Country Analysis of Family Planning and HIV/AIDS Programs: Cambodia

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Executive Summary

It has long been recognized that family planning (FP) is an integral part of reproductive health (RH) services and that family planning is of increasing importance in a context of high HIV prevalence. Family planning helps all women, including HIV-positive women, avoid unwanted pregnancies and empowers HIV-positive couples to limit the size of their family. Family planning programs (FPPs) are also an effective way of helping to reduce the burden of the HIV/AIDS epidemic on health services and on society.

It has been just over a decade since Cambodia's first cases of HIV/AIDS began to emerge. This was not long after the country's first FP initiatives were introduced. Since then, the response to both the epidemic and the unmet need for family planning has been commendable. However, there is still much to be done to reduce the impact of the epidemic and increase access to family planning. It is becoming increasingly clear that for the burden on Cambodia's health services to be reduced and for families to protect themselves from HIV/AIDS and unwanted pregnancies, HIV/AIDS and FP programs and services must re-address their traditional emphases and work together.

This report examines the present situation of both the HIV/AIDS epidemic in Cambodia and the progress of its FP program. It examines the trends in funding, staff resources, impact of the epidemic on personnel, and the activities of the government, private health sector and nongovernmental organizations (NGOs) in both sectors. Finally, the report will examine the efforts being made to integrate HIV/AIDS and FP services so that they jointly address these issues that are having such a profound effect on Cambodia's development.

Abbreviations

ADB	Asia Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral treatment
ARV	Antiretroviral
CDC	Centers for Disease Control and Prevention
CoC	Continuum of care
CPR	Contraceptive prevalence rate
DFID	Department for International Development
DHS	Demographic and Health Survey
DSW	Direct sex worker
FHI	Family Health International
FP	Family planning
FPP	Family planning program
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS
HC	Health center
HIV	Human Immunodeficiency Virus
IEC	Information, education, and communication
IMR	Infant mortality rate
INGO	International nongovernmental organization
IUD	Intrauterine device
JICA	Japan International Cooperation Agency
KAP	Knowledge, Attitudes, and Practices
KHANA	Khmer HIV/AIDS NGO Alliance
MCH	Maternal and child health
MDG	Millennium development goal
MOH	Ministry of Health
MOP	Ministry of Planning
MPA	Minimum Package of Activities
MSC	Marie Stopes Cambodia
MWVA	Ministry of Women and Veterans' Affairs
NAA	National AIDS Authority
NCHADS	National Center for HIV/AIDS, Dermatology and STDs
NGO	Nongovernmental organization
NIS	National Institute of Statistics
NMCHC	National Maternal and Child Health Center
OD	Operational district
PEP	Post-exposure phrophylaxis
PLHAs	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PSI	Population Services International
RACHA	Reproductive and Child Health Alliance
RGC	Royal Government of Cambodia
RH	Reproductive health
RHAC	Reproductive Health Association of Cambodia
SQHN	Sun Quality Health Network
STI	Sexually transmitted infection

TBA	Traditional birth attendant
TFR	Total fertility rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UP	Universal precautions
VCCT	Voluntary confidential counseling and testing
WHO	World Health Organization

Introduction

At 1.9 percent, Cambodia's HIV prevalence rate is the highest in Asia. The predominant mode of transmission is heterosexual, and the epidemic has now crossed over from men and the commercial sex industry to the general population of sweethearts[1], wives, and children. Communities, social security networks, and health services are becoming overwhelmed with the responsibility of caring for people living with HIV/AIDS (PLHAs), orphans, and vulnerable children. It has never been more important, therefore, to support and expand FP activities in Cambodia to ensure that all women and couples are able to avoid unintended pregnancies. Without this, it will not be possible to support HIV-positive couples in meeting their RH needs or to reduce the HIV/AIDS burden on community and public services.

The purpose of this case study is to examine the status of FP and HIV/AIDS interventions in Cambodia, the trends in funding for these two sectors, the situation of staff deployment in the health sector—including the impact the epidemic has had on personnel—and the role of NGOs[2] and the private health sector in the implementation of FP and HIV/AIDS services.

[1] "Sweethearts" refers to a range of relationships that exist outside of marriage and are not one-time, commercial sex acts.
[2] NGOs (nongovernmental organizations) is the term used commonly in Cambodia to describe the local and international non-profit agencies.

Methodology

The research for this report was carried out in December 2004 and January 2005. There were three phases to the research. The first was a desk review of relevant documents that provided information on the historical progress of FP and HIV/AIDS interventions in Cambodia. The second phase was the completion of 22 interviews with representatives of donor agencies; NGOs; the National Center for HIV/AIDS, Dermatology and STDs (NCHADS); the National AIDS Authority (NAA); the private health sector; and the Ministry of Health (MOH) at the central, operational district (OD), and health center (HC) levels. The third and final phase was the collection of data referring to the financial allocation to HIV/AIDS and FP programs in Cambodia, some population-based survey and service statistics, and data on staffing patterns. It should be noted that, prior to the 1980s, health services and facilities were practically non-existent in Cambodia and therefore no data were recorded. For some data entry sections, such as "health staff allocated for HIV/AIDS and FP" and "STI prevalence rates over time," centrally based records have only just been established and are not collected annually.

Background

1. The Family Planning and Reproductive Health Situation in Cambodia

The Khmer Rouge-led genocide of 1975–1979 had a significant impact on Cambodia's demographic and fertility profile (de Walque, 2004; NIS & ORC Marco, 2001). Following the end of the regime, a baby boom occurred and continued, with the result that 55 percent of the population is under the age of 20 (NIS & ORC Marco, 2001). This has significant implications for the situation of reproductive health and maternal mortality in Cambodia (NIS & ORC Marco, 2001).

FP services and modern contraceptives were available for the first time in Cambodia in 1991. These services were either supported or operated by international NGOs (INGOs). In 1994, with support from the United Nations Population Fund (UNFPA), the Royal Government of Cambodia (RGC) took the first steps toward implementing its own FP program, which included the introduction of services at health centers, FP education, and training of public health sector staff. In the same year, the *Maternal and Child Health Plan 1994–1996* was developed that introduced specific objectives for lengthening the interval between births. To meet these objectives, the MOH approved its first *Birth Spacing Policy for Cambodia* (MOH, 1995a), which advocated the provision and use of a full range of contraceptive services: "the availability of reversible and affordable contraceptives will be increased so that all couples may have access to them" (MOH, 1995a).

In 1997, the MOH issued its *National Policy and Strategies for Safe Motherhood*. This policy provides guidelines to integrate all components of safe motherhood into all maternal and child health and FP activities (MOH 1997a). The implementation of all safe motherhood and FP activities is overseen by the National Maternal and Child Health Center (NMCHC), under its National and Reproductive Health Program.

Maternal Mortality

At 450 per 100,000 live births, Cambodia's maternal mortality ratio is one of the highest in the region (NIS & ORC Macro, 2001). An estimated 2,000 Cambodian women die each year of childbirth-related causes (MOH, 1997b), and many more women will suffer from pregnancy-related complications (POLICY Project, 2000).

One possible reason why rates of maternal mortality and morbidity are so high is that comparatively low numbers of women have access to skilled attendance at—and following—childbirth. Although differences between urban and rural areas exist, on average, only 10 percent of births take place in a health facility (MOH, 2004a) and, as one respondent from the MOH noted, only 820 health centers are currently functioning and 226 of these do not have a midwife.

Contraceptive Prevalence and Unmet Need

The first contraceptive prevalence recorded in Cambodia was 7.0 percent in 1995 (MOH 1995b). The latest estimate of Cambodia's Contraceptive Prevalence Rate (CPR) is available from the Demographic and Health Survey (DHS) 2000. The DHS puts the CPR at 19 percent for modern methods. There are, however, important differentials between different sectors of the population. For example, currently married women in urban areas are 32 percent more likely to use a modern contraceptive method than married women in rural areas, and women with secondary education or higher were nearly twice as likely to use contraception than women with no education (NIS & ORC Marco, 2001).

The 1995 Knowledge, Attitudes, and Practices (KAP) Survey on Fertility and Contraception in Cambodia rated unmet need[3] to be as high as 84 percent. This survey also showed that, significantly, the demand for limiting family size was greater than the demand for birth spacing, indicating that women were in need of long-term or permanent contraceptive methods (MOH, 1995b). The 1995 KAP survey also found that, first, nearly two-thirds of the women surveyed, who knew a method of contraception, could not name a source of supply for those methods and, second, a significant number of women who were using a modern contraceptive had never consulted a trained service provider.

According to the KAP survey, the vast majority of the women surveyed knew that condoms could prevent HIV transmission but did not recognize condoms as a contraceptive method (MOH, 1995b). Other studies have shown that confusion exists about which contraceptive methods prevent transmission of STIs, including HIV, and which contraceptives only prevent pregnancy (Sprechmann *et al*., 1997).

The 2000 Demographic and Health Survey (DHS) showed that the unmet need for family planning has dropped to 33 percent. Among the 19 percent of married women who are currently using a modern contraception method, injectable contraceptives are used by 31.2 percent of women, followed by the pill, (used by 30.4%), female sterilization (6.4%) and intrauterine devices (IUDs) (5.0%) The percentage of women using condoms as a contraceptive has remained persistently low since 1995, at only 4.3 percent (NIS & ORC Macro, 2001).

Major STI Prevalence

It is difficult to assess actual STI prevalence in Cambodia because many cases are not reported. Awareness of STIs, excluding HIV/AIDS, is low, with less than 40 percent of Cambodian women having heard about such infections in 2000 (NIS & ORC Macro 2001). In the late 1990s, only about 3 percent of antenatal clients at public health facilities were tested for syphilis, and it was estimated that 11,000 pregnant women per year would remain undiagnosed and untreated for syphilis prior to delivery, thus increasing the risk of stillbirth, perinatal death, or premature delivery (MOH, 1997c).

However, since 1996, when the first STI prevalence survey[4] was conducted, STI prevalence has dropped. In the 1996 survey, it was estimated that nearly one-quarter (23.2%) of female direct sex workers (DSWs) had gonorrhoea (Ryan and Gorbach, 1997). The next STI prevalence survey[5], in 2001, found that the rate of gonorrhoea in DSWs was 14 percent (NCHADS/FHI, 2001). The greatest changes in prevalence are evident with STIs that require high rates of partner change (e.g. genital ulcer disease and gonorrhea). This appears to be consistent with the results of the HIV behavioural surveys, which show that condom use between DSWs and clients has increased and the overall number of commercial sex acts has decreased (NCHADS/FHI, 2001; UNAIDS, 2004).

RH clinic attendees were also included as a target group in the 2001 STI prevalence survey (NCHADS/FHI, 2001). This group was found to have low levels of STI prevalence (e.g. no cases of primary syphilis were found), and the risk of this group contracting an STI appears to be related to their husbands' (not their own), behavior (NCHADS/FHI, 2001). Of the 438 RH clinic attendees who were asked if they thought their husband had sex with other women, 18.7 percent said "yes." However, 91.5 percent of the women surveyed never used a condom when having sex with their husbands (NCHADS/FHI, 2001).

[3] Women are considered to have an "unmet need" for contraception if they want to stop childbearing or want to wait more than two years before having another child and are not currently using a contraceptive method (Beaufils, 2000).
[4] This survey documented prevalence rates in selected populations (DSWs, police/military, and women attending RH clinics) in three cities (Phnom Penh, Battambang, and Sihanoukville).
[5] This survey documented prevalence rates in selected populations (DSWs, police, and women attending RH clinics) in seven provinces (which included Phnom Penh, Battambang, and Sihanoukville).

Although surveillance data suggest that, overall, efforts to encourage safer sexual behaviour have had a positive impact on STI prevalence rates, it must be borne in mind that problems remain for those who require treatment for STIs in terms of access to drugs and quality of services and referral (RACHA, 1999; UNAIDS, 2004), and that safer sexual behaviour is not always applied outside of commercial sexual activity. Condom use between DSWs and their regular partners, for example, is consistently lower than between DSWs and their clients.

Level of Unsafe Abortion

The *Birth Spacing Policy for Cambodia* stipulated that abortion should not be promoted as a FP method (MOH 1995a). In 1997, a law was passed making abortion legal in the first 12 weeks of pregnancy. However, information on abortion is limited because it tends not to be openly discussed. In the DHS 2000, it was estimated that nearly 9 percent of women ages 45–49 had had at least one abortion at some point in their lives, but these figures are considered to be underestimates (NIS & ORC Macro, 2001). Complications of abortion are a major cause of maternal mortality in Cambodia (Lester, 2002). In the 2000 DHS, the women who had had an abortion in the last five years were asked where the procedure had been carried out. Nearly one-quarter of them (23%) had had the abortion in their own home. Of all the women who had had an abortion, 9 percent had not had any assistance. Women were more likely to have an abortion without trained help, and outside of a health facility, if they lived in a rural area (NIS & ORC Macro, 2001). Traditional methods for performing abortions persist, including: abdominal massage, oral herbal medications, and insertion of plants stems into the vagina or cervix (White 1995). These procedures are generally conducted by traditional birth attendants (TBAs) or traditional healers (*kru khmer*). However, staff working in the gynecology services within the public health center report that abortions are a significant part of their work in both the public and private sectors. These practitioners usually use curettage (Goodburn *et al*., 1997). In the private health sector, cost of services appears to be related to the quality of the procedure, with those who cannot afford to pay running the greatest risks (Lester, 2002).

Level of Exclusive Breastfeeding

The 2000 DHS showed that nearly 96 percent of infants in Cambodia are breastfed for some period of time. However, of the children who are breastfed, only a minority will be breastfed immediately after birth and only 18 percent of children less than two months old are exclusively breastfed. By five months, only 5 percent are exclusively breastfed (NIS & ORC Macro, 2001).

Based on international estimates, the risk of HIV transmission from an infected mother to her child during breastfeeding is said to be 25–45 percent (WHO/UNICEF/UNAIDS, 1998). International guidelines suggest that, where appropriate, HIV-positive women should consider feeding their children exclusively on formula to help prevent HIV transmission, if conditions to do so exist (WHO/UNICEF/UNAIDS, 1998). However, in the face of inconsistent supplies of formula, unsafe preparation practices, and the threat of infectious diseases, exclusive formula feeding is not currently a recommendation for Cambodia. The National Policy on PMTCT (prevention of mother-to-child transmission) states that "HIV-infected women should be given full information about infant feeding options. However, mothers should be encouraged and counselled to exclusively breastfeed their infants for six months and then abruptly wean them" (MOH, 2001).

2. The HIV/AIDS Epidemic in Cambodia

HIV Prevalence

HIV was first detected in Cambodia in 1991, during screening of donated blood. The first cases of HIV/AIDS were diagnosed in 1993. Since 1994, Cambodia's Ministry of Health has been conducting national surveillance on the HIV epidemic. The HIV prevalence rate peaked in 1997 at 3.0 percent and has since declined to 1.9 percent (NCHADS, 2004).

This decline has been attributed to:

- Changes in behaviour leading to higher condom use among commercial sex relationships due to the countrywide 100% Condom Use Program[6]
- Changes in behaviour leading to fewer commercial sex acts
- AIDS-related mortality from cases diagnosed at the beginning of the epidemic. Currently, the number of AIDS deaths per day exceeds the 20 estimated new infections per day (UNAIDS, 2004).

As the prevalence of HIV changes in Cambodia, so, too, does the epidemic's profile. While the number of unprotected commercial sex acts has fallen dramatically, condom use with sweethearts, regular partners, and between husbands and wives remains low. Thus, HIV is rapidly passing into the general population. Mother-to-child transmission (MTCT) is responsible for 5–10 percent of new HIV infections yearly (MOH, 2001). In 2003, HIV prevalence among antenatal care (ANC) attendees was 2.1 percent (NCHADS, 2004). This situation is compounded by the fact that overall access to and uptake of Voluntary Confidential Counseling and Testing (VCCT) for ANC and HIV-positive women clients is relatively low (Fletcher, 2003). Furthermore, access to antiretroviral treatment (ART) to help prevent MTCT is not yet possible for most women as, outside of Phnom Penh particularly, access to antiretrovirals (ARVs) is largely confined to those who can pay for the drugs and treatment (UNAIDS, 2004).

The other significant challenge is the increasing impact that the HIV/AIDS epidemic has on the Cambodian health services. In 2000, it was estimated that 12,000 people with AIDS would seek care from a system that could only provide a total of 8,500 beds for in-patients of *all* medical conditions (UNAIDS, 2000).

The Response of Cambodia to the HIV/AIDS Epidemic

In 1993, Cambodia launched its first five-year *National AIDS Plan* and, in 1998, the Ministry of Health established the National Center for HIV/AIDS, Dermatology and STDs (NCHADS). The role of NCHADS is to oversee the response of the MOH to the epidemic as well as to provide technical support for other partners. In 1999, the National AIDS Authority (NAA) was established to coordinate the national response (by all parties, both governmental and nongovernmental) to the epidemic.

The latest *Strategic Plan for HIV/AIDS and STI Prevention and Care 2004–2007* was published in September 2004. This plan has three overall objectives:

- To further reduce the HIV prevalence rate to less than 2 percent[7]

[6] The 100% Condom Use Program seeks to encourage consistent condom use in all commercial sex encounters. The program is implemented through awareness-raising activities, the provision of free condoms to sex establishments, and the periodic testing of sex workers for STIs and HIV. The program is credited for both significant behavior changes and declining HIV and STI prevalence levels.

- To increase the survival of PLHAs
- To ensure that NCHADS and provincial programs are evidence-based and managed cost-effectively (MOH, 2004b.)

To implement the plan effectively, a shared responsibility lies with the central level of the public sector (health and non-health) and the provincial and operational district (OD)[8] departments. NCHADS is responsible for the development of the overall strategy and the guidelines for implementation. The provincial departments develop operational plans based on these guidelines, and the ODs implement these plans. There are, however, many other stakeholders who contribute to the Strategic Plan. They include:

- The NAA
- Other departments of the MOH, such as the NMCHC, which holds primary responsibility for the PMTCT program, and the Hospital Services department who develops universal precautions (UP) policies
- NGOs and other organizations (including the UN and academic institutions) who have their own HIV/AIDS activities and who work jointly with the public sector
- Donors

[7] Recent revision of NCHADS prevalence statistics puts the current HIV prevalence rate at 1.9 percent; thus, this objective for the Strategic Plan will also be revised.

[8] Operational districts (ODs) have been established under the MOH's health coverage plan (HCP) in at attempt to expand and rationalize access to health facilities. Under the HCP, there are 73 ODs.

Discussion of Findings

1. Current Status of the Family Planning Program and Trends

Cambodia's FP initiatives started in 1991. Since then, as respondents from both the government and NGOs have noted, with the help of strong information, education, and communication (IEC) and advocacy campaigns and a lack of social and cultural barriers to adopting most contraceptive methods, progress has been impressive, with the CPR for modern methods growing from 7 percent in 1995 to 19 percent in 2000.

Generally speaking, most contraceptive methods are widely available within urban areas, (although factors of cost and quality of services will influence decisions over contraceptive choices). Outside urban centers, every health center can provide some modern methods of contraceptives, and, according to one respondent from the MOH, more than 200 can provide IUDs. Contraceptive pills and condoms are also widely available through private dispensaries and the public sector's community-based distribution program. However, for the long-term methods of contraceptives, and in some geographic areas, for IUDs, it is still necessary to visit the referral hospital (which is usually based in the provincial town).

While the rates of use of contraceptive pills and injectables have consistently risen, condom use for family planning, while increasing, is still low. The promotion of condoms as a dual protection method is recognized by all respondents as an important component of RH and HIV strategies in Cambodia, but promotion mechanisms are often weak and success has been inconsistent.

The unmet need for contraceptives, particularly long-term methods, is still high. Limited choice to contraceptive methods, especially in rural areas, and financial and physical access to services supplying contraception are key factors that influence this unmet need.

Status of Political Support for Family Planning

Cambodia's political support for family planning is high. It is listed as a priority in the MOH's *Health Sector Strategic Plan 2003–2007* and, in a speech delivered at the launch of the *National Population Policy* in 2003, Cambodia's Prime Minister said: "At the center of the policy is the right for all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children." As in many other developing countries, Cambodia has a rationale for supporting family planning. If the unmet need for contraceptives can be eliminated, and the crude birth rate reduced, then the high maternal mortality and morbidity rate could also be reduced (Ministry of Planning, 2002, MOH, 2004a). Maternal mortality and morbidity have long-term negative economic consequences on households and on society, as the number of orphans and out-of-school youth grows and rates of child mortality and morbidity increase.

Cambodia is a signatory of the Millennium Declaration, which was adopted in September 2000 by all 189 member states of the UN General Assembly. Family planning was not included as a Millennium Development Goal (MDG); however, under Cambodia's MDG, targets 4 and 5 focus on improving child health and reducing the infant mortality rate (IMR), reducing the total fertility rate (TFR) and increasing CPR:

MDG Target 4.6:	Increase the proportion of infants exclusively breastfed up to six months of age from 2 percent in 2000 to 49 percent in 2015.
MDG Target 4.7:	Increase the proportion of mothers who start breastfeeding their newborn child within one hour of birth from 11 percent in 2000 to 62 percent in 2015

MDG Target 5.2: Reduce TFR from 4 in 2000 to 3 in 2015.
MDG Target 5.4: Increase proportion of married women using modern FP methods from 19 percent in 2000 to 60 percent in 2015 (CSD/GSCSD/PMATU, 2003).

In 2002, the Ministry of Women and Veterans' Affairs (MWVA) revised its *Policy on Women, the Girl Child, STIs, and HIV/AIDS*. This revision was in response to the more comprehensive and multisectoral approach to HIV/AIDS stated in the NAA's *National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS, 2001–2005*. The policy recognized that, whereas formerly MTCT interventions had focused on the protection of infants born to HIV-positive women, it was essential to address the prevention of HIV in childbearing women. The revised policy also placed a greater emphasis on male involvement in RH decisions (MWVA, 2003).

Role of the Private Health Sector[9] and NGOs in Family Planning Programs

In general, the most common action taken by people in Cambodia seeking healthcare is to purchase medicines or seek treatment from a private source. Reasons that Cambodians prefer not to use the public (i.e. government) health system include: a lack of trust and understanding of the public health sector, the high informal fees charged by public sector personnel, and inadequate availability of the services, personnel, and drugs that clients expect (MOP, 1997). In Cambodia, quality of care is often perceived as "the more drugs prescribed, the better the care" (MEDICAM, 1999). Prescription drugs are widely available over the counter in private facilities, but there are large variations in quality standards (RACHA, 1998).

In Cambodia, the private health sector is largely unregulated, although bodies do exist which, in theory, attempt to monitor the quality of services provided by their members. One such body is the Cambodian Midwives Association, which offers training to its members through RACHA, and another is the Pharmacists Association of Cambodia, which attempts to enforce the quality standards set by the government. Both, however, have limited membership and are limited in their capacity to "monitor" their members (RACHA, 1998).

In 2002, Population Services International (PSI) created the Sun Quality Health Network (SQHN) of private sector clinics. As part of the network, these clinics are expected to provide good quality and affordable FP commodities, counseling, STI treatment, and VCCT. As of October 2004, the SQHN numbered 95 service delivery points in four provinces, in addition to Phnom Penh (PSI, 2004a). All of the clinics supply most contraceptive methods with the exception of IUDs. Each client should receive a health check before receiving counseling on his or her choice of contraceptive method—a service that is not likely common outside the SQHN. However, only a minority of these clinics are currently providing VCCT and surveys conducted by PSI using "mystery clients" showed that the levels of the promotion of condoms as a dual protection method were still low. According to one donor respondent, the low levels of promotion may be due to the fact that condoms still carry the stigma of being associated only with commercial sex. In addition, it is recognized that the fact that most service providers are men could be a barrier in encouraging discussion over contraceptive choice. In response to these issues, PSI has embarked on a training program, in co-peration with the National Reproductive Health Program, to increase the capacity of the service providers to promote condoms and improve counseling about FP choices.

In Cambodia, NGOs play a central and influential role in supporting the government healthcare systems and, as part of that, strongly participate in implementing FP initiatives. Some NGOs, such as the

[9] In Cambodia, the private health sector is taken to mean the hospitals, clinics, and pharmacies that provide healthcare services and medicines on a for-profit basis.

Reproductive Health Association of Cambodia (RHAC) and Marie Stopes Cambodia (MSC), work autonomously in establishing RH clinics, but it is more common for NGOs to assist the MOH in upgrading its own healthcare facilities, increasing the capacity of its staff resources, and developing and assessing its strategies. NGOs also play a lead role in piloting programs aimed at specific groups, such as youth, garment factory workers and migrants, and implementing IEC campaigns and community-based interventions.

The Reproductive Health Association of Cambodia (RHAC) also contributes significantly to Cambodia's RH and HIV/AIDS services. Since its creation in 1994, RHAC is now the largest RH health provider in Cambodia, outside the government, offering high quality and affordable clinical reproductive healthcare, education, and training in seven provinces.

More recently, RHAC has been focusing on the delivery of IEC and cost-effective services to people aged 12–25 and aims to promote the use of RH services by young people through peer education. Networks of volunteers have been trained to share information about sexual and reproductive health with their peers through libraries, karaoke, games, and discussion sessions, and special clinics are held for young people wanting to access RH services.

PSI distributes contraceptive commodities through social marketing. PSI's campaign launched in 1994, to advertise, distribute, and market the Number One condom has led to this brand being found in 97 percent of all the brothels surveyed in 2002 (PSI, 2004b). Number One condoms now hold an estimated 80 percent of the condom market in Cambodia. More than 137 million have been sold as of October 2004 (PSI, 2004a). Other NGOs, such as CARE, purchase supplies of the condoms from PSI to be socially marketed within their own health initiatives. In 2004, in response to the changing nature of the HIV epidemic and the dramatic increase in HIV transmission between men and their wives and sweethearts, PSI launched the OK Condom. The aim of this product it to overcome the stigma of condoms and to provide dual protection to couples.

2. Current Status of the HIV/AIDS Program and Trends

There is a general consensus that the government of Cambodia continues to respond commendably to the HIV/AIDS situation and has been responsive to the changing profile of the epidemic. By 1998, the government's response to the epidemic was one of Cambodia's biggest national programs; this helped to make the epidemic more visible and facilitated donor support.

Cambodia continues to develop its multisectoral approach to the epidemic, in which 26 ministries are involved. The Ministry of Education, for example, includes HIV education in the national curriculum, while the Ministry of Social Affairs is responsible for orphan programs. However, the performance of some of the non-health ministries working under the NAA umbrella does demonstrate an area of weakness in the response. According to one respondent from a donor agency, these ministries often lack the capacity and the funding to implement HIV/AIDS projects.

Reducing rates of "family infection" and caring for PLHAs and orphans are among the new challenges facing Cambodia, explained one respondent. Addressing these issues will require a commitment at the community level. Essentially, men must become more involved in RH choices and become more motivated to care for their own reproductive health and that of their partners, as well as protect their families. Awareness of HIV is already high. It is now important to reduce the stigma of the disease so that PLHAs and orphans can be supported by their communities.

Continuum of Care (CoC)

As the epidemic develops, it is essential to focus on efforts that supply care and support systems. It is also reasoned that more widely available ARV programs, expansion of home-care networks, and support for orphans and children will be key motivating factors to encourage people to acknowledge their HIV status (Fletcher, 2003). To this end, the Strategic Plan for HIV/AIDS and STI Prevention and Care in Cambodia 2001–2005 included the provision of a CoC to improve the quality and accessibility of care of PLHAs through the extension of HIV/AIDS care services nationwide. Substantial support is now available for the CoC program from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (NCHADS, 2003).

A number of pilot projects have been implemented for various components of treatment and care. Efforts are now underway to integrate, coordinate, and expand programs at national and local levels. It is reasoned that, in the CoC, the uptake and quality of each activity is dependent on the availability and quality of the other services (NCHADS, 2003). To this end, it is now crucial to develop strong and effective referral mechanisms at the OD level between health facilities, VCCT services, home-based care teams, PLHA groups, and NGOs. The RGC can now depend on a strong network of institutions to work on each component of the CoC and to refer clients from one service to another. For example, the Khmer HIV/AIDS NGO Alliance (KHANA) mobilizes people at the community level to use the services; the Asia Development Bank (ADB) and the World Bank provide resources for healthcare facilities; RACHA provides drugs and resources for logistics; United Nations Children Fund (UNICEF) supports the PMTCT element; and Family Health International (FHI) supports the provision of VCCT and ARVs and connects its clients with FP services.

Staffing Trends and Issues

There is no confirmation that the AIDS epidemic has had a direct impact on staff resources or staff morale through loss of staff from illness and death in the public health sector, the private sector, or within NGOs. However, it is recognized that the HIV/AIDS epidemic has created more jobs and more clients, but also placed a greater burden on NGOs, the public, and the private healthcare system.

Health personnel are continually leaving the employment of the MOH to work in the NGO or private health sectors. This is not necessarily because they are being drawn specifically into the HIV/AIDS sector, rather, it is almost always a decision based on financial criteria, as MOH salaries are comparatively low. According to one respondent from the MOH, this situation requires the MOH to continually train new staff who will then look for other positions once the training has been completed. Another respondent added that this turnover of personnel has obvious negative effects on the valuable resources of the MOH, and, in terms of HIV/AIDS, impedes the government's response to the epidemic. This problem is not confined to the MOH. One respondent noted that RHAC has also suffered from the loss of its highly trained staff to INGOs and the UN, because it cannot compete with their salaries and benefit packages.

One of the most significant challenges to Cambodia's health sector is how to care for the increasing number of PLHAs. In 2004, there were an estimated 19,815 AIDS cases (NCHADS, 2004). All will require medical care and counseling in addition to economic support for themselves and their families. Activities have already been implemented that help to equip health personnel—in the public and NGO sectors—to respond to the needs of PLHAs and HIV-positive persons. Some of these activities include:

- Training of home care teams on counseling and care (KHANA)
- Training of district hospital staff (Medecins du Monde Cambodge)

- Training in HIV testing, diagnosis, and treatment of opportunistic infections and HIV infection with antiretroviral drugs (FHI/NCHADS) (UNAIDS, 2004)

In addition, in 2003, NCHADS published the national guidelines for the prophylaxis of opportunistic infections in people living with HIV/AIDS, to be used by the growing number of caregivers of PLHAs.

Recent interventions, such as the Greater Involvement of People Living with HIV/AIDS (GIPA) promote the inclusion of HIV-positive people in the workplace and in formulating policy. NGO staff and public health sector staff supported by NGOs receive regular training on HIV/AIDS prevention and transmission.

Universal Precautions and Post-Exposure Prophylaxis (PEP)

In 2002, NCHADS finalized the "Guidelines for Medical Institution Universal Precautions." These guidelines include general recommendations for hygiene and sterilization in healthcare settings, including the handling and disposal of sharp objects. These recommendations are complemented by the establishment of an Injection Safety Committee, which is supervised by the Department of Hospitals of the MOH. This committee oversees the distribution of safety boxes and disposable syringes and issues instructions on how these should be used and disposed of (UNAIDS, 2004). According to one respondent, NCHADS is currently lobbying for the equipment required for effective UP to be included on the MOH's essential drug and equipment lists.

Staff of health facilities at HC and OD levels have basic equipment such as gloves and needle disposal boxes, and many have received training in UP, but UP are not always applied in reality. One respondent from the MOH commented that service providers speak of not having enough time to put on gloves or opting not to wear gloves for fear of client complaints about discrimination.

The protocol and drugs for PEP are not universally available, at least in the public health sector (UNAIDS, 2004). The policy for PEP is under development and should be approved by the MOH in 2005. Little is known about the implementation of PEP protocols or the use of UP in the private health sector. Members of the SQHN have received information from NCHADS about PEP and UP, and have gloves, masks, and needle boxes. However, two respondents commented that day-to-day application of UP in the private health sector is usually erratic.

3. Perceived Need for Family Planning in the Face of the Ongoing HIV/AIDS Epidemic

There was unanimous agreement among all respondents that family planning was as important, if not more important, in the face of the HIV/AIDS epidemic, and that FPP had a key role to play in the response to the epidemic. However, the vertical nature of all RGC-driven health programs makes it extremely difficult for one sector to work in tandem with another. Despite this, there is a general consensus that interventions for FP and for HIV/AIDS should be integrated wherever possible. Important linkage points for the two areas include VCCT and a strong referral system. VCCT for pregnant women should, for example, help to increase access to FP services, and, as one respondent from the MOH noted, this is more cost effective than administering courses of ARVs to pregnant HIV-positive women. VCCT will also facilitate referral to other services, such as STI services, provided that the referral system addresses the common barriers that prevent clients seeking such services, such as discrimination and lack of confidentiality.

It is only recently that cultural assumptions about the sexual behaviour of Cambodians, particularly of young people, have been challenged (Fordham, 2003). For example, an issue receiving increasing attention is that of sweetheart relationships. Lovers, hand-holding, and sugar daddies are all referred to as

"a sweetheart relationship." Within these kinds of relationships, there is evidence to suggest that sex is becoming more common, especially in urban areas. Therefore, sexually active unmarried women are increasingly at risk of unwanted pregnancy and HIV/AIDS.

Research conducted by PSI showed that while the number of encounters with DSWs had decreased and condom use with DSWs has increased, men were not using condoms consistently in their sweetheart relationships. The research found that the more affection and trust there was in the relationship, the less likely it was that a condom would be used (PSI, 2002). This is further exemplified by PSI's 2003 nationwide KAP study, in which 87 percent of the respondents agreed with the statement that "suggesting condom use implies mistrust" (PSI, 2004c). In response to these alarming findings, PSI, with Department for International Development (DFID) funding, launched a new condom brand in 2004, called the OK Condom. This brand is targeted at sweetheart relationships and married couples and is designed to encourage the use of condoms in a trusting relationship and to act as a dual protection method.

Integration and Cooperation

The integration of HIV/AIDS and RH services is seen as a powerful tool in the fight against the epidemic, and it is acknowledged that both HIV and FP services must undergo a fundamental change in their approach—not only to promote integration but also to support the new priority of preventing family transmission of HIV. There is a call for services, both of RH and HIV, to become more "male friendly." One respondent noted that men particularly should feel confident about going for testing, understand the importance of changing their behaviour, and use condoms for dual protection.

Efforts to integrate services are increasing at the central level of the public health sector. There is attendance at working group meetings for PMTCT and STI prevention by both NCHADS and NMCHC, referral guidelines are included in maternal and child health (MCH) training strategies, and the promotion of condoms as a dual protection method is officially advocated. At the referral hospital level, there is a growing PMTCT program and more VCCT services at hospitals with HIV testing facilities. However, at HC and clinic levels, vertical programming is so entrenched that referral systems between essential services are sometimes nonexistent. Government-run STI clinics, for example, have no access to FP services. Integration occurs at the health center level but only in the sense that there is not enough staff to take responsibility for each of the services—in addition to their outreach activities—so responsibilities are shared among the staff. Some service providers explained that information about family planning and HIV/AIDS is distributed verbally by health center staff, while levels of IEC materials and training on HIV prevention are often low (although this will not always be the case in NGO-supported health centers). Furthermore, low salaries and a lack of incentives result in a severe shortage of staff in rural areas. As one respondent from a donor agency noted, it is clear that for integration of services to be successful and sustainable, it will be necessary to strengthen the services and the facilities offered by health centers.

NGO projects and the areas of the public sector supported by external donors fare better. Examples of successful integration of services are now emerging in Cambodia. They include: PSI's OK condom which promotes dual protection; CARE's garment factories project, which addresses both the HIV/AIDS and RH education needs of an emerging high-risk group; the UNFPA adolescent health program; FHI's CoC program in Battambang, which includes counseling and family planning to women on the PMTCT program; RHAC's integrative programs of testing, counseling, referral, and treatment; and RACHA-promoted training and IEC for government HC staff on family planning, HIV prevention, dual protection, and counseling skills.

FHI now integrates HIV-prevention initiatives among high-risk groups, such as the military and DSWs, with efforts to promote knowledge of RH among their wives, families, and sweethearts. All project

beneficiaries receive counseling on how to access services, such as FP and STI counseling and education about dual protection, and women are helped to access PMTCT services.

Good cooperation exists between the MOH and many NGOs, which allows a more thorough integration of services. For example, IEC campaigns and effective counseling, aided by RACHA, have helped the MOH reach its target for Voluntary Surgical Contraception in 11 districts. In CARE's target operational districts, the NGO has distributed integrative IEC materials to health centers, which cover HIV/AIDS and family planning. CARE also assists pregnant women in these ODs to access VCCT and follow-up services through an opportunity-costs scheme. FHI works closely with RHAC to ensure that FHI's high-risk target groups have access to RH services.

The Prevention of Mother-to-Child Transmission of HIV

In Cambodia, MTCT is expected to become the main route of transmission of HIV in the next five years (UNAIDS, 2004). Already, one-quarter of all new HIV infections are from mother to child (NCHADS, 2003). In response to this, Cambodia has launched the *National Policy of Preventing Mother-to-Child Transmission of HIV*, which focuses on preventing the transmission of HIV to infants of HIV-positive mothers and on helping women who are HIV negative to remain so. This policy is a collaboration between NCHADS and the NMCHC. The policy states that "the main objective of the PMTCT program is to improve acceptability, accessibility, and quality of health services and information of reproductive health and HIV/AIDS/STIs" (MOH 2001). According to the policy, a package of activities should be integrated into routine health services. This package contains:

- VCCT, HIV education, condom promotion, and negotiation skills development to prevent HIV infection among women of childbearing age and their husbands/partners and to avoid wanted pregnancy among HIV-positive women
- Interventions such as antiretroviral drugs, safe delivery practices, and safer infant feeding practices to reduce MTCT
- Provision of information on care services to HIV-positive women and their families

This policy also recommends the adaptation of infrastructure to, for instance, accommodate counseling and education activities at health centers, the reallocation and development of staff resources—such as the establishment of trained counsellors at the health center level—and consistent and continuous supplies of drugs (including those for post-exposure prophylaxis).

While these recommendations are logical, their implementation is unlikely—at least in the near future—at health centers that are not in receipt of donor funds. Despite the expansion of the PMTCT program (in eight provinces by the end of 2004), few women outside of Phnom Penh attend antenatal services and even fewer deliver at public health services. Eighty-nine percent of women deliver at home, and most of these home births (66%) are attended by TBAs (NIS and ORC Marco, 2001). Of those women who are attending antenatal clinics in rural areas, only 6 percent have access to public sector HIV testing (Fletcher, 2003). The implementation of PMTCT programs countrywide is a priority of MOH. However, the current awareness of PMTCT programs at community level is low (KHANA, 2003), and, according to one respondent, uncertainty persists over how best to access the women who give birth at home.

Voluntary Confidential Counseling and Testing (VCCT)

VCCT is recognized by many of the major donors as being essential to help prevent HIV infection and as the entry point to the continuum of care. "The quality of the first encounter often influences future health and treatment-seeking behavior" (KHANA, 2003). The major donors supporting VCCT are the UNICEF, ADB, and the World Bank. As of 2004, there are 75 government-endorsed VCCT centers with plans to

increase this number to 102 in 2005, according to a government respondent. However, most of these are concentrated in the Phnom Penh region and operate as a stand-alone service, making little attempt to refer and follow-up clients. There is concern that levels of use of these clinics are low and that the quality of counseling is poor (Fletcher, 2003). There is an urgent need for VCCT services to be established in referral hospitals across the country, as this will significantly aid the referral system between VCCT and prevention and treatment services. National recommendations for such referral mechanisms do exist and must now be adapted to the local situation (NCHADS, 2003).

There are indications that pregnant women are not using public sector VCCT services (Fletcher, 2003). Improving access to VCCT for pregnant women through the NMCHC and eventually to referral hospitals throughout the country is a strategic object for NCHADS. In addition, RHAC, CARE, and RACHA are expanding VCCT services within their RH services. The use of these VCCT services will depend, however, on the increasing access of pregnant women to ANC services.

4. Funding Trends

Funding for Family Planning Programs

Data on funding for family planning appear to be far less accessible than comparable data on HIV/AIDS funding. One of the possible reasons for this is that, despite the vertical nature of Cambodia's public health sector, it is difficult to identify government (and sometimes donor) funding specifically for FP activities, as such activities feature in numerous MOH budgets. For example, the budget for the Minimum Package of Activities (MPA) (i.e., services at the health center level) will include family planning, as will the budget for the NMCHC in Phnom Penh. DFID has pledged GB£15.4 million to support the implementation of the government's *Health Sector Strategic Plan (2003–2007)*. The aim of the plan is to strengthen the sector and improve access to services, especially in poor and rural areas. DFID's contribution will be combined with funding from the World Bank and ADB and will support, among many other programs, efforts to reduce maternal mortality.

UNFPA has estimated that in 2005, Cambodia's resource requirements for RH programs will be nearly US$29 million, rising to US$36.3 million by 2015 (UNFPA, 2004). However, while demand for funding for RH programs is increasing, respondents suggest that actual funding from international donors has decreased over the past five to ten years. Some respondents argue that the quantity of funding earmarked for HIV/AIDS interventions has been detrimental to RH programs. Others suggest that, while RH budgets from both the RGC and donors seem small in comparison to the budgets for HIV/AIDS, support for reproductive health has not actually decreased in real terms as a direct result of increasing support for HIV/AIDS. Whichever is the case, the MOH is in the process of lobbying donors to increase their support for reproductive health, because funds from the national budget for reproductive health, although stable, are not sufficient.

UNFPA continues to be one of the largest supporters of RH projects and supports the public sector at the health center level. For its second funding cycle, which finishes in 2005, the UNFPA program in Cambodia has a budget of US$26 million. Seventy percent of this is earmarked for reproductive health, which includes—specific to each project—HIV prevention.

UNFPA, KFW, and DFID (who funds the OK Condom, which is marketed as a contraceptive) all provide funds for contraceptives. While funding for contraceptives is relatively secure until 2006, demand for contraceptive supplies often outstrips supply, and in the case of condoms, stocks purchased as contraceptive commodities are often distributed en masse at public events for HIV prevention. In response to this, a commodity security working group has been established, which is currently in the process of forecasting needs up until 2010.

Funding for HIV/AIDS Services

The response of Cambodia to the HIV/AIDS epidemic, by both the public sector and by national and international NGOs, is largely driven by the priorities and areas of influence of the donors. Undoubtedly, this has resulted in several high-quality, well-resourced and integrated initiatives. However, this high volume of aid for HIV programs has placed a high demand on Cambodia's capacity to effectively use, disburse, monitor, and coordinate these funds and, as one respondent from a donor agency also noted, such close ties to donor initiatives also ensure that the response to the epidemic is vulnerable to down-turns in donor support.

Cambodia has received significant support for its efforts to tackle the HIV/AIDS epidemic from the GFATM. For the first round, Cambodia received US$11.2 million for its HIV/AIDS programs, and for the second round, US$5.3 million. US$8.8 million was approved for round four (GFATM, 2004). A call for proposals for round five of the GFATM has just been announced, and the priorities have been listed as the CoC, the prevention of further transmission through a focus on families and couples, and PMTCT. Cambodia was also nominated as one of four rapid scale-up countries by USAID. This has led to significant funding from USAID for HIV programs and contributed to levering funds from other donors.

Through the *Strengthening Cambodia's Response to HIV/AIDS, 2003–2008* program, the Cambodian government has received support from DFID of GB£15.6 million. This funding will be channelled into the NAA, NCHADS, and the Ministry of Education, Youth and Sports. From 2001 to 2006, DFID also supports PSI with GB£5.7 million to increase the distribution of condoms (Number One and OK condoms) through private and NGO channels.

Many HIV programs have expanded beyond prevention and targeting of high-risk groups into care and treatment. However, while funding support for these areas is high, one respondent pointed out that funding can never be sufficient for the treatment and care of PLHAs, as costs of increased access to ARVs and admissions to hospices are continually rising.

While funds for HIV/AIDS are substantial, respondents noted that they are not evenly distributed in the public sector. For example, NMCHC is responsible for the national PMTCT program, yet does not have access to the government budget for HIV/AIDS services or NCHADS funds. Donors such as UNICEF, Japan International Cooperation Agency (JICA), USAID, and the CDC support the PMTCT program but funding is still not sufficient to support the necessary growth of the program. However, it is acknowledged at a central level that this must be addressed, as it is understood that a well-supported, nationwide PMTCT program, which runs in tandem with continuing prevention programs, is likely to be far less expensive than the long-term care of orphans.

The top-down distribution of HIV/AIDS funds, particularly for treatment and care, ensures that such services are often inaccessible at HC and referral hospital level. This forces people, usually in areas outside of Phnom Penh, to depend on the unregulated private sector, thereby incurring impoverishing costs for often dubious services.

PSI, FHI, RHAC, RACHA, and CARE are all examples of international and national NGOs who are integrating HIV/AIDS interventions with RH interventions. The rationale for many of these NGOs is that HIV/AIDS is a RH issue and that the promotion of RH is an essential aspect of HIV promotion. HIV/AIDS is also a development issue that has an impact on entire communities and should not, therefore, be addressed in isolation. In many cases, this has allowed NGOs to access funds from donors primarily concerned with one or the other of these issues. In situations where the capacity of one NGO to raise funds for or implement an essential cross-issue activity is lacking, collaboration with partners is

necessary—such as FHI's collaboration with RHAC to provide RH services to sweethearts and families of high-risk groups.

Summary and Conclusions

This report examines the provision of FP services in Cambodia in the context of high HIV prevalence. Issues such as the status and trends of funding for both HIV/AIDS and FP programs have been discussed, as have the issues of staff deployment, the role of the private health sector and NGOs and the impact the epidemic has had on health staff resources. With respect to FP programs, HIV/AIDS services, and the integration of the two sectors, the following conclusions can be made:

Family Planning Programs

The prospects for family planning in Cambodia appear positive. There are high levels of awareness and approval of modern contraceptive methods. There is the political will to support FP activities and there is close cooperation between the RGC and international and national NGOs. There is also a willingness on the part of the government to adopt community-based interventions for the education and distribution of contraceptive methods.

However, the full range of FP services is still inaccessible to many Cambodians, and challenges to further progress exist. The FP activities of the public sector suffer from a lack of decentralization of financial, technical, and human resources. There is an urgent need for personnel, facilities, and commodity supplies to be better established outside of the urban areas and for funding for FPPs to reach down to the HC level. Adequate staffing resources of public FP programs are threatened by unsustainably low salaries and, currently, human resources flow from the public and national NGO sectors into the international organizations where rates of pay and benefits are higher. There is also a flow of staff from the provincial to the urban areas. This seriously impedes the functioning of the public health sector at OD and HC levels.

The private health sector in Cambodia is largely unregulated. This is a significant area of concern because demand for private health services is so high. Addressing the problems related to the private sector may help to reduce the level of complications due to abortion and improve the quality of FP counseling and referral. The Sun Quality Health Network is a model of how NGOs and the private sector can cooperate, and it shows how steps can be taken to help regulate the quality and practices of private practitioners.

Decisions over FP (and HIV protection) are usually made by men. It is essential that men are persuaded to be more involved in FPPs and shown how their educated decisions can protect both themselves and their families. Until then, condom use as a method of dual protection (or as part of dual method use) will remain at unsatisfactory levels, and men and their families will always be vulnerable to STIs and unwanted pregnancies.

HIV/AIDS Services

The targeted response to the HIV epidemic has been highly effective. The challenge now lies in establishing effective care and support networks for PLHAs and their dependants, and in reducing the impact of the epidemic on sweethearts, wives, and children as well as other vulnerable groups such as adolescents, injecting drug users, and men who has sex with men.

Currently, donors are responsive to Cambodia's urgent need to tackle the HIV/AIDS epidemic, and resources have been given a significant boost with the support of the GFATM. However, according to one respondent, current levels of donor support are not sustainable, and donor support is not always channelled to areas of greatest need. Just as with FPPs, one of the most significant obstacles to the implementation of HIV/AIDS services is the lack of resource decentralization. Staff salaries and budgets

allocated to referral hospitals and health centers are grossly inadequate (NAA, 2001). Furthermore, while the RGC and donors have responded quickly and generously to the epidemic, sufficient financial resources have not been committed to the multisectoral response, particularly at the provincial and community levels.

Policies exist for UP and PEP but, in practice, both are implemented erratically and are under-resourced. The drugs and equipment required for PEP will be given a boost with the injection of GFATM funds, but it is essential that these resources are filtered down to the provincial level.

Integration of Services

The HIV/AIDS epidemic is changing and priorities are changing with it. As new target groups emerge, such as drug users and adolescents, and more women, children, and families are affected, it is essential that the response to the epidemic becomes more integrative.

Currently, the integration of FP and HIV/AIDS services is limited, but within UN- and NGO-supported programs, models of integrative services already exist. RHAC has operated integrative services since its establishment 10 years ago, and other examples exist in localized CoC and PMTCT programs. Within the public health sector, however, the vertical nature of the system has impeded integration at all levels. Many public-sector services, such as STI clinics and VCCT centers, operate in isolation and offer little in the way of referral or counseling. Efforts have been made to improve the situation through the health sector reform process and the implementation of the MPA. However, this in itself poses additional challenges to the improvement of services at HC level, as staff are expected to take on more responsibilities without a corresponding increase in technical and financial resources.

In comparison to HIV/AIDS programs, FPPs are vulnerable to shortages of funds. Funding for FPPs needs to be increased in real terms, but such programs can also be supported through integration of HIV and FP services. This would permit the mobilization of resources toward projects incorporating FP activities. If integration is to occur in other than localized situations, resource decentralization and collaboration between public, private, and NGO services is critical.

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