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HARM REDUCTION MODEL OF **COMPREHENSIVE DROP IN CENTER** FOR PEOPLE WHO USE DRUGS



OPERATIONAL RESEARCH OF
KHANA MEANCHEY DROP IN CENTER

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LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ATS	Amphetamine-type stimulants
DIC	Drop in Center
EW	Entertainment Workers
FGD	Focused Group Discussion
HAARP	HIV/AIDS Asia Regional Program
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
IP	Implementing Partner
IPPM	Implementing Partner Program Management
KDFO	Khmer Development of Freedom Organization
KMDC	KHANA Meanchey Drop In Center
M & E	Monitoring & Evaluation
MARP	Most At Risk Populations
MMT	Methadone Maintenance Treatment
MSI	Marie Stopes International
MSM	Men who have sex with men
NACD	National Authority for Combating Drugs
NCHADS	National Center for HIV/AIDS Dermatology and STD
NSP	Needle and Syringe Program
OI/ART	Opportunistic Infection/ Antiretroviral Therapy
PLHIV	People Living with HIV
PWUD/PWID	People who use drugs/people who injecting drugs
RHAC	Reproductive Health Association in Cambodia
SFODA	Sacrifice Families and Orphans Development Association
SHCH	Sihanuk Hospital Center of Hope
SPA	Standard Package of Activities
SRH	Sexual and Reproductive health
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNICEF	The United Nations Children's Fund
USAID/ SAHACOM	United States Agency for International Development/ Sustainable Action Against HIV and AIDS in Communities
VCCT	Voluntary and Confidential Counseling and Testing
VHSG	Village Health Support Group
WHO	World Health Organization

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EXECUTIVE SUMMARY

Established in June 2010 as a model for drug programs in Cambodia, the KHANA Meanchey Drop in Center (KMDC) provides a wide range of activities and services for people who use drugs (PWUD/PWID). This include: peer networks; referrals to methadone maintenance treatment (MMT); a learning center for medication prescription and counseling; a research center for drug related health issues, HIV and others health problems; a center for Information, Education and Communication (IEC); and provision of capacity building support for Implementing Partners (IPs).

An operational research was conducted to assess the innovative model of the Center, identify barriers, challenges and lessons learned during program implementation. This report details on the findings of the research.

Both quantitative and qualitative methods were employed in the operational research. The quantitative data was collected from KMDC's monitoring and evaluation (M & E) database and reports. The qualitative data was collected from interviews and focused group discussions (FGD) with more than 30 respondents, ranging from key informants to PWUD/PWID, in an effort to obtain a comprehensive picture of the KMDC. Desk reviews and consultative meetings were also used to complement this study.

Overall, findings from the study show that the KMDC's delivery of harm reduction interventions to PWUD/PWID is on the right track. Furthermore, KMDC also possesses several unique features, such as the provision of comprehensive services at the Center; the integration of gender perspective into its services; the establishment of an enabling environment; and the recruitment of PWUD/PWID as peer outreach workers. In addition, it has been found that the success of the KMDC is strongly associated with the level of political support for drug programs in the country.

While it is beneficial for PWUD/PWID to be able to access a diverse range of services at KMDC, the KMDC should continue to improve itself in order to become a "One Stop Comprehensive Service Center". Provision of Sexual Reproductive Health (SRH) services, such as family planning and Sexually Transmitted Infection (STI) diagnosis, care and treatment need to be strengthened. Also, in line with the feedback received from PWUD/PWID, vocational trainings should be redesigned to allow for greater flexibility.

In the future, KMDC should also continuously strive to create an enabling environment and initiate community development in the Center's surrounding neighborhood. Existing services at the KMDC should be made accessible not only for PWUD/PWID, but also for other members of the community where the Center is located.



INTRODUCTION

1.1. THE DRUG USE SITUATION IN CAMBODIA

Cambodia's position as a transit point on regional drug trafficking routes has resulted in the country's experiencing the effects of an emerging wave of drug abuse. According to Non-Governmental Organization (NGO) officials working in the field, the number of people who use drugs (PWUD/PWID) in Cambodia is on the rise, as is the likelihood of it spreading within rural areas of the country.

The estimated size of PWUD/PWID population at the national level has not been updated since 2007. At the time, the National Authority for Combating Drugs (NACD) estimated there were 5,900 PWUD/PWID nationwide, while the National Center for HIV/AIDS, Dermatology and STD (NCHADS) put the number between 9,100 and 20,100, including approximately 1,100 to 3,000 people who injecting drugs (PWID). [1].

Although the HIV/AIDS prevalence in Cambodia has substantially decreased over the last two decades (from 2% to 0.8% in 2010) [2], the HIV prevalence among most at risk populations (MARPs) remains elevated. PWUD, particularly those who inject drugs, place themselves at greater risk for Human Immunodeficiency Virus (HIV) and Hepatitis C and/or Hepatitis B infection, by sharing needles and syringes and having unprotected sex. A study conducted in 2007 found the HIV prevalence among injecting drug users to be 24.4%, while the prevalence among those who do not inject drugs is low at 1.1%. [3]. This is a cause for concern regarding the spread of HIV among MARPs and further spread to the general population, due to the bridging characteristics of the groups.

KHANA has participated in the national HIV response in Cambodia for over a decade. Most of KHANA's implementing partners (IPs) have implemented HIV focused prevention targeting MARPs, mainly entertainment workers (EW), men who have sex with men (MSM), and PWUD/PWID. The program interventions have included a number of activity packages, including peer education (dissemination of information through educational sessions by peer educators); safe behavior practice; and HIV and Sexually Transmitted Infection (STI) diagnosis, care, support and referrals to treatment providers. Other activities implemented include dissemination of information through radio; workshops on drug use and HIV prevention; and education on safe injecting and provision of needle and syringe program (NSP) for PWID.

The implementation of programs targeting PWUD/PWID started in 2005. In 2006, KHANA signed a Memorandum of Understanding (MoU) with NACD. From that time up to 2010, a total of 7,367 PWUD/PWID (1,048 injecting drug users and 6,319 Amphetamine-type Stimulants (ATS) users) have been reached. [4]

1.2. INTRODUCTION TO THE KMDC PROJECT

The KMDC draws on KHANA's long experience in working in civil society response to HIV/AIDS in Cambodia, as well as international good practice through KHANA's links with the International HIV/AIDS Alliance and other strategic partners. The KMDC, with recognition from the local authority of Meanchey District, Municipality of Phnom Penh, was established in June 2010. The Center intends to foster closer engagement with the community

that it supports, through programs delivered in partnership with KHANA's implementing partners.

Direct implementation is a new area of work for KMDC and is expected to serve as a model for future program innovation and development. Being more closely connected to the communities through the KMDC assists KHANA in bringing the voices of the communities to national and regional policy and program debates, and to build the evidence base for programs that respond to the needs of the beneficiaries, particularly in the areas of HIV, health and development.

The KMDC provides a wide range of harm reduction services, including peer networks; referral to methadone maintenance treatment (MMT); learning center for medication prescription and counseling; research center for drug related health issues, HIV and others health problems; center for information, education and communication (IEC), and provision of capacity building to support IPs [5].

The program implementation at the KMDC has not been documented systematically since the beginning. Before the Center was established, a rapid needs assessment was conducted to map existing resources and identify the needs and gaps of services for PWUD/PWID [6]. The Operational Research (OR) reported in this report was conducted to document the program implementation at the KMDC, examining which efforts have been successful as well as identifying challenges and lessons learned, including the impact of the Village and Commune Safety policy.



1.3. OBJECTIVES OF THE STUDY

The objectives of the study are:

- To obtain a clear insight into the implementation of KMDC as KHANA's harm reduction model, and identify what makes the KMDC model for PWUD/PWID so unique.
- To identify barriers, challenges, and lessons learned from program implementation.
- To provide recommendations on improving the implementation of harm reduction programs at the KMDC



METHODOLOGY

The operational research utilized a combination of quantitative and qualitative methods. The quantitative method referred to the collection and analysis of KMDC Monitoring & Evaluation (M & E) database to determine the trends of service uptake, profile of the PWUD/PWID, and KMDC program coverage. The qualitative method was used to gain a comprehensive understanding of the issues related to the KMDC. In addition, desk reviews and consultative meetings were conducted to collect different perspectives on the project.

2.1. QUALITATIVE METHODS

Qualitative data was collected through interviews with key informants and focused group discussions (FGD) with PWUD/PWID. As shown in Table 1 below, a total of 8 interviews and 4 FGDs were conducted.

Qualitative study participants

A purposive sampling was used to select participants for the qualitative study. Key informant interviews were conducted with service providers at KMDC (outreach assistant, nurse, project manager, and doctor), along with other stakeholders and local authorities that have been working with KMDC: nurses at the referral health centers, village chief, communal council, and MMT staff.

PWUD, including those who inject drugs, were asked to participate in FGDs. The following criteria were used to select PWUD/PWID for the FGD:

- The individual is a male or female PWUD/PWID, who uses drugs either regularly or occasionally. Occasional drug use is defined as 2 (two) times per week or less in the past

month. Regular drug use is defined as 3 (three) or more times per week in the past month [7].

- The individual has accessed services at the KMDC facility or has been reached by KMDC's community outreach program.
- The individual agrees to participate in the study.
- The individual is at least 15 years of age.

Table 1: Summary of Qualitative Study Participants

Participants	Number	Data collection method
Center manager (KMDC)	1	Key informant interview
Doctor (KMDC)	1	Key informant interview
Nurse (KMDC)	1	Key informant interview
Outreach assistant (KMDC)	1	Key informant interview
Village chief	1	Key informant interview
MMT staff	1	Key informant interview
Health center staff	1	Key informant interview
Pharmacist	1	Key informant interview
PWUD (3 PWID)	24	4 FGDs
Total	32 people	8 key informant interviews and 4 FGDs

Data Collections

The interviews were conducted by trained interviewers who have experience in fieldwork. The interviews with key informants were held at a time and location convenient for them. Verbal informed



consent was obtained from the participants prior to interviews or FGDs.

In terms of the management of the whole assessment, the KHANA research team leader was the main coordinator of the study, who also performed data cleaning, developed the outline of the report and wrote the first draft of the report.

It should be noted that, additional data collection was conducted in the period between March and April 2012 on the following topics: peer outreach groups, reasons why female PWUD/PWID access services at KMDC and vocational training by KMDC staff members.

Ethical considerations and informed consent

The participation in this study was voluntary and anonymous. Interviewers were required to verbally confirm the consent of the participants. Respondents' identities were strictly protected. Even though the discussion was taped, it was strictly confidential. No person outside of the research team had access to any part of the discussion. Participants who required either health

treatment or non-health services were referred to KMDC treatment Center and/ or other appropriate government service facilities with their consent.

2.2. CONSULTATIVE MEETING

The first consultative meeting was conducted with Implementing Partner Program Management (IPPM) and Technical Support and Best Practices (TSBP) Departments of KHANA. The meeting was aimed at gaining technical inputs for the operational research. The second consultative meeting was conducted to finalize the protocol and tools used in the research. The involvement of KHANA Senior Management Team was necessary to ensure that key issues are documented in the research. The third consultative meeting was held in order to obtain additional inputs, comments, and suggestions on the first draft report, and the fourth consultative meeting with the KMDC team took place to ensure the completeness of the report.

2.3. DATA EXTRACTION FROM KMDC DATABASE

As a supplement to the interviews with PWUD/ PWID and key informants, M & E data were retrieved from KMDC database and program reports. These data were used to understand the characteristics of PWUD/PWID reached by KMDC, to quantify the number of KMDC PWUD/PWID beneficiaries and to identify trends.

2.4. DESK REVIEW

The documents listed below were reviewed by the research team. However, only relevant findings from those documents were presented in this report.

- Community Need Assessment Report, 2010
- KMDC Reports 2011 (Quarterly, Semi-Annual)
- Concept note, KMDC Aide Memoire, March 2011



- Universal Precaution Guidelines
- Cambodian Drug Law
- Needle Syringe Program Guidelines

2.5. DATA MANAGEMENT AND ANALYSIS

M & E data from the database and program reports were reviewed and analyzed using STATA 10. Gender and age group specific stratifications were considered in the analysis. All qualitative data were transcribed in Khmer and classified by pre-identified themes. Relevant themes were translated into English and were inserted into the final report.

2.6. PRESENTATION OF RESEARCH PROTOCOL AND DISSEMINATION OF THE FINDINGS

The research protocol and tools were presented to KHANA staff members to get their input. The dissemination of findings was carried out in two phases. First, the preliminary findings were

disseminated to the appropriate KHANA staff members in order to gain their comments, inputs, and recommendations. The input obtained was then incorporated into the final version of the report before it was presented back to KHANA staff.

2.7. STUDY LIMITATIONS

This study was subject to a number of limitations. The principal limitation was that the M & E data available at the KMDC was insufficient to provide the quantitative information needed for the research. Secondly, the research was conducted and managed internally by the research team at KHANA. This presented the possibility of some information bias with regards to the positive results reported. However, in order to offset this risk, it should be noted that the research team works independently from the KMDC. Also, an independent local consultant was involved in the analysis and report writing stage. At the very least, this would serve to minimize the bias, if not eliminate it completely.

In the method of investigation, there was no mechanism set to validate the quality of data extracted from the KMDC database. Therefore, miscalculation or misreporting could have occurred. However, the KMDC has an existing system to check the quality of the data entered into the database, as well as a system to minimize double counting of PWUD/PWID reached by peer educators and those who access services directly at the KMDC.



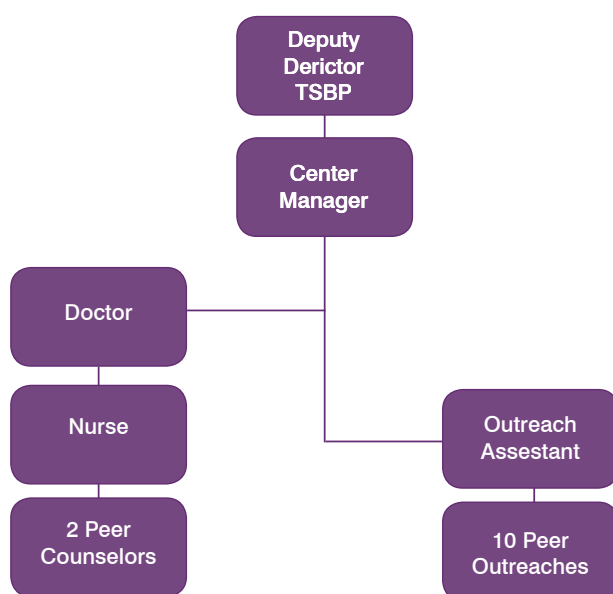


FINDINGS

3.1. STRUCTURE AND MANAGEMENT OF THE KMDC

KMDC is a KHANA Drop in Center. The KMDC staff members are directly under the managerial line of KHANA's Technical Support and Best Practice department (TSBP) and consist of: 1 center manager, 1 medical doctor, 1 nurse, 1 outreach assistant, 2 peer counselors, and 10 peer outreach workers. The peer outreach workers consist of both men and women who were PWUD/PWID themselves.

Figure 1: Structure of the KHANA Meanchey Drop in Center



3.2. UTILIZATION OF SERVICES AT KMDC

There are two types of services provided at KMDC: facility-based and community-based services. The services are modeled on international best practice, which is a comprehensive package of services believed to be effective. This package includes 16 key interventions that contribute to the

improvement of the HIV, health and development status of people who use drugs, based on the International HIV/AIDS Alliance good practice guide and KHANA Standard Package of Activities (SPA). The summary of the key package activities is listed in Table 2 (See detail in KMDC Aide Memoire, March 2011)

Although the NACD has granted KMDC the license to implement Needle and Syringe Program (NSP) in 2011, KMDC do not distribute clean needles and syringes to PWID through community outreach. KMDC has only implemented facility-based NSP. This is due to a number of reasons, ranging from community discrimination to fear of police arrest when distributing needles and syringes through community outreach activities.



TABLE 2: SUMMARY OF THE KEY PACKAGE ACTIVITIES OF KMDC SERVICES

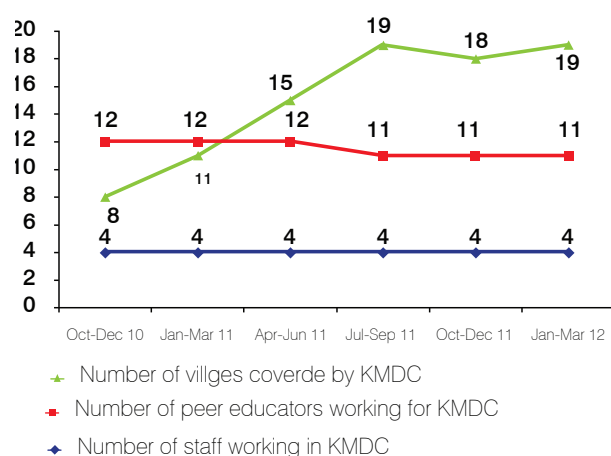
	Harm Reduction Interventions	DIC	Outreach	Link to other Facilities	Remarks
1	Needle and Syringe program	✓			Could not be conducted through community-based outreach program. NACD did not recommend NSP through outreach because distributing needles and syringes to PWUD/PWID may be perceived by the community as promoting drug use.
2	Opioid substitution therapy	✓		✓	Screening, assessment and follow-up at the DIC, and referral to the Clinic for Mental Health and Drug Dependence.
3	HIV testing and counseling	✓		✓	Provision of pre-test and post-test counseling, and referral to Steung Meanchey HC and RHAC clinic.
4	Antiretroviral therapy	✓		✓	Provision of counseling, follow-up, and referral to SHCH and Chhouk Sar.
5	Prevention and treatment of STI	✓	✓	✓	Provision of information, education and referral to STI clinics. In the future, KMDC aims to provide a more comprehensive and integrated sexual health services.
6	Condom promotion for PWUD/PWID and their sexual partners	✓	✓		Provision of information, condom through educational sessions at the DIC, as well as through outreach activities, and IEC materials.

7	Targeted information, education and communication	✓	✓	✓	Provision of information through educational sessions at the DIC, outreach activities, and IEC materials (i.e. leaflets, posters, flipbooks, and booklets on methamphetamine and heroin)
8	Hepatitis B Virus (HBV) diagnosis, treatment, and vaccination			✓	So far, the only activities planned are educational sessions on HBV, either through outreach activities or directly at the DIC, and referral to health facilities.
9	Prevention, diagnosis and treatment of Tuberculosis (TB)	✓	✓	✓	Educational sessions, either through outreach activities or directly at the DIC, and referral to health facilities.
10	Advocacy and creating an enabling environment	✓			Quarterly meetings with local authorities, parents and PWUD/PWID. In collaboration with AusAID, WHO, UNAIDS and FHI 360, KMDC also delivered a presentation on drug related HIV risk behavior and harm reduction programs for law enforcement agencies in Phnom Penh and selected provinces.
11	Basic health services, including overdose prevention and treatment	✓	✓		Provision of information through educational sessions at the DIC, and through outreach activities and training workshops for selected IPs.
12	Sexual and reproductive health services	✓	✓	✓	Educational sessions, either through outreach activities or directly at the DIC, and referral to health facilities.

13	Home based care and support for HIV-positive PWUD/PWID		✓	✓	Home visits and linkages to community-based care and support team provided by one of KHANA's IP based in Stung Meanchey.
14	Family support for parents and children of PWUD/PWID	✓	✓	✓	Home visits and referral to support programs provided by other NGOs to improve children's access to education. The families of PWUD/PWID can also access counseling support available at the DIC.
15	Access to justice and legal services	✓			Provision of legal information and consultation for families of PWUD/PWID who are arrested by the police. If the arrested PWUD/PWID is currently receiving treatment from KMDC, the Center can inform this to the law enforcement agency. Three such cases were identified, and KMDC recruited lawyers to provide legal assistance to all three cases. The cases were documented by the KMDC.
16	Livelihood development/ economic strengthening			✓	The DIC provides modern musical class. Other livelihood development support is provided based on demand through KHANA's livelihood center and other private shops such as for cookery, beauty salon skills, gardening and auto mechanic skills.

The number of PWUD/PWID reached by KMDC could be used as an indicator to measure the achievement of the KMDC. Note that the KMDC provided services on site, as well through peer educators/ outreach workers. After nearly 2 years of implementation, only 4 full time staff members are currently employed at KMDC (Figure 2).

Figure 2: Number of staff at KMDC & villages covered by KMDC



Profile of PWUD/PWID population reached by KMDC

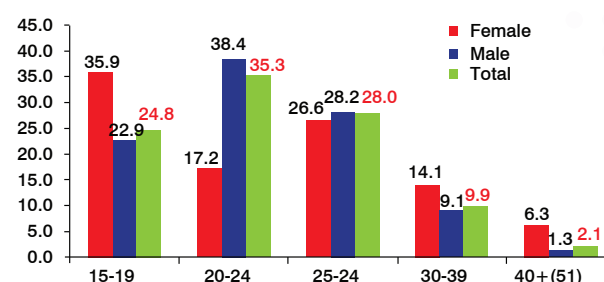
According to the KMDC database, as of the period of January to March 2012, a total of 433 PWUD/PWID were registered into the program. The data shows that 63 (14.5%) of those registered were female and 370 (85.5%) were male. The PWUD/PWID data was disaggregated by gender (male and female), method of drug use (injecting and non-injecting), and disclosure status (hidden and disclosed), as illustrated in Table 3. Note that, the hidden PWUD/PWID means that the individuals are not known to be people who use drugs by their family members or local authorities.

Table 3: Characteristics of PWUD/PWID who accessed KMDC services

Status	Male		Female		Total	
	Freq	%	Freq	%	Freq	%
ATS user	286	77.3	51	81.0	337	77.8
Injecting drug user	84	22.7	12	19.0	96	22.2
Disclosed	203	54.9	33	52.4	236	54.5
Hidden	167	45.1	30	47.6	197	45.5

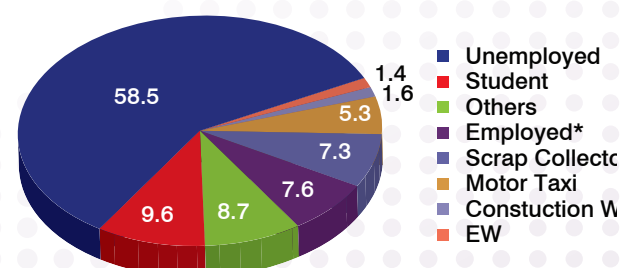
The majority of PWUD/PWID who accessed the DIC services was between the ages of 15 and 29 years old. Less than 15 % of PWUD/PWID was aged between 30 and 50 years old (Figure 3).

Figure 3: Age distribution of PWUD/PWID who accessed KMDC services



While the majority (58%) of PWUD/PWID was reported to be unemployed, 10% of them were reported to be students and less than 10% were either scrap collectors, motor taxi drivers, construction workers, entertainment workers (EW), or others (Figure 4). Nearly 80% of the PWUD/PWID was single.

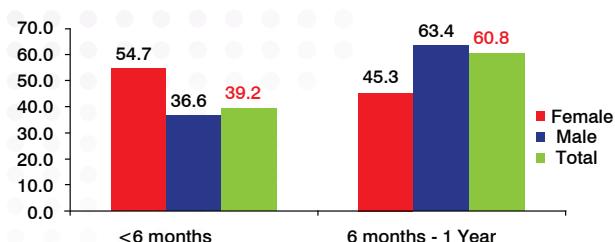
Figure 4: Employments of PWUD/PWID who accessed KMDC services



* No specific job provided

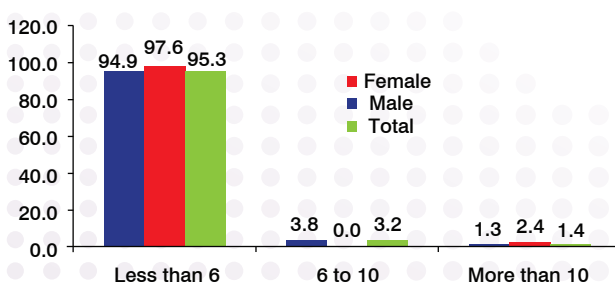
The majority (60.8%) of PWUD/PWID who accessed the services offered by KMDC have been doing so for at least 6 months. Most of them began accessing the services about 6 months after the establishment of the KMDC.

Figure 5: Proportion of PWUD/PWID by duration of service access at KMDC



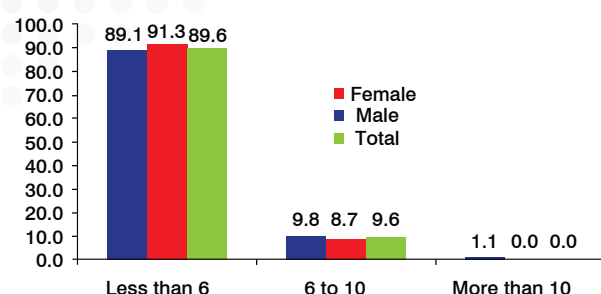
Figures 6 and 7 illustrate the number of health education sessions PWUD/PWID received, either directly at the DIC or through outreach activities. It should be noted that, several PWUD/PWID received health education sessions from both outreach and the DIC. Consequently, when added together, the total number of those who received health education sessions may be larger than the total number of PWUD/PWID reached by the project. Figure 6 below shows that the majority of PWUD/PWID received between 1-5 health education sessions either from the community outreach and DIC in the last quarter (January to March 2012).

Figure 6: Proportion of PWUD/PWID receiving health education from outreach activities



*Male (n = 273), female (n = 41)

Figure 7: Proportion of PWUD/PWID reported receiving health education at the DIC



*Note: male (n = 92), female (n = 23)

3.3. SERVICES OFFERED BY KMDC

KMDC is a one-stop Drop- in- Center where a wide range of services is available for PWUD/ PWID. The services available at the KMDC range from provision of a place to rest, to provision of medical treatment and care. More importantly, all of the services have proved to be highly valued by PWUD/PWID. Consequently, the KMDC has attracted many drug users. .

"The services [provided] are services related to drug use, education on drug use, blood tests, medical services [such as] medicine for when we are ill, a place for recreational activities or for sleeping. For example, if you want to play volleyball, we can borrow the ball [for] physical exercise... We can also study, join music class and watch TV" (FGD, male)

"The center provides health services, food, a place to sleep and blood test for HIV. What I like most is health education on drug use, because it explains about drugs and our health" (FGD, male)

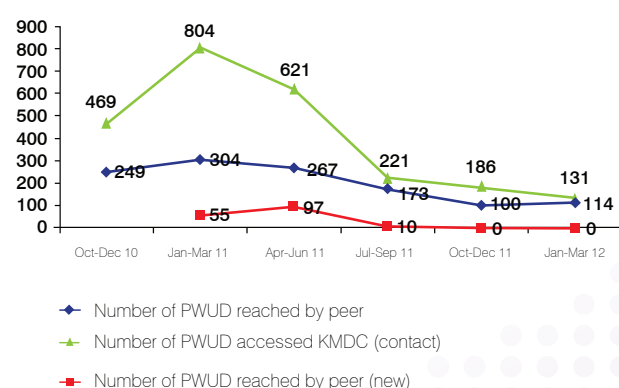
"For me, I am 100% satisfied, if I have [more] time I would always come to the center to get help, I do not come to play but to check my general health (FGD, male)

"With the HIV test, we could know our HIV status. With the urine test, we can know the level of our drug in our bodies" (FGD, male)

It has been found that, over the course of the project, the number of PWUD/PWID who accessed KMDC services on site increased sharply from 469 people in the period between October to December 2010 to 804 people in January to March 2011. Since then, the numbers have declined. The decline might be attributed to reporting issues, or due to their engagement at work. Also, based on HIV/ AIDS Asia Regional Program (HAARP) recommendation, KMDC concentrates more on PWID who inject, compared to PWUD who use other methods of drug use.

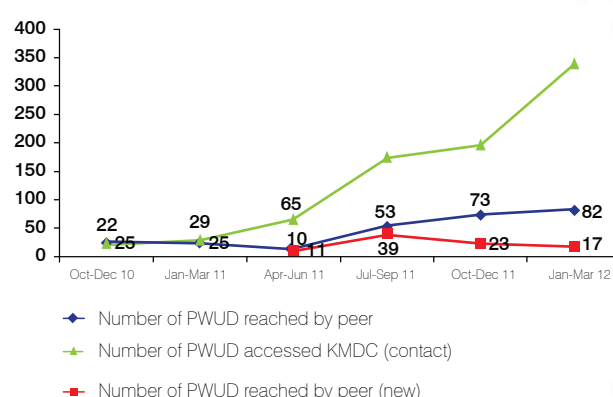
The Village and Commune Safety policy had also a marked effect on the program, as it has discouraged PWUD/PWID from disclosing their status. Many of them moved to other locations in search of employment. Even so, the number of PWUD/PWID reached by peer outreach program remained relatively stable over the course of the project. However, it should be noted that, in December 2011, there were no new PWUD/PWID reached by KMDC peer outreach workers. This might be due to the already high coverage of KMDC program or new PWUD/PWID hesitates to show up.

Figure 8: Number of PWUD/PWID accessing KMDC services



Data for the number of PWID who accessed services directly at KMDC facility (referred to as 'contacts') in Quarter 1 (Q1) is not available, because at the time data collection was not done routinely. However, from Q2 (2011), KHANA and HAARP required that the number of injecting drug users (both who accessed services directly at the Center as well as those reached through outreach activities) to be recorded. This also reflected the requirement of the donor to concentrate more on injecting drug users. The substantial increase in the number of contacts (see Figure 9 below) was the result of scaling up the program coverage through outreach activities.

Figure 9: Number of injecting drug users who accessed KMDC services

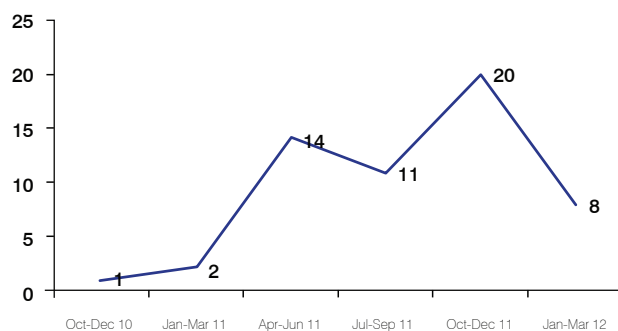


Medical consultation, treatment and referral

At the KMDC, there is one medical doctor and one nurse available who are responsible for tending to the medical needs of PWUD/PWID at the DIC. It was found that during the 9-month period between July 2010 and March 2011, the most common services they provided to PWUD/PWID were consultations (mostly related to drug use and mental health difficulties) and basic medical treatment services (such as upper respiratory infection, gastro intestinal disease, wounds, skin problems, and STIs). The next most frequently provided service was referral to Voluntary and Confidential Counseling and Testing (VCCT) clinics.

It should be noted that referral to STI services were high early on in the project due to the high STI uptake among the group. As shown below in Figure 10, the highest number of referrals to STI services was recorded between July-September 2011 period and October-December 2011. This is because during that same time, a large number of PWUD/PWID, who was also identified as being members of MSM or EW sub-populations, presented at the DIC. Most of them had been referred to KMDC by their friends and other NGOs. Once the initial group of people received treatment, it was expected that fewer STI untreated cases would be reported and fewer new referrals would take place in the following period.

Figure 10 : Number of PWUD/PWID referred to STI clinic service



One point that was raised during the FGD was that PWUD/PWID also received support in the form of medicine for illnesses not related to their drug use.

"There is medical service [at the center], [and we could] get medicine if we are not well" (FDG, female)

"When I was not well, Nak Kru [a female health provider] gave me medicine" (FGD, female)

Condom promotion & distribution

During the initial needs assessment at the KMDC, most PWUD/PWID was found to be sexually active. Consequently, provision of condoms and

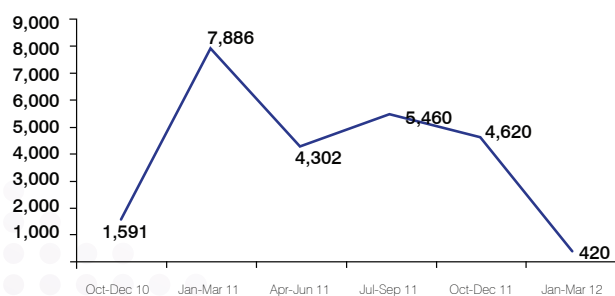
promotion of condom use is conducted through peer outreach activities and at the KMDC facility.

"..Through assessment of PWUD/PWID, we found that some PWUD/PWID have sex while they are on drugs because they cannot control themselves..." (Outreach assistant)

"We want them [PWUD/PWID] to always have condoms with them..." (Outreach assistant)

The trend that can be observed in Figure 11 is a marked decrease in the number of condoms distributed during the January-March 2011 period. The drop in demand for condoms has been explained by the fact that the condoms distributed in the previous period had not been used. Consequently, many PWUD/PWID declined to take more condom packs from outreach workers. Furthermore, it was noted that some PWUD/PWID preferred to take the condoms as needed, rather than receiving them on a monthly basis because it was inconvenient for them to carry a large number of condom packages, or to store them at home. The number of condom packages distributed bounced back in Q3 due to an increased number of contacts. An important point to note is that PWUD/PWID who are also EW are sometimes reluctant to take condom packages from the KMDC, as they can be arrested by the police if found to be in possession of condoms.

Figure 11: Number of condom packages distributed





Psychological support & counseling

The KMDC promotes VCCT among PWUD/ PWID reached by the outreach workers, as well as those who accessed services directly at the Center. The psychological support and counseling services seek to increase awareness of drug use, HIV status, and to promote early diagnosis and treatment of HIV.

The PWUD/PWID reached through outreach activities have been encouraged to get tested for HIV. In addition, the Center also runs large scale VCCT campaigns in communities to increase the knowledge and awareness of HIV among PWUD/ PWID, as well as the broader community. Both activities encourage PWUD/PWID to visit the DIC, where they are provided with pre-test counseling and education about HIV transmission. They are then referred to government health clinics for HIV counseling and testing.

Sexual reproductive health services

Sexual reproductive health (SRH) services have not been offered in the KMDC facility. However, all clients who required SRH services were referred to

a linked health center or RHAC clinic. It is noted that although these cases are generally referred, the KMDC's medical doctor and nurse possess sufficient general knowledge to provide counseling on SRH issues.

"Regarding sexual reproductive health, there is almost no services offered, for example, family planning, antenatal care... We don't have the capacity to offer [the services] yet..." (Medical doctor)

"If we see one family with many children, we give them information about family planning methods..." (Outreach assistant)

"I come here to do a pregnancy check-up and to talk with Bong Srey [a female staff] about drug use" (FGD, female)

Needles and Syringes Program

In order to obtain a license for the distribution of clean needles and syringes for PWID, KMDC has worked on both technical and management fronts. KMDC facilitated a workshop organized by the NACD to provide information on harm reduction to law enforcement officers in Phnom Penh and selected provinces.

An NSP license valid for one-year was obtained from NACD in 2011, but distribution of needles and syringes through community outreach program could not be implemented because the identity cards for KMDC peer outreach workers was not issued by NACD, and also because the community still lacks sufficient understanding of the harm reduction program. Therefore, needles and syringes were only provided at the KMDC facility. In 2011, more than 4,000 sterile needles and syringes were distributed to PWID at the KMDC facility (Highlighted report on main achievement in 2011, KMDC).

In July 2011, KHANA began to distribute clean needles and syringes through designated pharmacies that were frequently visited by PWID. However, this distribution channel failed due to the high mobility of the PWID, which was directly and

indirectly brought about by the frequent arrests resulting from the implementation of the Village and Commune Safety policy.

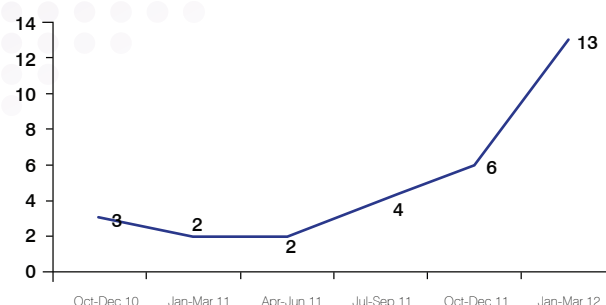
The NSP license expired in January 2012. Recently, a renewed license was issued for the KMDC to continue implementing NSP for the period of May 2012 to June 2013. It is expected that provision of needles and syringes through community outreach may be possible this time due to the green light from NACD. The implementation of community-based NSP should remain a priority for the KMDC. A background assessment conducted to 300 PWUD/PWID, shows that only 10 out of 300 have a history of originally injecting drug use (Personal communication with Dr. Ny Socheat). There is a need to further assess the linkages between ATS use and injection.

"I have collaborated with KHANA, I help supply syringes, needles, soap, toothpaste, towel... all of these [items] are in one package that I provide to KHANA's clients... and then KHANA pays me" (a pharmacist)

Other services

To access OI/ ART services, HIV-positive PWUD/PWID were referred by KMDC staff to the appropriate facilities, such as Health Centers, Chouk Sar clinic, Social Health Clinic and other facilities. Some PLHIV did not need referral, only transportation support from the KMDC. The number of HIV-positive PWUD/PWID receiving support from the KMDC increased from quarter to quarter. In total, 23 HIV-positive PWUD/PWID received support from KMDC.

Figure 12: Number of HIV positive PWUD/ PWID referred to OI/ ART services

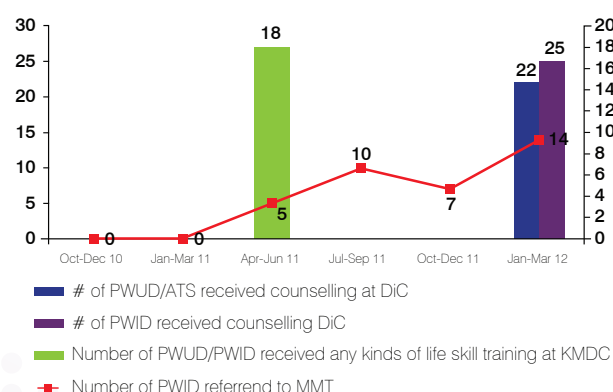


Although OI/ ART and MMT services are not available at the KMDC, PWUD/PWID who required the services were referred to the appropriate services.

"We don't have OI/ART service yet, but we can provide referral. We link patients to health services..." (KMDC, manager)

"We accept new patients for MMT through our networks, first we have [PWID] from Korsang and Mith Samlanh, the last one is from KHANA [KMDC]" (MMT staff).

Figure 13: Other services offered to PWUD/PWID at KMDC



Apart from health services, the KMDC also offers vocational training to PWUD/PWID. In the period between April and June 2011, a total of 18 PWUD/PWID received vocational trainings at KMDC, from farming techniques to high-tech skills (i.e. mobile phone repairer). However, the fact that the training did not attract much attention from PWUD/PWID suggests that the KMDC vocational training program has not yet met the needs of the target group. Therefore, it should be redesigned for the future.

This likelihood was corroborated by interviews carried out with PWID (26 PWID, including 6 female). The PWID indicated that although there were certain vocations that were appealing to them (such as tailor, cooking, electric technician, motorbike mechanic and barber), they did not indicate a willingness to commit to the training at all. Further consultation with the peer outreach workers and KMDC staff who conducted the vocational trainings revealed that the main priority of PWID was to have fast return from jobs such as construction workers, laborer, and porters.

Referral to other services

Apart from providing services within the facility, KMDC also played a role as a referral center. PWUD/PWID who accessed the KMDC were referred to several different services according to their needs. The KMDC database shows that by March 2012, 37 PWID had been referred to MMT.

"We refer [PWUD/PWID] to VCCT at the Steung Meanchey Health Center. TB [suspected cases] are also referred to Steung Meanchey Health Center. PWUD/PWID with STI [are referred] to the Health Center or RHAC clinic" (KMDC manager)

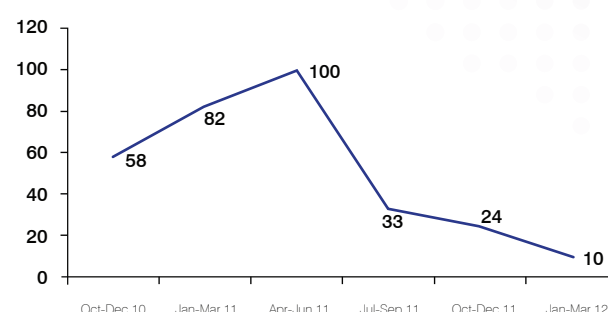
"[HIV test] is referred by KHANA [KMDC] and sometimes they [PWUD/PWID] come on their own..." (VCCT Clinic staff, health center)

The referral system used at KMDC is active referral. That is, a staff or a peer from KMDC accompanies the referred client to other services outside the

KMDC facility. Therefore, KMDC can verify the access to referred service on a case-by-case basis.

"...at my place [KMDC], if a client decides to have VCCT [HIV test] we will arrange everything...we arrange motor [taxi] or tuk tuk... We go with the client until they have received the service and go home, thus our referral is never missed [incomplete]" (KMDC manager)

Figure 14: Number of PWUD/PWID referred to VCCT service



Peer outreach services

All KMDC peer outreach workers are also PWUD/PWID, either no longer actively using drugs or only using drugs occasionally. This has been found to be very effective in working with PWUD/PWID, especially if the peer outreach worker is a former PWUD/PWID. During a peer outreach interaction, peer outreach workers provide PWUD/PWID with information on behavior change, negotiating condom use, and referrals to health services. Peer outreach workers also provide condoms and printed materials on harm reduction.

It has been observed that at the early stage of the project implementation, the number of contacts made with PWUD/PWID was lower than expected. This is because many new PWUD/PWID were reluctant to engage with peer outreach workers due fear of being arrested by the police who reinforce the Village and Commune Safety policy.

This has created a considerable barrier to the PWUD/PWID accessing the health and education services offered at the KMDC facility, and made it more challenging for the peer educators to reach PWUD/PWID with behavior change messages.

Creating an enabling environment

Both KHANA and KMCD are actively striving to create an enabling environment to improve the outcomes of program implementation for PWUD/PWID.

KMDC conducts a quarterly meeting with local authorities, health service providers, neighbors and parents of PWUD/PWID. KMDC also conducted activities to mark International Day against Drug Abuse and Illicit Trafficking and World AIDS Day, aimed at raising awareness on HIV/ AIDS and harm reduction, mobilizing support for the protection of the right to access health services, treatment and care, and fighting against stigma and discrimination. Many stakeholders, such as the head of Sangkats Police Force, Health Center staff, and local village authorities were invited to join the above activities.

KMDC staff members have also attended quarterly Health Center Management Committee (HCMC) meetings, where KMDC presented information on drug use and services offered by KMDC. Participants of the meeting include village chief, Health Center chief, commune chief, and representatives from Village Health Support Group (VHSG), women social affair staff, and other NGOs.

KMDC has also taken part in an exchange visit to Cambodian Children's Fund to build networking relationship with health services and collaborate in a joint effort to support low-income families with children who are out of school, including the families of PWUD/PWID.

Furthermore, KMDC staff members were invited to take part in a live radio talk show program entitled "No Means No" on Women's Media Center (FM 102) to discuss issues such as dealing with a family

member's drug use, prevention of drug abuse, introduction to MMT and sharing the experiences of MMT from other countries.

KHANA has facilitated a workshop on HIV and drug use related issues for law enforcement officials. The workshop was organized jointly by NACD and KHANA, with financial support from USAID/SAHACOM. A total of 221 (F=12) law enforcement officials (civilian police, military police, customs), municipal and court officials attended the workshop.

To generate and strengthen political support, KHANA also joined the NACD Drug and HIV/AIDS Technical Working Group, and regularly submit quarterly reports to NACD.

Being a model Drop In Center

In order to fulfill one of the objectives of becoming a model center for DICs serving PWUD/PWID in Cambodia, KMDC has facilitated many visits from donors, scientists, and program managers from various organizations and institutions, such as HAARP Bangkok, International HIV/AIDS Alliance, WHO, UNICEF and USAID.

KMDC also prepared experience-sharing sessions with other NGOs. During these sessions, discussions were held about the process of running a DIC, making contact or communicating with PWUD/PWID, registering/ recording the PWUD/PWID data, and providing PWUD/PWID with counseling, consultation and treatment services. In addition, KMDC provided technical expertise in building up skills and knowledge related to harm reduction interventions.

KMDC conducted monthly peer meetings and reflections with peer outreach workers from different NGOs, namely SFODA, KDFO, and KMDC. The objectives of the meetings were to provide an update on drug situation in coverage areas, define hot spot locations for Needle and Syringe Program, and to provide information about the status of KHANA's Needle and Syringe Program License issued by the NACD.

3.4. WHAT MAKES KMDC UNIQUE?

One stop comprehensive service

The FGD revealed that most of the PWUD/PWID who frequent the KMDC require several different services, and as the services on offer in the KMDC are diverse, the PWUD/PWID do not need to travel to several different locations in order to access the help and support they need. Consequently, the KMDC facility has become a safe place for PWUD/PWID to gather.

"The difference [from other NGOs/ DICs] is that there is medicine here, in other places if we are sick we need to go to health facilities... if we want to get trained they [other NGO] support, but we need to go to another place" (FGD, female)

"...the good point is that we can come and enjoy being here [KMDC] without going outside to other places. We can even sleep [nap during the day] here, do some physical exercises, play music, read stories; we can meet and talk with Krou [staff]..." (FGD, male)

Making different activities available under the same roof is very convenient for PWUD/PWID, since it allows them to access what they need with far greater efficiency. Furthermore, there are a variety of things to keep the PWUD/PWID occupied and this may give PWUD/PWID something to focus on other than drug use. In some cases, this has helped to reduce the frequency of drug use.

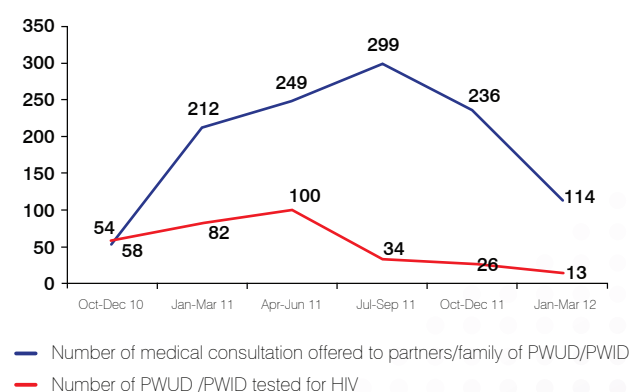
"...I haven't used drugs. I enjoy [my time] here [at KMDC]. When I am here, I forget everything [drugs]. When we get bored, we can watch TV, eat a snack, drink water, read stories, play drum or music, play volleyball or ball [football]. [It makes] us sweat...so we can reduce [our] drug use...now, I have reduced [drug use] a lot, [about] 60%..." (FGD, male)

Provision of support for parents and families of PWUD/PWID

KMDC understands that PWUD/PWID does not live in a vacuum. They may live with their partners, or even families. Therefore, providing services that are friendly not only to PWUD/PWID but also their sexual partners, spouses, family members and children may contribute to an increased number of PWUD/PWID frequenting the Center.

Discussions with KMDC staff and management team revealed that most PWUD/PWID and their partners come to the Center for health follow-up visit (counseling, consultation and treatment) although they are faced with many obstacles. These obstacles range from fear of police arrest to the cost of transportation.

Figure 15: Medical consultation and HIV test offered to PWUD/PWID and their partners



Based on the observation of the KMDC staff, many PWUD/PWID also tried to encourage and convince their drug using friends and/or partners to access the KMDC services. In the first year of project implementation, about 20% of PWUD/PWID, including 8% of injecting drug users, had either become abstinent from drug use or had decreased their drug use. This achievement has caught the attention of many people, especially those who have relatives that are PWUD/PWID. Many of them have referred their drug using relatives to KMDC for help and support.

"The feedback from our partners and key stakeholders, including NGO partners, Health Center, MMT clinic and village leaders, consider KMDC [to have a] clear procedure in providing services to PWUD/PWID, and they encourage [their] clients to access these services" (KMDC staff).

Gender perspective

Currently, KMDC has 3 male members of staff and 1 female member of staff. There are also 8 male and 4 female peer outreach workers, who make it easier to reach PWUD/PWID. No one was MSM. Although only a small percentage of PWUD/PWID is female (15%), KMDC has moved ahead with the integration of gender sensitive concepts into its services. This will prove to be very beneficial for female PWUD/PWID, especially those who are also EW. Many of these women encounter different forms of stigma and discrimination when trying to access services due to the social and cultural norms present in the Cambodian context which strongly disapprove of women associated with drinking, smoking, gambling or using drugs.

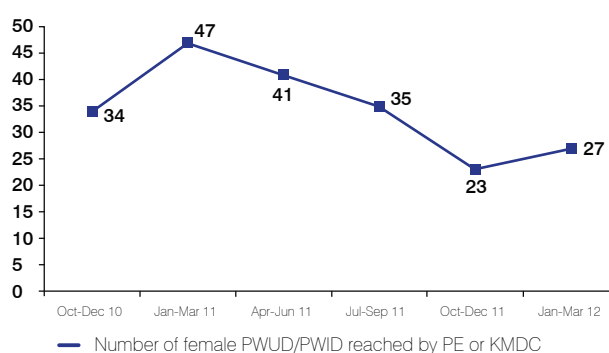
It has been observed that female PWUD/PWID are less likely to be supported by their families. They have particular needs regarding SRH, access to health services, skills for the negotiation of condom use and sharing needle sharing with partners. In Q1 (2011), there were a total of 47 female PWUD/PWID (45 ATS users and 2 injecting drug users), compared to 329 male PWUD/PWID (304 ATS users and 25 male injecting drug users).

The 4 female members of the outreach team have built trusting relationships with female PWUD/PWID and motivate them to access KMDC services and existing community health services. The facility-based services which are female friendly include; provision of a safe space, provision of single sex bathroom facilities, the option to choose between a male medical doctor and a female nurse when receiving a consultation, treatment, counseling, primary health care, body hygiene, or pregnancy

test. Moreover, activities offered at KMDC facility do not discriminate against any gender.

"There is a place [NGO] that provides similar services. For example, a place to sleep, play sports and vocational trainings such as to be a groomer, tailor, but only for female and not for kids with drug problems...only for kids who have been exploited or abused..." (FGD, female)

Figure 16: Number of female PWUD/PWID who accessed KMDC services



During discussions with female PWUD/PWID, several factors that make KMDC services appealing to them were brought up. The fact that the health services are provided free of charge was one of the main reasons, followed by the fact that KMDC clinic has a female nurse available to provide care for female clients.

"Before, there was [only] a male doctor, so [we] were shy of coming to [DIC], but now there is a female nurse, so we come to use the services" (Extracted from a discussion with a group of female PWUD/PWID at KMDC)

Coming into contact with female outreach workers also helps female PWUD/PWID to trust the KMDC. Female peer outreach workers have informed female PWUD/PWID of the availability of health services, and have also encouraged female PWUD/PWID to get tested for HIV or STIs at the

KMDC. Therefore, female PWUD/PWID felt that the services offered at KMDC would be appropriate for them, and that their confidentiality would be protected.

Peer Groups

KMDC peer outreach workers generally work in peer groups as opposed to alone. A peer group is comprised of a group of PWUD/PWID (either still actively using drugs or not) who provide outreach services to PWUD/PWID.

The benefit of using a group approach is that it decreases the possibility of outreach workers becoming involved in selling or distributing drugs through coercion, deception, or choice, during the process of doing outreach work with drug users. Implementing outreach activities in a group also provides a safer working environment for the peer outreach workers as it provides them with some protection from violence or sexual harassment that might occur during their work.

The group setting also allows the peer outreach workers to provide support to each other, such as in filling out forms or writing reports, complementing each other during health education sessions, assisting each other in following up with PWUD/PWID or referring them to other health services.

However, there have been some issues and challenges with the peer group relating to jealousy among the group, due to their active participation, personal discipline, limited education level, commitment, and the fact that moving in a group can attract unwanted attention from the police.

3.5. BARRIERS AND CHALLENGES

Working with PWUD/PWID is complex because of the subtle line that separates a PWUD/PWID and a drug distributor or drug dealer. There are numerous administrative barriers and challenges to be overcome before program for PWUD/PWID can be delivered. Below are the main barriers and challenges faced during the program implementation period of almost 2 years:

Peer outreach activities

Recruiting PWUD/PWID (former or occasional user) as peer outreach workers has helped to create trust among PWUD/PWID in the community. However, the high mobility of the peer outreach workers is a challenge, as is the fact that some of them have difficulty in reading and writing.

PWUD/PWID sometimes refuses to access services at the KMDC facility because they do not want their drug use status to be revealed. Most of them still partially hide their drug use from other people, especially their family members. Since the implementation of the Village and Commune Safety policy, many PWUD/PWID have been afraid of disclosing their drug use behavior out of fear of arrest by police or local authorities.

It has been observed that police have attempted to use peer educators or outreach workers as leads for locating PWUD/PWID or to trap wanted PWUD/PWID. Consequently, this has generated reluctance among PWUD/PWID in making contact with peer outreach workers or peer educators.

In March 2011, a case occurred in which a PWUD/PWID was arrested and sent to prison. The KMDC team kept in communication with the police to ensure that they could continue to meet with the PWUD/PWID and that the PWUD/PWID could maintain access to his opportunistic infection treatment and health check-ups.

Another challenge in implementing the outreach program was the fact that most PWUD/PWID had limited time to meet as their days were spent either working or using drugs. Thus, making a contact or organizing peer education session proved to be quite challenging.

Work hazards

KMDC in-house health provider staff and peer community outreach workers have been confronted with two types of working hazards.



Firstly, they have been constantly exposed to blood borne infections, especially HIV and Hepatitis, since a high proportion of PWUD/PWID were either HIV positive or had Hepatitis. Secondly, peer outreach workers, who are also PWUD/PWID themselves, may be vulnerable to wrongful arrests for crimes committed by other PWUD/PWID.

Village and Commune Safety policy

According to the PWUD/PWID, the level of implementation of the Village and Commune Safety policy vary from place to place. Consequently, it was very common for PWUD/PWID to move from one place to another place seeking safety from arrest. The local authorities where the KMDC is located are required to collect information on the identities of PWUD/PWID who frequent the KMDC facility. This requirement was a cause for great concern for both KMDC and the PWUD/PWID who access services at the KMDC. Eventually, KMDC agreed to provide the identity of only a small number of PWUD/PWID, so as not to compromise

their commitment to protect the confidentiality of all of their clients. KMDC has organized a number of sensitization meetings with local authorities and police to explain about the programs implemented by the KMDC, and also the impact of releasing information about PWUD/PWID to the implementation of the programs.

Increasing workload

When working with an increased number of PWUD/PWID, collecting routine data from the fieldwork can become daunting work. There are too many indicators to be collected from the field, and the indicators need to be sent quarterly to TSBP department and M & E Unit. Report must be submitted to the donor agency every other quarter (semi-annually). However, reporting and M & E system will not be included in this documentation. It will be reviewed as part of KHANA M & E assessment in July 2012.

3.6. LESSONS LEARNED

Selecting the location for a DIC must be done very carefully, to ensure that the location is convenient for most PWUD/PWID in the coverage areas. It has been observed that most of the PWUD/PWID who accessed the services in the KMDC are those who work or gather in areas near the KMDC facility. Traveling is one of the barriers for PWUD/PWID, because of the costs involved and the risk of encountering police en route.

PWUD/PWID generally does not disclose their drug use status to their families. Therefore, peer outreach workers should be very sensitive to the family's response. The most appropriate strategy must be carefully selected when approaching the family of a PWUD/PWID, to minimize the potential negative consequence for the PWUD/PWID. Support from their family is very important for PWUD/PWID, especially if they are on a program aimed at reducing drug consumption or quitting drug use completely.

When conducting health educational sessions at the KMDC facility, it is vital to provide transportation support for the PWUD/PWID. This is because travel costs could be the main barrier preventing PWUD/PWID from attending such sessions. Aside from that, PWUD/PWID should be compensated for their time away from their jobs.

KMDC implements an active referral mechanism, which ensures that PWUD/PWID receives the services (that they need) in the harm reduction intervention package.

Reaching drug users in communities and bring them to harm reduction services is costly; therefore, KMDC should ensure that each drug user could received services included in the harm reduction package. Thus, active referral mechanism proposed by KMDC may still be reasonable. Besides, providing general health care and treatment at the KMDC facility is a very attractive option for PWUD/PWID. Accessibility to general health care and treatment services should be extended to family members and partners of PWUD/PWID.

One lesson learned that should be highlighted is the failure of NSP network with designated pharmacies due to the high mobility of PWUD/PWID. A proper feasibility assessment or formative study should be conducted prior to such an intervention to guide a program planning.

The peer approach used in the KMDC outreach program has increased the Center's ability to reach PWUD/PWID and increased the effectiveness of the messages delivered, as the PWUD/PWID is more likely to listen to someone who has been in their shoes.

It is important for any harm reduction program to consider the broader spectrum of prevention strategies, which includes reproductive health. For example, unprotected sex puts PWUD/PWID at risk of becoming infected with HIV and/or other STIs. Promotion of safe sex can help to reduce the risk for HIV and STI transmission for both PWUD/



PWID and their sexual partners, including long-term sexual partners such as wives and husbands.

The 16 harm reduction interventions should be revisited, improved and strengthened. For example, some SRH services, such as family planning, STI care and treatment should be strengthened and expanded from only providing referral to providing a comprehensive service package within the KMDC.

In line with the feedback from PWUD/PWID, the vocational trainings for PWUD/PWID should be redesigned to make them more flexible to ensure value of money.

It is very challenging to maintain a high level of support from local authorities and police. At the early phase of program implementation, local authorities and police actively participated in activities and meetings organized by the KMDC. However, it has been observed later that it has become harder to invite them to KMDC events. This might be due to the enforcement of the safe commune and village policy.



CONCLUSIONS & RECOMMENDATIONS

After two years of implementing the harm reduction program, KMDC appears to have achieved its objective of delivering services to PWUD/PWID in the communities. However, to be a model for drop in centers, KMDC should continue to improve itself in order to become a “One Stop Comprehensive Service Center”. SRH services, such as family planning and STI diagnosis, care and treatment, need to be integrated into the current program. Gender balance among peer outreach workers at the KMDC should also be maintained.

Creating an enabling environment should be a top priority for KHANA and KMDC, to improve the outcomes of the harm reduction program implementation. To achieve this, both KHANA and KMDC need to be more active in applying different strategies to strengthen its relationship with local and high level stakeholders and policy makers, from local police to Government agencies and United Nations (UN) agencies.

Working with PWUD/PWID can be hazardous. KHANA should provide enough preventive measures for KMDC staff and outreach workers to protect them from needle stick injuries. They should also be provided with Hepatitis B vaccination.

The recruitment of PWUD/PWID as peer outreach workers has proven to be very effective for the program implementation. However, it has been difficult to obtain identity cards from NACD for all of the outreach workers. Therefore, KHANA is currently negotiating with NACD to issue an identity card to only the outreach assistant, who will lead the peer outreach workers in the field.

Focusing solely on PWUD/PWID may not be the best strategy for co-existing in the community and creating an enabling environment for the DIC. KMDC should aim at making the programs and services provided at the Center, such as vocational trainings and primary health care, accessible not only to the PWUD/PWID but also to other members of the community. This increased accessibility will contribute to the sustainability of the KMDC.

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APPENDIX: FIELD GUIDE

Introduction: (The following is to be read by the interviewer to the respondent): "KHANA is conducting an Operation Research on KMDC to learn more about the process of the innovative model of service implementation provided to PWUD/PWID; to explore barriers, challenges, and lessons learned from program implementation; to make recommendations about how to improve the KDMC in order to become a model for Drop in Centers. We would like to request your cooperation for about 60 minutes for a discussion. You are free to refuse to participate in this discussion. All answers will be totally confidential, your names will not be recorded. Please be totally honest with your responses. Your participation is very important.

FOCUSED GROUP DISCUSSION WITH PWUD/PWID

1. Demographic profile of respondents (age, gender, education and marital status)
2. How long have you been using drug?
3. What is your occupation?
4. What is your health status these days?
5. Where have you been given health services? Name of NGO, types of services you have received?
6. What do you think of those services? Did they meet your needs?
7. How did you find out about the services at KMDC (outreach and DIC)?
8. Have you ever received these services from any other organizations before? What are they?
9. What services provided at KMDC that are different from those you received from other organizations?
10. Did you receive any particular vocational training on life skills from KMDC? If yes, is it useful for you?
11. Among all of you, is there anyone who inject drugs? (If, Yes) Have you ever shared needles/syringes with your friends/partners? Have you ever have sex under the influence of drugs?
12. Has anyone here ever accessed methadone maintenance therapy (MMT) service? What do you think of it? Overdose?
13. What is your current situation? (in terms of relapse, abstinence, frequency of drug use, types of drugs, level of dependency)
14. Has anyone here ever been arrested? Why? Was there any legal aid provided?
15. What are the major barriers to access to services? As a PWUD/PWID, what do you think about the impact of the "Village-Commune Safety policy" to your access to services?
16. Has anyone here ever been involved in any work with KMDC?
17. Do you know any other NGOs or organizations that work with PWUD/PWID?
18. Do you have any suggestions to KMDC or local authorities?
19. Is there anything else you would like to share with us before ending this discussion?

INTERVIEW WITH KMDC CENTER MANAGER

1. Could you tell us about the structure of your center?
2. What are the goals/objectives (functions/roles) of your center? Why was this center established?

3. Who will benefit from your services? (PWUD/ PWID, community people, partners of PWUD/ PWID)
4. What are the interventions provided by your center (list down)? Could you describe the objectives of each service and target group who receive the service? How is it run? (referral, MMT, vocational training, outreach, IEC, enabling environment, OI/ART, STIs, VCCT)
5. What do you think about drug policy implementation (drug law, village/commune safety policies?) Can you tell us about the arrests and disclosures of PWUD/PWID? What is the role of your center in mobilizing community support for your work? How do you coordinate with local authorities?
6. What are the major barriers to program interventions for PWUD/PWID accessing services?
7. Has your organization been doing any advocacy work to meet the needs of the beneficiaries? How was it?
8. How do you deliver your services to ensure that they will reach your target population? (PWUD/PWID, their partners, community people)
9. What is your observation regarding the use of health services among PWUD/PWID? Why? Are they satisfied with this? What are their main needs? Could you fulfill those needs? How? Why?
10. What measures could service providers take to encourage PWUD/PWID to use services, abstinence, drop out or stop?
11. How could you predict the behavior change of the PWUD/PWID in terms of relapse, abstinence, drop out, and sexual risk behavior related to HIV?
12. What are the challenges and lessons learned from the program implementation that you would like to share?
13. Are there any overlapping target/ coverage issues? How to solve it?

14. What is it about the overall model of KMDC that makes it different from other DICs?
15. What would you recommend – in terms of service package – for KMDC to be recognized as best practice approach? How does this compare with your model?
16. How would you make the center work better?
17. Is there anything else you would like to share with us before ending this interview?

INTERVIEW WITH DOCTOR/ NURSE

1. Age of respondent
2. Could you please describe your role in this center?
3. What are the services provided by your organization are you in charge of? (medical treatment, counseling, regular follow up, referral to Health Center, in patient treatment)
4. Could you tell us how your service links to MMT clinic, VCCT clinic, STI clinic, Health Center and the role of what program
5. What you do think about the drug policies (drug law, village and commune safety policy) and how it could prevent PWUD/PWID from accessing the services at the Center? How has it shaped your service provision? Do they come more or less? What are your thoughts?
6. What is your observation regarding the use of health services among PWUD/PWID? Why?
7. How do you describe the PWUD/PWID's health status when they first come to the Center, compared to later?
8. Can you describe the behavior of the PWUD/ PWID in terms of health seeking behavior, drug dependence, abstinence?
9. What measures could service providers take to encourage PWUD/PWID to use the services?
10. What are the strengths and weaknesses of your health services?

11. What are the major barriers to program interventions for PWUD/PWID accessing the services?
12. Has your organization carry out advocacy work (access to health care, treatment, education...)?
13. How do you deliver your services to ensure that they will reach your target population?
14. Do you know any other NGOs or organizations that work on health related issues with PWUD/PWID? If yes how do they work?
15. What are the challenges and lessons learned from program implementation that you would like to share? Are there any recommendations that you think would help?
16. What is it about the overall model of KMDC that makes it different from other DICs? Is there anything else that you would like to share with me before ending this interview?
7. What is your observation regarding the use of health services among PWUD/PWID? Why?
8. What measures could service providers take to encourage PWUD/PWID to use services (HIV prevention sessions, NSP, vocational training)?
9. What are the major challenges for you as outreach assistant in working in this field? Is there any recommendation to respond to those challenges?
10. What are the lessons learned from the program implementation that you would like to share?
11. Are there any PWUD/PWID that have been dropped/ relapsed/ abstinent?
12. Does any of the PWUD/PWID come to the Center as a couple? How could you know? How often do they come?
13. Do you think coming as a couple help to make the counseling more effectively?
14. What do you think about the overall model of KMDC that makes it different from other DICs?
15. What is the model structure for the peer educator (PE) approach? How should tasks be delegated to the PEs?
16. Is there any overlapping target/ coverage issues? How do you respond to this?
17. Is there anything else you would like to share with me before ending this interview?

INTERVIEW WITH KMDC OUTREACH ASSISTANT

1. Could you please describe your role as outreach assistant in the center?
2. How do you think the implementation of drug policies (drug law, village-commune safety policy) could prevent PWUD/PWID from accessing the services? Why, or why not?
3. What is the role of your organization in the community involvement in supporting your work?
4. What are the major barriers to program intervention for PWUD/PWID accessing services in the community where the Center is located?
5. Has your organization carry out advocacy work (access to health care, treatment, educational sessions)?
6. How do you deliver your services to ensure that they will reach your target population in the community?

INTERVIEW WITH VILLAGE CHIEF

1. Age of respondent
2. How long have you been serving as the village chief?
3. Position of respondent?
4. What do you think of the existence of KMDC in your community?
5. Have you ever been involved in any KMDC meeting, sessions or workshops on sensitization on drug use and HIV prevention? If yes, what did you think of them?

6. In your opinion, how can this center help support PWUD/PWID (access to health service, stop using drug, abstinence)?
7. In your opinion, how does the village/commune safety policy impact PWUD/PWID's access to health services?
8. Have any PWUD/PWID in your community been arrested? What do you think about it?
9. What is your recommendation to KMDC for future activities?

INTERVIEW WITH HEALTH CENTER

1. Age of respondent
2. Sex of respondent
3. Position of respondent
4. How long have you been working here?
5. What is the name of your institution?
6. Who will benefit from your services? How often do they access the services? (any PWUD/PWID)?
7. What services does your institution provide? Could you describe the objectives of each service and the target group that receive the service? Any particular service for PWUD/PWID (are they male or female)?
8. What do you think of the impact of village and commune safety policy on the implementation of drug response programs?
9. How do you deliver your services to ensure that they will reach the most in need population (including PWUD/PWID)?
10. Do you know any other NGOs or organizations that work with PWUD/PWID? Have you collaborate with them?
11. In your opinion, what are the major barriers for PWUD/PWID in accessing health services?
12. What are the challenges and lessons learned from the program implementation you would like to share?

13. Is there anything else you would like to share with me before ending this interview?

INTERVIEW WITH MMT STAFF

1. Age of respondent
2. Sex of respondent
3. Position of respondent
4. How long have you been working here? How long has this service been established?
5. What is the name of your institution?
6. How many PWUD/PWID is reached by your MMT? How often do they come? Do they come in as couple? How about female PWUD/PWID?
7. What services are provided by your institution? Could you describe the objectives of each service?
8. How do you deliver your services to ensure that it will reach to the most in need PWUD/PWID?
9. Which NGOs refer the PWUD/PWID to your services? Does the NGO staff come along with them?
10. In your opinion, what are the major barriers for PWUD/PWID in accessing your services?
11. What do you think about the adherence of the PWUD/PWID to your service? Do they come every day? What are the effects if they do not receive a proper service?
12. What lessons learned from the program implementation would you like to share? What are your thoughts regarding the future of the MMT program?



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