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Qualitative
Baseline for the Cambodia Program

International HIV/AIDS Alliance
Frontiers Prevention Programme

BILL & MELINDA GATES foundation

International HIV/AIDS Alliance
Supporting Community Action on AIDS in Developing Countries

FRONTIERS PREVENTION PROJECT

KHANA
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Contents

1 **Executive Summary** p.5

2 **Introduction** p.9

2.1 Objectives of the study p.9
2.2 Overview of FPP evaluation p.10
2.3 Rationale of the study p.10
2.4 Operationalisation of key themes p.11
2.5 Overview of report p.12

3 **Methodology** p.13

3.1 Methods p.13
3.2 Process p.14
3.3 Respondents p.15
3.4 Analysis process p.15
3.5 Challenges in process p.15

4 **Findings** p.17

4.1 MSM p.17
4.2 SW p.27
4.3 PLHA p.34
4.4 Gatekeepers p.43

5 **Conclusions** p.51

5.1.1 MSM p.51
5.1.2 SW p.52
5.1.3 PLHA p.53
5.1.4 Gatekeepers p.53
5.2.1 Respondents p.54
5.2.2 Sites p.54
5.2.3 NGOs p.55

6 **Recommendations** p.57

6.1 Process - when we do this again p.57
6.2 How to measure change p.58
6.3 Programmatic recommendations p.58

Annexes

1. Guidelines for the focus group discussions p.60
2. Guidelines for the in-depth interviews p.67
3. NGOs consulted in FPP sites p.80
4. Field work schedule p.81
5. Transcription and translation p.85
6. Initial Analysis Framework and notes on using the analysis sheets p.86
7. Theoretical framework for FPP p.91
8. Overview of FPP Evaluation Framework p.92

ABBREVIATIONS

Acronyms of NGOs are listed in Annex 3

ARV	Anti-Retro Viral (treatment for HIV)
DSW	Direct Sex Worker (brothel based)
FPP	Frontiers Prevention Proramme of the International Aids Alliance
FGD	Fpcus Group Discussion
GSA	Geographical Site Assessment
IDI	In-Depth Interview
IDSW	Indirect Sex Worker (massage parlor, karaoke, beer garden, etc. based)
KAPB	Knowledge, attitudes, practices, and behaviour
KP	Key populations
MSM	Men who have sex with men
NGO	Non Governmental Organization
PLHA	People living with HIV/AIDS

Khmer terms used in report:

Ah Khteuy	Man who has sex with men (derogatory phrase)
Dharma	Buddhist teaching
Mekar	'Aunt' or brothel manager
Sangsaa	Sweetheart/lover (either sex)

1 Executive Summary

The International HIV/AIDS Alliance Frontiers Prevention Programme (FPP) aims to support the delivery of a comprehensive package of interventions within specific geographic sites that are seen as potential high HIV-transmission areas. In Cambodia three sites were selected: Battambag, Siem Riep and Sihanoukville.

The total set of interventions was finalised after conducting Participatory Site Assessments (PSA). The FPP is based on the premise that social capital can influence key population (KP) vulnerability to HIV through various pathways. Empowerment is visualised as the interplay between social capital, an enabling environment and access to services and commodities. The interventions seek to influence all these dimensions and pathways.

This study is a qualitative baseline for the outcome evaluation component of the evaluation of the International HIV/AIDS Alliance Frontiers Prevention Programme (FPP). The outcome evaluation is going to measure the effect of the FPP interventions at objective or outcome level. The objective of this study is to establish a baseline for all the issues to be evaluated during the end-of-project data collection phase.

The research questions for this outcome evaluation are:

- Does the FPP empowerment for prevention approach increase the level of social capital (community trust, reliance, responsibility and civic participation) among key populations actively involved in interventions (now referred to as KPs with high involvement)?

- Does the FPP empowerment for prevention approach increase the level of social capital among the wider key populations exposed to the intervention?
- Does increased social capital lead to increasing empowerment for prevention, actual reduction in risk behaviours and changes in knowledge attitudes and behaviour?
- Does the FPP approach lead to an enabling environment in which stigma and discrimination are reduced? What is the relationship between an enabling environment and social capital?

For this baseline study two methods were used: Focus Group Discussions (FGD) and in-depth interviews (IDI). The major issues covered include: knowledge, attitude and behaviour towards safe sex, self-efficacy, self esteem, experiences of stigma, discrimination and violence, social capital, involvement/participation in services and views of quality of services.

A total number of 93 interviews were conducted across sites: 21 group and 72 individual interviews. As respondents we recruited individuals of the following backgrounds[1] :

- Direct (brothel-based) and indirect (massage parlour or karaoke bar) sexworkers (SW) with either high (peer group educator) or low (not much contact) involvement with FPP NGO activities.
- Men having sex with men (MSM) who are either highly or lowly involved with FPP NGO activities.
- People Living with HIV/AIDS (PLHA) who are involved in FPP NGO activities.
- Gatekeepers of sexworkers (brothel, massage parlor, karaoke bar managers).
- FPP NGO staff of both management and program implementation level.

The interviews were analysed using an analysis framework developed by the International HIV/AIDS Alliance on the basis of reading through intial transcripts provided by the Cambodian research team.

Key findings: men who have sex with men (MSM)

- Discrimination was not as bad as it had been in the past, although there was still a range of stigmatizing responses to MSM behaviour, especially in rural and minority groups.
- MSMs were primarily discriminated against because of their sex work, rather than their sexual preferences.
- Peer group solidarity was strong, with MSMs working together and socialising as a group. They valued the support given by other MSMs in the face of discrimination and lack of knowledge in the general population, as well as enjoying having fun together.
- NGOs had helped considerably in bringing MSMs together, helping them when they were in trouble, and building their confidence through involving them in education programmes in their local communities.
- MSMs knew about key health and support services for them (some were delivering services themselves).
- Condoms are cheap and easy to find, although lubricants are more difficult to access. Condom use has increased in the past year, although precise figures are difficult to judge - between “60% of the time” and “almost always” were reported. It is clear however that condom use is not the norm with lovers (sangsaa), even when MSMs have other sexual partners.
- Knowledge of HIV has led MSMs to monitor their risky behaviour, such as the increased use of (free) blood testing services, and a reduction in the number of partners.

Key findings: Sexworkers

- Respondents identified with many 'peer' groups - not just their work colleagues. "Peers' could include neighbours, NGO staff and other sexworkers in the district, not just fellow workers in the brothels.
- While respondents stated that their community looked down on them as those who had lost their honour, there was also an acceptance of them as people supporting their families through their hard work - both attitudes prevailed.
- The “one-stop shop” approach of many NGOs influenced many respondents, who were pleased that attendance at one NGO put them in touch with a range of services, many involving home- or work-based delivery, which enabled them to access products and services they may otherwise have found too difficult or costly to obtain.
- Respondents were fully aware of the health services available to them. They were also aware of the key transmission routes for HIV, and could quote them easily. They knew from experience of what to do when things do not happen as expected.
- Respondents received their information primarily through the NGO training, but also from each other, from radio and TV government programmes, and from local hospitals and clinics.
- The role of the NGO as encourager and facilitator appears to be vital to women who were denigrated in their own communities and were very aware of the stigma attached to their profession.

[1] Recruitment was facilitated by FPP (and other) NGO in the various sites.

- Lack of education and knowledge (many respondents were illiterate), precarious financial position and fear of violence all contributed to their lack of self esteem.
- Peer group programs run by NGOs were the best for the respondents, but these programs need to focus more now on those who were "informally" part of the sector. It was realised that these more hidden groups represented the greatest current risk of increased infection. Respondents also thought that there needed to be more education programs for the police and local authorities, so that they understood more about the disease in their locality.
- Sex workers were fully knowledgeable about condoms, including those for women, which were generally agreed to be good. There was evidence of increasing use of female condoms. Respondents were also enthusiastic about the lubricants that were now more freely available - but were still not as easy to obtain as condoms.
- There is still evidence that condoms are not always used a) with husbands b) with lovers, c) with clients, even if the sexworker is HIV+.

Key findings: people living with HIV/AIDS (PLHA)

- In contrast with other groups in the survey, this group were more pessimistic, less articulate in interviews, felt isolated and had low self esteem.
- NGOs were the organisations that PLHA had most confidence in, both as consumers of services, and through their direct participation as volunteers.
- However, if PLHA had problems, they were more likely to discuss them with family or friends, rather than with NGO staff. They also maintained links with Wats and acknowledged the influence of Buddhist teaching on their perceptions of the illness.
- There was little confidence in public health systems - most PLHA used private practitioners for their medicines, primarily injections of "serum" to help them regain their strength. ARV treatment (if available) was accessed from public hospitals through NGOs.
- The length of time between infection, diagnosis and death, and the number of "AIDS families" had meant that the goodwill of the community towards PLHA had been severely strained, given the amount of care needed from within the family or village and the poverty of many of these communities.
- There were some interesting developments at a local level, where villages had discussed the issue as a community, and organised education and information for all, not just those directly affected by the virus.
- Legal and customary rights for PLHA seemed to depend on their health status, and whether they had the support of NGOs, as much as the fact that they were infected.
- The key messages that PLHA urge all to hear are: men must use a condom every time they have sex, everyone should have a blood test before getting married, teenagers must be educated about sexual behaviour and feelings, and everyone needs to understand how dangerous the disease is.

Key findings: gatekeepers

- Gatekeepers seemed to be more aware of the NGOs working in their sector than many of the sexworkers. The gatekeeping role was however only part of a more complex relationship between themselves and other organisations in the sector.
- Gatekeepers were now open to receiving NGO services, and knew of several types of services available in their vicinity. Many had attended NGO courses themselves, and had given training voluntarily with local NGOs. Some had taken part in research interviews.
- Gatekeepers are influenced by several factors when working with NGOs; in particular, concern for their employees' health and level of knowledge, the quality or good name of their establishment, and the fact that NGOs appeared to be doing good work in the community, as well as economic considerations.
- Gatekeepers operated within both formal and informal networks of control with regard to their employees, involving other gatekeepers, NGOs and the police.
- Respondents regarded their employees as part of their extended family. "They are my children, or my younger siblings" was a common response. There were instances where respondents were involved in decision making which reflected their perceived parental role, which may raise confidentiality issues.
- Gatekeepers were open about their work, and claimed that their employees were also. In fact for many it was appeared a source of some pride, as they were often being asked by NGOs for help and information.
- Most respondents gave instances of discrimination, especially with clients. While neighbours tolerated them, clients might call them names, try to reduce the price, or threaten them with violence.
- Legal rights are not properly understood, or enforced. Instead, police and local authorities use their powers to regulate the industry in their locality as they see fit. This includes registering all new sex workers in the area, and receiving payments from gatekeepers.

- In cases of violence police could be called upon to safeguard employees while at work, but employees themselves would have to choose to involve police in any other circumstances where they felt under threat.
- Some of the indirect sexwork establishments may be missing out on education programs, as karaoke bar owners and similar say that NGOs ask for "sexworkers" to attend their programs and their establishments deny any knowledge of sexworkers. Young employees may be particularly at risk.
- The fear of employees contracting HIV was not only about concern for the employee (and for business) but also that as employers they would be blamed, especially by the medical authorities, for not looking after their employees carefully enough.
- Gatekeepers were fully aware of the range of health services available, from public, private and NGO organisations. They themselves provided financial support services (loans and gifts) to employees.

Similar findings across key populations

- Peer group solidarity is strong, especially in the face of discrimination from the authorities and the general public.
- Each group was looking for a "place of their own" in which they could meet both socially and for education purposes. This perceived need was the same for sexworkers, PLHA, and MSMs.
- All were knowledgeable about HIV/AIDS, how it was transmitted, and the services available through NGOs in particular. This educational stage seems to have had its results. This does not mean that behaviours have necessarily changed however, especially amongst MSMs.
- The "proxy parent" role of gatekeepers and others in the industry needs to be better understood, especially how this affects their attitudes to information about their employees' health and personal circumstances.
- Condoms are not always used, especially with husbands/lovers and amongst MSMs. There appears to be an element of fatalism about this, and it is difficult to know whether any education campaign would be able to address this issue.
- While women working in the sex industry were generally denigrated for their work, those who had made a good living and were supporting their (often large, extended) families were admired for their efforts. The outcome seems more important than the process.

The transcripts did not indicate clear cut differences between the three sites.

2 Introduction

The International HIV/AIDS Alliance Frontiers Prevention Programme (FPP) aims to support the delivery of a comprehensive package of interventions within specific geographic sites that are seen as potential high HIV-transmission areas. FPP interventions are being implemented in India, Ecuador and Cambodia.

The total set of interventions - finalised after conducting Participatory Site Assessments (PSA) - are grouped into eight clusters, each of which has a number of elements or stages and is associated with different intervention types. The key concept in the theoretical rationale behind these interlinked clusters is "social capital", which is conceptualised as part of a broader process of empowerment. The FPP is based on the premise that social capital can influence key population (KP) vulnerability to HIV through various pathways. Empowerment is visualised as the interplay between social capital, an enabling environment and access to services and commodities. The interventions seek to influence all these dimensions and pathways. Annex 7 visualises the theoretical framework of the FPP.

2.1 Objectives of the study

This study is a qualitative baseline for the outcome evaluation component of the evaluation of the International HIV/AIDS Alliance Frontiers Prevention Programme (FPP). The outcome evaluation is going to measure the effect of the FPP interventions at objective or outcome level. A key expected outcome

is increased empowerment and social capital creation as a result of FPP interventions. But the evaluation will move beyond focusing solely on social capital and explore issues around stigma and discrimination and quality of services. The objective of this study is to establish a baseline for all the issues to be evaluated during the end-of-project data collection phase.

2.2 Overview of FPP evaluation

The overall FPP evaluation design comprises "external" and "internal" components the results of which will be triangulated with each other. 'External' means measuring the impact of the FPP interventions through a comparison site methodology. However, the relatively small Cambodia FPP does not include comparison sites and the Cambodia evaluation is thus limited to the internal components.

The external evaluation uses a quantitative knowledge/ attitudes/practices/behaviour (KAPB) baseline and follow-up survey in both intervention and comparison sites[3]. During the design phase, adding an 'internal' KAPB survey to the evaluation framework for Cambodia - to ensure the availability of quantitative impact data - was considered but financial considerations prevented this from materialising.

The internal components include:

- "Process monitoring' which is essentially the monitoring and tracking of activities in all intervention sites. Its focus is mostly on quantitative outputs;
- An NGO capacity assessment;
- A geographical site assessment (GSA)[4]. The GSA represents a snap-shot of what is happening within each site as well as outside sites at national/ provincial level. It tracks incidents that occur which might have an effect on FPP implementation or results.
- An outcome evaluation. Whilst the process monitoring focuses on activities and the external evaluation on impact, the outcome evaluation measures the effect of the interventions at objective or outcome level.

This study is the qualitative baseline for the Cambodia FPP outcome evaluation.

Annex 8 contains a visual overview of the FPP evaluation components.

2.3 Rationale of the study

The concept of social capital has recently moved beyond the realm of academia to become a concept frequently drawn on by both policy makers and practitioners. Although usefully applied in a range of contexts, the definition is widely contested across disciplines and the inherent ambiguity of the term has resulted in social capital tending to mean "all things to all people". The sociology, development economics and community psychology literature, in particular, offers seemingly endless terms and definitions describing more or less the same general ideas, including: community competence, community sense of identity, social support, social participation, co-operation for mutual benefit, trust, cohesive networks, etc.

Work around social capital has tended to focus on its effects at community or site level and not on a particular "community" or key group, e.g. sex workers or MSM and their links with the wider community or their cohesion within this wider community. The framework for the FPP focuses on the interplay between various 'communities' and the wider community.

Therefore, from the interventions research perspective of the outcome evaluation, the focus had to be on establishing a working definition that "makes sense" for each target community, and that offers the opportunity to show change either over time (or between intervention and comparison groups). This led to the emergence of a set of key components of social capital (see Box below).

This evaluation (and the FPP in general) is based on the premise that social capital can influence KP vulnerability to HIV through various pathways: civic participation in groups and associations; trust, solidarity and reciprocal support within SW groups; and trust, solidarity and support across different groups. Whilst social capital is a key notion within the FPP conceptual framework, it is useful to view it as part of a broader process of empowerment. Within the FPP, empowerment is visualised as the interplay between social capital, an enabling environment and access to services and commodities. The interventions seek to influence all these dimensions and pathways. The FPP program and this study view social capital as just one possible component which if increased, mobilised or facilitated, is hypothesised to lead to increased empowerment which in turn is likely to lead to decreased vulnerability to HIV infections.

Like social capital, the concept of empowerment is difficult to unpack and define. The FPP is using the phrase "empowerment for prevention" to describe the transformation process whereby

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3 *This survey is augmented by the collection of bio-markers (treatable and non-treatable STIs) as proxy indicators for HIV prevalence. In addition to knowledge and behavioural outcome indicators, the external survey incorporates some measures of social capital.*

4 *Unlike the other components discussed above, the GSA occurs in all sites, both intervention and comparison.*

key populations **(1)** become aware of HIV/STI risks and risk reduction strategies; **(2)** express hope or desire to avoid HIV/STI infection and/or to avoid infecting others with HIV/STI; **(3)** develop skills to reduce risk of HIV/STI transmission; (4) are motivated to use sexual health services and commodities as needed; and (5) express and experience a sense of adequate support from peers for HIV/STI risk reduction.

Taking these notions of social capital and empowerment one step further and starting to focus them in terms of the FPP, the underlying assumption of FPP is that interventions seeking to promote empowerment need to work at several levels: individual, community and wider environment. The 'package' of interventions that will be carried out in sites consists, therefore, of these 3 different levels. This mix, that is inherent in the design of the interventions, is also reflected in the design of the evaluation. As with the intervention, the evaluation design recognises that empowerment is generated by dynamic interaction between individual, community and environment.

The research questions for the outcome evaluation are all derived from this theoretical framework and target its validity[5]:

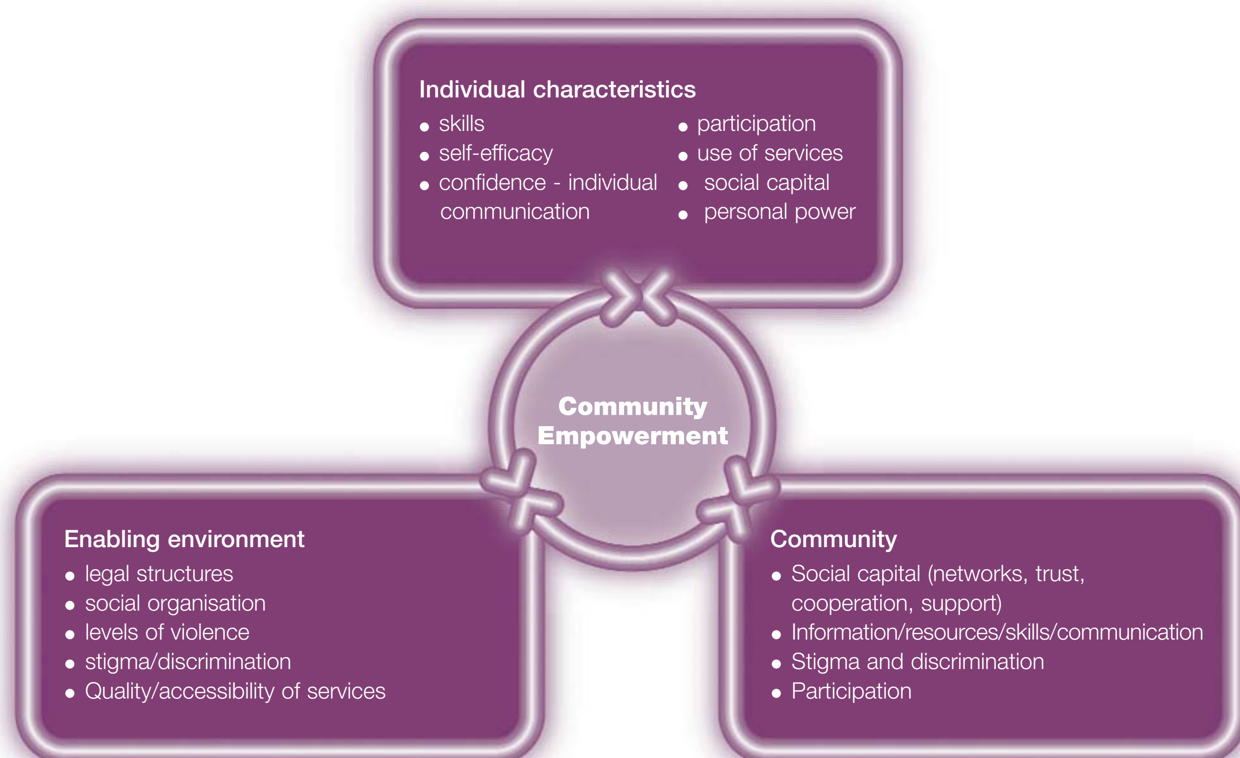
- Does the FPP empowerment for prevention approach increase the level of social capital (community trust, reliance, responsibility and civic participation) among key populations actively involved in interventions (now referred to as KPs with high involvement)?
- Does the FPP empowerment for prevention approach increase the level of social capital among the wider key populations exposed to th e intervention?
- Does increased social capital lead to increasing empowerment for prevention, actual reduction in risk behaviours and changes in knowledge attitudes and behaviour?
- Does the FPP approach lead to an enabling environment in which stigma and discrimination are reduced? What is the relationship between an enabling environment and social capital?

Obviously, this baseline does not answer these questions. It provides the first step towards an answer.

2.4 Operationalisation of key themes

The following diagram presents this framework and identifies the various concepts associated with the 3 levels: individual, community and wider environment. The diagram shows how key concepts like social capital and stigma/discrimination appear at more than one level.

Given the methodological choice for this outcome evaluation, the next step towards operationalisation is to define the aspects/dimensions of these concepts, at their various levels, that can be probed using in-depth interviews and Focus Group Discussions (FGD).



5 *The internal evaluation addresses more research questions, e.g. questions around NGO capacity building and costs of interventions, but these taken care of by other components of the internal evaluation.*

Box 1 below provides the overview of key concepts and their various aspects that were the basis form the development of the actual interview guidelines described in the next section on methodology/process.

Box 1
Key concepts for outcome evaluation:

1. **Exposure to interventions/Use of services/Active participation in FPP -**
   - Awareness of services; use of services; attendance at FPP training, workshops etc.
   - Extent to which services are participatory (responsive to need; accountability)
   - Quality (user satisfaction; perceived quality of service provision and commodities)
   - Active participation in FPP interventions (providing services; designing IEC; planning and implementing activities)
   - Leadership and decision making roles

2. **Effectiveness of site level approach -**
   - Extent to which referral systems work effectively (awareness; barriers to use; effective referrals)
   - Degree of co-ordination and collaboration between stakeholders within site
   - Strenght/effectiveness of communications networks

3. **Social capital -**
   - Community trust; solidarity (sense of community history/pride); strength of positive social norms; reliance and reciprocal support; strength of networks; quality/strength of communication; civic participation
   - From World Bank definition: processes between people that establish networks, norms and social trust, and facilitate co-ordination and co-operation for mutual benefit
   - Bridging (vertical social capital) and bonding (horizontal social capital) dimensions

4. **Self-efficacy/control over external events/self-esteem -**
   - Confidence handling issues in personal life / Coping skills
   - Self-esteem
   - Feeling of being in control / self-efficacy / influence
   - Increase in skills from FPP training - advocacy (mobilising others); strategic planning, IEC design, peer education/peer counselling

5. **Stigma, discrimination & violence -**
   - KP perceptions of stigma, discrimination, violence and harassment
   - KP experiences of stigma, discrimination, violence and harassment
   - Attitudes towards people living with HIV/AIDS
   - Attitudes towards KPs (NGO/health workers; gatekeepers)

6. **Empowerment for prevention/ Knowledge, attitudes behaviour change -**
   - Become aware of HIV/STI risks and risk reduction strategies; [awareness/knowledge]
   - Express hope or desire to avoid HIV/STI infections and/or to avoid infecting others with HIV/AIDS [risk aware/ motivation/attitudes]
   - Develop skills to reduce risk of HIV/STI transmission [skills]
   - Motivated to use sexual health services and commodities as needed [motivation/attitudes]
   - Express a sense of adequate support from peers for HIV/STI risk reduction [peer support]
   - Actual behaviour change

2.5
Overview of report

This report first describes the methodology used and the instrument design, fieldwork and analysis process. Then the substance of the interviews is described in a findings section, organised around the four key populations. The analysis follows the analysis framework as closely as possible[6]. The results of the interviews with NGO staff is not reported upon separately but was used in the analysis as background and triangulation information. The conclusions section first summarises the key findings per group. Then it summarises some tentative common threads emerging across themes about the various respondent groups, about differences between the three sites and about the impact of NGO interventions to date. The report ends with a set of recommendations. All relevant background documentation (interview guidelines, etc.) are contained in an extensive annexes section.

[6] *This is primarily baseline information, and needs to be clearly sectioned, so that future researchers can find their way around the sections easily and not have to search for information. Therefore, the report is tightly structured around the headings given in the analysis framework.*

3 Methodology

3.1 Methods

In this qualitative baseline study two methods were used: Focus Group Discussions (FGD) and in-depth interviews (IDI). The number of issues to be covered was quite large, too large to be addressed in one FGD. For this reason the FGD themes were split into two sets, henceforth called FG I and FG II. The Topics were divided between FGD I and II as follows:

Topics for FG I	Topics for FG II
Knowledge, attitude and behaviour towards safe sex	Involvement/participation in services
Self-efficacy, self esteem	Views of quality of services
Experiences of stigma, discrimination and violence	Awareness/effectiveness of site-level approach/issues
Social Capital	

The table below presents the overall envisioned structure of the data gathering per site.

Outline of data collection per site

KP	KP specifics	FGD		IDI
		I	II	
SW	High involvement	2	2	2
	Low Involvement			2
MSM	High involvement	1	2	2
	Low Involvement			2
PLHA				4
Gatekeepers				6
NGO Staff				6
TOTAL		**3**	**4**	**24**

The actual number of FGD and IDIs was determined by the realities of the three sites. Local Khana partners and other NGO's provided assistance in recruitment of informants and this resulted in slight differences in numbers of IDI of gatekeepers and NGO staff across sites. The total was unaffected. Annex 4 gives the overview of the actual group (total across sites 21) and individual interviews (total across sites 72) conducted at each site.

Annex 1 contains the guidelines used for the Focus Group Discussions, Annex 2 contains the guidelines for the in-depth interviews.

Originally, high and low involvement with NGO service providers was deemed an important KP distinction. High involvement was conceptualized as a peer educator kind of association with an NGO. In practice, the distinction between high and low involvement was difficult to make. The NGOs recruiting respondents made decisions that were not always confirmed by the involvement information provided by the individuals themselves as judged by the analysts. And of course some respondents have high involvement at one time, then low, and vice versa - a very fluid situation.

For analysis purposes, the team decided to ignore the a priori high/low involvement categorisation, instead describing in what way individuals involvement was high/low. E.g some sexworkers were volunteers with the NGOs, and this comes out in the text.

3.2 Process

The English versions of these guidelines were developed by Ms Sally Hendriks in close collaboration with International HIV/AIDS Alliance staff. The basis for the guidelines were a set of key issues, regarding which the FPP expects changes over time that - to a certain extent - can be seen as outcomes. From the very extensive lists of possible indicators (both quantitative and qualitative) to measure these[7], draft guidelines were developed in an iterative process between CAS Cambodia and Alliance's HQ, involving feedback from other FPP partner countries in which the outcome evaluation was also happening; this was in order to ensure similar approaches and questions were being asked in all 3 FPP countries.

Tools were translated by two translators (Lichea Piseth and Vuong Vuthikar), then checked by two others (Hean Sokhom and Kea Kunthmalia) and then as part of the three day training of the interviewers the instruments were verified for conceptual clarity and phrasing using group discussions of whole team.

The core instrument designer, Sally Hendriks, accompanied the team in the field for the first 10 days and remaining conceptual and phrasing unclarities were sorted our during the first days of interviewing. The team leader, Ms Lim Sidedine, had extensive

[7] *Described in two documents dated August 2003: Outcome evaluation matrix_Cambodia and Menu of tools_questions.*

experience as a qualitative researcher, including many FGD and in-depth interviews with sex workers. This experience proved essential to fine-tune (put into Khmer phrasing) the questions in response to the lack of understanding of certain questions by the interviewees.

3.3 Respondents

As respondents we recruited individuals of the following backgrounds:

- Direct (brothel-based) and indirect (massage parlour or karaoke bar) sexworkers (SW) with either high (peer group educator) or low (not much contact) involvement with FPP NGO activities.
- Men having sex with men (MSM) who are either highly or lowly involved with FPP NGO activities.
- People Living with HIV/AIDS (PLHA) who are involved in FPP NGO activities.
- Gatekeepers of sexworkers (brothel, massage parlor, karaoke bar managers).
- FPP NGO staff of both management and program implementation level.

Annex 4 gives a detailed overview of who was interviewed, be it as member of a FG or individually, when, at each of the three sites.

Recruitment was facilitated by FPP NGO's in the various sites[8]. Khana contacted them and requested assistance to the CAS team for recruitment. After this introduction, the researchers established direct contact with the NGO's and first contacts with interviewees were arranged during which the logistics for the actual group discussions/in-depth interviews were finalised.

Interviews with sexworkers were either conducted at their place of work, at the local NGO, or at the hotel of the research team. MSM and PLHA were interviewed at private houses or at the local NGO, gatekeepers mainly at their place of work and NGO staff at the NGO. Annex 4 gives a detailed overview of who was interviewed where.

Many informants were recruited through NGO's. Although the NGO had briefed the informants on the purpose of the interview and received informed consent and the venue for the interview had been based on informant preference, all interviews were preceded by an explicit informed consent introduction and cxonfidentiality assurances (see annexes 1 and 2: guidelines, for verbatim informed consent introductions).

3.4 Analysis process

The interviews were analysed using an analysis framework developed by the International HIV/AIDS Alliance on the basis of reading through intial transcripts provided by the Cambodian research team. This analysis framework was then adapted for the other 2 FPP countries. The framework was verbally shared and discussed with CAS during a half day meeting (19 July 2004). A paper version formulated by Ken Morrison arrived late July (see annex 6.1). The two core CAS researchers operationalised this version and their experiences provided the basis for a two day workshop (30 - 31 August), in which also Khana M & E staff participated[9]. The workshop resulted in a practical tool for the analysts (see Annex 6.2: Notes on using the analysis sheets). The analysis framework and this annotation tool were used by a team of analysts, some of whom had also been involved in conducting interviews, to extract the relevant data from the transcripts. The synthesising analysis was done by the main author of this report, Ms. Sandra Jones, research advisor to the Buddhist Institute and CAS.

3.5 Challenges in process

Three interrelated major challenges in the process were:

- The number of issues to be explored, both in the FGD and especially in the in-depth interviews were too numerous to allow for the kind of probing that would make optimal qualitative exploration.
- Some issues, especially the 'softer'ones like social capital and self-esteem, were conceptually difficult to delineate. Especially "social capital" is a concept for which there is no local language equivalent. The pressure on the interview time alluded to above prevented more open exploration of these issues. This on occasion also led to answers that, in hindsight, were not relevant to the framework.

8 *In Siem Riep assistance was also requested and provided by one non-FPP NGO: CWPD*

9 *Choub Sok Chamreun*

- Fieldwork time was budgeted tightly. Partner NGO's regularly had difficulties identifying potential interviewees and then scheduling interviewees so as to allow the researchers to complete the interviews in time. This sometimes led to even more pressure on the available interview time because the interviewer/FG moderators had to move on to the next interview/FGD. These difficulties were worsened by the above average defaulting upon appointments or not owning up to one's status/ profession (especially Indirect SexWorkers) of the key populations of this study.

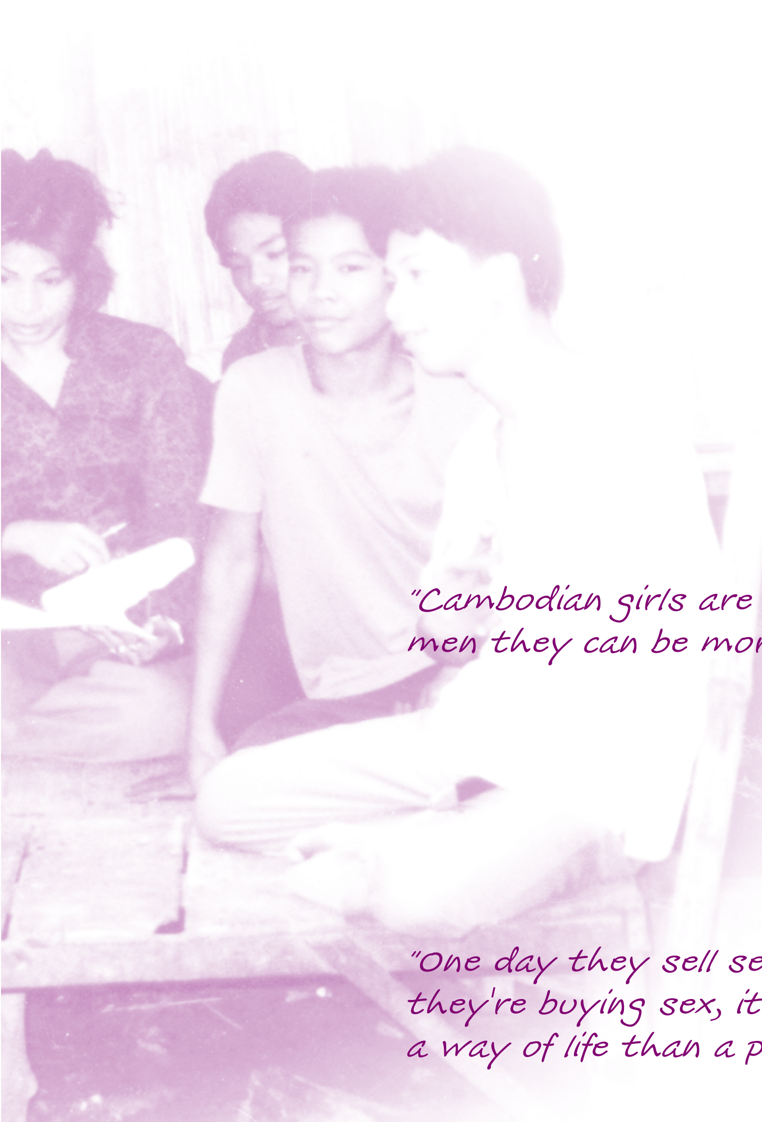
4
findings

4.1
men who have sex with men (msm)

"Women are for babies, and men are for fun"

Introduction

The term MSM (men who have sex with men) covers a large group of men including homosexuals, trans genders, bisexuals and others who have sex with other men. In the survey, three of the 13 men interviewed in depth said they were bisexual, the others ticked 'gay, homosexual' in the demographic survey. However, 8 of the 13, plus several of those in the focus groups stated that they had, or were likely to have, sex with women. This sexual fluidity means that sexual behaviour is the marker for MSM, rather than sexual identity (e.g. 'gay man'). Of the five key populations groups studied, the MSMs were the most homogenous in terms of age and education. All the in-depth interviews were of young men in their late teens and twenties, with one exception (age 42). This may have been because it is only now that young men are starting to be 'out'- and happy to talk about their experiences - a situation the previous generation would not have found possible. Also, they were all involved in the sex work industry, which is primarily a young man's occupation. In terms of education, two thirds had had some secondary schooling, while the rest had primary education only.



A recent paper[10] summarises the MSM population in Cambodia as complex, with two main groups: srey sros or transgenders, and those that are more “hidden”, called pros saat, handsome boy - or sak klay, short hair, or bisexual/ heterosexual men. While labelled as MSM, this does not discount sexual relationships with women - a study[11] in PP found that 60% of their sample of 'short hair' MSMs had had sex with both men and women. This was partly due to cultural considerations:

"Cambodian girls are more shy, so with men they can be more relaxed". [12]

MSM have a variety of attitudes to payment for sex, ranging from sex with a male “sweetheart”, characterised by no financial exchange, to the “just for fun” encounters, through to sex work where sex is exchanged for money.

"One day they sell sex. The next day they're buying sex, it's more a way of life than a profession". [13]

The FHI updated survey in 2004 stated that there may also be an element of power play in this - proving their desirability by being able to sell sex, but also buying to demonstrate their own economic power over partners.

Social capital

Involvement with NGOs and other groups

All the MSMs surveyed had had involvement with NGOs working in the HIV/AIDS area. The majority had worked for NGOs for a few months- others had only attended training sessions at their offices, and one had been working in the sector for up to four years. Their work was educative, training MSMs in the correct use of condoms, how to prevent SSI and in particular HIV/ AIDS, where to get supplies etc. working both in villages and at the NGO's offices. While they all had contact with one NGO in their town, they were generally unaware of what other NGOs working on the same issues were doing. However, they were able to describe the involvement of “their” NGO and the private sector (brothels, karaoke bars and nightclubs for example) in particular when NGO workers visited these establishments for educating sex workers in condom use or other anti-Aids measures. Other private sector links included visits from private companies distributing condoms and private health providers who did blood tests. Some MSMs also operated their own private businesses. One for example had opened a karaoke bar.

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10 Out of the shadows, Aids Alliance and KHANA, July 2003

11 FHI (Family Health International) 2000,

12 Stepping Out, Phnom Penh Post Issue 14/1, January 14-27 2005

13 Stepping Out, Phnom Penh Post Issue 14/1, January 14-27 2005

"Previously (I) worked at MHC (a local NGO) and then opened a karaoke establishment in Banteay Mean Chey and worked as a motorbike washer." (M,22,BB)

He was then called to do some evening education work for another NGO, before returning full time to his business interests. He is now back working for the first NGO.

Links with the public sector were also well understood when they related directly to the NGO, for example government run blood testing centers and medical centers. One MSM was working in a state school with RHAC, teaching from Grade 9 (upper high school level) on health issues. Another had done advocacy work with the local council and written anonymously to the local paper on MSM issues as they affected the local community.

MSMs therefore had links primarily (here) with one NGO, but also operated through a complex network of public and private sector groups. Given the proliferation of NGOs in Cambodia's economy, it is not surprising that they had knowledge of the names of other NGOs in their locality, but were usually vague about what these other organisations were doing.

Peer groups

MSMs in the survey had met their peers primarily through joining their local NGOs working on their issues. The NGOs held social functions as well as running programs, where MSMs could meet and socialise. Working together also helped to reinforce working relationships and also provide the linkages between MSMs who were "friends" rather than colleagues. For example, one man, trained with an NGO, said that this then enabled him to communicate effectively with his friends. Another said that he was involved with a formal peer-educating-peer group. Several respondents said it was important that MSMs should be knowledgeable about HIV and safe sexual behaviour.

"If for the first time they refused to be involved, it should ask them again and again until they would understand it and join it at last." (M,19,BB)

Students had also set up informal education groups at school.

Socially, peer groups tended to meet, at nightclubs and restaurants, or at local dances, often in the villages. Sexual encounters were possible at all of these venues, or at MSMs' homes or rented rooms. One respondent stated that his MSM group enjoyed going out "wooing" good-looking men in restaurants and at local dances.

"During meals, they could talk among themselves and occasionally saw a man (they related only to men). So the relation began with him (asked him his name, where he was living now) and then invited him to dance". (M,19,BB)

Influences of participation

All participants stated that working with the NGOs had influenced both themselves and the community around them. The NGOs were respectful to MSMs and had acted as liaison people when MSMs had approached the local council, or had an issue with the police. This may have been because of the education programmes run by the NGOs, which had raised awareness of MSMs, or maybe because MSMs were not regarded as a threat to society, and so their behaviour was tolerated, if not understood. Several participants stated that

they had become confident enough to participate in World Aids Day events, such as theatre performances at the local Wat, marches/gatherings and candle-lighting ceremonies.

However, several participants stated that they were still viewed as *"Ah Khteuy"* (effeminate man) and therefore preferred working with other MSMs. There was still much name calling, although the focus groups said that this was a lot less than previously, and was done primarily by children (and therefore could be ignored).

Confides in/confident with

The respondents almost invariably turned to their family and friends when they needed help or someone to confide in. The greatest number stated that their mother would be the one to turn to in difficult circumstances, followed by older siblings, and friends. While the NGOs had trained MSMs to be able to advocate for themselves, these organisations were turned to when serious events occurred.

"Respondent said when MSM having any dispute with people until they were beaten they had their friends to help them. In addition, when being STI infected they relied on the NGOs." (M,19,BB)

"When something unhappy happened to anyone among his friends such as being beaten by the gangsters he usually relied on his friends but in case of being seriously wounded he asked NGO(s) for assistance." (M,21,SR)

Relationships with the police were mentioned in this section, but with widely varying comments. Those that dressed as women gave several instances of being arrested by local police. One said that he had gone to a popular dancing place and had been arrested and his hands tied behind his back. However, this attitude had now changed and the police regarded the MSMs who dressed as women as "beautiful"- so much so that according to him, they now had sex with him instead. Whether he thought this was a better deal was not recorded. Several respondents said that they would go to the police if they were in trouble - the police liked them, as they did not cause trouble.

The NGOs were said to have helped the self-confidence of MSMs.

"I now have 70% self confidence". There is now "No need to hide".

Solidarity/bonding

Strong bonds were formed between those working, and to a lesser extent, attending, NGO programmes. Respondents talked of working together sharing tasks equally and helping each other when delivering education programmes, especially those in the villages (where presumably they would be more on their own than at the NGO offices in town.

Other strong bonds were forged when MSMs had a "love crisis" or when their families threw them out of home, and they needed a place to stay. Other MSMs rallied round, offering shelter and food while they came to terms with a new situation. This was often the case when MSMs came to town from the countryside, and had nowhere to stay. They also demonstrated solidarity when involved in sex work, similar to brothel workers - when a client became violent, or was very drunk; they were able to call on other MSMs to help them.

Social/community/environment trust

Respondents were remarkably positive about the government and its role - they had noticed that the government now recognised them as a distinct group, and not just *"Äh Kteuy"*. They also said that their work in educating the community about HIV had earned them respect in the wider community. Things were definitely changing within the community, although they still turned to their friends and others who understood them well for support and encouragement. So *the level of trust was growing, but there was still concern expressed by those from rural villages:*

"If the environment was shown as without hating and mistreating but more liking in general this would make him desire to live in his existing community." (Respondent who currently lived with friends in the city). *(M,21,SR)*

Influence

Voice/consulted with

Those currently working with NGOs reported high levels of consultation, but otherwise MSMs felt unlistened to. This may have been due to their youth - Cambodian decision makers tend not to consult actively with younger people. They discussed most issues within their peer group, rather than in consultation with NGOs. They do not feel that they have much influence except within their own groups.

Decision making participation

Again, the participatory approach to decision making is not widely understood or practiced in Cambodia. There was little response to these questions. Instead, answers focused on their own ability to make decisions about their lives, and their ability to plan and participate in "meeting and greeting" events when those more senior than themselves from organisations that have decision-making power come to visit the NGO or village.

Community sense of belonging

The respondents were keenly aware of their place in society, and their aspirations for their future roles. They repeatedly said that they were part of Cambodian society, and that they wanted to help develop their own villages and towns. They demonstrated a strong sense of national identity as their primary identification. Next, they saw themselves as members of their local group, village or town. Finally, they talked of their friendships and solidarity with other MSMs. These MSM groups helped and encouraged each other, and tried to ensure that good relationships flourished. When asked about the function of the MSM groups, respondents talked of their educative role primarily, but also mentioned social/sexual opportunities, where MSMs could meet new friends and "sweethearts".

Two or three respondents recognised that although MSMs were part of the local society, they still needed their own space, "a quiet place" within the community, somewhere those MSMs could meet safely. On the other hand, they also noted that if MSMs (currently known) were to withdraw from their local community, this would be likely provoke more comment or trouble. One noted that he knew of many (hidden) MSMs living in their communities, professional people, apparently integrated into their society, but in fact having no community sense of belonging with either group.

Stigma and Discrimination

Openness

Respondents in both focus groups and in depth interviews were candid about their sexual behaviour, and the fact that everyone in their villages knew about it. As one pointed out, in a small community, it is difficult to hide, especially for those who prefer to dress as women, or who wear makeup. Most felt that they were accepted in their villages as people, rather than as MSMs. They also stated that if they became HIV+, they would tell their family (at least).

Many were proud of their behaviour "He is a man, but more beautiful than a woman". Another had heard his mother say that he works harder around the house than any woman. However, while most were open in their own communities, they were aware of the dangers they faced, especially from clients. Respondents made a distinction between those who were primarily engaged in sex work, who are despised, or may be thrown out of their communities: and those who have "high ethical behaviour", and they gave examples of professionals e.g. doctors and businessmen, astrologers or teachers. These types of people are more likely to be "hidden" and accepted (even when their behaviour is known), due to their status in society and the overriding "goodness" of their character.

"People (who) know us usually slander and like to expose faults among us in public. When the gangsters have sex with us they get aware of our aim to have sex like this and then they inform all among their friends about it" (M,21,SR),

Isolation/Denial/Language/Association

There was a marked division between those MSMs who felt lonely and isolated, and those who happily lived either with their families or with other MSMs. Several of the in-depth interviews were with those who happily accepted their use of earrings, makeup and long hair. Others felt ashamed of their behaviour and wanted to live in separate housing. There were some instances of denial or confusion - the majority said that they accepted that their behaviour was just "how they were", but others tried to understand how they came to be MSMs.

The villagers said to the respondent: "you have no child(ren) to reflect you". But in fact, he could have reproduc(ed). (M,22,BB)

Several stated that their mothers made them MSMs by bringing them up as girls, dressing them in pretty clothes and letting their hair grow long.

One respondent however complained that (long hair) MSMs "spoiled Cambodian society" including its clothing and culture because Cambodian women had never worn "sexy" clothes in the past, but were modest in their dress and behaviour (unlike the long hair MSMs).

The Khmer word used generally for MSMs has been Ah Khteuy, a derogatory phrase. They noted the rudeness of some who shout at them, and the lack of knowledge generally about MSMs - they can't have children, their penises are bigger than ordinary men, they are hermaphrodite etc. But overall, the reaction to these interview questions was positive, saying that generally being called names was an annoyance that they accepted.

"his neighbours more discriminated against him. They hated his character/behaviour "so coquettish" towards men so when seeing them he could not communicate with them. In this way his neighbours showed their hate feeling towards him and left him at once" (M,25,SR).

Respondent said nowadays many people liked MSM and only a small number discriminated against them. However, a sense of discrimination affected MSM a lot. People of this sort said: "Hey, you sleep with "Khteuy", why don't you sleep with other people? (girls)."(M,19,BB)

MSMs were well aware of each other - and enjoyed meeting at discos, nightclubs and restaurants. They agreed in the focus groups and most of the in-depth interviews, that where advocacy work had taken place, (primarily through their own NGOs) discrimination and complaints about MSMs had reduced considerably. It was interesting that as a result of this work, several MSMs knew HIV affected neighbours, and that they were not afraid of them (as many villagers were), because they had never had sex with them, and already understood how the disease worked. This knowledge was however in marked distinction to their professed condom use - see below.

Rejection

Respondents had all experienced rejection through their behaviour. These instances fell into two main categories - rejection by the family (and often subsequent move to the city) and rejection through their sex work. Respondents paralleled this type of rejection with female prostitutes - it was the type of work that led to ostracism, rather than the gender of the worker. This may be a reason for the complex reactions to questions about acceptance- MSMs seem to be accepted or rejected through the way in which they earn money, rather than their sexual preferences, or their appearance.

Rights

The discussion on rights during the interviews showed a marked change in the attitudes of respondents. While they had talked optimistically about discrimination, and how it was lessening where groups had conducted education and advocacy programmes, they were clear that they still had few rights in society. Employers refused to employ them, society looked down on them, and they are denied their rights.

when performing any task people order him to do it and for instance said to him: "you should stop being like a girl any more but try to change your behaviour to a man. I wonder why you don't like being a man." This is a sort of violation of his rights (M,25,SR).

The police however, tended to leave them alone. One respondent was clearly knowledgeable about rights overseas, and the move in some countries to legalise same sex marriage, which he advocated for Cambodia (this topic has recently been a topic for debate in this country, with public support from the retired King Sihanouk).

Most problems regarding their rights appeared to happen during sexual encounter with clients, especially where clients were violent, beat the MSM or attempted sex without a condom. MSMs in these cases had felt vulnerable and isolated, compared with female sex workers in brothels, where the close presence of others was a check to potential acts of violence.

"He was sometimes a victim of discrimination or violence made by clients during sex. He had to do something according to their wish, if not he would be mistreated. He did not know whom he had to rely on for help as he was forced to go to a completely silent place (be silent) and he was forbidden to cry out; otherwise he would be beaten" (M,19,SR)

However, other MSMs said they felt in control in these circumstances, that they could reject a potentially violent encounter, or indeed reject any sexual advance as they wished. They also said that they could call upon other MSMs if they were in a difficult situation.

Social/legal framework

Respondents talked of various encounters with the police, but generally the police seem to leave them alone, apart from the occasional sexual favours. MSMs said they would go to the police if they had been beaten up, but would probably get a more sympathetic hearing from their own group or NGO. One instance was given of a Muslim MSM who had been severely beaten by his family when they learnt of his MSM behaviour. (They threw him into the sea). It is not known whether any organisation supported him through this time, but he was helped on that specific occasion by MSM friends. The attitude of minorities in Cambodia towards MSM behaviour awaits further research.

Experience

MSM recounted their bad experiences, primarily with clients. They had suffered rape, one within the grounds of a pagoda, beatings and painful sexual encounters. Nightclub owners had thrown them out when customers complained, and "gangsters" had inflicted violence on them. Each had a tale to tell but seemed to accept these situations as part of their lives. They also recounted experiences of feeling included within their families, being part of religious ceremonies, and being valued at work. They "like to have fun" and the bad times for these respondents at least, have been eclipsed by the strong bonds forged between themselves.

Self esteem

Education/life skills/negotiation

All were keen to work at jobs that fulfilled them especially working for NGOs (where the salary would be higher). They wanted to train and educate people, especially on health issues. Several wanted to work at jobs related to their MSM affiliations, such as clothing shops, wedding dresses or setting up guesthouse for MSM guests. Life skills/self esteem answers revolved around work, and the need to earn enough to live on.

Their negotiation skills also revolved around their work, primarily their sex work, and the use of condoms. While the general

response was that they often had to negotiate with clients about the use of condoms, it was not clear what happened if negotiations failed. One respondent reported an incident where a client refused to wear a condom, and the respondent then had to "go and get some water" in order to leave the scene safely. Others stated that they had told potential clients all the reasons for condom use, but did not elaborate on what happened next. Most said that they felt free to turn down clients they did not like, despite the money being offered. “He was too old” “He beat me first” (so I refused him). However, some repondents felt keenly the rejection of a client if they refused to have sex without a condom:

"I feel bad, I am not very good-looking or (they think) I am infected ...sometimes (they) ask my friend(s) to replace me."(M,19,SR)

Self acceptance

There were complex answers to questions on this subject. Respondents reflected on their circumstances not just from their own point of view, but also the judgment of groups around them. For example, -"My life is meaningful. I think I am born (alive), I am still happy no matter what I am" was echoed by many of the respondents. They seemed on the whole to be happy with their lives as they were. However, they were also aware of the influence of their behaviour on others' points of view. They had to be careful that their behaviour was moderated so that people would not criticise them. In this way they could live happily in the community even as "Khteuy". One respondent said that he really had confidence in himself but when people said he had no 'firm heart' (was morally weak) he was discouraged and did not have confidence in himself any more.

Their self acceptance was also boosted through their ability to make money for their families. If they had been ill, or were otherwise unable to earn, their feelings about themselves turned sad. Several respondents said that they very often thought of the poor food and living conditions for their families when they were unable to send money home.

Fear

Their greatest fear revolved around their work - fear of AIDS, fear of gangsters and drunks, fear of physical violence. They were also afraid that if they became HIV positive, their friends would desert them. It was unclear how this fear had translated itself into behavioural change. One respondent said that he was very afraid of AIDS because he kept forgetting to bring condoms with him prior to sexual encounters, or was forced to have sex without condoms. Fear may not have translated into changed behaviour for many. Another respondent who had become HIV + was fearful of the response from members of his family, and his neighbours. Only one respondent mentioned fear of the police.

Control and shame

This was another area where answers were unclear. Respondents were almost all young, several still living with their parents. They therefore told of parental control. They were also aware of their relative youth, and said that they could not be entirely self controlled as their elders also controlled them. One respondent interpreted the question as one of knowledge, and that as he was young he didn't “have any deep knowledge”. Several said that they became ashamed of their MSM behaviour when they had to explain it to, for example, parents, or others to whom the notion of MSM was new. They were sensitive to name calling, which could lead to feelings of shame.

Guilt/blame/fate and inferiority

The general view amongst respondents both in the in depth interviews and the focus groups was that MSMs were born they way they were, and there was little to be gained from speculating why, although several said that they did wonder how they had become MSMs. Some stated the influence of their mothers, although only one said that his mother made him an MSM by dressing him as a girl and treating him similarly. They seemed more concerned about their physical features, whether they were born 'pretty' and how to enhance their attractiveness to attract partners, rather than concerning themselves about their sexual preferences.

MSMs were aware of their need to be careful in their conduct in order to preserve good relationships in their communities. Several said that they would not take part in local ceremonies in case the villagers discriminated against them or complained about them. This 'need to be careful' when in the local community is an aspect of their often expressed need for their own space, spoken of in terms of dreams ("I want to run a guest house for MSMs") or other possibilities (a community group house where they can meet regularly) where they can be themselves in the company of other MSMs. There was also an acknowledgment of the role of more powerful members of society - several respondents spoke of gangsters raping sex workers and transmitting HIV despite sexworkers using condoms whenever they had the power to do so. There were also comments that high ranking military could do what they liked (see below) and that sexworkers had to live with the consequences.

Services

Health

Respondents were aware of all major health organisations in their area, where to go for blood testing, counseling etc. They could usually name at least three organisations (NGOs or state run organisations) who provided health services. They commented however that they would prefer to receive services from MSMs, rather than female staff. MSMs would also like health organisations to be advocacy organisations for MSM rights.

Support

Local NGOs were cited for their practical support - for example, offering transport to clinics and blood testing agencies, and giving free blood tests. They were also involved in employment support - either referring MSMs to appropriate agencies, or supporting their own efforts to find job through training. NGOs were also the place where many MSMs went as a kind of refuge. Several said that they went there when they had "mental tension" and the staff offered counseling, or just "time out" in a friendly environment.

Access

There did not seem to be any problems cited regarding access to services. While some products were difficult to find, such as lubricants, and some MSMs with fulltime jobs were only available on Sundays, they seemed to be able to find time to access whatever services they needed. Condoms were cheap and easy to find. However, it was noted that availability of both services and products decreased in the rural areas, and there was a call to increase both awareness of HIV and home visits to PLHA outside the main cities and suburbs, where the need was greatest for education and the alleviation of suffering. There was also some question over the payment of per diems for those attending courses (in Cambodia, attendees are generally paid a daily rate for attendance at training courses) MSMs were however happy with the work done by NGOs but conceded that much still needed to be done, especially in the rural areas.

Knowledge, attitudes and behaviour

"We advise them not to enjoy too much with having sex, but they don't follow this advice."(NGO,BB)

All respondents were well versed in the factors in HIV transmission. They were able to list the key behaviours that lead to infection, those which posed a lesser risk, and those which posed practically no risk. This was not surprising given that most had either worked for NGOs working in this area, or had attended courses on the subject. There were also several instances of the "poverty causes AIDS argument" but only analysed in terms of condom use - sexworkers got more money if they did not insist on the use of condoms, and so had to accept the client's wishes, as they were so poor.

Knowledge was gained primarily through the media (the government's TV AIDS campaign, radio or magazines) or through training with their NGOs and talking with other MSMs. Their knowledge of AIDS was also enhanced through training they had all received in the correct use of condoms, and in the prevention and treatment of other sexually transmitted infections.

MSMs were aware of treatment and other health services available locally. Their knowledge of other NGOs came primarily through word of mouth from other NGO workers when they met at service centers such as blood testing agencies, but this knowledge did not seem to be great.

Other KPs.

MSMs attitude to other groups was influenced greatly by the place of the group in the hierarchy. They said that they would never instruct high ranking (military) officers about the need for condoms, as their rank gave them the power to have sex with or without condoms, as they liked. On the other hand, if they were working with PLHA, they would feel compassion for them, if they were sick, and try and help them with medicine or food. If the PLHA were still well, MSMs would encourage them and try to get ARVs for them. The idea of encourage-

ment as a path to better health was mentioned frequently, and one which most MSMs felt able to do with PLHA. Most had friends or acquaintances who were PLHA.

Love, sex, condoms

MSMs 'usually' used condoms. Some said 60% of the time, others said "almost always". It was difficult to judge the number of sexual encounters where condoms were not used, but it was clear from the in depth interviews and the focus groups that there were clear instances where condom use was much lower than usual. The first was when clients forced, or bribed MSMs into unprotected sex. Several respondents indicated that foreigners offered them much higher prices for this service, which few felt that they could turn down. However, from the focus groups, this attitude may now be changing, as there were several instances where this behaviour was no longer tolerated. Many MSMs told of their change in behaviour over thee past year, confining their sexual behaviour to a few clients only. The second area where condoms were less likely to be used is with sweethearts or "sangsaa", regular partners where there is an emotional commitment to each other. One respondent said that he used condoms always with paying clients, and that in fact with foreign clients, it was insisted upon by the clients themselves. However, with his lover, they used condoms "about 30%" of the time. The level of trust between the partners seems to lead to an assumption that condoms need not be used in these relationships.

"We love each other and become sangsaa/lovers, so we needn't to use condoms." (M,19,BB)

Several respondents talked of their having "sangsaa" relationships without condom use while still having sex with other men, and other studies have remarked on this also.

There were a few strange ideas still around about condoms. One respondent gave a detailed description of how Americans brought HIV/AIDS to Cambodia in their condoms. There were many exhortations to stop enjoying sex, presumably ignored. There was a general discussion about whether two (or more) condoms should be used. It was agreed however that one was sufficient as long as it was good quality and had been put on correctly. Several MSMs complained that clients wearing more than one condom hurt them more and that anal sex lasted longer (which also led to a great risk of anal tearing and infection). Lubricants were now more readily available through NGOs but were not found in the shops where condoms were on sale, and many respondents were only vaguely aware that lubricants were available at all.

Behavioural changes also included instances where MSMs had been reminded of the shame they were bringing on their parents, had cut their hair and become "real men". How this had changed their behaviour was not elaborated upon.

Influences

Respondents generally considered that their behaviour had been influenced through a greater awareness of HIV/AIDS and the risky behaviour which leads to infection. Certainly their knowledge had grown, if compared with studies from several years ago. It is difficult to assess how far changes in knowledge has led to less risky behaviour amongst this group of young men, or whether the risk is ignored in the heat of the encounter:

"being attracted by the beauty of their sexual partners ...they did not use condoms at all." (M,19,BB)

Indications from this qualitative study show that MSMs do think that their behaviour has changed, in particular over the past year. They are also more aware of the need for blood tests, and the numbers of these tests have been increasing rapidly[14]. It appears that men are monitoring their risky behaviour more than before, at least. The influences on their behaviour seem to be the education programmes run by the government and NGOs, and their own networks, often again through the work of NGOs. Respondents remarked many times that their co-workers in these organisations were the greatest source of support and information for them, in good times and bad.

There was also an age factor at work. Two respondents in their late twenties said that over the past year they had realised that they were changing. One said that

[14] *Premarital AIDS tests popular, Phnom Penh Post Issue 12/21 October 2003*

"he saw himself that he was getting old so he needed a change in behaviour related especially to real love, to look for a real partner." (M,25,SR)

Sex was also becoming painful for this particular respondent, which was probably unsurprising, as he stated that he had had sex with about 100 partners over the past three months. He had decided to reduce this by 70%, and have only 30. Another respondent said that he was not as strong as before and that sometimes he lost consciousness because he had sex with 16 male partners (in one night). As a result he had decided to change his behaviour also.

Others also talked of the problems of many partners, and of multiple partners on the same occasion. One talked of seven partners at one time but realised that this was high risk behaviour and now kept it to "One or two (at a time)" It was unclear from this whether the changes would affect their income drastically, but presumably they had weighed the economic cost against the ongoing effects on their health.

4.2 sexworkers

"kradas min ach khchab phleung ban te"

(Paper can't wrap fire: the secret of HIV cannot be hidden)

Introduction

Much has been written about the sex work industry in Cambodia[15]. For this part of the report, findings from the interviews were viewed in relation to the results of similar surveys. The sample size for this survey was small (12 in depth interviews and 12 focus groups for sexworkers, across three sites. The 12 in depth interviews were with women aged between 18 and 32, with an average age of 25. Three had been in sexwork for many years, (between 6-13 years), although most stated 1-2 years. This is in line with other studies which have showed that sexwork is often carried out for relatively short periods of time, followed by other types of employment, or marriage. Sexwork may later be an option following for example, the break up of a marriage, financial crisis in the family, or other event which requires urgent access to funds.

The sex workers discussed in the report were all willing to identify themselves as Duch. Those who (indirect SW) who were recruited by NGO's but did not own up to that status upon actual contact with the interviewer (see 3.5 challenges section) were not included. IDI only has any meaning if the informant is fully willing and more or less comfortable with the interview topics. Whatever the NGO's knowledge about someone's background, in the interview situation only the actual willingness of ther interviewee is relevant. In case this kina of "misunderstanding" happened, the interviewer apologized, trying to avoid any sugestion of blame, and the interview was not continued.

Nearly all the women surveyed had dependants - some had whole extended families reliant on their incomes. While the average number of financial dependants was over four, one respondent cited parents, grandfather and seven other relatives, while another stated that she supported her mother and thirteen siblings on her earnings from sexwork.

As has been remarked upon in a recent study[16] high levels of mobility are common amongst this group. This holds true for these respondents also, although the mobility was not necessarily across the country to a new city, but more often a move from the provinces to the town. All the sexworkers surveyed worked in urban centres, and most had been born or raised either in the same District i.e. outside the city but not far enough to be in a different administrative area, or in a rural area such as Svay Rieng or Koh Kong District.

15 See for example, Life Histories and Current Circumstances of Female Sex Workers in Cambodia, CAS, 2004, Work, Life and Sex among Motor Taxi Drivers in Koh Kong, Cambodia, CARE International June 2000, Sex slaves - the trafficking of women in Asia, Brown L. (2000), Asia Books, Sweetheart relationships in Cambodia. Love, Sex and condoms in the time of HIV, PSI Cambodia, December 2002

16 Life Histories and Current Circumstances of Female Sex Workers in Cambodia, CAS, 2004

Social capital

It was clear from the responses that sexworkers knew the NGOs working on HIV issues in their geographical area. Most could name two or three NGOs that provided education or health programs and free condoms to sex workers. Occasionally, women recalled the staff names rather than the name of the organisation. At one location (KS) there was one major NGO which ran programs which appeared to be the 'hub' of various information and health education networks. Sexworkers not only attended programs, but many had been recruited into peer group programs, where they taught not only other sexworkers, but their families also. One stated that after conducting a peer group program, she convinced her brother, a construction worker, to go and get a free blood test.

There was general agreement that NGOs cooperated together. While the aims and resources of each were different, they all focussed on their clients' needs. For example, PLHA clients could be referred directly to health care centres, whether NGO or government run, and women who were destitute were put in contact with those NGOs which gave donations of rice, flour, medicines or money, or could offer free transport to health clinics.

Apart from a referral system, NGOs also cooperated through monthly meetings, recruiting sexworkers for peer programmes and running staff training programmes through umbrella organisations such as KHANA. Relationships are complex in the sector. Circumstances made some alliances which might otherwise not have happened. When the government attempted to close brothels in 2001 there was a concerted effort from a combination of NGOs and brothel owners, as well as their staff, to stop this happening. The event brought the different groups together to work towards a common goal. This cooperation appears to have continued, to the point where the brothel owners or managers are happy for NGOs to educate their staff in the brothel, and also occasionally became volunteer workers with the NGO themselves. This was particularly apparent in the KS interviews, where the network of workers/gatekeepers/authorities/ NGOs seems to be particularly strong.

While sexworkers were usually happy to remain clients of NGOs, attend training courses, use health services and the like, others wanted to participate in a more active way. Several respondents had become volunteer peer teachers with NGOs, after receiving training. Others had become part of a network of sexworkers who were contacted whenever there was any new training or education opportunity available to them. However, one sexworker was fully aware of her lack of education, and subsequent inability to join the NGO.

"I would like to join but I can't read. I don't have skills in speaking and writing. Actually, they choose only skillful people." (F,24,BB)

Sexworkers thought that NGOs listened to their views. Several respondents said that they had attended monthly meetings where problems relating to program delivery were discussed, solutions sought, and information disseminated.

NGOs also acted as promoters of health services. They reminded women of the need for frequent health checks, and arranged in one case that women were checked "once or twice a month" at the local public health clinic[17].

The overall picture was one where sexworkers believed NGOs worked well together, recruited them not only for training courses but also as peer group volunteers and were working to improve the levels of education on HIV and other STIs in the community. As one respondent remarked:

"Previously I can't get up from my mat, can't sing, I just stay in bed. When he came, I always cried; so, he brought me to a pleasure place, (he raised my spirits) as a result, I love this organisation so much." (F,32,SR)

[17] *This may have negative consequences, where women rely on medical tests to alert them to problems, rather than using preventative measures, such as condoms. See "Premarital AIDS tests popular" Phnom Penh Post 12/21 October 10-23 2003.*

Peer groups

Respondents referred primarily to their peers being the other workers in the brothel, or those who lived in the same street. They talked of the solidarity between themselves when faced with, for example, violent clients. Others referred to their peers as other NGO workers. One said that she had good relationships with her peers, whom she defined as other sexworkers, including MSMs and PLHA (some of whom may have left sexwork). One made the comment that her friends had so many different peer groups; work, family, study or other interests, that she only got to meet them occasionally to play cards, dance and have a drink together. These young women therefore identify with many "peer" groups - not just their work colleagues.

Influences of participation

NGOs, after some initial suspicion ("we thought they had come to sell us condoms") were welcomed as educators and advocates, as well as providers of practical help. After attending a training course, one attendee stated that she then wanted to inform her neighbours and friends about what she had just learnt. NGOs also encourage participation in particular events, such as World AIDS Day, or plays about HIV/AIDS. One respondent made a perceptive remark however when she said that they (sexworkers) had to start taking part in ordinary communal activities (such as New Year, the Water Festival, banquet/feasts) as well, like other people did. If NGO volunteers could be invited to join in the preparations for the celebrations of the annual calendar, then they could be seen as ordinary people, and not just as workers in the sex industry. She was committed to working with her NGO as a volunteer, and wanted to work within the NGO to get involved in the regular activities of her community.

The "one-stop shop" approach of many NGOs influenced many respondents, who were pleased that attendance at one NGO put them in touch with a range of services, many involving home- or work-based delivery, which enabled them to access products and services they may otherwise have found too difficult or costly to obtain. This included medical services, condoms and lubricants, advice on other employment options, micro-finance, and help with legal issues.

Confides in /confident with

Women clearly also looked on some of the NGO workers as their friends. When in trouble they would look to their friends, and these often included NGO staff.

"Sometime I went to their house because I had a trouble in my head and these trouble was released when I talked about something with them". (F,25,KS)

They also went to those in authority above them, occasionally the police, but more often the brothel keeper, especially when the trouble related to money- the mekar (brothel owner) could usually lend them some - or to health problems, when the mekar could let them off work for a while. Several respondents commented on the reaction of other people being a key to their confidence building. If they attempted something themselves, the encouragement of others was vital. This related not only to getting another job outside sexwork, but also taking opportunities when they presented themselves, such as further training or education. The role of the NGO as encourager and facilitator in these circumstances appears to be vital to women who had been denigrated in their own communities and were very aware of the stigma attached to their profession. The NGOs were "on their side".

Relationships with the police were mixed. While many stated that they trusted the police, several complained that the police expected free sex, or payment from them, on a regular basis. There is a complex relationship there waiting to be explored, as the police were certainly called upon to protect workers in brothels from violent or abusive customers, and generally help keep order. In return, brothel owners make unofficial payments for their services, give them free beer etc. - the women were often expected to pay as well, in cash or in kind. (see below).

Solidarity/bonding

Women talked of solidarity amongst themselves, demonstrated in particular by the lending of money, the exchange of information, and the support they gave each other during difficult times, such as when they were sick, or found out they were HIV+. They also said that NGOs were a good support for them, advocating on their behalf. Family and friends were also helpful, although women were aware that it put them at risk of criticism:

"Nak (my friend) stayed with me so they said that she was a bad person but she is very kind really..." (F,24,BB)

Environment/trust

Workers talked of the gradual build up of trust with the NGOs. One recalled a meeting which was held by the NGOs on the use of female condoms. The women were reluctant to go at first, but later agreed to participate. Whether this was shyness, or other factors, was difficult to check, but women generally in the survey said that it took some time to establish good relationships with NGO staff. However, once these had been made, staff became friends and mentors, neighbours who they turned to in troubled times.

Women also commented on general environment issues such as housing. Their housing situation, if they were not working in brothels, was often precarious. Rents suddenly doubled if the landlord realised the type of work being done by the tenant. One woman cited this housing problem as the main reason for her returning to her home province.

Decision making/participation

Most of the NGOs held planning or reporting meetings where local people were asked their views on various issues. One sexworker recalled an NGO Annual Meeting where local police, sexworkers and medical advisers were all present - they were divided into panels to discuss various issues as part of the local community's input into the strategic planning process of the NGO. This kind of opportunity helped to boost sexworkers' fragile confidence also:

"I think that I am social refuse; but social refuse can support the service for society too"

Stigma and discrimination

Openness/isolation

The women were all known as sexworkers in the local community - there was no point in trying to hide it. One said if she was HIV+ she would tell other people, as they were bound to find out anyway. She said, "Kradas min ach khchab phleung ban te" (literally, paper cannot wrap fire); this kind of secret is like fire. Paper cannot keep it hidden; the paper would be destroyed. However, several respondents said that they had been able to keep the source of their earnings secret from their families living some distance away. Only one woman surveyed admitted that she had HIV - although given the prevalence of the disease amongst sexworkers[18] it may well be that other women in the sample were HIV+ also. While respondents stated that their community looked down on them as those who had lost their honour, there was also an acceptance of them as people supporting their families through their hard work - both attitudes prevailed. One sexworker said that her honour was very important, and that therefore she tried to keep her work completely secret.

There was a definite sense of isolation amongst the respondents, especially from family. One recalled that her mother had refused to have anything more to do with her, and of the sense of loss this entailed. Respondents said that they had dishonoured their parents, who had brought them up, and were now ashamed of them. Others stated that they were unmarried but, no longer virgins, were unlikely to find a husband[19] and of the hopelessness that this engendered. The HIV+ respondent said that her neighbours did not let her, or her children, play with their children. Most reported being called bad names, or it being assumed that they were all HIV+ because they were sex workers.

"For instance, if we have typhoid fever and go to the healthcare providers, people in general think we are sick with HIV/AIDS, they say 100% sure." (F,21,KS)

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18 *Estimated at 33%*

19 *Histories and Current Circumstances of Female Sex Workers in Cambodia, CAS, 2004*

Several cited this ignorance and attitudes of neighbours as the key reason for turning to NGOs for education, support and the tools to fight back against discrimination.

Association

Respondents also however had absorbed the stigma and discrimination heaped upon them by allowing themselves to behave badly - some said that they had adopted the “bad girl” image, openly wearing short skirts, exposing their shoulders, or taking off clothing in public “in an immoral manner”. This was seen by the respondents themselves as spoiling women's value in general, and they were fully aware of the implications of their behaviour on women in their community. At the same time, they also said that around 70% of the community did not criticise their behaviour, and would not criticise their own daughters if something bad happened in their family, driving the woman into sex work as the only viable option. This pragmatic approach seemed to be prevalent throughout most of the interviews. If the only way to make a dollar was through sex work, so be it. Khamma was only mentioned once, that sexworkers were gaining bad khamma from having too many male partners.

Rights

Discussion on rights focussed mainly on whether sex work was illegal in itself - respondents were clear it was not, but discrimination still existed with them being labelled as criminals. This lack of clarity also led to other forms of discrimination, such as the “registration“ of prostitutes by the police and the monitoring of the women's movements outside the brothels, including visits to health centres. Many respondents spoke of their protest at the government plan to close brothels in 2001- a victory for them when the government withdrew the decision, but one which, according to one respondent, led to an increase in the police 'take' from brothel owners in compensation.

Other rights issues involved relationships with the brothel owners. Several respondents stated that their relationship meant that when police came round for their money, this was then deducted from the women's wages by the brothel owner. This was a source of contention for the women, who felt unable to protest effectively against unfair deductions from their wages, see also above.

There was also a cultural dimension to the rights issue. While abuse from clients was a clear breach of legal and human rights, it was also a demonstration of power and gender relations. Respondents repeatedly gave instances where clients demonstrated their power over them, from physical violence to other demonstrations of contempt:

"Sometimes the clients throw money down in front of SWs to show that they are rich. They can do everything they like with SWs. "(F,21,KS)

Self esteem

Education etc.

While the self esteem of individuals was generally low, three main reasons were given by the respondents, which may point to possible ways out of the situation. The first was their lack of education and knowledge. Many of the respondents were illiterate, and they felt this keenly, especially as many of them wanted jobs with the NGOs, who would only recruit those able to read and write well. Lack of ability to do simple arithmetic also made them vulnerable to cheating from customers and brothel owners. Increased knowledge about HIV/AIDS had not only increased their own understanding, but had also helped their self esteem through being able to transmit this knowledge to family, friends and neighbours.

Secondly, a secure livelihood was needed. Lack of money was an overriding fear. None of those surveyed wanted to stay in the sex industry for long, and many had plans for their own businesses. However, their responsibilities for family members were great, and covered several generations- from grandparents to parents, in-laws to siblings and children and even grandchildren. They needed to find a secure form of employment when their time in the sex industry ran out -through choice, or involuntarily through age or illness. Several of the NGOs ran programs which helped them to gain self employment skills.

Finally, the violence or threats of violence which occurred in their lives had made them fearful - the solidarity exhibited with their peers when violence did occur had meant though that these fears, at least with brothel workers, could be partly allayed by the women themselves. Respondents were still fearful of the use of drugs by clients - which led to violence or demands for unprotected sex - fear of contracting HIV, and fear of family finding out about their occupation.

Control

Discussions around control centred around economic issues. Respondents felt in control of their lives when they had the ability to earn an income, were able to send money to family and were able to plan for the future outside the sex trade. Several respondents said that having children meant that they had to be able to control their own lives for the sake of their children's future. The respondent who was HIV+ said that she was now able to control her life as she had a place to go at the pagoda when she was no longer able to look after herself - her family having rejected her. There she said she would listen to the monks and remove the evil from her life before she died.

Services

Health/Support/Peer

Respondents were fully aware of the health services available to them, which ones were free and which not. They also knew particular female health care workers whom they trusted. In the towns, there were a range of services available to them, from NGOs such as Medecins sans Frontieres, from government health clinics and local hospitals and from blood testing organisations or condom providers. There was some evidence of respondents going from service to service to find the one which suited them best, in terms of cost, accessability and helpfulness of staff. Support services consisted primarily of material support such as small donations of money, rice, medicines or cooked food. NGOs often helped the whole family, checking that children had been fed and were going to school for example. Some NGOs working with PLHA also gave greater support, such as helping set up workers in small grocery businesses, or providing regular funds for trips to health centres some distance away. Peer group services included formal training of sexworkers by NGOs to educate others, especially those in the indirect sex trade (karaoke workers, or "beer girls" for example), and also the informal information sharing that occurs when trained workers meet together with their own family and friends. In these less structured settings, valuable education work is done, facts about HIV explained, myths dispelled, and information about services given.

Distance/time/cost etc.

None of these seemed to be a great problem. As the sexworkers were in the towns, there were enough services available at the right times for them. Blood testing and monthly check ups at local hospitals were free. Several NGOs gave out free condoms, although others are now acting as distribution agents for the major manufacturers of condoms, selling to pharmacies, hotels and brothels, so this free service may not necessarily continue.

Respondents said that the attitude and thoroughness of the staff were good, they were friendly and did not look down on the sex workers. They explained things simply, followed up on any issues, while also telling respondents to come back if they had further problems.

Knowledge, attitudes and behaviour

Respondents were fully aware of the key transmission routes for HIV, and could quote them easily. More importantly, they were also aware of what can happen when things do not happen as described in the book - when clients are drunk or using drugs, cannot put on a condom correctly, when they decide to wear several at once, when a condom tears, or comes off during sex - or when a sangsaa (sweetheart) or husband assumes that he can have sex without a condom.

Sources/influences

Respondents received their information primarily through the NGO training, but also from each other, from radio and TV government programmes, and from local hospitals and clinics. Their attitudes were also coloured by articles and photos in the press, by knowing those with HIV, and their own feelings of guilt:

"AIDS would not be spread without sex workers".(F,23,KS)

They all agreed that condom use over the past year had increased, both because of the campaigns to use condoms, and their increased availability, usually at no cost. They also agreed that the peer group programs run by NGOs were the best, and suggested that these programs need to focus more now on those who walked the streets looking for clients, or who were 'informally' part of the sector. It was realised that these more hidden groups represented the greatest current risk of increased infections. Respondents also thought that there needed to be more education programs for the police and local authorities, so that they knew more about the disease in their area.

The other main recommendation concerned personal safety. Respondents knew where to gather to discuss issues, but these were usually public places, and not always safe. So they would like their own building to meet. One or two respondents had obviously thought this through beforehand, as they described in detail their ideal meeting place, its layout and furnishings.

Love/sex/condoms

Sex workers were fully knowledgeable about condoms, including those for women, which were generally agreed to be good, and were used at times when a man was reluctant to use a male condom, or when women needed to protect the lining of the vagina. Women also said that they were happier and more in control working with female condoms than trying to ensure that men wore properly fitted condoms. One respondent had started selling female condoms to fellow workers. There is continuing evidence however that condoms of either sort are not always used, especially in close relationships with lovers, and husbands, as has been noted in several recent studies. Respondents were enthusiastic about the lubricants that were now more freely available - they did not make the vagina "hot" and helped the client to climax more quickly. However these lubricants were not available everywhere that condoms were sold, and needed to be sold with the condoms to enhance their use.

Condom use

Condom use had grown, and in particular the use of female condoms, especially after training programs sponsored by the main manufacturer. However, knowledge takes time to alter behaviour - one respondent was well aware that, even though she was HIV+ she still continued to have unprotected sex:

"I was affected with HIV/AIDS but continued the act of transmitting this disease to other people. Especially, when my sex partner had a pregnant wife she would be transmitted HIV/AIDS and this was my fault". (F,25,KS)

She said she had contracted HIV by being raped by three men while returning home after meeting a client. She did not explain why she continued to have unprotected sex after finding out that she was HIV+.

4.3
people living with HIV/AIDS (PLHA)

Introduction

PLHA interviewed were mostly in their thirties or forties, with an average age of 33. Two thirds of them were male, all of whom stated that they had caught the virus through unsafe sex with sexworkers. The data on the women was less clear. Some had been sexworkers, but also said that they had contracted the disease from their husband/boyfriend. It may have been unclear to the women themselves how they had become infected. In contrast to the findings from other groups, which were often optimistic and demonstrated strong bonds both with peers, and with NGOs, this group were more pessimistic, less articulate in interviews, felt isolated (which indeed they were by most of their community) and had low self esteem. Of around 168,000 PLHA in Cambodia, it is estimated that only 10% receive health or support services (primarily provided by NGOs), and in 2004, of 28,000 PLHA who needed ARV treatment, only 4,233 received it[20] .

Social capital

NGOs association/affiliation to other groups

All those interviewed in depth had had direct involvement with NGOs, often as volunteers as well as consumers of their services. There were a bewildering number of organisations, known by their (English) acronyms, which respondents often had trouble remembering. Several came into contact with NGOs through going with their HIV+ partner. One said:

"When her husband did not die yet she often went to (NGO) clinic. Especially, five months ago as soon as she went there she was asked for interview". (F,35,KS)

Following a positive blood test, she started to help two NGOs with their work at the hospital, and followed this with working for a major local NGO on their HIV projects. She receives money and rice from local authorities (via another NGO), and has started a course of ARV treatment, costing $55 per month. Whether she has to contribute to this cost is unclear. She has given interviews to many NGOs.

Two interviewees had converted to Christianity following participation in HIV programs run by faith based NGOs. However, both were now receiving home based services for PLHA from others, and it is unclear what links they still maintain with Christian groups or churches. Several NGOs were Wat - based, and at least one used Buddhist monks in their home based care services to give counselling and spiritual aid.

One NGO was village based, and worked with 'many' PLHA in the community. They trained PLHA in advocacy activity and gave them information about HIV and opportunist infections.

Peer groups

While PLHA at times went and visited other PLHA in their neighbourhood, most did not. Nor did they have regular meetings with the NGOs, but did attend meetings organised by them when specifically invited. Occasionally, NGOs organised meetings in the community, at a PLHA's house, but this was often difficult for other PLHA who had to try and find the location by themselves. The pattern seems to be that NGOs organise meetings or other events at their offices, while PLHA receive specific services primarily in their own homes. All were aware of peers who had recently succumbed to the disease - and of family members

[20] *National Center for HIV/AIDS, Dermatology and STD (NCHAD)*

who reacted in a range of ways (see below) to their disease and its progress. Several respondents mentioned informal meetings at the health clinic which were often helpful. One said that after a chance meeting there with other PLHA, she came away with a recipe for a traditional cure:

Several respondents said that they kept in touch with NGOs so that any changes in their health could be quickly assessed.

They tell me to boil water with tamarind leaves, keep it warm and sit in it, whenever I have cervicitis." (F,24,BB)

Influences of participation

PLHA are a vulnerable group. Almost all respondents said that they made links with NGOs and other groups because they wanted to understand the disease, and learn what services might be available to them. In this way they felt they could be stronger, with a combination of good information, the knowledge that they were not alone, and that access to services was freely available to them. Several PLHA actively worked for NGOs in their programs, helping with home based care services, training others in advocacy, or working with the general population on anti-discrimination issues. This gave them a sense of hope that their lives were not useless, especially following unemployment as a result of illness. One respondent was focused on the years after her death, and in particular, wanted to ensure that services would be available to her children.

Others joined NGOs as they had heard that ARV treatment was more likely if they were actively involved with NGO programs.

One respondent said that she had no contact with any NGO until a fieldworker turned up unexpectedly at her house, following a referral from one of her PLHA friends. She is now getting regular health care checks at the local clinic.

Confides in /confident with

PLHA were a very mixed group in terms of their links to family, friends, NGOs and other organisations, such as the local Wat, who could also help them and provide confidential support. Some said that their families were not supporting them in any way, and that they relied totally on the services of the NGOs. Others said that family members, especially brothers, were helping them through providing accommodation or money, or looking after their children. One said that he had a relative who was also HIV+, and that they each supported the other, especially when either was sick.

There was little confidence in public health systems - most PLHA used private practitioners for their medicines, primarily injections of "serum" to help them regain their strength. ARV treatment (if available) was accessed from public hospitals through NGOs. NGOs were the organisations that PLHA had most confidence in, and not just as consumers - as one respondent said:

"When they need to recruit peer, I am called to come in" (to the NGO's office) (M,22,KS)

These organisations keep in touch with their clients as much as the clients use their services. NGOs often contact clients for input into training plans, research, or consultation with communities.

Decision making/participation.

There appear to be strong bonds between PLHA in this study and the NGOs that they are linked with. Respondents repeatedly acknowledged the feelings of hopelessness in their lives when they found out that they were HIV+, and the difference that contact with NGOs had made. This was especially in evidence when PLHA, as voluntary workers, visited sick peers, and were able to give them solace and comfort as they fought opportunistic diseases, depression and the fear of dying. However, they were not staff members of the NGOs and were not usually consulted with, nor did they find it easy to offer opinions on issues when asked. Respondents said that they came to learn and listen to others, but were reluctant to join in a discussion. If they had problems, they were more likely to discuss it with family or friends, rather than with NGO staff. They also maintained links with Wats and acknowledged the influence of Buddhist teaching:

"We also learn the dharma to know how to keep our feeling stable and calm. We will offer some foods or money to monks to help driving us from such sorrow." (F,32,SR)

One respondent stated that as AIDS was caused by men, *("Our lives are meaningless caused by those men"),* any future participation she might have would only be to set up a "women's place" for those women suffering from AIDS. She was not interested in helping men with AIDS.

Stigma and discrimination

Openness/isolation

Almost all respondents were open about the fact that they were PLHA. As one respondent said:

"When they saw that my husband died they understood very clearly I was HIV-infected." (F,28,BB)

It is difficult in a small community to keep such things secret, especially if a spouse is known to be infected. Also, several respondents had returned to their villages from the city, and this, coupled with bouts of illness, was usually enough to confirm suspicions in the rest of the community. Others told close family members, who then told others. One respondent moved to a new city when her husband died of AIDS, telling her new neighbours that she was divorced.

Respondents felt isolated due to their illness. One said that she tried to explain the tiredness and general unwellness she felt as a result of the virus, but was too tired to continue, and so felt even more lonely than before. "Since I get sick I never go out" was a common refrain. However, several respondents were well enough to help their peers with home visits and the like, attempting to assuage the isolation they felt. Others realised that friends they had alienated in the past may now be helpful to them, but were afraid of seeing them:

"He avoided friends because before he was sick, he used to fall in dispute" (with them). (M,22,KS)

Some tried to avoid coming to the attention of local authorities. One said that she knew that the local sangkat had gifts to give PLHA from NGOs but she was afraid to register. Others were determined not to let their illness be known, but to continue working as long as possible:

"I don't want the other know that I have AIDS, so I flee from my homeland to work for living. I am trying my best to work for my children and my old mother until the last minute of my life". (F,32,SR)

PLHA were still subject to abuse despite government and NGO campaigns, information and other programs aimed at reducing the stigma attached to the disease. While all had been subject to adverse verbal comment, their reactions had varied widely. For some, it was confirmation of their worthlessness to society, and that they had surrendered their rights to live in a community. For others, as a result of work by the NGOs, things were getting better for them, and that the bad language they used to hear had reduced considerably. Overall however, it was a bleak picture of isolation, stigma, and rejection by communities.

Association

Respondents first commented on the impact on the country of HIV. It had made people ashamed of their country, and fearful of sex, but those who continued unsafe sex practices would ensure that the disease continued, to the detriment of the majority. The length of time between infection, diagnosis and death had meant that goodwill had been strained to the limit. This, one respondent stated, was why she felt discriminated against - first her husband became gradually sick, four years later he was diagnosed with the disease, then later still, she found out she was HIV+ as well - her neighbours had initially been compassionate, but now regarded her whole family as "ínfected". The same scenario was played out with another respondent:

"Her relatives first act well at her when knowing she has AIDS, but they change their mind and behaviour. They said I am not important anymore because they cannot depend on me. They used very bad language to me. I was absolutely hopeless and heartsick."(F,32,SR)

Others gave specific instances of discrimination - neighbours washing a glass she had used three times with strong detergent, refusing to eat with her or let their children play together. All of these actions increased her feelings of isolation from the community, despite the fact that she had many neighbours, and some were still friendly towards her. One respondent was in the unfortunate position of being a food seller before finding she was HIV+. Now her business has collapsed, as no-one will buy food from her anymore.

Families could also isolate their less fortunate members. When one woman found she was HIV+, after her husband died of the same disease, her husband's family refused to have anything to do with her. She was still very angry:

"I hate my husband's family very much. They are so cruel. When I was sick, no one came to see me." (F,32,SR)

Other family members felt that they had their own businesses to protect:

"people did not buy her things as they detested her, especially her older sister did not come to see her anymore as her sister was afraid people would not buy her things anymore due to this"(F,35,KS)

PLHA were fully aware of the way in which the disease spread, but often felt the need to respect the prejudices of their neighbours. For example, one PLHA always brought her own cutlery and cup if she went out for a meal with anyone, to show that she was aware of their concerns. She was grateful that people still cared to include her in the community. PLHA frequently remarked on the friendliness of NGO staff who often came to visit them after work, or on holidays.

Rights

Most PLHA had various forms of identification and registration cards such as election cards, birth or other identity documents. However, rights seemed to depend on their health status as much as the fact that they were infected. For example, one respondent said that as long as he felt well, he could work, gain an income, help other PLHA and generally remain a full member of the community. However, when they became sick, any rights tended to disappear.

"Whenever I am too sick, discrimination is more increased. When having meal outside, others look at my face and feel afraid of (me)"(M,22,KS)

He wanted to visit a fellow PLHA in hospital, but was turned away as:

"In the hospital, they did not let him go in the room because his body is too thin, weak and nervous with wounds". (M,22,KS)

Other people, seeing the illness affect his skin, said that he no longer had any rights, and was only fit to die.

Respondents generally however believed that discrimination was lessening, and that there was more hope, now that ARV drugs were starting to become available. He gave the illustration of one of his friends who was a policeman and was HIV+. He had had no treatment or counselling, until his senior police boss had told him to go to the hospital and start to receive the help which would prolong his life. Up until now, according to this respondent, the police had never commented on the HIV status of their employees, but now the subject was becoming more acceptable to discuss. It may be interesting to see whether the advent of quantities of ARV drugs into Cambodia parallels a corresponding increase in registered HIV cases.

Social/legal framework

Khmer society is still coming to terms with the AIDS epidemic. Despite government campaigns, and the work of local and international NGOs, there is still much prejudice and lack of understanding at a local level. Respondents spoke of the "why us?" question which many voiced, meaning not only, why am I HIV+? (a relatively simple question to answer) to the wider question of why HIV has been, and remains a major problem across the whole country. While information campaigns have raised the issue, and presented the facts, some respondents reported that many in their community thought the campaign itself was "obscene", and was as much an expression of the moral decline of the country as AIDS itself. However, this was a minority view. There were some interesting developments at a local level. One commune had had several village meetings where the AIDS issue was discussed, as AIDS was prevalent in several local families. Respondents reported several local initiatives, around information and education for all villagers, not just those infected. It seems, in some places at least, to be seen as an issue for the whole community, and not just for those who are HIV+.

Experience

There were many stories given of the sadness and isolation felt as a result of prejudice, misinformation or simple lack of ability to cope with sick relatives for several years. Respondents gave example of people being abandoned in shacks outside the villages, or away from the rest of the community, or left in hospital. People had lost their jobs, or if they were self-employed, their businesses had collapsed due to their health problems. With this usually came absolute poverty, unless relatives or friends came to look after them. Several respondents were very bitter about catching the disease from their husbands, and then bearing the stigma and discrimination that came with this situation.

Others had their employment and social relationships reversed. One young man was the mainstay of his mother's food selling business, but when he got sick, she had to give up the business to look after him. His ability as a son to build up his mother's business and look after her during her old age had been destroyed, and he felt the shame of his situation keenly.

Self esteem

Education etc.

The PLHA in this survey generally had had little education, but they had all run businesses or had been employed before they got sick. Several continued to work - one was still successfully selling food by keeping her HIV+ status secret. It was the only

way to get enough to eat and send her children to school. Others worked in the home, looking after the house while other family members worked outside. With an eye to the future perhaps, several had started making offerings to the monks at the local Wat, and were having dhamma teaching. With the hope of ARV drugs on the horizon, many said that they wanted to return to work as soon as possible, in order to repay their relatives who had helped them while they were sick. Many were volunteers for local NGOs working on HIV issues, doing home visits etc. All this activity was seen as positive for their self esteem, even though several said that at times they were too tired even to greet visitors who had come to help them.

Negotiation skills

PLHA displayed many self-taught negotiation skills - their situation meant that they had to use these survival skills within an environment of discrimination due to their HIV+ status. Others experienced the vulnerability of their situation, especially following rejection from their family. After finding out that she was HIV+, following the death of her husband, one respondent had her only asset stolen:

"My brother-in-law took my motor bike. He said that the motor he took was his property because his brother my husband, had sold his heritage to buy it. So he took it back. I don't care. They can take anything they want." (F,32,SR)

Many had come to terms with their neighbours, accepting that relationships would not be straightforward. Several respondents said that their neighbours were in fact very compassionate towards them, but on the other hand would not let their children play with respondents' children. So boundaries had to be respected, and negotiated where possible. Respondents felt that with the advent of NGO programs, and national programs from the government, that these had strengthened their ability to negotiate the relationships they needed. The key was their health level. If sick, they had neither the physical nor intellectual strength to bargain - whereas once recovered, they were able to take a more active part in their community again.

Self acceptance

Respondents seemed remarkably accepting of the inevitability of their death. While one or two talked of ARV treatment making them well again, for most it was a small hope in a generally hopeless situation. Several respondents talked of money problems - they could accept their situation more readily if they knew there was adequate income to feed and clothe their children, or for ARV treatment for instance. Otherwise, they found it very hard to accept their fate.

Fears

They had all been fearful of HIV before they found themselves HIV+. Now, the fear had spread to other infections, such as TB, and the need to rely on others for the basic necessities of life. This was a great source of shame and inferiority for them, especially as they all came from poor families, who now had to shoulder a double burden - loss of income from an adult family member, and the need to look after and purchase medicine for them also. For many, it was their physical appearance that made them fearful - people judged them on this, and skin infections were feared, more than other symptoms. Respondents were fearful of the future, especially for their children and those they would leave behind in poverty. One respondent was immensely sad because she would never be able to remarry, or return to her home village (where her husband's family had thrown her out of the community).

Services

Health/Support/Peer

Respondents were aware of a wide range of services locally, although they did not always recall the names of the NGOs responsible. They were aware of home visiting, information on keeping well and fit, blood testing or other health services.

Support services, including the availability of money or food from certain NGOs, or transport of PLHA to health providers when needed were also discussed. The transport service in one centre had been free, but now PLHA had to contribute. This comment (that services once free were now having to be paid for) was made several times, and it is not clear whether this is a national problem, or only with one NGO. Certainly some NGOs give a range of food items and money to PLHA, while others do not.

PLHA also helped others in their situation through home visiting, peer group support and NGO volunteer work. Work by peer volunteers included making lists of PLHA from hospital records and then visiting them at home. This was followed up by further visits to ensure that medicines were being taken correctly, children were attending school, and talking with neighbours to demonstrate that PLHA were not to be discriminated against. Some respondents contacted NGOs in the hope of ARV treatment but this had not been possible. Whether this was because of their health status, or for other reasons was not clear.

Distance/time/cost etc.

Distance was not a problem - there seemed to be adequate home visiting, plus the availability of motorbike transport, at least to local health providers. However, cost was less easy to analyse. Some NGOs and clinics charged for their services, but if the PLHA had no money, services were not withheld. For private providers services had to be paid for, usually in advance. If patients had been referred in writing by NGOs, it was less likely that payment would be required:

"They won't get a bed payment, if I have this letter. If not they will get ten thousand [riels] for bed payment" (M,41,SR)

Belonging/trust

Respondents were generally positive about NGOs. They trusted the staff, and were aware that a linkage with an NGO was a useful way of ensuring that their rights were respected, and that services could be accessed more easily than if they tried on their own. This was apparent in several statements. One respondent said that "her" NGO had trained her, after she found that she was HIV+ and then sent her out into the community with a senior staff member until she was able to do visits on her own. She appreciated this ability of NGOs to look after her until she was skilled enough to work independently. Another stated that the NGO in his district listened to local people and had influence with health providers:

"(The NGO) paid attention to local people when there were any of them needed referred urgently to the health providers for operation. This was like this because some health providers did not pay attention to them while with (NGO) did it immediately"(F,35,KS)

There was also a comment that if NGO staff accompanied PLHA to health providers, they also got better treatment:

"When they accompanied the patients to the health providers the service was free of charge: they were provided with (free) medicines according to the diagnosis, in contrast, if they go alone they (have to) pay for everything or the medicines given are sometimes not effective." (M,31,KS)

Respondents commented favourably on the timing, quality of information, confidentiality and follow up procedures of NGOs. Only one respondent stated that he would visit a private provider first (no reason given). One respondent was getting ARV treatment in a city far from where she was living at a cost of $55 per month, plus the cost of travel and accommodation. How this was financed is not clear.

Knowledge, attitudes and behaviour

All respondents were knowledgeable about how HIV transmission occurs. But they never thought it could happen to them. As one of the respondents summed up:

"before, it was not important, I thought it was not serious but when it came to me, it was not light. It gives me much suffering. I feel so much sadness that this disease has come"(M,41,SR)

They are all receiving treatment for opportunistic infections, and to keep their diet as healthy as possible, either locally or at hospitals in Phnom Penh. One respondent said that she had been tested to see if she would qualify for ARV treatment but has not received it yet. (This seems to be a common occurrence throughout the country). Another had been receiving ARV treatment for eight months, plus treatment for tuberculosis.

Sources/influences

PLHA got information about AIDS and NGOs primarily by word of mouth, either from other PLHA or through health providers. NGO staff were friendly and welcoming, and their services regarded as high quality. NGOs also provided services that no-one else locally was doing, so the monopoly position was also a factor for PLHA. They were also fully aware of the power of NGOs in the health community (see examples above).

PLHA also had contacts through their families. There were several instances of "families of HIV+ people". One respondent for example got to know of local NGOs through her uncle becoming HIV+, and when she also tested positive, she already knew who to turn to. Others had spouses and children who were HIV+ .

Attitudes

Respondents' attitudes to other PLHA were informed and usually compassionate, although there were several comments that as a nationwide epidemic, it had demonstrated a decline in moral standards and diverted much needed funds from poverty alleviation to health care for people who were dying anyway. But for the majority, they noted that discrimination was not as bad as before:

"Nowadays, people had good relations with PLHA, for instance, they dared to have food in the small bowl with them, drink water with them and when they needed to kiss them they did so without hating them."(F,35,KS)

PLHA were also affected by cultural attitudes, especially about how one looked. One recalled hearing:

"I said to a young thin boy that he looks like an AIDS carrier." (F,32,SR)

Another said that he was scared of looking too thin, or of getting skin infections which would affect how others related to him. PLHA attitudes reflected the sadness of their position. One recalled visiting the pagoda with PLHA friends:

" We lived and took traditional herbs at the pagoda together. They are all dead now." (F,32,SR)

Love/sex/condoms

Respondents were fully aware of the availability and cost of condoms. At least one of the men in the individual interviews said that he still had sex, and not always with a condom. Another said that he used condoms with casual partners, but not with his girlfriend, although now he uses one every time. Most respondents however did not have current partners one stated that his younger brother had been very affected by his illness:

"Now he is very scared of AIDS. We don't know who has AIDS or not through looking at their physical appearance. Therefore, when they know how to protect themselves, they must always use condom with any girls." (M,22,KS)

Whether this has changed his younger brother's behaviour is not known.

Influences

PLHA used this section to discuss what they would like to see available to help them and any future sufferers. First, they call on the government to support them with food and money during the periods that they cannot earn anything. Next, they are looking for accommodation which could be used both for those that are sick, and also for those that are still well and working. Then, they call for more national TV and radio coverage of the disease, and the lives of PLHA.

"They must encourage men to use condom every time they have sex, introduce women to have blood test before getting married, educate teenagers not to be overjoyed (carried away), and tell them how dangerous the disease is." (F,32,SR)

One respondent said that he found books on the subject helpful, especially the training manual produced by one NGO. Respondents also stated how their behaviour had changed due to their infection. While most had stopped having sex, this was not always the case. The men said that they had stopped visiting night clubs and brothels, and the women urged every woman to ensure that both partners had blood tests before marriage. Some respondents had turned to religion - while two had converted to the Christian faith, and received support from their church, others had gone to their local Wat, or Buddhist based NGOs for spiritual and material help. One woman said:

"When I was at the pagoda, I thought about many things and couldn't fall asleep for nearly a full night. Then I listened to the dharma and stopped thinking unnecessarily. Later on my health was stable and my mind was very calm." (F,32,SR)

4.4 Gatekeepers

Introduction

Gatekeepers (primarily brothel owners or managers of karaoke bars) all had links to the NGOs in the study, either through education programs held for their employees or through direct involvement as participants in or contributors to programs. As with the recruitment of other informants gatekeepers were mostly contracted through NGO's. However, researchers took care to avoid a simple of too (positively) biased respondents. Some of the team had extensive experience in qualitative reserach in the SW industry and were familiar with the "pet" gatekeepers of local NGO's. They made sure that other/outside gatekeepers were included in the sample at each location. Around three quarters of the gatekeepers were female, and had relatively better education than their employees. Some were quite young - 26 or 27 years old, and the youngest woman, aged 27, stated that she had been to university. Several had attended senior high school, rare for women in Cambodia, where most do not progress beyond primary education.

Social capital

NGOs/association/affiliation to other groups

Gatekeepers seemed to be more aware of the NGOs working in their sector than many of the sexworkers. They could all recall several NGOs locally, and brothel owners had allowed an NGO (at times, more than one) to run education courses in the brothel for their employees. The karaoke bar/nightclub gatekeepers were less forthcoming. One karaoke bar owner allowed her staff time off to attend training at the NGO, but not on the premises. The gatekeeping role was however only part of a more complex relationship between respondents and NGOs. Some had been attendees at NGO training courses themselves, learning not only about correct condom use and avoidance of STIs, but also about what services were available to their employees (and for themselves). From their position, able to have more of an overview of the industry, they were occasionally called upon by NGOs to give training themselves. Their comparatively higher levels of education and training also meant that they were requested to give interviews to organisations which were conducting research. One woman said that she had done so willingly, at no cost, implying that this was not the first time she had been interviewed on the subject of sexwork.

Gatekeepers seemed open to receiving NGO services, and knew of several types of services available in their vicinity. Many had attended NGO courses themselves, and, in return, had given training voluntarily with local NGOs. They also had relationships with the public and private providers of services, such as organisations carrying out blood testing, as well as the monitors and government authorities locally. Gatekeepers also had to work with the Municipal Health Authorities, especially over the medical checks and blood testing of employees.

Peer groups

While the managers of sexwork establishments stated that they had little to do with each other, a surprising number also worked, either as volunteers or as paid staff, for NGOs in their sector. For example, one karaoke bar manager` was asked by an NGO to attend a training session, then train her staff on male and female condom use. She has also been working with another NGO in the sector for two years doing the same type of training. For each service, she is paid a small sum by the NGO. This may well have led to her meeting other karaoke bar managers, and other peers. At one site, there are now monthly meetings for the managers of sexworkers. This appears to have helped foster good relations between people who would normally see themselves as competitors in the industry.

Several respondents referred to their employees as their peers, stating that they were like family, and employees could turn to them if they had any problems.

Influences of participation

It is not simply economic considerations which drive brothel owners and managers of other sexwork venues to work with NGOs and other groups to keep STIs to a minimum. There

appeared to be a genuine concern for the work they did, the image of the industry, and the work being done by both government and NGOs. One gatekeeper noted the good work being done by a local NGO and she was keen to get involved. She was pleased that it ran training on wider women's issues, as well as health, and was happy for her employees to attend courses.

Others were primarily concerned with keeping their employees free from disease, especially the younger girls, who were mostly uneducated. Another was curious to understand more about female condoms, so went to a meeting at the NGO on this topic, and got involved after this in educating other groups. Finally, one gatekeeper was very concerned about violence from guests, and wanted to learn how to counteract this type of behaviour. She turned for help to a local NGO on this issue. Gatekeepers will respond to NGOs when the services/programs offered are relevant to gatekeepers' needs. In particular, the "cascade" method of training[21] seems to foster good relationships between NGOs and gatekeepers.

Confides in /confident with

In such a competitive industry, respondents were, somewhat surprisingly, happy to discuss issues with other gatekeepers, in particular about their employees. One respondent gave an example:

"... regarding the sex workers at her establishment, the owner of another establishment asked her: "what about your girls?" And she answered: "The girls at my establishment have no problems." The other owner continued: "Ah! Your girls were good but what about this one? Is she ill? " The respondent replied: "Oh! She has just arrived so she does not know a lot. I have to give her advice so that she will get better. You see? Most of the girls who come to work with me come from the countryside."(F,55,KS)

Another respondent said that she always went to the owners of other establishments if she saw any of their employees using drugs.

Gatekeepers also used the police in order to keep an eye on employees. New employees were always interviewed by the police, according to one respondent, so that she would not be accused (presumably of trafficking) if the girl's relatives came looking for her. The police let the respondent know if employees left the establishment, where they went, and when they came back. Whether this was a common phenomenon is not clear, but all gatekeepers had to pay the police, and it is probable that some police at least would let gatekeepers know if employees were 'straying'. Another respondent said that she had confidence in the police because she kept them happy by giving them beer on feast days.

There were others in whom they confided - NGOs in particular were seen as "good" and "honest". One respondent said that if she had not personally experienced an NGO training day, she would not have had the confidence in the organisation to send her employees.

Solidarity/bonding

Respondents were very clear that their main bonding was with their employees, who were in most cases regarded as part of their extended family. "They are my children, or my younger siblings" was a common response. Another said that he treated his employees as part of his family and would let them rest if they were ill, or ensure that they had the correct medical treatment. They were reminded of medical appointments, lent money for motorbike journeys, and for medicines. This parental role was evidenced in other ways, in particular where employees were young, or newly arrived from the provinces (see above).

There were several instances cited of workers who had moved on who still kept in touch with their old employer. On the other hand, employees occasionally came back to work with their old employers, especially if they had been badly treated elsewhere. Economic ties were also strong, including negotiations with clients where the presence of the manager ensured that the sexworker (and the manager) received the agreed sum. Respondents are also ready sources of loan money for sexworkers, and instances of loans at good rates of interest were given as examples of the solidarity between respondent and her employees. These financial transactions could even take place after employees had left the establishment. There was one instance given of a woman who had left sexwork and married, who returned to the brothel to borrow money after she had separated from her husband.

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21 Where a group is trained on a particular subject, then goes back to their workplace or home, and each member of the group trains another group, etc.

Decision making/participation

Respondents were happy that NGOs consulted with them and treated them well. However, one owner wanted to join the sexworkers group at an NGO, but as an employer was not allowed to participate. She found this difficult to accept.

There were also instances where respondents were involved in decision making which reflected their perceived parental role and may raise confidentiality issues. One respondent stated that owners went to the hospital with their employees if they were sick, and the doctors discussed the case with them in order to ensure that they could see for themselves what illness the employee was suffering from, what medicine she had to take, and what follow up appointment was needed. (The respondent was upset that at another clinic she was not allowed to be present during the medical examination, and felt that she was not fully informed, and that therefore she could not help the employee properly.) Respondents generally wanted to be more fully consulted with on issues to do with sexwork, and were happy to go to meetings.

Stigma and discrimination

Openness/isolation

Gatekeepers were open about their work, and claimed that their employees were also. In fact for many it was a source of some pride, as they were often being asked by NGOs for help and information. They also felt that the education programs run by NGOs had brought the issue of sex, and the need for condom use, out into the open, and thus brought their role into prominence too. Brothel owners were however fully aware of their economic role - they kept away from the employees of other brothels, for example, in case they were perceived as “poaching” good employees from other brothel owners. There were also some tensions when workers from one brothel entered another “house”. This had apparently not been acceptable to the brothel keeper - he had a business to run.

Most respondents gave instances of discrimination, especially with clients. While neighbours tolerated them, clients called them names, tried to reduce the price, or threatened them with violence. After all, they were just prostitutes. There were several instances of distinct puzzlement voiced by clients. Why do you do this job? You are not beautiful but why would you want to do this job?

Association

It was the rich women, especially the wives of high ranking government officials, who were most vocal in their discrimination, according to the respondents. This may be because their husbands enjoy time with “bar girls”, and their wives are afraid of catching diseases, especially HIV (not an unfounded fear, given the huge increase in HIV infections in married women over the past few years).

Respondents had changed their views on PLHA as a result of information and education on the subject. Before, they would have little to do with PLHA, but now they understood and the fear has lessened. However, they still believed that PLHA were often left to their own devices, especially when they were sick. Several said they would still be wary of eating a meal with a PLHA.

Rights

Gatekeepers were fully aware that their employees had few rights, and those that they had were not properly understood or enforced. Police were called when clients were misbehaving, and took money from brothel owners (and often their employees) for this service. They also kept an eye on the sexworkers outside the brothels, especially if they seemed to be soliciting in the streets, where the women were often threatened with arrest (usually reduced to an on the spot 'fine'). Gatekeepers stated however, that many disputes where the police were called out involved employees arguing over money which had been borrowed from the brothel owners, rather than issues with clients. For example, one brothel owner said that (in other areas of the city) brothel owners were keen that sexworkers pay off debts quickly, insisting that they receive clients when they were ill, or take drunken or abusive clients. The financial pressures on the sexworkers had led to several violent encounters with gatekeepers. The reason she knew about this was that these sex workers 'had escaped' and had come to her for help.

Gatekeepers were also quick to accuse some of their employees of violence where clients became argumentative, and the women immediately became violently angry. This provoked the client to violence in turn.

There were also instances of manipulation - where clients stated that their (high ranking) relatives would pay, and the brothel owner was told to go and ask them for payment - something

the gatekeepers would not dare to do. Others came to the brothel with no money and accused the girls of stealing their wallet - there were many instances quoted by respondents of clients trying to get away without paying. (Gatekeepers also acknowledged that some employees did steal from clients). For the higher ranking officials who attempted to get away without paying, police were not always called - for those lower on the social scale, police meted out punishment as required. Police always had the ultimate sanction of closing down the brothel - one respondent felt that this might happen if her employees did not attend the health clinic every month, for example. Police presumably obtained records of these visits. A combination of unclear laws in this area, lack of understanding of rights, and the power of the police authorities, has led to a complex set of relationships for the brothel owners to deal with.

Gatekeeepers were also concerned about the drug trade, especially in karaoke bars and brothels. It was not clear how far they themselves were implicated, but several said it was an industry that was no good for their work, but paradoxically, some brothel owners (not themselves!) forced sexworkers to use drugs and also sell them to clients. Again they "knew many" other brothel owners who behaved in this way, and there is evidence from other studies to support this assertion. Other instances were given of sexworkers forced by gatekeepers to have sex with clients wielding guns, or indulge in painful or dangerous sexual practices. Gatekeepers interviewed stated that they themselves did not behave in this way:

"she does not force sex worker to have sex with a person like a drunken man or one with a bad smell or the way of having sex was not good" (F,29,K8)

However, they all said that they were in charge - they decided which clients were acceptable. Employees also needed permission to leave the premises, and if it was not given, then that was the final word.

Social/legal framework

While the laws on sexwork are national, they are enforced (if at all) at a local level, together with any local decisions which the authorities might choose to make. In one location the system was clear:

"When new sex workers arrived she was obliged to accompany them to the health providers for medical examination and then to the mondul (administrative centre), and sangat (commune) authorities, to the police and the Military Police for registration so that they would not be arrested. She was obliged to tell the village chief so that he could write a letter to the mondul authorities about the number of new sex workers. This was for registering them for medical examination and for police payments. We cannot keep it secret, otherwise we will be punished. "(F,55,K8)

If she told the MP that there were no sex workers at the establishment but they found out later that this was untrue, the MP would close down the business. It was also stated that a range of policemen interrogated all new sex workers about their background in order that "police would be able to defend her from any accusation". Payment was also expected from gatekeepers for new employees:

"When we have a new girl we always give 10,000 riel to the Military Police for each girl and 20,000 riel if we are late "(F,29,K8)

Gatekeepers also realised their obligations to keep employees “in line”. Apart from requiring permission to leave the brothel, gatekeepers said:

"we do not allow the girls go outside openly, do not let them call the guests (clients) along the street and do not let them wear sexy clothes" (F,44,KS)

Experience

Gatekeepers seemed resigned to the fact that their profession had to deal with men who were often intoxicated, violent or otherwise abusive. They told of clients wielding firearms, refusing to pay, taking over an hour to have sex without extra payment, using electric shocks on the girls, or beating them up. The police were often called in such instances. However, there were also times when the employees were victims of violence from “gangsters” that they consorted with outside work, or family members demanding money from them. In these circumstances, the gatekeepers left it to the employee to sort out and generally would not involve the police themselves. There was therefore a clear line of responsibility drawn - police could be called upon to safeguard employees while at work, but employees themselves would have to choose to involve police in any other circumstances.

Self esteem

Education etc.

Gatekeepers had a wide range of educational backgrounds, from none to University level. This gave them an advantage over their employees, as many of the sexworkers were illiterate, and felt this gap in their education keenly. Sexworkers often believed that gatekeepers used their enhanced numeracy and literacy skills to enforce control and on occasion defraud them of their earnings. Owners and managers often act as gatekeepers for educational opportunities as much as employment, allowing some to attend NGO courses but not others. This is especially so when NGOs ask for “sexworkers” to attend their programs and many indirect sex establishments deny any knowledge of sexworkers. However, one karaoke bar owner freely admitted that her establishment had sexworkers, and she herself had attended meetings with local NGOs to ensure that her employees attended and were aware of the need for safe sex practices. She was especially worried about the younger women, who she felt did not understand the risks well enough, and were easily lured by the promise of extra money for sex without a condom.

Negotiation skills

Although respondents did not discuss their own relationships with various authorities, it is clear from preceding evidence that their negotiation skills needed to be good in this industry. With the law unclear, and unevenly enforced, they had to fall back on their own relationship skills to be able to make a living and keep reasonable relationships with a wide range of people. Respondents talked mainly in this section about financial negotiation, especially with clients who were slow in paying, and with employees to whom they had lent money (often a considerable sum, several hundreds of dollars in some cases).

One respondent, hearing that a client had forced her employee to have sex without a condom, visited him in his home. His reaction was not given, but the gatekeeper said that she accused him of risking his family's lives for the sake of 5,000 riel. (And presumably the life of her employee also). She explained:

"I am the boss so I protect my sex workers." (F,55,KS)

Self acceptance

This revolved around being accepted by their community. Basically, if they were making money, they were accepted. One respondent said that the people in her home district knew about her job but they have never talked rudely to her. On the contrary, they said, "If you have money, you have every thing" However, gatekeepers also appreciated being accepted and listened to by the NGOs. This had definitely increased their self esteem and their own feelings about the sex industry.

Fears

There were a wide range of fears talked about by respondents, mainly covering risks to their business, and their reputation within the community. Even those with solid business history over many years were afraid that the authorities might close them down if something untoward occurred between themselves and those in power. Others said that they did not drink alcohol as they had to keep a careful eye on clients, especially around their own daughters. There was a general fear that employees were having unprotected sex and might contract HIV or other diseases from sangsaas or clients. This was a fear not only about the employees' health (and for business) but also on their own behalf, that they would be blamed, especially by the medical authorities, for not looking after their employees carefully enough. Respondents were also afraid that medical test information might become known to neighbours, who would then discriminate against their establishment. While respondents were happy with NGO services and approaches, some respondents still felt shy about approaching NGOs, as they were perceived as very busy people.

Services

Health/Support/Peer

Gatekeepers were fully aware of the range of health services available, from public, private and NGO organisations. Some gatekeepers said that they kept a strict tally of monthly visits by their employees to health clinics, although whether this was primarily for police/local authority control was not clear. Some gatekeepers accompanied their employees for blood test and other health services, so that they knew exactly what occurred, if their employees were ill or not, and what advice the doctors were giving. Others lent the women money so that they could take a motorbike to the clinic.

Support services related mostly to the provision, usually a loan, of money for various reasons. Gatekeepers often made substantial sums in loans to employees, and even to ex-employees. One gave 20,000 riel (about $US5) to a sex worker for transport to return to her native village when she was pregnant and being mistreated by her husband. Another lent money to an employee for medicine for family members (a common occurrence), or to (re?) purchase a plot of land. Occasionally ex-employees came back to ask for money but were usually refused. The message was - you have moved on in your life, don't turn back.

There was little evidence of discusion among gatekeepers (peer group) regarding the type or quality of services available from NGOs. One respondent's mother worked for one of the major local NGOs, which encouraged links between the NGO and the establishment. Otherwise, gatekeepers did not work with each other regarding the provision of services - the NGOs acted as liaison (where required) between individual businesses and service providers instead.

Distance/time/cost etc.

These did not generally cause a problem. Relationships with NGOs were good, NGO staff were polite, organised meetings around the gatekeepers' timetables, and phoned in advance of any visit. They also kept appointments they had made, and the gatekeepers trusted them. Similarly, with health clinics, appointments were made, and respondents said that clinic staff did not mind if the women attended more often than the once a month recommended, especially if they were ill, or felt in need of further appointments.

Meetings with local officials from the Health Department were not so straightforward. If officials wished to meet gatekeepers, they sent an invitation, with a specific time and date. One respondent stated:

"they are not sincere with ordinary people. For example, last year they said that if people from karaoke establishments did not go to them for a meeting the karaoke business would be closed down and they would complain (about) them to the higher authorities."(F,35,BB)

However, if gatekeepers wished to meet officials, it was a different matter. Health Department employees were difficult to contact, and were unhelpful. Respondents said that local authorities focussed entirely on the HIV/AIDS issue, rather than any other problem which faced the industry.

Cost

Prices for products and services varied from place to place. Sometimes (or some types of) condoms were free, depending on where they were obtained. A box of condoms (5,000) cost $45 in one place, or $50 if bought on credit, although in other places they appeared to be free. Number 1 (major brand) condoms cost 4500 Riel for 100 in one place, and 4200 in another. Women's condoms were more than twice as expensive; a box of 20 cost 2,000 riel (elsewhere, 1,800 riel). With the range of condoms growing, market forces are starting to influence their cost - while the basic ones are still cheap, or free, fancier brands are being sold direct to brothels and other sexwork establishments at a range of prices.

Medical examinations were free if they were organised/authorised by the NGOs - this was usually the regular monthly examination. One gatekeeper mentioned that if the police ordered a health check for one of her employees, then this was also free. However, private health providers charged for all appointments and services, and some services provided by the NGOs relating to women's health were also charged for, although the amounts were small, 2-3000 riel. Some private clinics charged 6,000 riel for a blood test - it was unclear why sexworkers would use this service, given the free tests available locally.

Lubricants were becoming more widely available, but respondents wanted to see these with all condoms, so that lubrication was available every time a condom was used. The overall reduction in healthcare costs for their employees has obviously helped the gatekeepers. As one said:

"Sometimes they have syphilis and sometimes they cannot urinate or something like that. I used to waste my money on doctors who came to examine and to inject them, but now I don't have to pay one Riel" (F,44,KS)

Knowledge, attitudes and behaviour

Gatekeepers were fully knowledgeable about HIV transmission, including the risks of various forms of sexual behaviour, sharing needles, mother to child transmission etc. They were also aware of the various tests and medical checks that were available locally, and keen to use NGOs' other services -most NGOs were also involved in a range of other programs - to help sex workers into other trades once their careers in sexwork finished. Several had already encouraged their employees to look to tailoring or beauty services training with the NGOs as an alternative employment.

They received their information primarily from the NGOs that they were in contact with. Other sources were TV, radio and handouts from government agencies. They listened carefully to those 'in charge', for example doctors "We don't want doctors to blame us" and local officials ("We cannot refuse, we have to go. If we don't go, they will close our doors, and stop our business").

Other KPs, PLHA

Respondents said that they pitied PLHA, and that after under-standing about HIV, were happy, for example, to buy food from

vendors who were HIV+. Several said that they did not know if any of their employees had HIV, but that several “had left without reason”. They focussed on the effect the disease might have on their employees. None said that they themselves had HIV+ employees, but they were aware that there were many women working in karaoke bars, who although were “fat” i.e. still looked healthy, were infected. Because they looked fine, clients rarely wanted to use condoms with these women.

Respondents could understand why HIV+ employees might not want to know their HIV status - it would affect their earning power while they were still well, and there was a certain fatalism which meant that they were often reluctant (according to the gatekeepers) to have a blood test to check their status. The reasoning was, they used condoms and felt well, so they did not need a test. If they felt that they might be infected, a test would confirm their worst fears and reduce their earnings significantly, if not lose them their job altogether. The true level of infection was therefore difficult to judge. However, most gatekeepers encouraged (or forced) their employees to have blood tests on a regular basis (usually every six months.) They were sceptical of figures issued in newspapers and the “official” numbers of PLHA in their area, but agreed that the numbers had declined, primarily through the deaths of those infected. Respondents looked to the NGOs to give them information about which of their employees had HIV. Whether this happened or not was unclear, but one respondent registered her anger at learning from a third party (not an NGO worker) that one of her girls was HIV+, as she had been the last to know. She was very disappointed that no-one had told her, especially as she saw her role as one of proxy parent as much as employer.

Most respondents had had some experience with PLHA. Several talked of giving money to the families affected, or giving advice about medicines, and paying for doctors to give injections of serums to give them more energy. One said that one of her employees left, owing her money, but as she was HIV+, the respondent cancelled the debt and let her go back to her village.

Love/sex/condoms/condom use

Respondents were unanimous that condom use had increased significantly in the past year. Some quoted men who attempted to wear more than one condom to reduce the risk of infection or breakage - “some up to five!” They all encouraged their employees to wear condoms, and provided them for them, including those gatekeepers running karaoke bars and other venues for indirect sex work. However, they acknowledged that it was difficult to monitor condom use - especially with “sangsaa”.

They were also aware of the feelings against their employees if they returned to their home village infected with HIV. Villagers hated and feared this return from the towns, and often discriminated against the women, sometimes forcing them to return to the town in search of treatment and accommodation.

Various types of condom are now available. Female condoms seem to be gaining in popularity. In the past, NGOs distributed condoms at no charge, but now various organisations are selling a range of condom to gatekeepers and direct to sexworkers, so the market has become more complex.

5 conclusions

5.1.1 Key findings: men who have sex with men (MSM)

MSMs were well aware of their own NGO's programmes, as most had either worked directly for/with the NGO or attended training courses run by the NGO. However, they were usually unaware of the programmes run by other NGOs in their geographical area.

Peer group solidarity was strong, with MSMs working together and socialising as a group. They valued the support given by other MSMs in the face of discrimination and lack of knowledge in the general population, as well as enjoying having fun together.

NGOs had helped considerably in bringing MSMs together, helping them when they were in trouble, and building their confidence through involving them in education programmes in their local communities.

Discrimination was not nearly as bad as it had been in the past, although there was still a range of responses to MSM behaviour, especially in rural and minority groups.

MSMs were primarily discriminated against because of their sex work, rather than their sexual preferences.

Self acceptance, and self-confidence, revolved around their ability to make money, primarily for their families. If they were sick, or otherwise had no money to send home, this profoundly affected their confidence levels.

They were aware of the need to preserve good relationships in their communities, and most regulated their behaviour accordingly. They looked forward to “a place of their own” where they could be themselves in a safe environment.

MSMs knew about key health and support services for them (some were delivering services themselves).

Condoms are cheap and easy to find, although lubricants are more difficult to access. Condom use has increased in the past year, although precise figures are difficult to judge (between “60% of the time” and “almost always” were reported. It is clear however that condom use is not the norm with lovers (sangsaa), even when MSMs have other sexual partners.

There are still myths around condoms, for example that the UN brought HIV to Cambodia in condoms, or that several need to be worn at the same time.

Knowledge of HIV has led MSMs to monitor their risky behaviour, such as the increased use of (free) blood testing services, and a reduction in the number of partners.

5.1.2 Key findings: Sexworkers

Sexworkers knew the NGOs in their geographical area working on HIV issues. Most could name two or three NGOs that provided education or health programs and free condoms.

Respondents identified with many “peer” groups - not just their work colleagues. "Peers' could include neighbours, NGO staff and other sexworkers in the district, not just fellow workers in the brothels.

NGOs encouraged participation in particular events, such as World AIDS Day, or plays about HIV/AIDS. Respondents said however that they had to start taking part in ordinary communal activities (such as New Year, the Water Festival, banquet/ feasts) as well. If NGOs could be invited to join in the preparations for the celebrations of the annual calendar, then the respondents could be seen as ordinary people, and not just as workers in the sex industry.

The 'one-stop shop' approach of many NGOs influenced many respondents, who were pleased that attendance at one NGO put them in touch with a range of services, many involving home- or work-based delivery, which enabled them to access products and services they may otherwise have found too difficult or costly to obtain.

The role of the NGO as encourager and facilitator appears to be vital to women who were denigrated in their own communities and were very aware of the stigma attached to their profession.

It took time to establish good relationships with NGO staff and this gradual build up of trust could not be rushed.

While respondents stated that their community looked down on them as those who had lost their honour, there was also an acceptance of them as people supporting their families through their hard work - both attitudes prevailed.

This lack of clarity about the legal status of sexwork has led to discrimination, such as the illegal “registration” of prostitutes by local police and the monitoring of women's movements outside the brothels, including their visits to health centres. (See also section on Gatekeepers)

Lack of education and knowledge (many respondents were illiterate), precarious financial position and fear of violence all contributed to their lack of self esteem.

Respondents were fully aware of the health services available to them. They were also aware of the key transmission routes for HIV, and could quote them easily. They knew from experience of what to do when things do not happen as expected.

Respondents received their information primarily through the NGO training, but also from each other, from radio and TV government programmes, and from local hospitals and clinics.

Peer group programs run by NGOs were the best for the respondents, but these programs need to focus more now on those who were “informally” part of the sector. It was realised that these more hidden groups represented the greatest current risk of increased infection. Respondents also thought that there needed to be more education programs for the police and local authorities, so that they understood more about the disease in their locality.

Respondents knew where to gather to discuss issues, but these were usually public places, and not always safe or confidential. So they would like their own building to meet.

Sex workers were fully knowledgeable about condoms, including those for women, which were generally agreed to be good. There was evidence of increasing use of female condoms. Respondents were also enthusiastic about the lubricants that were now more freely available - but were still not as easy to obtain as condoms.

There is still evidence that condoms are not always used a) with husbands b) with lovers, c) with clients, even if the sex-worker is HIV+.

5.1.3
Key findings: people living with HIV/AIDS (PLHA)

In contrast with other groups in the survey, this group were more pessimistic, less articulate in interviews, felt isolated and had low self esteem.

NGOs were the organisations that PLHA had most confidence in, both as consumers of services, and through their direct participation as volunteers. Many PLHA worked for NGOs in their programs, helping with home based care services, training others in advocacy, or working with the general population on anti-discrimination issues.

There was little confidence in public health systems - most PLHA used private practitioners for their medicines, primarily injections of "serum" to help them regain their strength. ARV treatment (if available) was accessed from public hospitals through NGOs.

If PLHA had problems, they were more likely to discuss them with family or friends, rather than with NGO staff. They also maintained links with Wats and acknowledged the influence of Buddhist teaching on their perceptions of the illness.

PLHA were still subject to discrimination and abuse despite government and NGO campaigns, information and other programs aimed at reducing the stigma attached to the disease.

The length of time between infection, diagnosis and death, and the number of "AIDS families" had meant that the goodwill of the community towards PLHA had been severely strained, given the amount of care needed from within the family or village and the poverty of many of these communities.

Legal and customary rights for PLHA seemed to depend on their health status, and whether they had the support of NGOs, as much as the fact that they were infected.

There were some interesting developments at a local level, where villages had discussed the issue as a community, and organised education and information for all, not just those directly affected by the virus.

Respondents were aware of a wide range of services locally, although they did not always recall the names of the NGOs responsible.

PLHA have asked first, that the government support them with food and money during the times that they cannot earn anything. Next, they are looking for accommodation which could be used both for those that are sick, and also for those that are still well and working. Then, they call for more national TV and radio coverage of the disease, and the lives of PLHA.

The key messages that PLHA urge all to hear are: men must use a condom every time they have sex, everyone should have a blood test before getting married, teenagers must be educated about sexual behaviour and feelings, and everyone needs to understand how dangerous the disease is.

5.1.4
Key findings: Gatekeepers

Gatekeepers seemed to be more aware of the NGOs working in their sector than many of the sexworkers. The gatekeeping role was however only part of a more complex relationship between themselves and other organisations in the sector.

Gatekeepers were now open to receiving NGO services, and knew of several types of services available in their vicinity. Many had attended NGO courses themselves, and had given training voluntarily with local NGOs. Some had taken part in research interviews.

Gatekeepers are influenced by several factors when working with NGOs; in particular, concern for their employees' health and level of knowledge, the quality or good name of their establishment, and the fact that NGOs appeared to be doing good work in the community, as well as economic considerations.

Gatekeepers operated within both formal and informal networks of control with regard to their employees, involving other gatekeepers, NGOs and the police.

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Respondents regarded their employees as part of their extended family. "They are my children, or my younger siblings" was a common response. There were instances where respondents were involved in decision making which reflected their perceived parental role, which may raise confidentiality issues.

Gatekeepers were open about their work, and claimed that their employees were also. In fact for many it was appeared a source of some pride, as they were often being asked by NGOs for help and information.

Most respondents gave instances of discrimination, especially with clients. While neighbours tolerated them, clients might call them names, try to reduce the price, or threaten them with violence.

Legal rights are not properly understood, or enforced. Instead, police and local authorities use their powers to regulate the

industry in their locality as they see fit. This includes registering all new sex workers in the area, and receiving payments from gatekeepers.

In cases of violence police could be called upon to safeguard employees while at work, but employees themselves would have to choose to involve police in any other circumstances where they felt under threat.

Some of the indirect sexwork establishments may be missing out on education programs, as karaoke bar owners and similar say that NGOs ask for 'sexworkers' to attend their programs and their establishments deny any knowledge of sexworkers. Young employees may be particularly at risk.

The fear of employees contracting HIV was not only about concern for the employee (and for business) but also that as employers they would be blamed, especially by the medical authorities, for not looking after their employees carefully enough.

Gatekeepers were fully aware of the range of health services available, from public, private and NGO organisations. They themselves provided financial support services (loans and gifts) to employees.

Relationships with NGOs were good, but those with local authorities were more problematic.

Costs of products and services varied widely, and some items which in the past were free eg condoms, could now be purchased as part of a wider range of products.

Gatekeepers were fully knowledgeable about HIV transmission, including the risks of various forms of sexual behaviour, sharing needles, mother to child transmission etc. They were also knowledgeable about the range of other services provided by the NGOs including alternative employment for sexworkers.

5.2.1 Some tentative conclusions regarding respondents

Some of the key findings cut cross the various KP and is worthwhile highlighting these similarities because they indicate common sigues, problems and opportunities for interventions.

Peer group solidarity is strong, especially in the face of discrimination from the authorities and the general public.

Each group was looking for a “place of their own” in which they could meet both socially and for education purposes. This perceived need was the same for sexworkers, PLHA, and MSMs.

All were knowledgeable about HIV/AIDS, how it was transmitted, and the services available through NGOs in particular. This educational stage seems to have had its results. This does not mean that behaviours have necessarily changed however, especially amongst MSMs.

The “proxy parent” role of gatekeepers and others in the industry needs to be better understood, especially how this affects their attitudes to information about their employees' health and personal circumstances.

Condoms are not always used, especially with husbands/ lovers and amongst MSMs. There appears to be an element of fatalism about this, and it is difficult to know whether any education campaign would be able to address this issue.

While women working in the sex industry were generally denigrated for their work, those who had made a good living and were supporting their (often large, extended) families were admired for their efforts. The outcome seems more important than the process.

5.2.2 Some tentative conclusions regarding sites

The transcripts did not indicate clear cut differences between the three sites. So, the following conclusions are based more on the impressions of the field workers than on the interview transcripts. However a real limitation to the systematisation of these impressions was that the time constraints of field work prevented key populations being interviewed by the same interviewers across sites.

Cambodia is not a geographically big country, and has a population - uprooted by several decades of civil war - that is quite mobile. And SW are even mobile to an extreme extent .

Battambang, Sihanoukville and Siem Riep are all in second tranche of cities after Phnom Penh and 'innovations' are likely to appear in all of these cities without too much time delay. To give but one example, when amphetamines started becoming a problem, Battambang, because of its location close to the Thai border (at that time the source of most pills), was affected first. It did take only between one to two years for the spread of the problem, not only to Phnom Penh but also to the other bigger cities like Siem Riep and Sihanoukville.

HIV/AIDS is one of the country's policy successes, an issue that stands out in terms of the political will shown to deal with prevention. This made for a strong push irrespective of location for active implementation of prevention policies, involving service providers, authorities, and public awareness campaigns.

All of this makes for more across-site similarities than differences in attitudes of KP, service providers and authorities and in the supply of services.

Across-site similarities/differences regarding MSM

In all sites the MSM interviewed they were selling sex. This is probably indicative of the population reached by the NGOs. However field workers noticed differences in preferred occupations/avenues to sexwork across sites. In Battambang most MSM worked as masseurs or hair dressers; in Sihanoukville, work in bars, or selling on the beach were prominent livelihoods.

Peer support seemed stronger and better organised in Battambang than in Sihanoukville. MSM in Battambang and Siem Riep reported higher levels of stigma and discrimination than those in Sihanoukville. This might be linked to higher levels of group awareness (rather than to actual higher levels of discrimination). However the fieldworkers also had the impression that MSM in Battambang and Siem Riep are less willing to “come out” than those in Sihanoukville. So the true linkages between actual social conditions and subjective awareness are not that easy to pin down.

Across-site similarities/differences regarding SW

Siem Riep brothels seemed better environments, in terms of cleanliness, quality of rooms, quality of service, and number of clients than either those in Battambang or Sihanoukville. Their different clientele profile, a much higher percentage of foreign (mainly Asian) tourists, is possibly the reason.

Female condoms were known to Sihanoukville SWs but less to those in Battambang or Siem Riep.

In general, SWs were more alike across sites than MSM. This is probably related to the high mobility of SW, meaning that a woman now working in Siem Riep might have been working in Battambang half a year ago and might move on to Sihanoukville next year.

5.2.3 Some tentative conclusions regarding NGOs

The work of NGOs in education, information gathering and consulting with the sex industry has raised the profile of gatekeepers (in particular) and the perceived level of discrimination against them has dropped, in contrast to the stigma against PLHA and others who are not part of the NGO outreach network.

Peer group programs seem to have had the greatest effect in the sector, although the “peers” have to be chosen carefully and well trained to maintain their credibility.

6 Recommendations

6.1 Process - When we do this again

When doing the final review we propose to limit the number of issues to be addressed in the interviews. Better to probe a limited number of issues in depth than try to cover a lot superficially:

- It is quite clear that regarding the KABP issues only condom use (practice) with lovers is still a major issue, so we propose to concentrate on that.
- The questions on involvement/participation in services and the views of the quality of services did not generate much useful information. We propose to include these questions only in the interviews with indirect SW, the only group for whom this still seems a major issue.
- This leaves more space to explore the issues of self-efficacy/self-esteem, social capital and stigma/discrimination/violence and their interrelationships in depth.

We propose to allow more time for interviewee selection. Given the qualitative nature of the study we propose to go for a more case study like approach in which a limited number of well selected key informants, who are able and willing to verbalize their experiences, feelings and thoughts well, are interviewed with sufficient time (which probably means spreading the interview out over two occasions) to explore issues in depth. A design could look as follows:

MSM (4 IDI), DSW (3 IDI), IDSW (3 IDI), PLHA (4 IDI), Gatekeepers (4 IDI): Total 18 interviews/site. Room for the approach advocated is created by leaving out interviews with NGO staff (which turned out to have more of a check than a primary data function) and leaving out the FGD (but see below).

Sites seem very comparable. However, although big differences are unlikely, some more in-depth exploration of potentially more subtle differences - even if only to rule them out - is advisable. Across site comparisons require the same researcher to deal with particular issues/key populations at each site. The design of the follow-ups must allow enough time for this.

In addition to this we propose to organize one FGD for each KP (MSM, DSW, IDSW, PLHA) and one each for gatekeepers and NGO staff, in total 6, with 3 participants from each site. And make site comparision the major objective of these discussions. Obviously some travel costs and per diems would be involved but the added value of this apporoach mauy be considerable.

Total number of interviews would reduce to 60.

6.2 How to measure change

Measuring change using quantitative indicators is normally quite straightforward (although obviously constrained by the validity of the indicators). One has indicators, does a baseline, measures the same indicators again and assesses the change against a pre-established threshold of what constitutes meaningful change. Using the qualitative data contained in this report as a baseline in that sense is much less straightforward.

In a quantitative approach one would repeat an indicator question and assess the level of change in the answer pattern. Following the same approach with the qualitative baseline questions might not be as effective. We suggest two strategies in using the results of this study as a baseline:

- One can take the analytic summary description of the key population situation in 2004 regarding the various aspects of key concepts as input for questions in follow ups. For example, Solidarity/bonding as part of the key concept Social capital for MSM, this baseline concludes that Strong bonds were formed between those working, and to a lesser extent, attending, NGO programmes. Next time a question can be asked directly probing this effect of working for and/or attending NGO programmes.
- Another strategy is to select key population respondents who have been living at the particular site for a couple of years and ask them directly for assessments of change regarding aspects of key concepts.

A third strategy is directly connected to the process suggestions above: by allowing for more time to explore the connections between social capital, self-esteem, and the role in this of NGO interventions/services as case studies changes over time can be included in the interview.

The three strategies can all be applied within the same design because they are in no way mutually exclusive.

6.3 Some programmatic recommendations (no order of importance)

NGOs now need to reach out to those working informally in the sex industry, including street-based sex workers and other individuals who have been missed by programs with brothels, karaoke bars and other establishments,

Further education work may need to use the media creatively, for example the use of well-known media figures from TV and radio etc to highlight the HIV issue.

Continued awareness raising on condoms in order to dispel existing myths remains essential.

More exlicitly targeting of males is important, including clients of SWs; there is need to work with/carrying out programmes with clients of SWs.

There is a need for education for those working in the sex industry, including gatekeepers, on their legal rights, many of which are unclear, and how these can be upheld.

There is also need to work with MSM to raise their awareness about their rights, existing regulations, laws and policis.

Further research is needed on the relationships between sex workers, (especially gatekeepers), and the authorities, in particular local authorities and the police, covering both legal and administrative issues and power/patronage relationships. It would also be useful to understand better the “proxy parent” role of gatekeepers towards their, often young, female employees.

For PLHA, apart from NGO's, families and other intimate and wat-based organizations seem (potentially) important support structures. How best to facilitate these structures is an open question that needs more attention from practitioners.

For MSM and SW, families are equally important potencial support structures - or sources of stigma/discrimination/ and even violence and attacks on self-esteem. The exploration of

family-centred interventions is another area that is as yet not entered by NGOs.

Findings show that should work with MSM with positive experiences, build on them, use for advocacy, awareness raising

Issues for SWs around life-skills learning, basic literacy and numeracy, training around livelihood possibilities, and possibly linking up with orther NGOs working in the area, giving credit, income generation projects, etc. should be explored further.

For PLHA there is need for or need to encourage different kinds of support groups: for woman only, for those on treatment, run by peers not be NGOs, etc.

For PLHA there is need to provide information/programmes around planning for future of children

Information on nutrition, well-being, other illnesses related to HIV (STIs, TB, etc.) and how to deal with them appears an important issue to explore further.

Annex 1
Guide lines for Focus Group Discussions

Estimated time for each focus group session is two hours. Because the number of issues to be covered was too large to address in one FGD we chose to address 4 themes in one FG and the other 3 themes in a second FG. Thus there are two different versions of the focus group guidelines, each covering different topics. For the schedule of how many FGD of which KP were conducted in each location: see annex 4.

Start group session:
End group session:
Number of participants:
District:

All Focus Group Discussions were preceded by a **standard introduction:**

First of all I would like to thank you a lot for participating in this discussion group. During this meeting we would like to get as much information and opinions as possible about several sex worker/MSM and HIV/AIDS related topics. With this information we would like to evaluate existing support/service organisations and NGOs in the area and find out participation of sex worker/MSM in these organisations. Furthermore we would like to know the sex worker/MSMs' opinions about several topics. This information will help to improve the NGO's work or will keep there performance level high.

Before we start the discussion I would like to point out your various rights as a participant in this discussion.

First of all, everything which is said during the interview is confidential, no one outside the research team, will know what has been discussed during the meeting. When the study is finished, the collected data will be destroyed. Everybody's identity and personal details will be protected, we will not ask for names or birth dates, and even if names are given we will not write them down. Furthermore no one, except the person who recruited you, will know about you real identity.

Participation in this discussion is on voluntary basis, you may ask any question you have about the discussion and the way we work. You may also refuse to reply to any question that you are uncomfortable with and of course you can leave the discussion group at any time as you wish.

Across Cambodia we will conduct several discussion groups and in-depth interviews about several sex worker/MSM and HIV/AIDS topics: in Battambang district, Siem Riep district and Sihanoukville district.

During this meeting we will focus on the following issues:

[FOCUS GROUP 1]

1. Knowledge, attitude and behaviour towards safe sex
2. Self-efficacy, self esteem
3. Experiences of stigma, discrimination and violence
4. Social Capital

[FOCUS GROUP 2]

1. Involvement/participation in service
2. Views of quality of service
3. Awareness/effectiveness of site-level approach

Each issues is divided INTO subcategories, and will discussed systematically. If you feel that relevant issues are left out, I encourage you to express these issues, for the aim of this meeting is to get as much relevant information as possible. Furthermore I once again like to point out that everything that will be said during this meeting is absolutely safe and private, and anonymity of each participant is guaranteed.

1. **Demographic information SW & MSM, FG 1 & 2**
   Before we start with the discussion I would like to know some basic information about the group.

   1. Do you as participants know each other?
   2. Can you tell me your age, so that we can establish the average age in this group? (use blackboard, and if they don't want to give age, ask to write it down)
   3. Can you tell me how long you have been involved in sex work/are having sex with other men?
   4. Do you all come originally from the Battambang/Siem Riep/Sihanoukville district?
   5. Can you tell me how long you have been living in the Battambang/ Siem Riep/Sihanoukville district?
   6. (SW) Can you tell me in which type of sex work you are involved? (Try to let them answer themselves, if they don't understand come up with different types of sex work)
   7. (MSM) What is your marital status?

[FOCUS GROUP 1]

I. Knowledge, attitude and behaviour towards prevention

Awareness and Knowledge:

First we would like to talk several minutes about the knowledge and awareness about HIV/AIDS in this district

- Can you tell me what you know about HIV/AIDS?
- Can you tell me about the ways preventing HIV/AIDS?
- Can you tell me what is known about HIV/AIDS in your community
- Can you tell me something about misconceptions about HIV/AIDS in your neighborhood?
- Can you tell me how many SW/MSM are infected in your district? And how many people in total? How many in Cambodia? How many in the world?
- Can you tell me something about SW/MSM living with HIV/AIDS in this district?
  (extra info: what happened with them, where do they go, do they still work, how does it affect there lives)
- Do you know a places where you can get diagnosed and obtain treatment?

Attitude and Motivation

We would like to get some information about the general attitude among SW/MSM towards HIV prevention and the motivation to provide safe sex.

- What is the norm among SW/MSM in this district concerning (un) safe sex?
- What is the norm in general in this district concerning (un) safe sex?

Preventive behaviour

Now I would like to find out about the actual behaviour towards prevention, among sex workers/MSM.

SW

- Can you tell me how many percent of SW prevent themselves from HIV? In what way? In what situation? (clients or songsaar)
- (SW) In general do clients want to use condoms?
- Can you tell me something about STI/HIV checks in the sex worker in this district? (Where? do a lot of sex workers use these facilities? who pays?)

MSM

- How many percent of MSM in this district have safe/unsafe sex? What are the methods used of having safe sex?
- Can you tell me if there are MSM, who work as male sex workers? How many of them in total?
- Can you tell me if there is a difference among MSM for money and MSM just for themselves, in the practice of safe sex?
- Can you tell me something about the norm of STI/HIV checks in the gay scene?
- Can you tell me something about the norm of STI?HIV checks in this community? And what is the difference with the msm group?

II. Self-efficacy, self esteem

Next I would like to know something about your skills and self esteem of SW/MSM to deal with difficult situation in live.

SW & MSM

First I would like to find out if you feel strong enough to deal with difficult situations you encounter in live.

- What kind of difficult situations you and other SW/MSM encounter? (make a list)
- Can you tell me something about the ways SW/MSM can deal with these difficulties in this district?

....

- (SW) Who are people who are in control of the sexual live of SW? (Themselves, a mebon etc)
- (MSM) Can you tell me something about the control you and other msm have over their sexual live?

....

- (SW) Are SW able to refuse clients who don't want to use a condom?
- (MSM) Can you tell me about the ability of refusing lovers if they don't want to use a condom? How does this work?

....

- What would be the consequences of such a refusal?
- (SW) And for personal reasons?
- Can you tell me something about what would increase or decrease the self-esteem of a sex worker/MSM? (maybe make list)
- (MSM) In general, what do MSM think about himself or herself? How do you see yourself?
- Can you tell me how the community among each other thinks and talks about SW/MSM? Can you come up with some examples?

III. Experiences of Stigma, discrimination and violence

Next I would like to discuss your experiences of discrimination, stigmatisation and violence toward SW/MSM. What the signs of stigmatisation's there are and how you feel about it. Furthermore we would like to know about your knowledge of discrimination towards people who are infected with HIV.

- (SW) Does your community have special word to describe sex workers? (make list)
- (MSM) Are there special names that refer to MSM?

....

- (SW) Can you tell me how people in this community respond when they hear someone is a sex worker?

....

- (SW)In general do people around sw know that they are working as a sex worker? (who knows and who doesn't? Family, friends, people from your old villages, the neighbors you have now.)
- (MSM) Can you tell me if, the people in this area know who is gay and who is having sex with man. (How do they know or don't know)

- (MSM) Do people from the gay scene usually inform there family and relatives about there sexual orientation?

....

- (MSM) Can you tell me how people responded and what the consequences were when they hear that someone is MSM?

....

- Can you tell me something about discrimination/stigmatisation towards SW/MSM in your district.
- What kind of?(probe: Harassment, Isolation, Restrictions, Violation of rights, Violence)
- On which places it happened most? Make a list
- By which person? (make a list)

  - In what way does stigmatisation/discrimination affect SW/MSM the most? What are the consequences?
  - Can you tell me something about violence towards SW/MSM in this community?
  - (extra info: How, who, where and when?)
  - (SW) Can you tell me something about sexual harassment or rape in the sex worker scene?
  - Can you tell me something about what happens after SW have experienced violence or rape?

- (SW) Do SW experience stigmatisation in the way that people think you have HIV/AIDS because you are a sex worker?
- (MSM) Do people in your community make a connection between MSM and HIV/AIDS?

....

- Can you tell me something about the way people in your community think about people living with HIV/AIDS?
- Can you tell me what the general opinion among SW/MSM is, about people living with HIV/AIDS.

....

- Do man from the MSM scene/SW take care of SW/MSM who are infected with AIDS in this area?

IV. Social Capital

The last topic I would like to talk about is community involvement and trust, which takes into account the social environment and community dynamics that can help support positive behaviour changes including trust, reciprocal and solidarity. Social capital is the way people are connected and networked with other (groups) of people.

- Can you as groups come up with a good definition of Social Capital? What specific characteristics belong to social capital?
- What characteristics, of your social environment and community dynamics, makes lives for SW/MSM more pleasant?
- What characteristics of your social environment and community dynamics makes lives for SW/MSM more difficult?
- Please tell me how does your community organise itself? (What are the structures? who is at the highest level? Who is next? Their respective roles and responsibilities etc.)
- How does the SW/MSM group relate within these structures and hierarchies?
- Which groups and people or important to know as a SW/MSM, in order to live your live in the most pleasant way.
- Are there any specific groups or people who can harm SW/MSM? Which groups or people?
- Are SW/MSM integrated in the community they live in?
  - Which are the features that would make you feel more part of a community and what are features, which make you feel make less part of the community?
- What are the social norms in your community towards positive behaviour? Is it normal to help relatives? And neighbors? And strangers?
- How is the solidarity among your community people?
  - And towards you, as a sex worker?
- Can you explain me about the solidarity, support and concurrence between sex workers in this district?
- Are there any unwritten rules or norms concerning dealing and treating other SW/MSM in this district?

....

- Can you tell me something if SW/MSM are part of other groups beside the SW/MSM group?
- In general, can you tell me about the involvement of sex workers/MSM in organisations?
- Where do SW/MSM go when they have problems?

- Can you explain me how much influence sex workers/MSM have in this community?

We reached the last question:

- Can you tell me if there is a safe place in the neighborhood, where SW/MSM can come together, to meet peers, get information and share concerns?

[FOCUS GROUP 2]

V. Involvement and participation in services

Now we will start with the real topics of this meeting. We want to find out as much as possible so feel free to add issues which are not discussed. First we would like to find out what you know about your community, the health system, the NGOs and other organisations in the neighborhood.

- Can you, as a group make a list of all the NGO's and organisations in this district working on SW/MSM topics? (With this question the researcher can use a blackboard)
  - *Can you point out for every NGO and organisation what there main goals are?*
- Can you, as a group make a list of all the NGO's and organisations in this district working on HIV/AIDS topics? (With this question the researcher can use a blackboard)
  - *Again, can you point out for every NGO and organisation what there main goals are?*
- Can you list any groups that are especially set up for (and by) SW/MSM
  - *If they answers yes, ask how many of them have participated in these groups. How big is the percentage of the total group of SW/MSM which are presented in these groups?)*
  - *What do these groups do? How are these groups connected to the rest of the community?*
- From all the sex workers/MSM in the area, you belong to the group that is highly involved in organisations and NGO working on HIV/AIDS topics.
- Can you give me examples of what kind of roles sex workers/MSM can have in NGO and other organisations?
  - *Can you tell me how the rest of the NGO workers respond to SW/MSM working there?*
  - Can you tell explain me if this kind of involvement is paid or voluntary?

- Next topic I would like to discuss is the involvement of Sex workers/MSM in policy making and decision making.
  - *Can you explain me how decisions concerning SW/MSM or HIV/AIDS topics and programs are made.*
  - *Can you explain how you, as sex workers/MSM are involved in decision-making?*

- Can you tell me something about the places where you can go if you have problems related to violence, health issues, human right and legal issues?
- Can you make a list of what should be changed in NGO's, organisations and government, so that sew workers/MSM would become more involved.

VI. Views on quality of service

Next we would like to talk about the quality of the help and organisations in this district.

- Can you tell me something about the way sex workers/MSM can get in contact with the NGO's and organisations?
  - *(Let them answer, try to find out if in general the organisation are easy to get in contact with and open to encounter)*
- Can you tell me something about the accessibility of the NGOs and organisations?
  - (Extra info: are they nearby, is the location easy to find)
  - What are the opening times of the NGO's and organisations?
  - Are these times convenient for sex workers/MSM?

- In the beginning of the discussion we made a list of NGO's and organisation working on HIV/ AIDS and on sex worker/MSM topics. I would now like to find out what you all think about the service they provide. We go trough the list once more, can you tell for each NGO how you perceive their service? Can you say something about the following issues?
    - Attitude towards SW/MSM
    - Technical expertise
    - Trustful
    - Follow up
    - Information provided
    - Openness/approachable

- If quality is not so good: Can you tell me what NGO's and organisations can change so the quality of there service will increase?
- Can you tell something about the access and quality of condoms in this area?
    - *(Extra info: where can you get them, is the supply big enough, how much do they cost)*
- Can you tell me something about the access and quality of other products necessary for sexual intercourse? (example lubricants)
- Can you tell me what kinds of help sex workers/MSM need most?

VII. Awareness/effectiveness of site-level approach/issues

The last topics I would like to discuss, is the relation between different groups and organisations in this district.

- Can you tell me how different NGO's and organisations work together?
    - *If they don't work together: what can be changed so they will work together in the future?*
    - *If they don't work well together, what can be changed to improve this?*

- Can you tell me something about the way sex workers/MSM work together?
    - *(SW: How do they work together during workings hours, and how do they work together during non-working hours?)*
    - *If they don't work together: Why? What can be done to change this?*
    - *If they don't work together well: How can this be improved?*

SW

- Are there any unwritten rules or norms concerning dealing and treating other SW in this district?
- Can you tell me how, in general, the relationship is among mebons, club owners and other people involved in the sex industry? (extra info: do they work together, are they concurrent etc)
- How is the relationship of these people towards SW?
    - *Do SW always have to listen to what mebons and mummy's say?*
    - *Do SW give comments and advice to them?*
- The next relation we would like to talk about is between you and clients. Can you tell me something about the relation between SW and clients?
    - *Do SW see clients on a regular basis?*
    - *Are SW free to express what they want towards their clients?*
    - *In general, who would you say is in charge, the client or the SW?*
    - *Is there another relationship then a provider-customer role between SW and clients?*
    - *If SW are in trouble, does a client have the ability to help?*
- In general, can you tell me something about how the relationship between police and all the people involved is?
    - *Did this relation changed in the last years?*
- Are there people who are a threat to SW or of whom SW are afraid?
    - *If yes, who are they and why are you afraid of them?*

Now we arrived to the last questions of this meeting:

- Can you tell me how relationships should be changed, to make the sex industry a more safe place to work?

MSM

- How are MSM integrated in society?
- With which other groups. Do they have a lot of contact? And how are these relations?
- Can you tell me about places where MSM come together?
- How is the relation between governmental institution and MSM?
- Did this change the last year?

The next questions concern men who have sex with other men for money (or other material values).

- In general, how many men in the scene have sex with other men for money?
- Can you tell me how contacts with clients are established?
- Can you tell me how the relation between male sex worker and his clients is?
  (Let them answer. If they find this difficult mention this issues:
  - *Do men see clients on a regular basis?*
  - *Are male sex workers free to express what they want towards their clients?*
  - *In general, who would you say is in charge, the client or male sex worker?*
  - *Is there another relationship then a provider-customer role?*
  - *If male sex workers are in trouble, does a client have the ability to help?*
  - *Is there a difference between male sex workers and female sex workers?)*
- Are there any people or institutions who are a threat to MSM or of whom MSM are afraid?
  - *If yes, who are they and why are you afraid of them?*

Now we arrived to the last questions of this meeting:

- Can you tell me how relationships should be changed, to make this community a more comfortable place for MSM?

[FOCUS GROUPS 1 & 2]

After having had this session, do you think that there are any topics which have not been covered but are important for people working with sex workers/MSM, to know? What are these topics and why would it be important to discuss them in the future?

I would like to thank you very much for the time and effort you have put in this discussion. If they are any questions remaining or the procedures are unclear, feel free to contact us in our research center. A report on all the focus groups and in-dept interviews among the different key populations will be published; participants who are interested in the findings can contact us in our research center.

Annex 2

Guide lines for in-depth interviews

All in-depth interviews were preceded by a **standard introduction:**

Before we start the interview, I would like to thank you for the time and energy you are willing to put in this interview. During this meeting we would like to get to know as much as possible information and opinions about several HIV/AIDS related topics. With this information we would like to get a broad overview of the way NGO's works in different districts in Cambodia. Furthermore we would like to know how different topics are perceived by people who are involved in some way with HIV/AIDS situation.

Before we start the discussion I would like to point out several right of the participant.

First of all everything which is said during this interview is confidential, no one outside the research team, will know what has been discussed during the meeting. When the whole research is finished, the collected data will be destroyed. Everybody's identity and personal details will be protected, we will not ask for names or birth dates, and even if names are given we will not write them down. Furthermore no one outside the person, who recruited you will know about you real identity.

Participation in this interview is on voluntary basis, you may ask any question you have about the interview and the way we work. You may also refuse to reply to any question that you are uncomfortable with and of course you can leave the interview any moment as you wish.

Across Cambodia we will hold several discussion groups and in-depth interviews about different HIV/AIDS topics. These interviews and meeting take place in the Battambang district, Siem Riep district and Sihanoukville district. All the information that will be collected will be put together and then a report will be written. If you are interested in reading this report afterwards, you can mention this to me after the interview. I will provide telephone numbers and addresses.

During this interview we will focus on the following issues (for an overview, see table 1 below):

Table 1: Issues mentioned in introduction of in-depth interviews

	1	2	3	4	5	6	7
(Empowerment of) Knowledge and behavioural change	*	*	*	*	*	*	*
Exposure to Fpp intervention	*	*	*	*	*	*	*
Awareness of NGO scene, participation					*		
Use of service	*	*	*	*	*		*
Quality of service	*	*	*	*	*	*	*
Participation of the key population in this NGO	*	*	*	*		*	*
(Effectiveness of) Site level approach	*	*	*	*	*	*	*
Social capital	*	*	*	*		*	*
Self-efficacy, control of external events, self esteem	*	*	*	*		*	
Stigmatisation/discrimination and violence	*	*	*	*	*	*	*

Notes

1 = Sex worker high involvement | 2 = Sex worker low involvement | 3 = MSM high involvement | 4 = MSM low involvement
5 = gatekeeper | 6 = PLHA | 7 = NGO staff

Each issue is divided by subcategories, and will be discussed systematically. If you feel that relevant issues are left behind, I encourage you to express these issues, for the aim of this interview is to get as much relevant information as possible. Furthermore I once again like to point out that everything that will be said during this meeting is absolutely safe and private, and anonymity is guaranteed.

Next followed a section with
general information and socio-economic background information

General information (all except NFGP staff)

Age……

Date of Birth:………

Years living in district:……………………………………………years……………………………………Months

Town living in?……………………………………………………………………………………………………

Where were you born? Country……………………………………District……………………………………

Where were you raised? Country……………………………………District……………………………………

Sex (only for Gatekeeper, PLHA, NGO staff)

Are you registered as a sex worker?…..........yes…..........no (only SW)

Specifically for NGO staff

Name NGO:………

Number of staff:………………………………………………………………………………………………………

Objective of the NGO:…………………………………………………………………………………………………

………

Type of respondent: ……………………………………1. Director……………………………………2. Field worker

Working length at NGO:…………………………………………………………………………………………………

Length time on HIV/AIDS topic:…………………………………………………………………………………………

Nationality:………

Socio-economic background (All except NGO staff)

(ALL) Do you know ho to read a newspaper:…………1. yes…………2. no

(ALL) Do you know how to write a letter……….......….1. yes…………2. no

(ALL) What is the highest level of schooling that you completed?

……………………………………………………………..……1. none
2. primary
3. secondary low
4. secondary high
5. University
6. No answer

(MSM, PLHA) What is your current occupation?………………………...............……..............……............………...........……

……………………………………………………………………………...........……….............………...........………................

(SW) Thinking about the last months, what has been your average daily individual income from your work in the sex industry?

……

(SW) How much you get paid per client on average? ……………………………………………………………………………………

(SW) How many clients do you have on average a day?…………………………………………………………………………...............…

(SW) Do you have another of income outside of sex work?

………………………………………..………….......….................................... 1.yes…........................2.no

if yes, what source……………………….. 1. steady job:……………....

2. temporary job:……........…
3. pension/aid
4. help from family and friends

(ALL) How much is your take home income a month………………………………………………………………......……………………

(ALL) Do you share a house with other people?……………...............................…….................... 1.yes………..................2.no

If yes, with whom…………………………………………................……….................……….................………...............

……………………………………………………..................………..................………..................…………………………

(ALL) Are there other members of the household for whom you take financial care?

……………………………………………………...............………... 1.yes……...............……2.no

(If yes, who are they…….....…

……..............……………….)

(ALL) Are there other members of the house hold who take financially care of you?

………1.yes……….................…2.no

(If yes, who………...…………

……

(ALL) How many children do you have?…………………………………………………………………………………….……………

(SW, PLHA, Gatekeeper) Martial status:……..……………….. 1. single
2. married/living together
3. divorced/separated
4. widowed
5. No answer

(MSM) Martial status:………………………………... 1. Single
2. Married (woman)
3. Living together (men)
4. living together (woman)
5. Boyfriend (not living together)
6. Girlfriend (not living together)
7. Divorced/separated

(MSM, PLHA) Do you currently have a regular partner?……………………...

(MSM) How many occasionally partners did you have in the last 3 months?…...

(And in the last month?……………………...…………………)

(MSM) How do you classify your sexual orientation?

1. Gay, homosexual
2. Heterosexual
3. Bisexual
4. Other……………………………..

(MSM) Do you have sex with other men for money?……….................................…................ 1.Yes……................................…2.no

(If yes, how much do you get paid per client?)…..……….

……………………..……………………………………

(SW) How long have you been involved in sex work?:

……………........……year………..…......…….months

(SW) In what kind of places do you usually work?

(Gatekeeper) What is you relation with the SW?……………….. 1. Mebon/Brothel owner
2. Nightclub owner
3. mummy/tai pan
4. other……...................................…

(Gatekeeper) How long have you been involved in working with the sex work scene?:

……………........……year………..…......…….months

(Gatekeeper) Have you been working yourself as a SW before?……......................................1.yes……...............................…2.no

(If yes, as what, where and how long……………………………………………………………………………………………..…….

……

(SW, MSM) Have you ever had a test for a HIV antibodies (an AIDS test)?……………………………………………………..……..

(If yes, when was the last time you were tested?

1. less than 1 month ago
2. less than 6 months ago
3. less than a year ago

4. less than 3 years ago
5. more than 3 years ago)

If yes, Was this testing voluntary?

If yes, Did the testing include counseling?

(SW, MSM) Do you think you will be tested (again) in the future?

(PLHA) How did you find out that you had HIV/AIDS?

(PLHA) When did you find out that you were infected? When were you tested for HIV/AIDS

(PLHA) Did you have regular test before you got infected?

(PLHA) What is the most likely way you got infected?……………...……

1. unsafe sex with partner
2. unsafe sex in profession
2. shared needles
3. blood transmission
5. don't know
6. no answer

(PLHA) How many years you know that you have an HIV infection?

……….......................................………....

In-depth Interview issues

INSTRUCTION: From here on the questions will be mainly open ended and therefore will only be taped.

Knowledge and Behaviour

I would like to begin the interview with some general questions about HIV/AIDS contamination.

SW & MSM

1. Can you give examples of high risk, low risk and no risk sexual activity's for HIV infection?
2. What do you do to prevent your self from getting infected with HIV/AIDS?
   (Do you use condom and is this prevention consistent)
3. Did you change your behaviour the last 12 months, to decrease a possible HIV/AIDS infection?
4. Are there circumstances in which you might accept higher risk activities? What are they?
5. Do you feel responsible, to promote condom use among your friends
6. How do your friends and other SW/MSM think about condom use?
7. How has the existence of the disease HIV/AIDS in Cambodia affected your life? How has it affected those who are close to you?
8. Do you know anybody who has HIV and how has it affected him or her?

PLHA

1. Can you give examples of high risk, low risk and no risk sexual activity's for HIV infection?
2. Can you tell me if you in the past, before you got infected, knew about high risk behaviours towards HIV infection?
3. In the past did you took any precautions not to get infected by HIV/AIDS?
4. When you found out that you were infected did you took any precautions not to infect other people? (and is this behaviour consistent?)
5. How has HIV affected your life? How has it affected those who are close to you?

Gatekeeper

1. Can you give examples of people who got HIV infected?
2. Can you tell me something about what kind of precautions this brothel/club takes, to prevent SW from becoming infected with HIV/AIDS?
3. Did this change over the last year?
4. Do SW in this brothel/club get regular STD/HIV checks?
5. Who organises and pays for these checks?
6. What happens with the results?
7. Do the tests include counseling?
8. What should be changed in the sex industry to make it a safer place to work?

NGO Staff

1. What kind of methods are used in this district (and by this NGO) to provide knowledge to sex workers, MSM and PLHA on HIV/AIDS?
2. Are there other techniques, beside providing information, to motivated key populations to have safe sex?
3. What kind of interventions concerning HIV/AIDS are working well and what of interventions are not working that good?
4. Can you tell me something about the availability and quality of condoms in the area?
5. What would be the best way the decrease the amount of HIV infections in this area?

Exposure to intervention

SW, MSM & PLHA

1. Do you know any NGO or group working in this district that does work related to HIV/AIDS or sex workers?
2. Can you tell me what these organisations are exactly doing?
3. Have you personally been in contact with any organisation (or individuals from an organisation) providing information or services related to HIV/AIDS prevention?
   (if yes, which organisation, what are their functions, and how was the contact?)
4. What did that contact involve?
5. Are you aware of any organisation or groups that have been set up specifically for SW/MSM/PLHA?
   (If yes, which ones and what is their function?)
6. Have you been involved in any of these groups are organisations?
   (How long and for what reason)
7. Can you tell me if you know the following NGO. If you do know them can you explain me what kind of service they provide?

For Battambang read: CWD, CDA, AS
For Siem Riep read: MHC
For Sihanoukville read: KWCD

Gatekeepers

First I would like to ask your opinion about several organisations and NGO working in this district.

1. Do you know any NGO or group working in this district that does work related to HIV/AIDS or sex workers?
2. Can you tell me what these organisations are exactly doing?
3. Have you personally been in contact with any organisation providing information or services related to HIV/AIDS prevention? (if yes, which organisation, what are their functions, and how was the contact?)
4. Are you aware of any organisation or groups that have been set up specifically for sex workers? (If yes, which ones and what is there function?)
5. Have you been in contact in any of these groups or organisations? (For how long and for what reason)
6. Do you know the following NGO's? (list NGO with FPP approach in the area see above)

NGO Staff

1. Can you tell me something about the service this NGO provides?
2. Did the service the NGO is providing changed over the last year? (What changed, how it was before how it is now, and what is the difference)
3. Can you give an indication if this change was positive or negative? (why, ask for reasons)
4. Have you heard of the FPP approach? (If yes, ask if they are using this approach. If no give explanation, and ask if using this approach)
5. Did staff members attend training or workshop? (if yes, what training and how long, how many staff members, if no, why not)

Effectiveness of site level approach, awareness of NGO scene, participation

Gatekeepers

1. Would you like to participate more actively in the activities that NGO working on HIV or Sex workers conduct in the future? (why?)
2. Whenever decisions in the HIV/AIDS area are made, do you (or other gatekeepers) have any involvement? (if yes, what kind, if no, do you know how it possible to become more involved?)

Next I would like to ask some questions about the relation between certain people involved in the sex scene.

3. Can you tell me something about the relation between brothel owners and other gatekeepers and the NGO in the district. In general, how is the relationship between gatekeepers and NGO's?
4. And in general how is the relationship among brothel owners and other gatekeepers?
5. Can you tell me about the relation you have with sex workers?
    - Do you have any authority about the sex workers?
    - Do you see the sex workers as your friends?
    - Do you still have contacts with sex workers who don't work in your place anymore?
    - Do sex workers come to you for help, when they have problem?
    - With what kind of problems they come to you?
6. How is the relation between you and police?
7. Did this relationship change in the last year?

Use of service

SW, MSM, PLHA

1. How and from who did you get to learn about the above mentioned NGO's and organisations?

2. Do you know how you could get in closer contact with these organisations?

NGO Staff

During the next section I would like to find out who uses your services.

1. Can you give us an indication how many and which people you reach with your NGO? Direct, direct or trough other ways. (how many SW, how many MSM, IDU, PLHA etc)
2. How is the service of the NGO delivered? (Trough one on one help and advice, through media, trough training, financial support)
3. Can you tell me how you get in contact with Key populations?
   (does the NGO approach them, does the key population come to NGO? How does the key population know about the service of the NGO)
4. Does the NGO provides standard help or does the NGO gives different kind of help?
   (for example does a NGO, which test people on HIV, also look for different job if the SW would as for it)

Quality of service

SW & MSM

1. Do you have access to the NGO, and other organisation in the neighborhood?
2. Can you tell me something about the quality of these services (probe: Friendly, Technical expertise, attitude towards PLHA, Involvement, Follow up , Affordable)
3. Would you go back to the listed NGO's? Or would you recommend to others?
4. What would you like to see different in the NGO's you just rated?
5. Can you tell me something on the (non) availability and quality of condoms in the area? (Where, why, expense)
6. Can you tell me something about the availability and quality on other products like lubricants, which are used before, during or after sexual intercourse?
7. Can you tell me something about the information that is available on HIV/AIDS?
   (Quality, the amount, relevant, easily understood, timing)
8. Can you tell me something about places where you can get STI checks and treatment?

PLHA

I would like to know what you think about the services the different NGO's, working on HIV and related topics, provide.

1-5 same as above

1. Can you tell me something about the information that is available on HIV/AIDS?
   (Quality, the amount, relevant, easily understood, timing)
2. Can you tell me something about places where you can get STI checks and treatment
3. Do you have access to lab testing of the viral load? If yes, can you tell something about this?
4. Do you any access to clinical care? If yes, can you tell something about this?
5. Do you have any access to ARV or OI diagnoses and treatment? If yes, can you tell me something about this?

Gatekeepers

1. I would like to know what you think about the services the different NGO's, working on HIV and SW topics, provide.
   (Probe about: Friendly, approachable, good, affordable, involvement, timing, caring, access, confidential, quality)
2. What would you like to see different in the NGO's, so you would become more involved with them?
3. Can you tell me something on the (non) availability and quality of condoms in the area? (Where, why, expense)
4. Can you tell me something about the availability and quality on other products like, lubricants, which are used before, during or after sexual intercourse?
5. Do you promote SW to use condoms? Do you provide condoms to the SW?

6. Can you tell me something about the information that is available on HIV/AIDS in this district? (Quality, the amount, relevant, easily understood, timing)
7. Do you provide information on HIV/AIDS to sex workers?

NGO Staff

Next I would like to talk about the quality of the services NGO's in this district provides.

1. Can you tell me what is different between your NGO and other NGO in the district?
   (ask for reason, and difference between other NGO)
2. How would you describe the quality of the NGO's in this district working on HIV topics?
3. Can you tell me, what you think should be improved in the NGO's working on HIV/AIDS in this district?
4. If money wasn't the question, what would you change in your NGO?
5. Can you tell me something how the staff in this NGO gets trained?

Active participation of KP

SW, MSM & PLHA

1. Have you ever contributed in any way to assist an NGO, other group or activity concerning SW or HIV issues?
   (If yes, can you tell me in what way this contribution took place when did this contribution took place and how long)
2. Would you like to participate more actively in the actively in NGO activities dealing with HIV (or SW/MSM) issues in the future? (If yes, how and why?)
3. Have you integrated any of your friends or family members in any activity NGO' activity dealing with HIV (or SW/MSM) issues? (If yes, which friends or family members what do they do, where?)
4. Whenever decisions in the HIV/AIDS area have been made, have you ever been you consulted?
   (if yes, what kind of advice you give, and do you feel that your opinions have been taken into consideration.)
5. Can you tell me how sex workers can become more involved in policy making and decision-making process related to HIV (or SW/MSM) issues?

NGO Staff

During the next section I would like to find out if the key population for who the NGO is set up is participating in the program, and in what way they are involved.

1. Can you tell me who the people are who work in this NGO? And what there jobs (welfare workers, volunteers, doctors, locals, barangs, key population.
2. Can you tell me if and how the Key population is involved in this NGO?
3. Can you tell me if the meetings in this NGO are open to attend?
4. Does the NGO work with (in)formal key population activity groups?
5. Can you tell me what the involvement of the key population is in other committees advisory groups in the area?
6. Can you tell me how decisions are made in this NGO?
   (how big is the involvement of Key population? How is the actual decision made, by veto, does key population only give information, are they consulted, joint decision?)
7. Can you think of a way, how the key population can be more involved in this NGO in the future?

Effectiveness of site level approach

SW, MSM, PLHA

1. Can you tell me how is the relationship between different NGO in this site? (if they work together: How do they work together)

2. Can you tell me something about the relationship between NGO's and government service providers, and private health care providers?
3. Can you tell me something about the relationships between NGO and private companies?
(Local media, bars, restaurants, business).
4. In general, how is the relationship between SW/MSM/PLHA and NGO's?
5. Can you tell me something about the opinion in politics towards SW/MSM?

SW, MSM

6. Can you tell me something about the relationship among SW/MSM, NGO's and gatekeepers, such as brothel owners, mummy's and other people involved in the sex industry..
7. In general, how is the relationship with the police and SW/MSM?
(Has this changed in the last year)

SW

8. The next relation we would like to talk about is between you and clients. Can you tell me something about the relation between SW and clients?
    - Do you see clients on a regular basis?
    - Are free to express what they want towards their clients?
    - In general, who would you say is in charge, the client or you?
    - Is there another relationship then a provider-customer role between you and clients?
    - If you are in trouble, doe a client have the ability to help?
9. Do you feel afraid for any of the above-mentioned people or institutions?
(If yes, for who and why)
10. Can you tell me how relations among people and institutions should be changed to make the sex industry a safer place to work?

Gatekeepers

Next I would like to ask some questions about the relation between certain people involved in the sex scene.

1. Can you tell me something about the relation between brothel owners and other gatekeepers and the NGO in the district. In general, how is the relationship between gatekeepers and NGO's?
2. And in general how is the relationship among brothel owners and other gatekeepers?
3. Can you tell me about the relation you have with sex workers?
    - Do you have any authority about the sex workers?
    - Do you see the sex workers as your friends?
    - Do you still have contacts with sex workers who don't work in your place anymore?
    - Do sex workers come to you for help, when they have problem?
    - With what kind of problems they come to you?
4. How is the relation between you and police?
5. Did this relationship changed in the last year?

Social capital

In the next section I would like to discuss community involvement and trust. I would like to know how the social environment and community could help support positive behaviour, like trust, reciprocal help and solidarity. Therefore I would like to know about the connection of the SW/MSM/PLHA with the rest of the community.

SW, MSM, & PLHA

1. Can you tell me if there are places where SW/MSM/PLHA come regularly together…
   - for socialising?
   - for sexual purposes?
   - for other activities?

   (If yes, what kind of places are that, what are these places for? do you feel safe, do other people know about them)

2. If you were allowed to build a place for SW/MSM/PLHA to come together what kind of place would this be? Can you tell me something about that?
3. Can you tell me something about mutual support, solidarity and concurrence in the sex scene/among gay people and MSM/PLHA? (If yes, How do you support each other?)
4. Who are your most close friends and where do you know them from? Are some of them also sex workers/MSM/PLHA?
5. Do you know a lot of people in the area around your working place? (not PLHA)
6. Can you tell me where you go, when you have problems? (Do you go to different places for different problems? What are important people to know if you are in trouble?)
7. When other SW/MSM/PLHA have problems, do they sometimes come to you for help? (If yes, With what kind of problems do they come to you, how do you respond, how much time do you spend by helping)
8. Do you feel part of your neighborhood community? (If yes, what makes you feel part of this community (If no, why not? How would you feel more part of this community)
9. What about the SW/MSM community? (same as 48, not PLHA)
10. Do you like to live in this place? (if yes, For what reason If no, why not, and what should change that you would like living here)
11. To how many formal or informal groups do you belong? (What do these groups and what role do you play in this group. Explain that a group can be a family, friends, work, religion, sports club etc)
12. Did you undertake individual political activities (or group activities), like signing a petition, writing to the newspaper, contacted a local consular, attended a council meeting?
13. Can you tell me something on the amount of influences the SW/MSM/PLHA group has in this community. (in NGO's, police, government)
14. Are there situations/ places/people which you rather avoid because you are scared of them?
15. Can you out in order, what things you fear most:
    - no work
    - no home
    - poor health
    - no friends
    - not liking yourself?
16. Do you own official documents such as I.D. card working paper, voting card, social security and birth certificate?

NGO Staff

In the next section I would like to discuss social capital. I would like to know how the social environment and community can help support positive behaviour, like trust, reciprocal help and solidarity. Therefore I would like to know about the connection of the key population with the rest of the community.

1. Can you tell me how sex workers are connected to the rest of the community?
2. And how is the relation between sex workers?
3. Can you tell me how PLHA are connected to the rest of the community?
4. And how is the relation between PLHA?
5. .And can you also tell me how the last key group, the MSM are connected to the rest of the community.
6. And how is the relation among MSM?

Self-efficacy/control of external events/self esteem

In the next section, I am going to ask some question about the way you see yourself and about your feelings and emotions.

SW, MSM, PLHA

1. If a crisis would occur in your live how capable would you be of dealing with it?
2. How confident are you about your ability to handle personal problems?
   (How do you see that you have/have not confidence)
3. Are there situations, which you rather avoid, because you find them difficult to handle?
4. In what way and what kind of factors would increase or decrease you self-confidence?
5. Do you have friends (or family) with whom you feel you can discuss very intimate problems
6. Can you tell me something about the amount of control you have over your own life, to do the things you want to do?
   (what kind of decision can you make by yourself? What kind of decision have to be discussed with other?
   Which other people have control over your live?
7. What factors would increase or decrease this perceived control?
8. Do you think you have any control over your own health?
   (For example: Do you think you can prevent illness if you take care or do you think HIV protection helps)
9. Are you able to refuse a client, when he doesn't want to use a condom?
   (Can you explain to me how this works and what the consequences are?) (not PLHA)
10. Are you able to refuse a customer for personal reason?
    (Can you explain me how this works and what the consequences are?) (not PLHA)
11. Can you tell me how satisfied you are with your life?

Stigma/discrimination & violence

The next section I would like to know about stigmatisation, discrimination and violence towards SW.

SW, MSM, PLHA

1. There are different levels of stigmatisation and discrimination. I will read out loud different levels, can you tell me for each level if you ever have experienced it?
   - ◻ Harassment
   - ◻ Isolation
   - ◻ Restrictions
   - ◻ Violation of rights
   - ◻ Violence
2. Can you tell me which kind of discrimination you find the most difficult to deal with, and why?
3. Can you tell me in which kind of situation you experience discrimination/stigmatisation the most?
4. Can you give me some examples of situations you experienced discrimination/stigmatisation?
5. What do you think and do you feel after being discriminated/stigmatised?
6. Can you tell me something about violence towards SW/MSM/PLHA?
7. What do you do whenever you experienced discrimination or violence? Where do you go?
8. Do the people in your community know, that your are working as SW/MSM/PLHA?
   (who knows and who doesn't know. If yes, how come, if no, why not. How did the people respond to whom you told?)
9. What does your community say about SW/MSM/PLHA?
10. What does your family say about SW/MSM/PLHA?

SW, MSM

1. Is there discrimination towards people living with HIV/AIDS in the SW/gay Scene? (Why do you think this?)
2. I am going to read out loud several statements. Can you for each statement indicated how much you agree with it?
   You can rate from: “I agree a lot, I agree, I don't agree, and don't disagree”, “I disagree” and the last one “I disagree a lot”

- ◻ Sero-positive woman have a right to give birth to children.
- ◻ Friends who become infected remain my friends.
- ◻ I wouldn't share a meal with a person who has AIDS.
- ◻ People who have HIV should live in a separate community.
- ◻ Homosexuality is the cause of AIDS.
- ◻ Results of the AIDS test should be made public.
- ◻ I would take care of people who are infected by HIV.
- ◻ People with HIV/AIDS are dirty.
- ◻ Allow PLHA in public places like swimming pools and restrooms.

3. Are there any beliefs about PLHA, which you want to add?
4. If you would be infected with HIV/AIDS to whom would or wouldn't you tell this?

PLHA

1. Can you tell me, if discrimination towards PLHA changed the last year?

Gatekeepers

Next I would like to ask some questions about stigmatisation, discriminations and violence towards sex workers.

1. Can you tell me something about stigmatisation/discrimination towards SW? (how often en in what kind of situations)
2. In what kind of situation does it most occur?
3. Can you tell me something about violence towards SW?
4. I what kind of situations does it most occur?
5. Does your brothel/club take any precautions towards discrimination and violence?
6. Is there discrimination towards people living with HIV/AIDS in your neighborhood? (how can you tell?)
7. What happens with the sex workers who become infected with AIDS/HIV?
8. I am going to read out loud several statements. See above…
9. Do you think people who are infected with HIV tell this to their environment?

NGO Staff

The next subject is stigmatisation, discrimination and violence towards the key population.

1. Can you tell me something about the opinions in this community towards, sex workers, MSM and PLAH?
2. Can you tell me something about the opinions of the staff members in this NGO towards sex workers, MSM and PLAH?
3. Can you tell me how these opinions show in their behaviour towards clients?
   (do they shake hands, are they treated as ill persons etc. etc.)
4. Can you tell me if the NGO workers concerned about getting infected by HIV through there work?
5. Can you tell me if NGO workers would agree if key populations would work in the NGO?
6. What is a good way to prevent stigma, discrimination and violence towards key populations?

SW, MSM & PLHA

We now arrive at the last questions:

1. What are you plans for the future?

After having had this session, do you think that there are any topics which have not been covered, but are important for people working with sex workers to know? What are these topics and why would it be important to discuss them in the future?

I would like to thank you very much for the time and effort you have put in this discussion. If they are any questions remaining or the procedures are unclear, feel free to contact us in our research center. The report of all the focus groups and in-dept interviews among all the different key populations will be published in the summer, participants who are interested in the finding can also contact us in our research center.

Annex 3
NGOs consulted in FPP sites

1/ Battambang

CVD	:	Cambodian Vision Development
CDA	:	Cambodian Development Action
AS	:	Aphivat Satrey

2/. Siem Reap

MHC	:	Men's Health Cambodia
BfD	:	Buddhism for Development
CWPD	:	Cambodian Women for Peace and Development

3/. Kampong Som (Sihanoukville)

KWCD	:	Khmer Women's Cooperation for Development

Annex 4
Field work schedule

Summary Overview

Battambang

Total Focus groups = 7

Fg 1 for MSM (1), Fg2 for MSM(2), Fg 1 for SW (2), Fg2 for SW (2)

Total Indepth interviews = 22

MSM high inv. (3), MSM low inv. (2), SW high (2), SW low inv. (2), PLHA (4), Gate keeper (3), NGO (6)

Siem Reap

Total Focus groups = 7

Fg 1 for MSM (1), Fg2 for MSM(2), Fg 1 for SW (2), Fg2 for SW (2)

Total Indepth interviews = 25

MSM high inv. (2), MSM low inv. (2), SW high (2), SW low inv. (2), PLHA (4), Gate keeper (8), NGO (5)

Sihanouk ville

Total Focus groups = 7

Fg 1 for MSM (1), Fg2 for MSM(2), Fg 1 for SW (2), Fg2 for SW (2)

Total Indepth interviews = 25

MSM high inv. (2), MSM low inv. (2), SW high (2), SW low inv. (2), PLHA (4), Gate keeper (8), NGO (3)

Notes :

- Fg1=mixed groups of high & low involvement participants, Fg2= seperate groups for high & low involvement individuals
- MSM=Men having Sex with Men, DSW=Direct Sex Worker, ISW=Indirect Sex Worker, PLHA=People Living with Hiv Aids

Detailed Overview

No	Province	Date	Focus group	Indepth	No. of participant	Name of interviewer	Location
1	Battambang	29-04-04	Fg2: ISW low inv.		6	Mealea and Kannitha	Veal Sre Mouy Roy restaurant
2	Battambang	29-04-04	Fg2: ISW high inv.		7	Mealea and Kannitha	CVD office
3	Battambang	29-04-04		CVDdirector (M= 42y)	1	Heng Kim Van	CVD office
4	Battambang	29-04-04		CVD staff (M= 27y)	1	Heng Kim Van	CVD office
5	Battambang	30-04-04	Fg1: DSW high and low		6	Mealea and Kannitha	Massage Antarak Cheat shop
6	Battambang	30-04-04	Fg1: DSW high and low		5	Sidedine and Kannitha	At hotel
7	Battambang	30-04-04		ISW high (F= 18y)	1	Mealea	Tean Samai guest house
8	Battambang	30-04-04		Gatekeeper (F= 35y)	1	Heng Kim Van	Lum or kessa shop
9	Battambang	30-04-04		Gatekeeper (F= 43y)	1	Ly Chan Piseth	Penty shop
10	Battambang	30-04-04		CDA Director (M= 38y)	1	Ly Chan Piseth	CDA office
11	Battambang	30-04-04		CDA staff (M= 32y)	1	Heng Kim Van	CDA office

No	Province	Date	Focus group	Indepth	No. of participant	Name of interviewer	Location
12	Battambang	01-05-04	Fg2: MSM low inv.		5	Kim Van and Piseth	Dankateap village
13	Battambang	01-05-04	Fg2: MSM high inv.		5	Kim Van and Piseth	Prek khporb village
14	Battambang	01-05-04	Fg1: MSM high and low		7	Kim Van and Piseth	Prek khporb village
15	Battambang	01-05-04		DSW low (F= 24y)	1	Lim Sidedine	Villa teu Mouy shop
16	Battambang	01-05-04		DSW low (F= 24y)	1	Hem Kannitha	Villa Teu Pi shop
17	Battambang	01-05-04		MSM high (M= 19y)	1	Hem Kannitha	Kako village
18	Battambang	01-05-04		MSM high (M= 42y)	1	Lim Sidedine	Prek khporb village
19	Battambang	01-05-04		MSM high (M= 22y)	1	Ke kantha Mealea	Otaki village
20	Battambang	01-05-04		MSM low (M= 19y)	1	Lim Sidedine	Kako village
21	Battambang	01-05-04		**MSM low** (M= 18y)	1	Ke Kantha Mealea	Taproch village
22	Battambang	01-05-04		DSW high (M= 20y)	1	Lim Sidedine	At hotel
23	Battambang	1-05-04		Gatekeeper (M= 32y)	1	Kim Van	At brothel
24	Battambang	01-05-04		AS director (M= 39y)	1	Kim Van	AS office
25	Battambang	03-05-04		AS staff (F= 24y)	1	Kim Van	AS office
26	Battambang	3-05-04		PLHA (F= 41y)	1	Kim Van	AS office
27	Battambang	03-05-04		PLHA (M= 48y)	1	Hem Kannitha	AS office
28	Battambang	03-05-04		PLHA (F= 28y)	1	Ke kantha Mealea	AS office
29	Battambang	3-05-04		PLHA (M= 31y)	1	Lim Sidedine	AS office
30	Siem Reap	05-05-04		PLHA (F= 32y)	1	Hem Kannitha	At home of respondent
31	Siem Reap	05-05-04		PLHA (F= 41y)	1	Kim Van	At home of respondent
32	Siem Reap	05-05-04		PLHA (F= 33y)	1	Ke kantha Mealea	At home of respondent
33	Siem Reap	05-05-04		BFD staff (F= 43y)	1	Lim Sidedine	BFD office
34	Siem Reap	05-05-04		BFD director (M)	1	Saly	BFD office
35	Siem Reap	06-05-04		MSM high (M= 24y)	1	Ke kantha Mealea	At hotel
36	Siem Reap	06-05-04		MSM low (M= 22y)	1	Hem Kannitha	At hotel
37	Siem Reap	06-05-04		ISW high (F=27y)	1	Ke kantha Mealea	At hotel
38	Siem Reap	06-05-04		ISW low (F= 25y)	1	Lim Sidedine	At hotel
39	Siem Reap	06-05-04		MHC staff (M= 45y)	1	Lim Sidedine	MHC office
40	Siem Reap	06-05-04	Fg2: ISW low inv.		5	Mealea and Kannitha	At hotel
41	Siem Reap	06-05-04	Fg2: ISW high inv.		7	Sidedine and Kannitha	At hotel
42	Siem Reap	06-05-04	Fg2: MSM high inv.		6	Kim Van and Piseth	At hotel
43	Siem Reap	06-05-04	Fg2: MSM low inv.		8	Kim Van and Piseth	At hotel
44	Siem Reap	07-05-04	Fg1: MSM high and low		6	Kim Van and Piseth	At hotel
45	Siem Reap	07-05-04	Fg1:SW low and high		7	Mealea and Kannitha	At hotel
46	Siem Reap	07-05-04	Fg1: DSW high and low		7	Mealea and Kannitha	At hotel
47	Siem Reap	07-05-04		PLHA (F= 32y)	1	Piseth	At home of respondent

No	Province	Date	Focus group	Indepth	No. of participant	Name of interviewer	Location
48	Siem Reap	07-05-04		DSW high (F=29y)	1	Sidedine	At hotel
49	Siem Reap	07-05-04		DSW low (F=27y)	1	Sidedine	At hotel
50	Siem Reap	07-05-04		Gatekeeper (F=51y)	1	Piseth	At brothel
51	Siem Reap	07-05-04		Gatekeeper (F=57y)	1	Piseth	Banlong guest house
52	Siem Reap	08-05-04		MSM high (M=21y)	1	Kannitha	At hotel
53	Siem Reap	08-05-04		MSM low (M=25y)	1	Mealea	At home of respondent
54	Siem Reap	08-05-04		Gatekeeper (F=46y)	1	Mealea	At brothel
55	Siem Reap	08-05-04		Gatekeeper (F=49y)	1	Piseth	At brothel
56	Siem Reap	08-05-04		Gatekeeper (M=37y)	1	Kim Van	At brothel
57	Siem Reap	08-05-04		Gatekeeper (F=27y)	1	Kim Van	At brothel
58	Siem Reap	08-05-04		Gatekeeper (F=48y)	1	Kannitha	At brothel
59	Siem Reap	08-05-04		Gatekeeper (M=26y)	1	Piseth	Tokyo Massage
60	Siem Reap	08-05-04		CARITAS staff (M=25y)	1	Sidedine	CARITAS Office
61	Sihanouk ville	17-05-04		PLHA (F=25y)	1	Kannitha	KWCD office
62	Sihanouk ville	17-05-04		PLHA (M=22y)	1	Piseth	KWCD office
63	Sihanouk ville	17-05-04		PLHA (F=35y)	1	Mealea	Guest house
64	Sihanouk ville	17-05-04		KWCD director (M=33y)	1	Kim Van	KWCD office
65	Sihanouk ville	17-05-04		KWCD staff (M=33y)	1	Sidedine	KWCD office
66	Sihanouk ville	18-05-04		ISW high (F=23y)	1	Mealea	KWCD office
67	Sihanouk ville	18-05-04		ISW low (F=26y)	1	Sidedine	KWCD office
68	Sihanouk ville	18-05-04	Fg2: ISW low inv.		8	Mealea and Kannitha	KWCD office
69	Sihanouk ville	18-05-04	Fg2: ISW high inv.		7	Sidedine and Kannitha	KWCD office
70	Sihanouk ville	18-05-04	Fg2: MSM high inv.		8	Kim Van and Piseth	KWCD office
71	Sihanouk ville	18-05-04	Fg2: MSM low inv.		7	Kim Van and Piseth	KWCD office
72	Sihanouk ville	19-05-04	Fg1: MSM high and low		6	Kim Van and Piseth	KWCD office
73	Sihanouk ville	19-05-04	Fg1: DSW high and low		8	Sidedine and Kannitha	KWCD office
74	Sihanouk ville	19-05-04	Fg1: DSW high and low		7	Mealea and Kannitha	KWCD office
75	Sihanouk ville	19-05-04		MSM high (M=19y)	1	Kim Van	KWCD office
76	Sihanouk ville	19-05-04		MSM low (M=28y)	1	Piseth	KWCD office
77	Sihanouk ville	19-05-04		DSW high (F=21y)	1	Sidedine	KWCD office
78	Sihanouk ville	19-05-04		DSW low (F=25y)	1	Mealea	KWCD office
79	Sihanouk ville	20-05-04		MSM high (M=19y)	1	Kim Van	KWCD office
80	Sihanouk ville	20-05-04		MSM low (M=24y)	1	Piseth	KWCD office
81	Sihanouk ville	20-05-04		Gatekeeper (F=29y)	1	Kannitha	At brothel
82	Sihanouk ville	20-05-04		Gatekeeper (F=44y)	1	Mealea	At brothel
83	Sihanouk ville	20-05-04		Gatekeeper (F=35y)	1	Piseth	At brothel

No	Province	Date	Focus group	Indepth	No. of participant	Name of interviewer	Location
84	Sihanouk ville	20-05-04		Gatekeeper (M=41y)	1	Kannitha	Massage Kolab shop
85	Sihanouk ville	20-05-04		Gatekeeper (F=28y)	1	Mealea	Cobra guest house
86	Sihanouk ville	20-05-04		Gatekeeper (F=33y)	1	Sidedine	At brothel
87	Sihanouk ville	20-05-04		Gatekeeper (F=55y)	1	Kim Van	At brothel
88	Sihanouk ville	20-05-04		PLHA (M=31y)	1	Sidedine	At home of respondent
89	Sihanouk ville	21-05-04		Gatekeeper (F=42y)	1	Sidedine	At home of respondent
90	Sihanouk ville	21-05-04		KWCD staff (M=47y)	1	Mealea	KWCD office
91	Sihanouk ville	28-05-04		MHC direct. (M=29y)	1	Sidedine	Phnom Penh

Notes

- F= Female, M=male
- Fg1= Mixed groups of high & low involvement participants, Fg2= Seperate groups for high & low involvement individuals
- MSM=Men having Sex with Men, DSW=Direct Sex Worker, ISW=Indirect Sex Worker, PLHA= People Living with HIV/AIDS

Annex 5
Transcription and translation

All tapes have been fully transcribed. Most have been fully translated into English but for a limited number of interviews the analyses has been done in Khmer and only the excerpts that proved relevant within the analytic framework have been translated.

Focus Group Discussion Transcripts of which only framework relevant excerpts have been translated

Siem Riep

41, 46

Kampong Som

72

Indepth Interview Transcripts of which only framework relevant excerpts have been translated

Battambang

8, 9, 16, 19, 20, 21, 23, 28, 29

Siem Reap

33, 38, 39, 52, 53, 57, 58, 59, 60, 91

Kampong Som

63, 66, 77, 78, 86, 87, 88, 89

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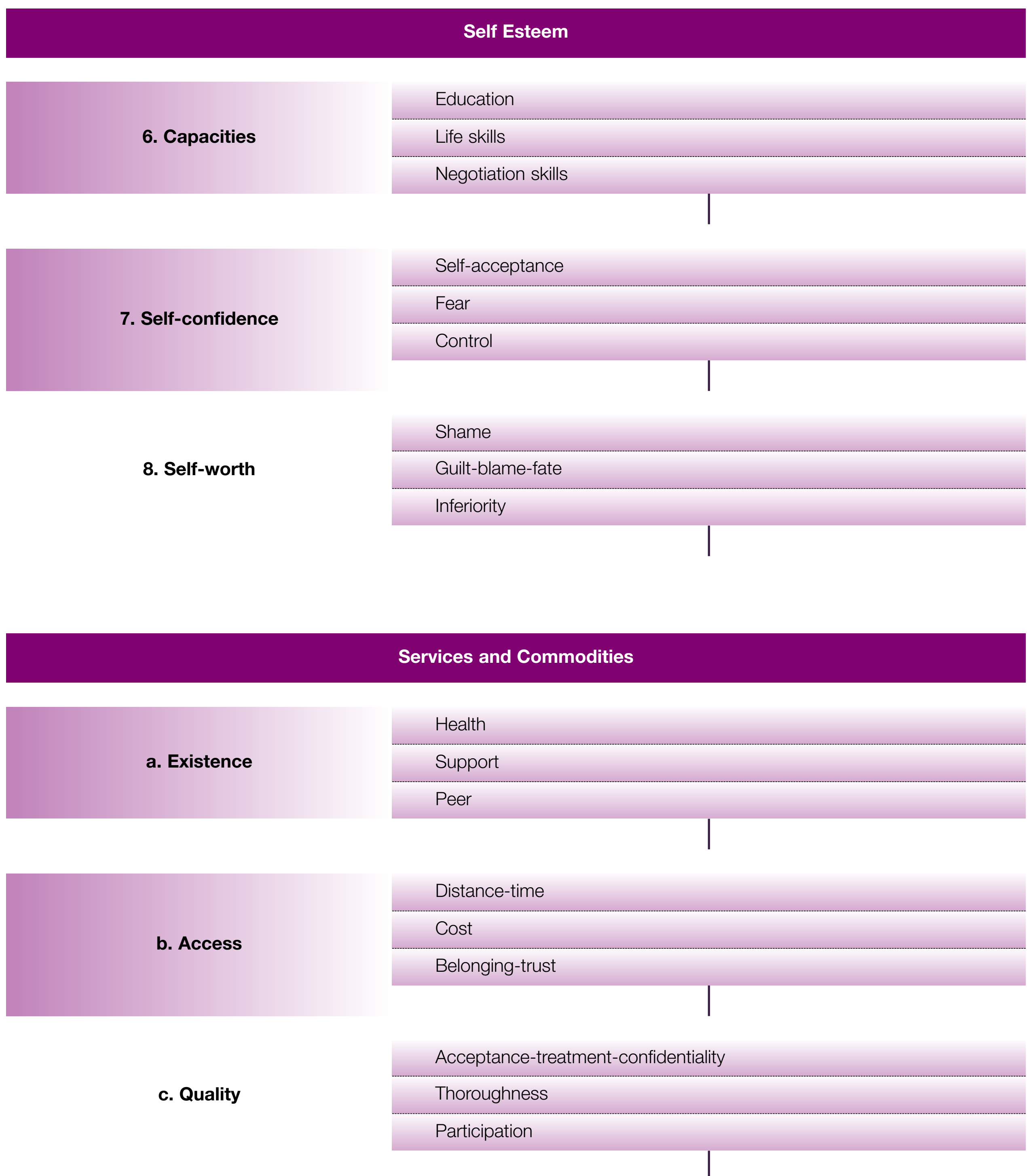
Annex 6

Initial Analysis Framework and notes on using the analysis sheets

6.1 Initial Analysis Framework

Social Capital	
Involvement	NGOs/associations/affiliations
	Peer
	Influences of participation
Trust - confidence	Confide/confident
	Solidarity
	Social-community-environment trust
Influence	Voice
	Decision-making (political)
	Community sense of belonging

Stigma and Discrimination	
1. Internal	Openness
	Isolation
	Denial
2. Stigma	Language
	Association
	Rejection
3. Discrimination	Rights
	Social-legal framework
	Experience


Self Esteem
6. Capacities
Education
Life skills
Negotiation skills
7. Self-confidence
Self-acceptance
Fear
Control
8. Self-worth
Shame
Guilt-blame-fate
Inferiority
Services and Commodities
a. Existence
Health
Support
Peer
b. Access
Distance-time
Cost
Belonging-trust
c. Quality
Acceptance-treatment-confidentiality
Thoroughness
Participation

Knowledge, Attitudes and Behaviour	
a. Knowledge	Transmission-prevention
	Treatment-services
	Sources/influences
b. Attitudes	Other KPs , PLHA
	Love, sex, condoms
	Influences
c. Behaviour	Condom use
	Partners
	Influences

Demographics	
Demographics	Age
	Education
	Identity
Experience (high/low)	NGO experience
	Peer experience
	HIV experience
Other	Partner
	Family - dependents

6.2 Notes on using the analysis sheets.

R = respondent (interviewee)

These analysis sheets should help you to gather the relevant data from the interview transcriptions. (NB It is not a full explanation of all terms used in the analysis framework, but was the result of testing the framework over a two day workshop in Cambodia 30/31 August with some of the analysts.)

You need to include in each answer:

a) A summary of the data from the interview sheets and

b) Quotes if they are relevant. All quotes should have quote marks "" around them and be referenced to the page of the interview where they occur.

Demographics (page 1)

Complete this section briefly.

Social capital (page 2)

This section shows how R is involved with organisations or other groups in society, what trust or confidence R has in them, and in others, and any influence R has within the organisations or groups.

Involvement: Which organisations or groups is R part of, or involved with, and what influences R's choices - a) to participate or not, and the level of participation and b) which groups to be involved with?

Trust/confidence: Who does R confide in - if things go wrong, who does R talk to, for example. Who is R confident with? This can include groups or individuals.

Influence: Voice - is R listened to when stating an opinion? Is R consulted if group decisions are being made?
Community sense of belonging: does R feel part of a particular group(s) or organisation? Which one/s?

Stigma and discrimination (page 5)

This section looks at how R feels about themselves based on how they think society judges them, plus their knowledge and experience of discrimination.

Internal:
Openness: is R happy to talk about their work, or that others know about their job/activities?

Isolation and Denial: Do they feel isolated from any person or group, e.g. family, homeland, friends. Do they deny there are any problems with their work/activities?

Stigma:
Association: is R blamed through their associations e.g. with other sex workers or brothel owner?

Discrimination:

Rights: do they know their rights/responsibilities?
Social/legal framework: Describe how R sees this.
Experience: what happens in reality? Give instances of discrimination (or not). Who discriminates? Who does not?

Self Esteem (page 7)

This section looks at the skills each R has, and how confident they are. It also looks at how each R feels about themselves in terms of negative feelings of guilt and inferiority.

Capacities: Education - give more details than in the Demographics section.

Life skills: for example, ability to work/look after small children, ability to budget financially, having several jobs at the same time, help others in the community.

Self-confidence: Self-acceptance: Does R accept themselves as they are? Are they reasonable about their assessment of their strengths/weaknesses?

Fear: what or who are they afraid of? Does R use fear themselves? When and how?

Control: Does R feel in control of their life? Do they make decisions for them? Are these major or minor decisions?
Is R confident about the future?

Self-worth:
Guilt-blame-fate: Do others blame R? Does R think their current position is fate? Do they think it is kamma?

Services (page 9)

This section looks at the services available to the KPs, whether Rs are aware of these, whether access is difficult, and if so, what the barriers are, and how those accessing services view the quality of the services.

Access:
Belonging/trust: Does R trust the service provider? Do they have a sense of belonging when they access services on a regular basis?

Quality: Thoroughness: are all courses completed? E.g. training courses, medicine/check ups. What happens if any are interrupted?

Participation: does R feel part of the service, and not just a recipient? Is R consulted with as part of the service? Are R's views listened to?

Knowledge, Attitudes and Behaviour (page 12)

This section looks at what the R knows about HIV/AIDS, where they get their information, what they think of issues around the disease, and what they actually do. Each part of the section looks at what influences their decisions.

Knowledge:
Sources/influences: where do they get their information? Who do they listen to? Who/what do they trust to give them good information?

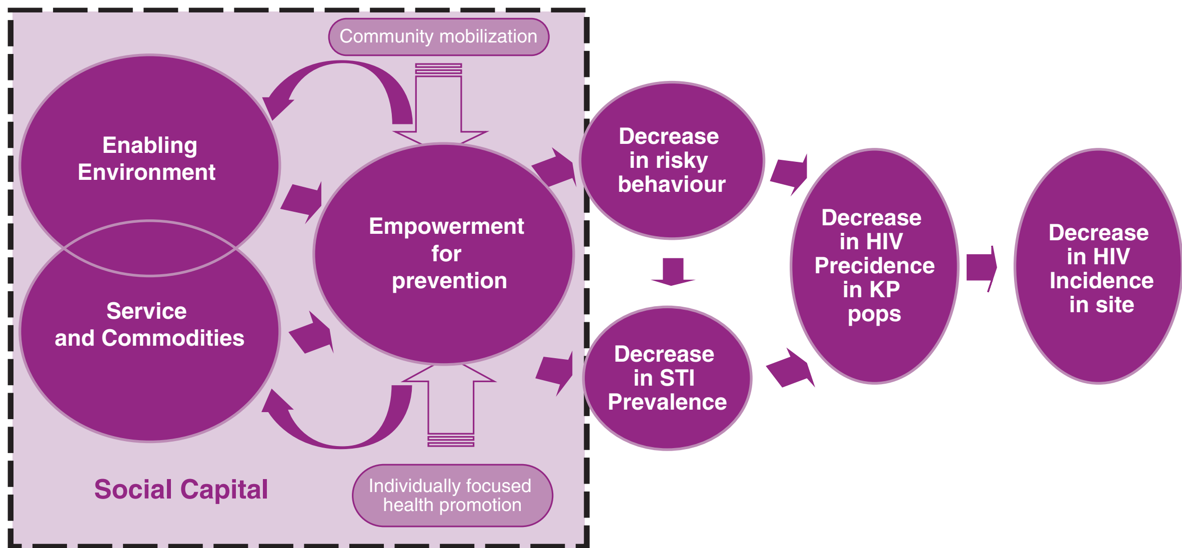
Attitudes:
Other KPs, PLHA: what do they think of the other groups in this survey? What do they think about people with HIV/AIDS?

Influences:
How did R reach these opinions? Who/what did they listen to? Was there a particular event which changed their opinion?

Behaviour:
Partners: this includes all sexual partners, not just sweethearts.

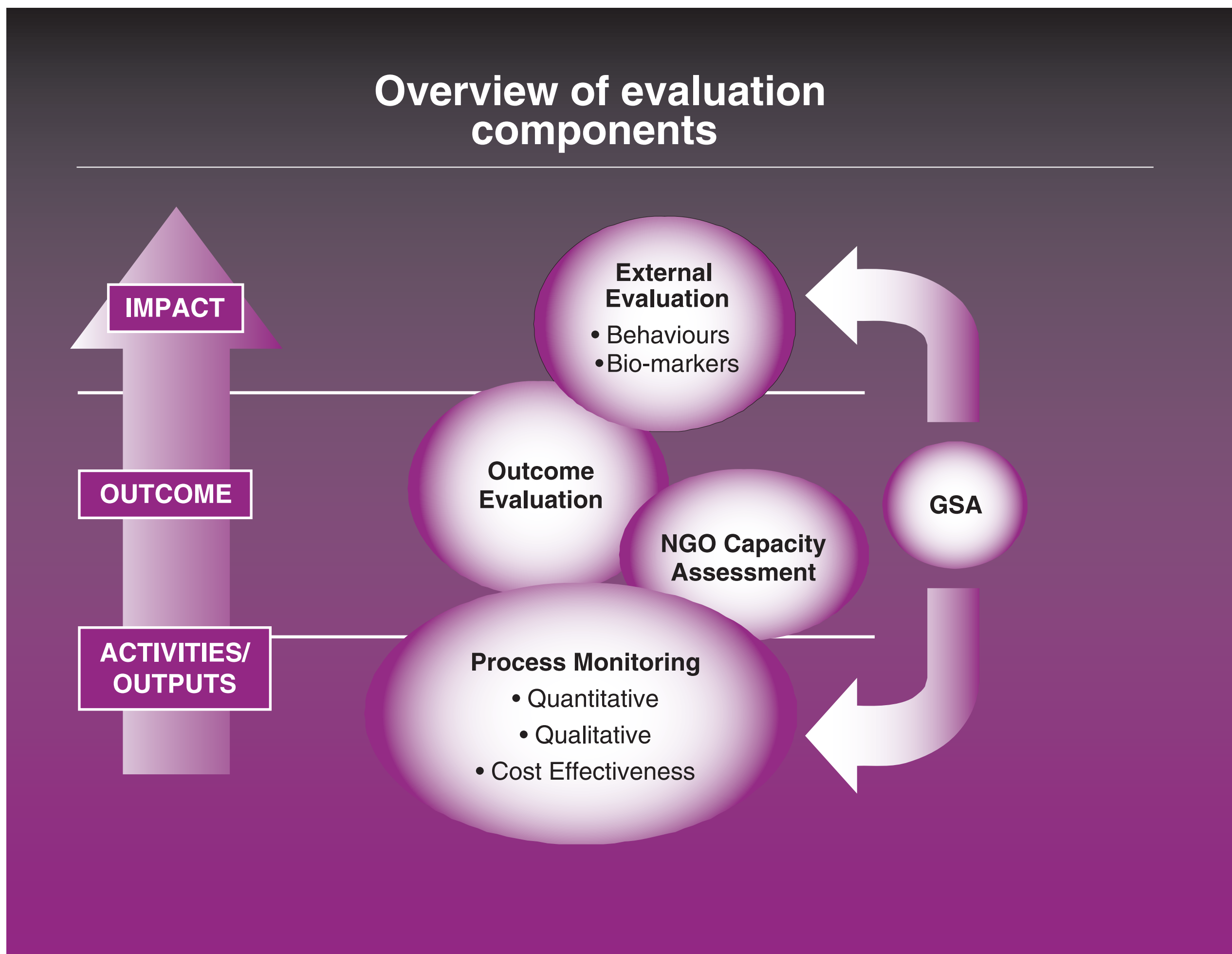
Annex 7
Theoretical framework for FPP

Theoretical framework for FPP



Annex 8

Overview of FPP Evaluation Framework



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