



# Cambodia

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## KEY POINTS

1. Policies, guidelines, and a strategic plan are in place in Cambodia to meet the UN's four-pronged strategy to prevent vertical transmission, however, practical application has been limited.
2. The majority of births (78 percent) occur at home or outside public health facilities in which prevention of vertical transmission services are available. As a result, the vast majority of women of childbearing age miss the opportunity to be tested for HIV.
3. Access to prevention of vertical transmission services is hindered by poor integration with broader health care services, most notably key maternal and child health services.
4. Health care providers are directed to provide all mothers with information on the potential risks and benefits of all forms of feeding; however, many public-sector and civil society personnel reportedly are heavily biased in favor of the formula feeding option.

## RESEARCH PROCESS AND METHODOLOGY

This report is based on i) a desk review of documents including the National Strategic Plan for PMTCT 2008-2015, the national prevention of vertical transmission guidelines from 2005 and the 2007 Cambodia PMTCT Program Joint Review Report; and ii) a total of 25 interviews with key informants. Interviews were conducted with government representatives (10 individuals total) from the National Maternal and Child Health Centre, the National AIDS Authority, the National Centre for HIV/AIDS Dermatology and STIs, and the Takeo Provincial Health Department; one person each from three UN agencies (UNAIDS, UNFPA and UNICEF); eight representatives of international and local NGOs, including ActionAid International, Care, World Vision, Family Health International, HIV/AIDS Coordinating Committee, the Cambodian Community of Women Living with HIV/AIDS, and the Cambodian People Living with HIV/AIDS Network; and four individuals associated with a private-sector maternity and a children's hospital. Researchers also conducted a roundtable discussion with 25 midwives and held two focus group discussions with pregnant women, one in an urban area at Takeo Health Centre (10 women), and one in a rural area at Samrong Health Centre (12 women).

## 1. BACKGROUND INFORMATION

Estimated HIV prevalence among adults (15 to 49 years of age) in Cambodia has declined from a peak of 2.3 percent in 1997 to about 0.9 percent in 2006. Projections indicate that, if interventions are sustained at current levels, HIV prevalence will further decline before stabilising at 0.6 percent by 2011. However, a resurgence of the epidemic cannot be ruled out given the relatively high prevalence among most at-risk populations, including female sex workers, their clients and other sexual partners; men who have sex with men (MSM); and injecting drug users (IDUs). For example, a study in 2008 conducted by the MoH and the Ministry of Interior indicated that HIV prevalence among IDUs is 24.4 percent.

Based on new HIV prevalence estimates and projections, the number of people living with HIV (PLHIV) was estimated at 64,750 (including 3,350 children under the age of 15) in 2007. Some 29,200 adults were in need of antiretroviral therapy (ART), a number that is expected to increase to 35,100 by 2010.

Cambodia's prevention of vertical transmission program was started in 2000 with the formation of a national technical working group and prevention of vertical transmission secretariat at the National Maternal and Child Health Centre (NMCHC). Since then there has been a gradual increase in the percentage of HIV-positive pregnant women who receive ART to reduce the risk of vertical transmission; that share increased from

7 percent in 2004 to 14 percent in 2007. Meanwhile, estimated vertical transmission declined from 30.5 percent of all births to HIV-positive women in 2001 to 11.4 percent in 2007<sup>6</sup>.

In 2007, the prevention of vertical transmission program tested and provided pre- and post-test counselling to 16.1 percent of Cambodia's pregnant women. It also provided ARV prophylaxis to 11.2 percent of the estimated total number of HIV-positive pregnant women and later to their newborns. The low level of coverage is highlighted by the fact that 83.9 percent of all Cambodian pregnant women in 2007 did not know their HIV status and no ARV prophylaxis was provided to either mothers or infants of 88 percent of births involving an HIV-positive mother.

As of September 2008, there were 154 sites and 76 operational districts with at least one health centre providing prevention of vertical transmission services.

## 2. STATUS OF SERVICE DELIVERY AMONG AND FOR WOMEN

*“With PMTCT policy, strategic plan, SOPs and guidelines, we have the foundation for a scaled response, and we are confident in achieving the universal access target for PMTCT in 2010.”*

**Tony Listle, UNAIDS  
country representative**

Several different government agencies share responsibility for HIV/AIDS services of importance to women. NMCHC implements prevention of vertical transmission intervention within its maternal and child health (MCH) services unit; the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) provides VCT, ART and OI services; and the National AIDS Authority (NAA) has a national coordination and resource mobilization role.

The prevention of vertical transmission program has benefited from money provided through Rounds 4 and 7 of the Global Fund as well as various UN agencies, bilateral agencies (notably those of the United Kingdom and the United States), and international and national NGOs. (Cambodia was hoping to use resources from the Global Fund's Round 8 to further scale up the PMTCT program, but the country's proposal for that round was denied. A new proposal is being prepared for consideration for Round 9 funding.)

The Cambodian prevention of vertical transmission policy and strategic plan 2008-2015 requires that services be based on the UN's four-prong strategy<sup>7</sup>. The policies, guidelines and standard operating procedures for all of the prongs are in place in Cambodia, but practical application has been limited. As observed by some NGO respondents, “Everything is clear on paper, but not in implementation.”

6 Towards Universal Access report 2008, UNAIDS and WHO.

7 Additional information about the UN's four-prong strategy may be found online at [www.unicef.org/aids/index\\_preventionyoung.html](http://www.unicef.org/aids/index_preventionyoung.html).

Members of the Cambodia country team developed a scorecard, based on a scale of A to D<sup>8</sup>, to measure each of the four prongs' availability and implementation to date. The results are as follows:

1. Primary prevention of HIV infection (Prong 1): B+. Many institutions, including the NAA, UN agencies and NGOs, focus on primary prevention among the general population, but few programs specifically target women and girls. The Ministry of Women Affairs' strategic plan for the prevention of HIV/AIDS among women and girls 2008-2012 intends to address the gap by increasing primary prevention among women and girls.
2. Prevention of unintended pregnancies among HIV-positive women (Prong 2) is weakest and can be given a C. The main reason is lack of positive prevention programs and insufficient access to condoms. However, the revised National Strategic Plan for Comprehensive and Multispectral Response to HIV/AIDS (2008-2010) focuses on positive prevention and scaling up for increased access to prevention of vertical transmission services.
3. Prevention of HIV transmission from mother-to-child is between B+ and C-. Despite the priority given to this by the NAA and the MoH, the drop-out rate from the prevention of vertical transmission program among HIV-positive mothers is still very high, often because service providers are highly and overtly critical of them and their behaviour.

In addition to highlighting the debilitating impact of HIV-related stigma and discrimination, the high drop-out rate indicates poor follow-up strategies and mechanisms for both mothers and infants. One reason is that it is unclear who or what is responsible for follow-up among those involved: health centre staff, the prevention of vertical transmission secretariat, NCHADS, community health workers or NGOs. It is hoped that such problems will be addressed by the National Strategic Plan for Preventing Mother-to-Child Transmission of HIV 2008-2015, which aims to further scale up services and achieve the UNGASS goal of reducing the percentage of HIV-positive babies born to HIV- positive women by 50 percent by 2010.

4. Provision of care and support for HIV-positive mothers, their infants, partners and families (Prong 4) is faring better than others and can be given an A-. The early focus of the national response to HIV/AIDS was on treatment. Over the past two decades NCHADS has allocated significant human, financial and technical resources toward this goal. Most women in need of ART have access to it, but coverage to infants born to mothers living with HIV remains limited due to lack of follow-up.

8 A = highest availability, B = high availability, C = low availability, and D = lowest availability.

*“PMTCT is poor in Cambodia: poor in terms of quality, cooperation, collaboration, coverage of services and high maternal mortality.”*

UN agency representative  
in Cambodia

## CHALLENGES OF THE PREVENTION OF VERTICAL TRANSMISSION PROGRAM IN CAMBODIA

- There has been a relatively low level of utilization of ANC services (30 to 50 percent). The majority of births (78 percent) occur at home or outside medical facilities in which prevention of vertical transmission services are available<sup>9</sup>. As a result, the vast majority of women of childbearing age miss the opportunity to be tested for HIV. Among the reasons for such low levels are lack of transportation; financial barriers; social/cultural norms and practices; and lack of confidence or trust in health care providers, especially those connected with the government.
- There is little awareness about prevention of vertical transmission interventions among the general population, including health care workers. This is largely due to limited availability of information about vertical transmission and low levels of education among women in rural areas.
- Access to prevention of vertical transmission services is hindered by poor integration with broader health care services. As of September 2008, there were 154 prevention of vertical transmission sites nationwide. Only 50 of them are housed in health centres – where most women in rural Cambodia go for ANC services – and the total number of sites is just a fraction of the nearly 1,000 health centres across the country.
- Many health centres have weak infrastructure in terms of qualified, motivated and committed staff, particularly in regards to midwives. This is due to a limited pool of health workers, low salaries and incentives; inadequate medicine supplies, equipment and buildings; and poor technical guidance, supervision and management systems. Many health care personnel work for only a few hours each day at health facilities; the rest of the day they may be at other jobs because they need to supplement their income.
- Weak planning, forecasting, procurement, logistic and supply management systems result in frequent stock-outs of prevention of vertical transmission drugs, HIV test kits and ARV medicines.
- The National Technical Working Group for PMTCT (TWG-PMTCT) has limited representation from the NGO and private sectors. This has resulted in poor coordination and limited awareness about prevention of vertical transmission among many NGOs that provide health-related services.

9 National Strategic Plan for Preventing Mother-to-Child Transmission of HIV, 2008-2015.

A key overarching challenge is institutional. Most respondents said that the scale-up of the prevention of vertical transmission program is inhibited by weak collaboration and cooperation between two key national health programs, NMCHC and NCHADS. The coordination of joint activities at national and sub-national levels remains limited despite a joint statement and set of standard operating procedures co-signed by NMCHC and NCHADS and approved by the health minister.

The growing divide in influence and resources is cited as a main reason for the lack of collaboration. Even though both NCHADS and NMCHC are equal in authority, NCHADS has more capacity in terms of human, technical and financial resources because HIV/AIDS spending has almost tripled over the past decade, while spending on maternal and child health has remained static. As one respondent observed, “There cannot be very good collaboration between rich and poor....It is very difficult to convince the rich to be coordinated with the poor.”

Efforts have been initiated recently to improve the situation by developing better linkages between HIV-related health services and other health services. One pilot project begun in four districts in April 2008 reportedly has shown good results with higher coverage of HIV testing among pregnant women than the national average and improved follow-up services for those testing positive<sup>10</sup>.

### **LESSONS LEARNED FROM THE PREVENTION OF VERTICAL TRANSMISSION PROGRAM**

Despite its many limitations, the prevention of vertical transmission program has played a vital role in increasing pregnant women’s utilization of antenatal care (ANC) and other services. Many respondents said that prevention of vertical transmission services will contribute significantly to a reduction in maternal and infant mortality and thus boost progress toward reaching several of the UN’s Millennium Development Goals (MDGs), notably goals 4, 5 and 6. Moreover, the prevention of vertical transmission program has helped boost HIV awareness among men, an increased number of whom are now directly engaged in ANC services with their wives, partners and family members. Many husbands of pregnant women who receive HIV tests are also seeking tests.

Other lessons learned from the ongoing scale-up of prevention of vertical transmission in Cambodia, as identified by country teams and respondents:

- Greater integration of prevention of vertical transmission services with maternal and child health services is needed to improve the

<sup>10</sup> Funds from the Global Fund’s Round 7 grant are supporting this pilot project, called “Linked Responses”, which is being implemented by NCHADS. Current plans are to scale up the project if the country’s Round 9 application is approved.

delivery of effective programs to prevent HIV infection in infants and young children.

- Effective scale-up of the prevention of vertical transmission program can only be achieved by providing more adequate infrastructure, increased training and resources for staff, and more reliable supply systems. It is difficult for public health systems characterized by low motivation and weak infrastructure to provide ANC and ART services to either women or infants.
- Most prevention of vertical transmission activities, including training and supervision, are initiated and conducted at the central level in Phnom Penh, Cambodia's capital. Such excessive centralization limits the technical capacity of management teams at the provincial and operational district levels to adequately implement services at the local level.
- A prevention of vertical transmission program is more likely to be effective in the long term if it implement pilot projects before scaling up national interventions. In Cambodia, the program was pilot-tested in three provinces before being expanded nationwide.
- A prevention of vertical transmission program should include partnerships with local policymakers, researchers, physicians, communities, NGOs and the private sector to increase awareness and support for project activities. For example, community norms, ideas, and support for a particular program or activity can influence a woman's decision to test for HIV. Unfortunately, such partnerships are far too few in number in Cambodia.
- The effective provision of rapid HIV testing, which is available at all prevention of vertical transmission sites in Cambodia, requires strong collaboration among ART, prevention of vertical transmission and laboratory staff. However, such collaboration is often lacking at sites in Cambodia, which means that some clients are not notified of their rapid test results on the same day they take the test.

### **3. HIV TESTING: ACCESS AND OTHER ISSUES**

A total of 212 VCT sites were operating in Cambodia as of December 2008; of those, 154 offered prevention of vertical transmission services. Provider-initiated HIV testing and counselling (PITC) was implemented in 2006 within various medical settings including prevention of vertical transmission, STI and tuberculosis clinics. This has increased HIV testing uptake and helped ensure appropriate referral to other health services. PITC implementation has also been beneficial for the prevention of vertical transmission program.

In 2008, according to government records, a total of 97,796 pregnant women obtained ANC services at government ANC clinics that offer prevention of vertical transmission services. Of those individuals, 67,973 (69.5 percent) were tested for HIV, and 15,529 (22.8 percent) of their

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husbands/partners were also tested. Of the 63,655 women who received the results of their HIV test, 383 (0.6 percent) were HIV-positive and subsequently referred to prevention of vertical transmission services; similar referrals were also made for an additional 363 pregnant women already known to be HIV-positive. More than 90 percent of these HIV-positive pregnant women reportedly received some prevention of vertical transmission prophylaxis. (It is important to note that the current VCT operating procedure and database management system only requires the classification of client by sex and not by pregnancy status.)

One major factor that prevents some women from accepting testing is the need to seek their partner's consent. If and when they do get tested, however, they may face some obstacles to adequate service provision. The overall quality of prevention of vertical transmission services is improving, but significant problems remain. Often, for example, prevention of vertical transmission specialists are able to devote only a few minutes to pre-test counselling for each client because of high demand and the fact that the specialists usually have additional responsibilities at their health centres. Confidentiality of test results is also not always guaranteed or ensured for women and their children.

According to several PLHIV respondents, some health care providers criticize HIV-positive mothers for becoming pregnant. Health care workers with insufficient training on prevention of vertical transmission often persuade HIV-positive women to abort their babies by telling them that they will die if they do not take that step. Given such pressure, it is not surprising that some HIV-positive mothers choose not to deliver at health care facilities.

#### **4. INFANT FEEDING GUIDELINES AND TRENDS**

Breast-feeding is considered normal in Cambodia and the National Policy on Infant and Young Child Feeding Practices (from 2002) recommends exclusive breast-feeding for up to six months after birth. The 2005 Cambodian Demographic and Health Survey reported that 60 percent of children younger than six months were exclusively breast-fed and that nearly half (46 percent) of mothers breast-feed their children until they are at least 2 years old.

The infant feeding guidelines in the national policy on prevention of vertical transmission (from 2005) focus primarily on informed decision-making. They state that HIV-positive mothers should be provided with as much information as possible about the risks and benefits of various feeding options. Health care providers are urged to support mothers who choose to breast-feed and they are directed to recommend formula feeding only when replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS).

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Research findings indicate that such guidelines are not always followed in practice, however, by all stakeholders involved. Many public-sector and civil society personnel reportedly are biased in favour of the formula feeding option. An NMCHC representative said that NGOs in particular “interpret AFASS as simply asking HIV-positive mothers the question, ‘Do you accept formula feeding?’ with the understanding that the answer will always be yes”. As it stands now, nearly all (95 percent) of HIV-positive mothers in Phnom Penh, the capital and largest city, formula feed their babies up to six months after birth; the comparable rate in rural areas is far lower, at 45 percent.

Some NGOs and government facilities provide formula free of charge, but in most cases clients and their families must purchase it on their own. As a result, many women have no option other than breast-feeding, even when the child is older than six months.

Reports from across the country indicate that regardless of whether HIV-positive mothers breast-feed, follow-up with assistance and support for infant feeding practices is limited.

## 5. IMPACT OF VIOLENCE AND STIGMA

HIV-related stigma, domestic violence and lack of male involvement in antenatal care continue to discourage many women from accessing prevention of vertical transmission services in Cambodia. A 30-year-old participant of a focus group discussion at a health centre in Takeo province said that pregnant women often do not want to disclose their status to partners and families because they fear rejection, isolation and being forced out of their homes.

More effective prevention of HIV transmission among women is also hindered by cultural norms that leave them vulnerable to physical and sexual violence, often at the hands of their husbands<sup>11</sup>. Two respondents observed that such violence is often even greater (due to self-stigma) when the male partner is HIV-positive.

Another issue affecting pregnant women in general is the high rate of violence against women in Cambodia. According to one human rights NGO, more than 1,000 cases of violence against women and children were reported in 2008—a number that is almost certainly far lower than reality given the fact that the majority of such instances are not reported or are classified otherwise. At least one fifth of Cambodian women are thought to experience domestic violence every year. Addressing this problem is complicated by cultural and social norms that at the very least excuse such abuse. Recent studies indicate that more than half of Cambodian

*“I hope that PMTCT will  
be scaled up for the good  
health of mother and child.”*

**HIV-positive woman**

<sup>11</sup> Such violence and abuse was documented extensively in a 2005 publication from GTZ, “Gender-based violence and HIV/AIDS in Cambodia 2005”.

women justify a husband's violence against his wife for one reason or another, although young, urban, and educated women are less likely to consider domestic violence to be acceptable in any circumstance.

## 6. ASSESSING THE WORK OF GLOBAL AGENCIES

The prevention of vertical transmission program has received a high level of attention and support from many donors over the years, including bilateral agencies (such as DFID); UN agencies (including UNAIDS, UNFPA and UNICEF); and multilateral entities (including the Global Fund and WHO).

In 2007, the Cambodia PMTCT Program Joint Review was conducted with the financial support of UNICEF, the Clinton Foundation and the US Centers for Disease Control and Prevention (CDC). Technical advice for this process was provided by international consultants from UNICEF, WHO, CDC and the World Bank.

However, the disbursement of funds, particularly those provided through Global Fund grants, has been slow, a situation that has caused substantial delays in the expansion of services. Most of the donor money is channelled to only one institution (NCHADS), thereby leaving only a limited amount for the more appropriate institution, the National Maternal and Child Health Centre (NMCHC).

## RECOMMENDATIONS

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1. *Integration of services:* UNAIDS and the NAA should increase their resource-mobilization efforts and donor agencies should provide greater financial support for scale-up and integration of prevention of vertical transmission services in all health care facilities.
  2. *Policies and guidelines:* The MoH should revise guidelines to make the private sector more inclusive in comprehensive service delivery for prevention of vertical transmission. The new guidelines should allow services to be provided directly by health care facilities in the private sector, including all hospitals and clinics. The private sector should also be permitted (and should even be encouraged) to submit proposals to the Global Fund through the Country Coordinating Mechanism.
  3. *Coordination and management:* Civil society and private-sector representation in the national technical working group for prevention of vertical transmission (TWG-PMTCT) should be increased. This would help improve coordination among NCHADS, NMCHC, NAA, NGOs and the private sector and, ultimately, increase access to adequate services. The role and responsibilities of different representatives also should be made clear and specific in the TWG-PMTCT's terms of reference.
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4. *Financial support for women:* Pregnant women, particularly those from poor and marginalized communities, should be given financial and in-kind incentives by government agencies and/or donors to seek out and complete all stages of ANC, VCT and other prevention of vertical transmission services. Such incentives might include food and nutritional support and stipends for transportation to and from health care facilities.
  5. *Supply:* Government agencies such as NCHADS, NMCH, and the MoH's Central Medical Store, which are responsible for procurement, supply chain and logistics management systems in Cambodia, should strengthen their efforts to ensure consistent and regular availability of HIV test kits and ARVs for use in prevention of vertical transmission services.
  6. *Information-sharing and awareness:* NMCHC should develop and maintain a website that provides a centralized source of information and resources regarding prevention of vertical transmission, ANC and infant feeding. The website can help raise awareness about prevention of vertical transmission in general, especially among health care workers, program managers and policymakers.
  7. *Quality of services:* The MoH, the Ministry of Finance and/or donor agencies should identify ways to increase salaries and incentives of personnel providing prevention of vertical transmission services. Two important goals would be to have health care facilities open 24 hours a day, with at least one midwife present all the time.
  8. *Human rights:* Prevention of vertical transmission training should be provided to all health services providers and NGO implementers – not just to prevention of vertical transmission personnel. Such training would increase their understanding of prevention of vertical transmission and key human rights issues related to HIV, including confidentiality, non-discrimination and the importance of protecting a women's right to informed consent.
  9. *Community health systems:* Policymakers with the national prevention of vertical transmission program should increase linkages with all health-oriented service providers at the community level, including those operated by NGOs and the private sector as well as unaffiliated traditional birth attendants and community health workers. A full range of community members should also be involved in program planning and implementation to help reduce stigma and discrimination and to improve community awareness of HIV and prevention of vertical transmission services beyond MCH settings.
  10. *Breast-feeding:* HIV-positive mothers should receive appropriate information and counselling regarding the risks and benefits of various feeding options so they can make informed decisions. NMCHC should disseminate the national policy for infant feeding in the HIV context through its website, workshops and meetings to increase understanding at all levels of prevention of vertical transmission
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services and partners, including NGOs. NMCHC and NCHADS should establish a mechanism to follow up with HIV-exposed children to monitor appropriate infant feeding practices and their impact, and to offer appropriate counselling and advice to HIV-positive mothers during all facility visits.

11. *Male partner involvement:* The two national programs (NCHADS and NMCHC) should develop strategies to encourage male partners of pregnant women to be tested for HIV and engage more fully in prevention of vertical transmission services as part of a broader effort to involve the entire family in HIV treatment and care. Such strategies might include specifically urging male partners to accompany pregnant women to at least one ANC visit, sending written invitations to partners, and having community workers conduct home visits. Outreach activities to reach men who are at high risk, such as IDUs, male sex workers, and MSM, should be developed.
  12. *Counselling:* ANC procedures should be reorganized to provide pre-test information to groups of pregnant women (rather than individually). A group pre-test session would help to reduce the burden on providers and allow more time for the individual post-test counselling session. Pre-test counselling should explicitly address stigmatization of HIV-positive women and the potential for negative reactions to lead to violence. Such counselling should also provide tips to pregnant women on ways to persuade their partners to be tested for HIV, engage more fully in ANC activities, and consider behaviour-change counselling if appropriate.
  13. *Peer education:* All pregnant women should be encouraged to become peer educators. Requests could be made by health care providers during counselling sessions.
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