers or local networks of village health volunteers. Participants of Group B explained that dual method promotion was unlikely to work because if an FP client is happy with one method of contraception, then he/she will not want to use another method for fear of provoking a reaction. However, both groups were aware that dual protection was being promoted.

*The volunteers in our village and the health center tell us that condoms help to stop pregnancy and HIV. (Woman, Group B)*

#### *The Use of FP Services*

If FP clients wish to use the pill or condoms, their source of supply is usually the network of village health volunteers. If they want to use the injection, they go the health center. Sometimes, if the health center is closed, people will visit the houses of health center staff and receive FP services from there.

Both groups felt that FP services, provided by both health center staff and village health volunteers, had improved and that the service providers were accessible, friendly, and had more knowledge. For example, the pill is generally provided with advice on how to take it, whereas before, no such advice was forthcoming. Participants from both groups described how they also receive a general health check and a follow-up visit from the service provider. In circumstances when the client's health is not good, the service provider will advise them to use condoms as opposed to the pill as the method of contraception.

*Before, the volunteers who came to my village didn't know much. Now they can tell me about the pill and take my blood pressure. (Woman, Group B)*

Participants from Group B explained that clients now preferred to use the public services rather than established private providers because the private providers were expensive, and unlike the improved public service, the private providers did not issue instructions as to how to use the contraceptive method.<sup>4</sup>

Group A explained that, in general, people like to get the approval of their village head before doing something new, and in their commune, village leaders had enthusiastically approved of family planning; therefore, the service was very popular. This is echoed by the participants of Group B, who highlighted the benefits to health of family planning and the advantages that it had for their livelihoods.

*If we couldn't get family planning, we would have too many children. Some would get sick and we would have to sell our land. (Woman, Group B)*

Although village health volunteers make house visits to explain about family planning, Group A thought that most people learn about family planning from the TV and radio.

Neither group was fearful of visiting health centers or using FP services and methods. Both groups referred to their awareness of HIV and its routes of transmission as explanations of why they were not afraid. However, a participant from Group B mentioned that she knew she could not get HIV from the contraceptive pill because these pills were supplied from a "higher level" and therefore must be safe.

*The pills they have at the health center come from a higher level in Phnom Penh, so we know they are safe and don't have HIV. (Woman, Group B)*

Neither group felt that the HIV/AIDS epidemic had an impact on FP services. They did not think that service providers were afraid, and had always continued to be welcoming to all clients. In addition, the waiting times for FP services were never longer than 10 minutes, and the desired contraceptive methods were always available. Therefore, no one felt that the staffing or quality of such services had been compromised.

Group B wanted to see more hygiene and safety practices in FP service delivery, such as health personnel wearing gloves during IUD insertions.

### ***Family Planning and HIV+ People***

The participants from both groups are aware that HIV can be transmitted from an HIV+ woman to her child and therefore think that there is a very strong need for FP services for HIV+ people. Group A was of the opinion that HIV+ women should not have children at all and that their need for family planning was greater than people who had negative HIV status.

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<sup>4</sup> However, it is common for public health practitioners to operate an additional, private service to supplement their income.

*Women with HIV shouldn't have children. Who will look after them when their parents die? (Woman, Group A)*

Group A stressed that everyone, including HIV+ persons, should receive the same quality of FP services with no discrimination. However, in terms of FP for HIV+ persons, both groups felt that the condom should be promoted as a dual protection method. One woman in Group B recommended that HIV+ women not use the pill or injection because these methods will make the women feel even sicker. However, others disagreed, pointing out that the side effects of the pill and injection only lasted for one or two months.

### ***Male Involvement in Family Planning***

Most women in Group B agreed that, in general, husbands would take their wives to their FP appointments at the health center but would usually wait outside. However, there was general agreement that while in the past, education tended to only focus on women, in more recent times, education initiatives have targeted both men and women. Only one woman (in Group B) said that her husband participated in their FP decisions.

In terms of condoms, both groups felt that if it was ever to become easier for women to ask their husbands to use condoms, men must be encouraged more to participate in FP counseling and services. Group B felt that this was the role of the health center staff.

*If we ask our husbands to use condoms, they say we don't trust them. But if someone from the health center tells them, then they would believe that condoms were good. (Woman, Group B)*

### ***Voluntary Confidential Counseling and Testing (VCCT) and Prevention of Mother-to-Child Transmission (PMTCT) of HIV***

None of the participants had heard of VCCT or PMTCT. The participants knew it was possible to be tested for HIV in Takeo Province or Kampot town (up to 80km away) as it had been broadcast on the radio. Only two women had had access to these testing services, but neither had been tested themselves; both were accompanying friends.

## **2. HIV+ Women**

FGDs were held with one group of 11 (Group C) and one group of nine HIV+ women (Group D). All were in ARV programs. Some of these women had never had children, some had living children, and some had had children that died. All of these women had been married, but some were widows. All living husbands are HIV+ and are also on ARV programs.

### ***The Need for FP Services***

The participants from both groups strongly agreed that FP was extremely important for HIV+ women, even more so than it was for HIV- women. All the respondents said that they did not want any more children because of their HIV status. They said that they would not be able to look after more children because of their poor health and their poverty. They knew that it was possible to transmit HIV through breast milk and worried that they lacked the money to buy infant formula. The participants from both groups would, in general, obtain their FP commodities from the Reproductive Health Association of

Cambodia (RHAC), the public health service, some private health service providers, Marie Stopes, and local NGOs.

*HIV means that our health will get worse and we won't be able to work. How can we take care of more children? (Woman, Group D)*

Participants in Group D wanted FP information to be more comprehensive so that they could fully understand all the choices and choose the appropriate method according to their HIV status. Condoms were used by most of the women in both groups as their FP method because many shared the belief that contraceptive pills and injections can provoke a bad reaction in an ARV user. Neither group had received information on this and more information was desired. They also understand that using condoms will help protect them against other STIs and different strains of HIV. Their principle concern was that they not become infected with a strain of HIV that is resistant to their ARV dosage. They think that this is a possibility if their husbands are also on an ARV program. However, all of the participants knew women with husbands who are HIV+ but who object to using condoms and will use violence if their wives try to insist. In such cases, these women either refuse to have sex, and the husband goes elsewhere or, in one or two cases, the women have become pregnant.

Group C thought that there should be more promotion of condoms as an FP method because they were best for HIV+ people. Currently, there is too much focus on the contraceptive pill yet not enough counseling on how to take the pill and what to do if one is forgotten. This is particularly true of the private sector, where counseling in family planning is rare. Both groups also thought that information to HIV+ persons in rural areas was lacking and that there was no encouragement for men to join their wives at FP counseling sessions. They hoped that a greater understanding among men would assist the use of condoms in marriage. Group D thought that there should be a counselor in every OD<sup>5</sup> hospital to encourage men to participate in family planning and to explain how to prevent HIV transmission.

In general, women initiate the use of FP services and will be responsible for obtaining the commodity. One woman in Group C thought that the ARV drugs should contain a contraceptive so women would not have to negotiate condom use with their husbands.

IUDs were not often used because they were expensive (especially from the private sector) and not always available (from the public sector).

### ***The Use of Condoms as a Contraceptive Method***

The women in both groups strongly agreed about the importance of using condoms as a method of dual protection. They wanted to use condoms not only to prevent pregnancy but also to prevent themselves from becoming infected with ARV-resistant strains of HIV. According to the participants of both groups, information on dual protection is available at all FP outlets, counseling sessions, home visits, and at their ARV clinics in the Russian Hospital. However, many of these information routes are largely dependent on women passing the information on to their husbands. Participants in Group D knew of some HIV+ couples who were not using condoms and therefore thought that information on condoms as a dual protection method had to be stronger and more widely available, particularly to men.

If the women were permitted by their husbands to use a condom for marital sex, then they bought the condoms. If a husband had sex outside of marriage, then he would buy the condoms.

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<sup>5</sup> Operational districts have been established under the Ministry of Health's (MOH's) Health Coverage Plan (HCP) in an attempt to expand and rationalize access to health facilities. Under the HCP, there are 73 operational districts.

*I know when my husband is having sex with other women, because he goes out and buys a condom. (Woman, Group C)*

One woman in Group D thought that if the quality of condoms were improved so it feels more natural, then more people would probably use them.

## **The Use of FP Services**

The participants of both groups felt that the attitudes and behavior of service providers needed to change. They were particularly concerned about the discrimination evident in the private sector, where HIV+ persons are regularly charged two or three times the normal rates. One participant in Group D said she knew of doctors in the private sector who refused to treat clients that they thought were HIV+. Positive persons often prefer to use private services because they think it will be less likely for their HIV status to be discovered, compared with going to a public health provider. However, clients also believe that private service providers will guess the HIV status of each client and treat them accordingly. One participant from Group C explained that a person who was poor and HIV+ was the most unfortunate of all because the clients with money were always treated better in the private sector.

*They (the doctors) guess your HIV status and then decide how to treat you and how much you will pay. (Woman, Group C)*

According to the focus group participants, HIV+ persons will never disclose their HIV status unless they absolutely have to—such as when they attend the ARV clinic at the Russian Hospital. This particular facility is praised by the participants for its friendly and non-discriminatory approach. In general, however, HIV+ people fear discrimination, particularly in rural areas.<sup>6</sup>

The participants are concerned about the lack of integration of HIV and FP services. At FP facilities, there might be some HIV information, but there is no FP information at HIV service centers. Participants of Group D pointed out that people in Phnom Penh and people from rural areas who did not want their communities to know their HIV/AIDS concerns were most likely to receive HIV services from the Russian Hospital, the Military Hospital, or Calmette Hospital, and it was these hospitals that should attempt to integrate their HIV services with FP services.

*When people go for an AIDS test, no one tells them about family planning. (Woman, Group C)*

At health center level, both FP and HIV services might be offered, but to ensure confidentiality, clients wishing to seek HIV counseling are ushered into a separate room. The participants from Group D pointed out that this led to under-usage of the services as no one wanted to be seen entering or leaving the room. The participants wanted staff at the health center level to be trained in all services and to deal with all clients in a sensitive and confidential manner.

Participants from both groups agreed that HIV+ persons lacked information about family planning. TV, radio, and home care teams were cited as the most usual sources of information about family planning. However, participants from Group D said they never got FP information from the home care teams that

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<sup>6</sup> Three women in Group B used RHAC for their FP needs, but none had disclosed their HIV status. This has excluded them from other, potentially beneficial, services.

visited them, and participants from both groups pointed out that some HIV+ persons did not have access to any of these information sources.

### ***Male Involvement in Family Planning***

Both groups thought that there was an urgent need for men, particularly HIV+ men, to be more involved in FP decisions. According to the participants of Group D, some men hid their HIV status from their wives. They thought that media campaigns, through TV and radio, would help encourage men and convince them of the importance of disclosing their HIV status to their wives. This group also thought that male sterilization should be promoted.

### ***VCCT and PMTCT***

Half of the participants of Group C had used VCCT services before they became members of the ARV Association (they had received testing but under different circumstances).<sup>5</sup> Those VCCT services did not provide information on family planning but did provide information on condoms—as a form of protection against HIV (if the client was not already positive) and against other STIs (if the client was HIV positive). No one in Group D had had access to VCCT services.

Two women from each group had personal knowledge of the PMTCT services at the National Maternal and Child Health Center (NMCHC). Both were very impressed and thought that all services should aspire to be of similar quality.

## **3. Service Providers**

The Kampot service provider group (Group E) consisted of five village health volunteers and five health center staff. There were no men in this group. The Kandal service provider group (Group F) consisted of two hospital staff, one staff member of the Operational District office, and the rest from the local health center. There were two men in this group.

### ***The Demand for FP Services***

Since 2000, the demand for family planning has clearly increased. The service providers think this is a result of better and more widely distributed information and because of access to information and services at the community level. Group E thought that in 2004, there were more than 200 new users per month.

There is also a greater awareness of HIV/AIDS although some misinformation persists—such as the notion that condoms contain the virus. When the service providers in Group E hear such myths, they go to the community to try to correct it. As awareness levels rise, there are greater levels of condom use—although most of these are used to protect against HIV rather than for family planning.

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<sup>5</sup> In Cambodia, VCCT is thought of as a distinct service, either offered by a specialized public sector center, or by an NGO that specializes in offering such services. Therefore, if someone is asked if they have had access to VCCT, they will probably answer negatively unless they have had access to a service known as such. Most people learn of their HIV status from a regular blood test. In some testing centers, there is no counseling, either before or after the test. These women may have had had some form of counseling (otherwise, how else would they have had access to ARV services?), but it may have been informal and they would not have thought of it as VCCT.

*People used to think that condoms contained AIDS because the people that used condoms got AIDS. That's why nobody likes to use them. We tell them that is wrong. (Woman, Group E)*

Participants from both groups acknowledge that family planning is still a sensitive issue for many people, and many do not want to be identified as using FP services. Therefore, the service providers in Group E attempt to build trust with the clients and will make sure that the services are kept as confidential as possible, keeping one room in each health center especially for counseling. However, Group F thought it would be easier if discussions on family planning and HIV were held at clients' houses. Participants of Group F mentioned that they always offer information on family planning when they attend a home birth. Unlike Group E, the members of Group F do not work with a network of village health volunteers. They tried to establish a network, but it failed because people already had established supplies of FP commodities and medicines.

The service providers in both groups encourage clients to choose their own FP methods. However, when asked, they will give advice, explain side effects, and suggest alternatives. Each new client will receive a leaflet on the available FP choices. There are nine health centers in Group E's OD, and only two of them are equipped to provide IUDs.

### ***Male Involvement***

These service providers think it is important that more men participate in FP counseling and decisionmaking. They explain that in cases where men do not participate, they are more likely to reject family planning and use domestic violence. The service providers make the point that it is the men who usually make the decisions within marriage and, therefore, if they understand the benefits of condoms in preventing HIV and unwanted pregnancy, the use of condoms is likely to increase.

The participants of Group E thought that in general, more men are participating in FP decisionmaking. They think this is due to the messages regarding condom use on the TV. Since nearly every household in their area has a TV, this has helped their work significantly.

*Men make all the family decisions. They must be involved in family planning education. (Man, Group F)*

### ***The Use of Condoms as a Contraceptive Method***

According to Group E, there is increasing effort on the part of service providers to encourage clients to use condoms as an FP method. However, despite there being an up-turn in condom sales, they think that most of the condoms distributed are used for extramarital sex. Large quantities of condoms are sold during events (e.g., the Water Festival), and male clients will often admit that they are buying condoms for sex outside their marriage. Group E acknowledged that the brand of condoms supplied to their health centers are not of good quality and not popular with clients. Participants from both groups also have their private practices in which they will sell the popular Number One or OK condoms.

However, there appears to be a small increase in the number of condoms being distributed to married couples. One participant in Group E said that over the past year, she had counseled five or six couples wanting to use condoms as an FP method whereas, before 2004, she had not counseled anyone about this.

Group F estimated that of all the condoms distributed by their health centers, only about 10–20 percent is used for family planning.

No service provider in either group promoted dual methods. Participants from both groups promoted dual protection but stressed there was no official policy. Participants from Group F had received some training from the NGO SHARE in the promotion of dual protection.

Group F thought that a general dislike of condoms, including by women, is preventing them from being used as a common FP method. Couples prefer not to include condoms in their discussions about family planning. Beliefs persist that condoms are only used for extramarital sex. However, if a couple agrees to use condoms, then it is the woman who will collect them from the service provider.

### ***Integration of Services***

In general, the participants of the focus groups were skeptical about services integration at the health center level. Both groups thought that the services can only be integrated through education and counseling. Currently, there are no HIV/AIDS services at these health centers. For Group E, the nearest facilities for blood testing are 60km away and for Group F, the nearest facilities are in Phnom Penh (about 20km). Group E thought that there should be ARV treatment available at their health centers but currently, people in the area who are HIV+ are going to the provincial hospital for treatment. Tuberculosis (TB) patients can receive treatment at the health centers, but the service providers admit that they are afraid of treating them.

Participants of Group F added that FP and HIV services should not and could not be integrated because of the clients' fear of discrimination. Furthermore, these health centers do not have the facilities to accommodate the needs of HIV+ persons or those who want information about HIV.

*Right now, we can tell people about AIDS, but we can't help people who are HIV+.*  
(Woman, Group E)

### ***The Working Environment***

All participants worry about exposure to HIV through their work. Most of these service providers are also birth attendants, and many give injections. They do have needle disposal guidelines and are equipped with needle disposal boxes, but some worry that handling needles can transmit HIV. If they scratch themselves, they squeeze the blood out and then wash the scratch with water. Plastic gloves are used as much as possible although sometimes childbirth is so quick that they do not have time to put the gloves on. In those cases, they stand to one side as the baby is born. Participants from Group F stressed that in all situations, the well-being of the patient is uppermost in their minds, and no one has been denied services on the grounds that they might be HIV+. In Kandal Province, health center staff who work with TB patients receive a financial bonus.

*HIV is a like a landmine. It is hidden everywhere and could get us at any time.* (Woman, Group E)

There are no guidelines available for post-exposure prophylaxis and no drugs. Training so far has covered general "dos and don'ts", but it is not about HIV prevention specifically, and not everyone has had this training. Some of the participants from Group F will go for regular blood tests, but this is not an instruction from the Ministry of Health (MOH). Most staff desire more information and training in HIV symptoms, transmission, prevention, and how to care for persons living with HIV or AIDS (PLHAs). Group F thought that all health staff should receive this training, regardless of their position, and that NGOs tend to neglect the importance of training government staff.

Workloads have increased in the sense that people require more information on HIV and condom use. The participants in Group E explained that the two staff at each health center who are responsible for maternal and child health (MCH), antenatal care (ANC), and family planning are now responsible for HIV/AIDS education. There are not enough staff at the health center level to adequately cover these services, and the participants of Group E rely on a network of volunteers to carry out education at the village level. The health center staff train these volunteers, and they themselves have received training from NGOs.

The work of these volunteers has resulted in the health centers receiving more clients as clients get information from the volunteers and then expect the services from the health center. There is an increasing number of TB patients, and the service providers suspect that some of these have HIV. Many of these TB patients require home visits to ensure that they are taking the medication correctly.

None of the participants of either group were aware of staff members being lost to AIDS.

## Summary and Conclusions

From the discussions with the three target groups, the following trends are identified:

**The demand for family planning is growing.** This is explained by effective IEC from radio and television, the dependable and accessible supplies of contraceptive commodities, and the improving service and knowledge of the service providers. Modern methods of family planning are also gaining increasing acceptance at the community level.

**The demand for condoms as an FP method is still low compared to other methods.** There is continued resistance from men, and to a lesser extent women, to using condoms within marriage. This is explained by a general dislike for condoms and the enduring implication that condoms are used only for illicit sex.

**Family planning is important because of, and not in spite of, the HIV/AIDS epidemic.** Both HIV-negative persons and HIV-positive persons think that people with or at risk of HIV have an even greater need for family planning than those who do not perceive themselves to be at risk.

**Dual protection is promoted by service providers but dual methods are not.** This is partially explained by the concerns FP clients have for the side effects of contraceptive methods. Therefore, if one method is found that is thought agreeable, a second one is unlikely to be adopted in case it interferes with the first. Exceptions to this are situations within marriage when a condom is used during pill-free days.

**The involvement of men in FP and HIV/AIDS services is still minimal and should be increased.** Although both clients and service providers felt that there had been a small increase in the involvement of men, this involvement has to be further increased if issues, such as the use of condoms within marriage, were to improve. Some felt this to be the role of the health services, and others felt that media campaigns had a part to play.

**Neither clients nor service providers felt that services in the public sector had been compromised over fears of HIV transmission.** However, in some cases, such as during the treatment of TB patients or at a delivery, service providers admitted they felt scared.

**HIV+ women were concerned about discrimination,** particularly when using the services of the private health sector. This is problematic because currently, people who are HIV+ or who are concerned about their HIV status prefer to use the private sector as they believe it is more discreet than the public sector. However, they can be charged two to three times the standard rates. Thus, HIV+ people who are poor often face a double stigmatization by the private sector.

Significantly, fear of discrimination and the prevailing stigma felt towards those with HIV/AIDS has resulted in HIV+ people and people who are concerned about their HIV status never voluntarily disclosing their status to the health services, thus excluding themselves from a variety of potentially beneficial facilities.

**Service providers acknowledge the sensitive nature of both family planning and HIV/AIDS.** However, their attempts to accommodate the special requirements of actual and potential clients of both FP and HIV/AIDS services had not always met with approval from those clients. For example, separate rooms at health facilities for HIV/AIDS counseling were felt by many to be tantamount to exhibiting their concerns about their HIV status.

**Minimal integration of FP and HIV/AIDS services exists**, particularly at the health center level. As yet, health centers are not able to provide HIV/AIDS services, even at the most basic level, such as providing information. Moreover, there is little evidence of HIV/AIDS services, even in Phnom Penh, providing information on the importance of family planning and helping to enable clients to access FP services.

**Awareness of HIV/AIDS is high, although misconceptions among HIV+ women, FP clients, and service providers still persist.** Concerns about the side effects of other contraceptive methods exist for HIV+ women using ARVs. While this may help to ensure relatively high levels of condom use, it can also ensure that dual methods of contraception are not adopted. This is particularly significant in situations where a partner of an HIV+ woman objects to using a condom. Not all FP service providers have had even the most basic training about HIV transmission and protection.

None of these service providers have access to post-exposure prophylaxis instructions or drugs.

**Awareness among FP clients of VCCT and PMTCT is extremely low.** Less than half of the HIV+ women, all of whom live in the Phnom Penh or Kandal environs, had had access to either VCCT or PMTCT. However, participants who had received PMTCT services at the NMCHC thought they were of excellent quality.

## **Annex 1: FP/Antenatal Clients Focus Group Discussion**

### ***Instructions to Interviewer:***

*It is your job to facilitate the discussion. It is not your job to concentrate on recording information. That is the scribe's role. Explain how the focus group interview will work—in particular, stress the confidentiality aspects. Check whether anyone requires clarification. Explain that you will be leading the focus group and that your colleague will be recording what is said. Ask permission to tape record the session.*

*Encourage all the participants—try to draw anyone who is quieter into the discussion. Make it clear that they should feel free to ask questions too.*

*Try to end on an up beat!*

### ***Instructions to Scribe:***

*Tape record the session. Also, take notes to record the group's discussions in as much detail as possible, so that we get a sense of the range of views expressed. Always record WHO made WHICH comments. Record as much verbatim as possible in the notes to cross check with the tape recorded version.*

*Before you leave, ensure that you have all the details necessary to complete the focus group write-up cover sheet*

### **Introduction and Consent:**

*Introduce the focus group and get verbal consent on tape from all the participants in the group and explain the issues around confidentiality.*

In the process of obtaining verbal consent, make it clear that

- Everything they tell you will be completely confidential—although their views may be contained in any reports that will be written, nobody outside of the group will know who has said what and their names will not be used.
- Encourage them to interrupt with anything they think is important.
- Get permission to take notes and record the proceedings.

***NB: Please use the focus group questions below as a guide, but use your own initiative to prompt and further explore the group's responses.***

## QUESTIONS

1. In general, how has the HIV/AIDS epidemic in this community affected men and women's needs for family planning services?
2. Should family planning be promoted and provided differently now, if at all, in light of HIV/AIDS in your community? If so: How? Why?
3. Do women and men have any fears about using family planning or attending family planning clinics in light of HIV/AIDS in your community? If so, what are those fears?
4. How are dual method use (using a condom + another contraceptive) or dual protection (using a condom for both disease and pregnancy prevention) promoted at family planning clinics, if at all?
5. What barriers do women in your community have to using a condom (or a condom with another form of contraception)?
6. What could be done in your community to make it easier for women to use condoms?
7. Where do they usually obtain FP services and what changes have they experienced in receiving FP services?
8. Have you been to a VCT clinic or a center that provides PMTCT? If so, what FP services, if any, were offered? (Prompt for FP counseling)
9. What FP services would you like to see available at a VCT center?
10. Do you think that the increase of HIV/AIDS in this area has affected the services available in the antenatal/FP clinic? If so, how? (Prompt: fewer staff, staff less willing to provide services for fear of HIV/AIDS, fewer supplies and medicine or contraceptives available).

*Give the group space to raise any other issues that they feel are relevant. Explore with the group what the practical implications of the issues are and what the practical alternatives are.*

**Thank the group for participating in the group discussion. Provide tea/soda and biscuits.**

## **Annex 2: PLHA Focus Group Discussion**

### ***Instructions to Interviewer:***

*It is your job to facilitate the discussion. It is not your job to concentrate on recording information. That is the scribe's role. Explain how the focus group interview will work—in particular, stress the confidentiality aspects. Check whether anyone requires clarification. Explain that you will be leading the focus group and that your colleague will be recording what is said. Ask permission to tape record the session.*

*Encourage all the participants—try to draw anyone who is quieter into the discussion. Make it clear that they should feel free to ask questions too.*

*Try to end on an up beat!*

### ***Instructions to Scribe:***

*Tape record the session. Also, take notes to record the group's discussions in as much detail as possible, so that we get a sense of the range of views expressed. Always record WHO made WHICH comments. Record as much verbatim as possible in the notes to cross check with the tape recorded version.*

*Before you leave, ensure that you have all the details necessary to complete the focus group write-up cover sheet*

### **Introduction and Consent:**

*Introduce the focus group and get verbal consent on tape from all the participants in the group and explain the issues around confidentiality.*

In the process of obtaining verbal consent, make it clear that

- Everything they tell you will be completely confidential—although their views may be contained in any reports that will be written, nobody outside of the group will know who has said what and their names will not be used.
- Encourage them to interrupt with anything they think is important.
- Get permission to take notes and record the proceedings.

***NB: Please use the focus group questions below as a guide, but use your own initiative to prompt and further explore the group's responses.***

## QUESTIONS

1. In general, how has the HIV/AIDS epidemic in this community affected men and women's needs for family planning services?
2. Should family planning be promoted and provided differently now, if at all, in light of HIV/AIDS in your community? If so: How? Why?
3. Thinking specifically about HIV+ women and men, what are their needs for family planning?  
Probe: Is family planning still considered a need among HIV+ women and men in this community?  
Probe: Do HIV+ women and men feel more or less need for family planning in light of their status?
4. Do you think that the family planning information and services that you receive is different because of your HIV status? Is so, how?
5. How are dual method use (using a condom + another contraceptive) or dual protection (using a condom for both disease and pregnancy prevention) promoted at family planning clinics, if at all?
6. What is the best way to reach HIV+ women and men with family planning information and services?
7. Have you been to a VCT clinic or a center that provides PMTCT? If so, what FP services, if any, were offered? (Prompt for FP counseling)
8. What FP services would you like to see available at an MTCT or a VCT center?
9. Do you know anyone who has been denied access to services or treatment at a health clinic in this community or that serves this community because of their HIV status?  
Probe: What types of services were denied?  
Probe: How was the denial of access communicated?

*Give the group space to raise any other issues that they feel are relevant. Explore with the group what the practical implications of the issues are and what the practical alternatives are.*

**Thank the group for participating in the group discussion. Provide tea/soda and biscuits.**

## **Annex 3: Service Provider Focus Group Discussion**

### ***Instructions to Interviewer:***

*It is your job to facilitate the discussion. It is not your job to concentrate on recording information. That is the scribe's role. Explain how the focus group interview will work—in particular, stress the confidentiality aspects. Check whether anyone requires clarification. Explain that you will be leading the focus group and that your colleague will be recording what is said. Ask permission to tape record the session.*

*Encourage all the participants—try to draw anyone who is quieter into the discussion. Make it clear that they should feel free to ask questions too.*

*Try to end on an up beat!*

### ***Instructions to Scribe:***

*Tape record the session. Also, take notes to record the group's discussions in as much detail as possible, so that we get a sense of the range of views expressed. Always record WHO made WHICH comments. Record as much verbatim as possible in the notes to cross check with the tape recorded version.*

*Before you leave, ensure that you have all the details necessary to complete the focus group write-up cover sheet*

### **Introduction and Consent:**

*Introduce the focus group and get verbal consent on tape from all the participants in the group and explain the issues around confidentiality.*

In the process of obtaining verbal consent, make it clear that

- Everything they tell you will be completely confidential—although their views may be contained in any reports that will be written, nobody outside of the group will know who has said what and their names will not be used.
- Encourage them to interrupt with anything they think is important.
- Get permission to take notes and record the proceedings.

***NB: Please use the focus group questions below as a guide, but use your own initiative to prompt and further explore the group's responses.***

## QUESTIONS

1. In general, how has the HIV/AIDS epidemic in this community affected men and women's needs for family planning services?
2. Should family planning be promoted and provided differently now, if at all, in light of HIV/AIDS in your community? If so: How? Why?
3. Has the rising prevalence of HIV/AIDS in your area affected counseling for family planning in your facilities? If so, how?

(Prompt, e.g., no time for FP counseling, worries about exposure)

4. Does your OD/HC have a policy for promoting dual method use (using a condom + another contraceptive) or dual protection (using a condom for both disease and pregnancy prevention)?

Probe: What is the practice at your OD/HC? Are clients discouraged from using non-barrier methods (like pills or the IUD)?

Probe: How do the health staff go about discussion with clients about dual method use or dual protection?

5. Do staff worry about being exposed to the possibility of HIV infection at work? What have some staff reactions been to this worry about HIV? Are there any guidelines for post-exposure prophylaxis? Are drugs for post-exposure prophylaxis available?
6. Do staff take any extra precautions for treating clients in light of HIV/AIDS? If so, what precautions? Is guidance provided on safe procedures? Are there any barriers to taking extra precautions?
7. Are staff called to do more at work due to HIV in this area? In what ways are staff called to do more work?
8. Has the HIV/AIDS epidemic had any impact on the staffing levels in the clinics where you work? What about in the overall healthcare delivery system? (Prompt: illness and mortality among providers and staff)
9. Do you feel that FP and HIV/AIDS services can be integrated at the clinic level? How? What elements?

Probe: What types of training would be necessary for this to take place?