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NATIONAL AIDS AUTHORITY

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NATIONAL REVIEW OF FAITH-BASED RESPONSES TO HIV IN CAMBODIA

A joint initiative of the National AIDS Authority and the Ministry of Cult and Religion

Technical and financial support
provided by UNICEF

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Jo Kaybryn and Katherine Moriarty

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Contents

Foreword

Across Cambodia, faith-based organisations are an important part of the national response to HIV and AIDS. This publication highlights the significant role that faith-based actors have in the social and economic development of children, women and families.

This review provided a unique opportunity to document Buddhist, Christian, Muslim and inter-faith initiatives providing varied and wide ranging responses to HIV. Together they mobilise volunteers, and implement innovative HIV prevention, treatment, care and support, and impact mitigation interventions inclusively to all community members. Far from shying away from complex and sensitive issues, nearly half of the participating faith-based organisations work with key affected populations, and over two-thirds provide sexuality and family planning education.

The commitment of faith-based organisations to meeting the wider social and economic needs of Cambodians affected by HIV is clear. They support children to access education, provide nutritional support and vocational training, and implement income generation activities, all of which help to re-establish financially stricken families. Notably, selected faith based organization have demonstrated important work in supporting family and community based social protection initiatives which ensure that vulnerable children are cared for by their families, rather than promoting institutional care which has adverse effects for children.

Despite their successes, faith-based organisations remain acutely aware that HIV-related stigma and discrimination continues to seriously hamper their and others' efforts to respond effectively to people affected by HIV. Their approaches to tackle stigma capitalise on the unique role that faith leaders have in reaching out to communities, and three quarters of organizations reviewed promoted the meaningful involvement of people living with HIV in their responses. Faith-based initiatives demonstrate the profound impact that faith leaders and people living with HIV can have.

There is a need for greater collaboration and information sharing at sub-national and national levels between faith-based and secular initiatives, and this review is an important step towards recognising, documenting and connecting with faith-based organisations in Cambodia. We admire their commitment, their diligence and their achievements.

The Ministry of Cult and Religion extends its appreciation to the researchers, Jo Kaybryn and Katherine Moriarty, and to the National AIDS Authority and UNICEF Cambodia for their support in conducting the review.

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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
CHO	Cambodian Hope Organisation
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
MoCR	Ministry of Cult and Religion
MoH	Ministry of Health
MoSAVY	Ministry of Social Affairs, Veteran's and Youth Rehabilitation
NAA	National AIDS Authority
NGO	Non-government organisation
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PAS	Provincial AIDS Secretariats
PDCR	Provincial Departments of Cult and Religion
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
STI	Sexually transmitted infection
UNICEF	United Nations Children's Fund
VCCT	Voluntary Confidential Counselling and Testing

Executive Summary

Introduction

In Cambodia, there are a wide variety of faith-based initiatives and actors responding to protecting children and vulnerable families from HIV and to caring for those who are living with HIV in one form or another. These include a government led initiatives, a multitude of faith influenced NGOs, secular NGOs and international organizations. In spite of the myriad of activities by different organizations and actors, systematic and up to date information across the various faiths and religions is not easily available in the country. Little is known about which good practices may be in place and could potentially be scaled up. This includes information on whether faith-based initiatives are reaching population groups which are hard to reach and marginalized.

The National AIDS Authority and the Ministry of Cult and Religion, in partnership with the United Nations Children's Fund, implemented a national review of faith-based responses to HIV in Cambodia between April and August 2011. The review aimed to ascertain the contributions of faith-based actors to the national HIV response, to identify good practices and inform national and sub-national coordination, planning and programming efforts to advance equitable approaches to protect vulnerable families and children.

Cambodia is one of the few countries in the region where the Ministry of Cult and Religion introduced the Policy on Religious Response to the HIV/AIDS Epidemic in Cambodia in 2002 in order to support and encourage faith-based responses. In close collaboration with the National AIDS Authority, the Ministry of Cult and Religion established the National Faith-Based Technical Working Group in 2004 to support the implementation of the policy and oversee faith-related HIV initiatives. The review of faith-based responses was one of the technical working group's priorities.

The profile of HIV in Cambodia has changed dramatically in recent years. National HIV prevalence has declined to an estimated 0.8% in 2010, down from a high of 2.4% in 1998 (1). More than 75,000 people are currently living with HIV in Cambodia, while more than 60,000 households are directly affected by the disease (2). As HIV prevalence has declined among the general population, it has become increasingly concentrated among key affected populations, with comparatively high HIV prevalence reported among people who inject drugs, female sex workers, men who have sex with men, and transgender persons. By end of 2010, there were an estimated 85,921 orphans and vulnerable children due to HIV.

Faith in Cambodia

Theravada Buddhism is the official religion of Cambodia, with more than 95% of the population identifying as Buddhist. Religious freedom is guaranteed by the constitution. Just over 3 % of the population identify as Muslim, while less than 1% identify as Christian. Indigenous faiths are still practiced by indigenous peoples throughout Cambodia, particularly in the northeastern provinces of Ratanakiri and Mondulkiri.

It is impossible to reflect on HIV and faith in Cambodia without reference to the significant impact of the Khmer Rouge era. When the Communist Party of Kampuchea (the Khmer Rouge) came to power in 1975, senior monks were killed, pagodas were destroyed and the practice of religion was made punishable by death. By the time the Khmer Rouge fell in 1979, an estimated 65% of Buddhist monks had been killed or died from starvation or overwork in forced labour camps. Exact figures are not known but between 100,000 and 500,000 Muslim people of Cham descent were also killed (out of a population of 700,000). With many senior monks gone and pagodas and religious texts destroyed, the Khmer Rouge era created a discontinuity in Cambodia's Buddhist practices.

Methodology

The review had four objectives:

1. **to identify the number and type of faith-based initiatives responding to HIV in Cambodia;**
2. **determine the coverage of this work;**
3. **collect information on organisational practices, policies, funding and scope of activities; and**
4. **identify examples of good practice, based on pre-determined criteria.**

Selected secular organisations were included in the review because they specifically targeted or collaborated with faith leaders in their HIV responses. Review methodologies included a literature review, a national survey of faith-based initiatives across 24 provinces, nine key informant interviews in Phnom Penh and 11 program visits in seven provinces.

Limitations

The literature review was limited to documents written or translated into English. The national survey was implemented by the Provincial AIDS Secretariats and the Provincial Departments of Cult and Religion, and responses were received from 17 out of 24 provinces[1]. Participation was voluntary and some organisations declined to respond. In other instances, government departments were not able to identify faith-based responses to HIV in their respective provinces. Therefore, survey results are based on available data and do not necessarily represent the full spectrum of faith-based responses to HIV in Cambodia.

[1] *Banteay Meanchey, Battambang, Kampong Cham, Kampong Chhang, Kampong Speu, Kampong Thom, Kampot, Kandal, Koh Kong, Pailin, Phnom Penh, Prey Veng, Pursat, Siem Reap, Sihanoukville, Svay Rieng and Takeo.*

While the review was not designed as an in-depth evaluation of the various interventions, the methodology used good practice criteria developed by the NAA, MoCR and UNICEF, to identify promising practices. Mission organisations or missionaries with a sole mandate for evangelism, proselytising, or conversion, with no development remit were not included in the review. The review did not attempt to assess impact or outcomes of the interventions presented.

Finally the selection of the 24 program participants who were interviewed was not random as the external consultants relied on faith-based organisations to identify them and facilitate their participation. However, organisations were asked to adhere to some principles such as selecting a balance of male and female participants and emphasising their voluntary participation.

Ethical considerations

Informed consent was obtained from each interviewee. While most program participants were eager and agreed for their names and photos to be included, a small number asked to remain anonymous. Their rights to privacy and confidentiality have been respected.

Summary of responses reviewed

Organisations and departments who participated in the review

The review of faith-based responses to HIV included a total of 51 initiatives in 17 provinces across Cambodia. This included 14 Buddhist, 16 Christian, one Muslim and five multi-faith organisations. Additionally, four secular organisations and 11 provincial government departments took part in the review.

Awareness of national policies and guidelines

Participating organisations demonstrated a very high level of awareness of the Policy on Religious Response to the HIV/AIDS Epidemic in Cambodia, the National Strategic Plan for the Comprehensive and Multisectoral Response to HIV/AIDS 2011-2015, and the National Guidelines for the Prevention of Mother to Child Transmission of HIV. Of the 28 organisations working with children, 21 said their work was informed by at least one national policy or guideline related to children i.e. policies related to the prevention of mother-to-child transmission of HIV, paediatric antiretroviral therapy or orphans and vulnerable children.

Organisational Capacity

Three quarters of the organisations participating in the national survey employed between two and 19 paid staff members. Collectively, organisations engaged a total of 4,769 volunteers (although one organisation reportedly accounted for 3069 of these).

HIV budgets and funding sources

The HIV budget for most organisations was between USD 20,000 and USD 60,000, while five had budgets of less than USD 10,000 and five had budgets over USD 100,000 per annum. A significant number of organisations (more than a third) received funding from international secular non-government organisations (NGOs) and almost a quarter received funding from Cambodian secular NGOs, demonstrating that faith-based initiatives are well-linked beyond their immediate faith networks, both within and outside Cambodia. Nine organisations received funding from international faith-based organisations, and four from Cambodian faith-based organisations. One government led initiative received funding from UNICEF.

Target populations and coverage

Most faith-based initiatives reported reaching between 100 and 2,000 clients. Collectively, these initiatives appeared to reach 1,104,060 people living with and affected by HIV. However, there may be some inaccuracies given the high figures provided by some organisations. For example, one organisation indicated its services reached more than 400,000 people, thus it is likely that higher figures reflect the total population of a specific target area, rather than the exact number of people reached directly by services.

Forty-four percent of respondents reported working with at least one key affected population including people who use drugs, sex/entertainment workers, prisoners, survivors of sex trafficking, indigenous people, clients of sex/entertainment workers, migrants and mobile populations, and men who have sex with men. There were no organisations working with transgender persons.

Prevention

Ninety-seven percent of respondents reported engaging in HIV awareness-raising interventions, while 92% reported implementing Prevention of Mother-to-Child Transmission (PMTCT) activities. Although faith-based organisations have sometimes been described as shying away from sexuality and family planning education, 69% of respondents reported engaging in such activities. A significant number of organisations reported engaging Buddhist monks in HIV prevention interventions. Some monks tackled sensitive issues such as sexual transmission of HIV and condom use. However, it was more common for monks and public health professionals to work together in teams – monks would discuss HIV prevention within the context of the Five Buddhist Precepts while health workers provided health related advice.

Treatment

Very few organisations reported providing ART or OI services. This is unsurprising given the Royal Government of Cambodia's policy of providing free ART and OI services to people living with HIV. A significant number of organisations did, however, provide pre and post-test counselling, while many supported program participants to travel to and from health facilities.

Care and support

Eighty-nine percent of survey participants reported providing psychological and spiritual support to people living with and affected by HIV. Organisations of all faiths explained that monks were generally well respected among target populations, and were therefore called on to lead meditation sessions or undertake outreach work. Three-quarters of respondents reported providing home-based care services to people living with and affected by HIV, while only 11% of respondents provided hospice, respite or palliative care services.

Impact mitigation

Eighty-eight percent of organisations provided material support for children to access basic education, while 77% provided food and

nutrition support. Other kinds of material support (such as water filters and mosquito nets) were also provided. Sixty-eight percent of respondents reported implementing income generation activities, while 59% reported providing vocational training.

While the majority of respondents reported working with orphans, only 12% operated orphanages. It seems most initiatives reviewed were in line with the general trend toward home and community-based care for orphans and vulnerable children, though relatively few organisations (only 9%) reported helping find foster homes for orphans.

Enabling environment

Ninety-one percent of survey participants indicated they worked to reduce HIV-related stigma and discrimination. Faith leaders reportedly played a key role in reducing stigma and discrimination because of their status within their community. While gains have been made, the experiences of some community members highlighted the need for ongoing work in this area.

Seventy-six percent of respondents reportedly promoted the meaningful involvement of people living with HIV, while 58% were engaged in systemic advocacy and 27% undertook research.

Cases of good practise

The following six examples of good practice were selected as meeting at least a range of agreed criteria.

Good Practice Criteria

1. Practice adheres to national guidelines and standards related to HIV prevention, treatment, care and impact mitigation (e.g. MoH National Guideline for the Prevention of Mother-to-Child Transmission of HIV, MoH National Guidelines for the Use of Paediatric Antiretroviral Therapy, MoSVY Policy on Alternative Care for Children, and the MoCR Policy on the Religious Response to HIV).
2. Practice has been formally evaluated and/or there is evidence of success/impact.
3. Organisations have received national or international recognition (e.g. awards) by governments or UN agencies for target interventions.
4. Practise is suitable for replication or scaling up and further study.
5. Methods or approaches have not been previously documented.
6. Services are not conditional upon recipients changing faith/religion.
7. Practice contributes to increased community acceptance and social inclusion of people living with HIV and key affected populations (sex/entertainment workers, people who use drugs, men who have sex with men and transgender persons).
8. Practice reaches hard-to-reach populations, including hard-to-reach women and children.
9. Practice promotes gender equity and human rights.
10. People living with or affected by HIV (and key affected populations) are actively involved in interventions.
11. Methods or approaches emphasise sub-national collaboration and information sharing.
12. Methods or approaches emphasise sustainability and local capacity building.

Meaningfully involving people living with and affected by HIV in prevention, treatment, care and impact mitigation

While this initiative meets many of the above criteria, it is particularly relevant to criteria 10 (People living with or affected by HIV are actively involved in interventions) and 7 (Practice contributes to increased community acceptance and social inclusion of people living with HIV).

Based in Kampong Cham province, Buddhism for Social Development Action (BSDA) oversees 15 self-help groups for orphans and vulnerable children and 10 self-help groups for adults living with HIV. These groups are led by trained Community Support Volunteers (10 adults and 15 children) who are living with or affected by HIV and generally come from the same villages as self-help group members.

Community Support Volunteers provide home-based care services to 165 HIV-affected households in two districts, providing psychosocial and spiritual support while linking households with relevant prevention, treatment and care services. Activities are carried out in partnership with the Kampong Cham Provincial People Living with HIV Network (PPN+) in order to ensure effectiveness and sustainability.

In addition, BSDA works to ensure participation of people living with and affected by HIV in local governance and to increase the transparency and accountability of local government institutions. BSDA staff support Community Support Volunteers to attend Commune Council meetings (and other meetings held at the village, commune and district levels) so they can communicate their social, economic and health needs to local government representatives.

Adapting to the needs of marginalised community members

This initiative meets several criteria, but is highlighted because it reaches hard-to-reach populations, including hard-to-reach women and children (criteria 8) and because approaches emphasise sustainability and local capacity building (criteria 12).Vision Fund Cambodia has also received international recognition (criteria 3) for its microfinance activities.

Vision Fund Cambodia is a licensed microfinance institution providing financial services (savings and loans) to low income households, including households affected by HIV. Targeting poor households who had otherwise been excluded from accessing conventional financial services, Vision Fund Cambodia offers low-interest loans with a range of flexible repayment options.

Vision Fund Cambodia has adapted their financial services to meet the specific needs of people living with and affected by HIV. HIV-affected households are offered a special interest rate of 2%, compared with the standard rate of 3%. People living with HIV are not required to produce collateral when applying for loans. Vision Fund Cambodia also works in partnership with various non-government organisations and private institutions to provide health and financial education and vocational training to loan recipients.

In 2009, Vision Fund Cambodia was ranked 51st among the 100 top microfinance institutions in the world by the Microfinance Information Exchange (MIX) against criteria including outreach, efficiency and transparency.

Providing community-based care for orphans and vulnerable children

This initiative satisfies several of the above criteria. Of particular relevance are criteria 1 (practice adheres to national guidelines and standards) and criteria 6 (services are not conditional upon recipients changing faith).The initiative also contributes to increased community acceptance of people living with HIV (criteria 7).

Based in Takeo Province, Partners in Compassion has been supporting local families and communities to care for orphans and vulnerable children since 2001. In addition, they provide residential care to orphans where family or community-based solutions could not be found.

Managed by Partners in Compassion, the Wat Opot Children's Community is home to 65 children between the ages of one and 19. Roughly half are living with HIV though children are never segregated according to their status. Wat Opot Children's Community goes to great lengths to support the social, cultural and spiritual development of its residents. Children are free to visit school-friends and neighbours, and welcome to receive visitors at any time. They are also encouraged to stay in touch with any extended family members (those who are unable to provide kinship care due to significant health, financial or other reasons) and visit relatives and friends during religious and cultural festivals. Children are free to maintain their own religious beliefs and to manifest such beliefs in religious practice.

In addition, Partners in Compassion works to strengthen the capacity of disadvantaged families to care for children within the home environment so as to minimize the need for residential care. In 2011, home-based care is provided to 475 people living with HIV and 808 vulnerable children. Vocational training and start-up capital for income generation activities is also provided.

Ensuring access to HIV services through comprehensive coordination

The work of Caritas Cambodia is highlighted here because it reaches hard-to-reach populations, including hard-to-reach women and children (criteria 8) and ensures sub-national collaboration and information sharing (criteria 11).

In Siem Reap province, Caritas Cambodia works to raise awareness of HIV and sexually transmitted infections (STIs) and supports community members to accessing testing and treatment services.

Caritas is one of three organisations operating in Sot Nikom district and has developed strong linkages with local partners. In consultation with the district health authority, the three organisations avoid duplication and maximise coverage by sharing responsibility for the district's 23 health centres and nearby villages. Caritas Cambodia is responsible for 14 villages and 16 health centres. The close relationship between Caritas Cambodia and these health centres results in practical cooperation which saves lives.

Caritas: One community member shared her story: When she was pregnant, Ream accessed HIV testing but did not return for her result. Health centre staff realised she had tested positive for HIV, knew she was pregnant, knew what village she lived in, and were aware that Caritas Cambodia worked in that village. Without breaching Ream's privacy and her right to confidentiality, a midwife from the health centre accompanied Caritas Cambodia staff the next time they visited her village. When the midwife found Ream, she passed on the message that her test results were ready for her to collect. Ream returned to the health centre, collected her test results and ultimately accessed PMTCT services. As a result, her twins were born HIV-negative.

Working with diverse faith communities to reduce stigma and discrimination

The following initiative exemplifies good practice criteria 7 (practise contributes to increased community acceptance and social inclusion of people living with HIV and key affected populations) and criteria 6 (services are not conditional on recipients changing faith).

The Islamic Local Development Organisation (ILDO) commenced HIV interventions in 1997 and has successfully provided HIV prevention, treatment, care and impact mitigation services to Muslim communities that had previously received little in the way of public health messaging. But it was ILDO's ability to reach out to people of all faiths that transformed the life of a young Buddhist woman named Sarorng. Sarorng was ostracised by her community after testing positive to HIV. Restaurant owners asked her not to sit down, stall holders asked her not to touch their produce and community members kept their distance from her.

One day, ILDO staff and volunteers came to Sarorng's village to raise awareness of HIV. At a community meeting organised by ILDO, Sarorng told fellow villagers about the discrimination she was experiencing and many were moved to tears. As a result, community members gradually began speaking with her again.

ILDO recognised Sarorng's bravery in sharing her experiences, as well as the impact this had on reducing stigma and discrimination. The organisation subsequently invited her to speak at other community events; to provide her personal perspective and inspire others to speak out. Sarorng is now a long-time volunteer with ILDO. She remains a committed Buddhist and feels her faith is respected by her Muslim colleagues, just as she respects theirs.

Harnessing the positive social standing of monks

The following intervention reaches hard-to-reach populations, including hard-to-reach women and children (criteria 8) and actively engages people living with HIV (criteria 10).

Founded in 1990 by a group of Buddhist monks, Buddhism for Development aims to promote socially-engaged Buddhism in Cambodia, placing special emphasis on the role of monks in community and social development.

Buddhism for Development volunteers first visited Svay Sinan in 2005 after they noticed she was losing weight. They visited Sinan on several occasions, asking about her health and suggesting she access HIV testing, but each time she sent them away. Eventually, Sinan received a visit from one of Buddhism for Development's monk volunteers. Even though the monk essentially said the same thing as previous volunteers, Sinan's respect for monks meant she listened more carefully to what he had to say and finally heeded his advice. She accessed HIV testing and discovered she was indeed HIV-positive. With ongoing support from Buddhism for Development, Sinan accessed the treatment she needed and has since become an active volunteer, providing peer support to other people living with HIV.

Discussion and conclusions

Working with faith leaders to strengthen community engagement

The ability of faith leaders to influence individual behaviours and community social norms was highlighted by Buddhist, Christian, Muslim and secular organisations alike.

However, all organisations, regardless of faith, recognised the particular benefits of engaging Buddhist monks in community-level interventions, particularly in the provision of psychological and spiritual support to people living with HIV and in HIV awareness raising and stigma-reduction among the general population. Due to their status within Cambodian society, the presence of a monk at a community meeting was believed to strengthen community participation and lend credence to social and public health messages.

Organisations frequently highlighted the capacity development needs of monks, particularly those from rural areas, who often had only a basic level of education. In addition to providing HIV awareness training to newly ordained monks, some organisations provided ongoing refresher training, recognising that the HIV epidemic and treatment environment was constantly evolving.

Linking religious discourse with HIV prevention messaging

Community meetings and religious sermons were frequently utilised to communicate HIV prevention messages to the general population, as well as addressing issues of stigma and discrimination within the community. On such occasions, monks often used the Five Buddhist Precepts to encourage qualities such as loving-kindness and compassion, while discouraging high-risk behaviours. While some monks felt comfortable discussing sensitive issues such as sexual transmission of HIV and condom use, the majority preferred to use euphemisms or to avoid discussing such matters entirely. Accordingly, monks often teamed up with health professionals or volunteers when speaking publically about HIV.

While many faith-based organisations provided HIV awareness education to the general population, fewer organisations implemented targeted HIV prevention interventions among key affected populations such as sex/entertainment workers, men who have sex with men, transgender persons and people who use drugs. There is a need for faith-based organisations to build organisational capacity in this area and/or build partnerships with local organisations working effectively with relevant populations.

Providing psychosocial and spiritual support to people living with HIV

Monks frequently provided spiritual support to people living with and affected by HIV by leading meditations, either at pagodas or during self-help group meetings. Community members explained these meditations helped them reduce stress and anxiety and deal with the challenges of day-to-day life. Community members also reported receiving moral counselling and guidance from monks and other faith leaders who helped them make wise choices and feel hopeful about the future. Such interventions would appear critical in light of recent studies which found significant numbers of people living with HIV had experienced psychosocial and mental health issues including low self-esteem and suicidal thoughts.

However, some community members viewed their local pagoda/mosque/church as playing only a marginal role in their day-to-day lives, and would be more likely to seek advice from a trusted friend or relative, or from a health professional. Accordingly, organisations would be advised to engage health workers and other professionals alongside faith leaders so as to provide a range of options to community members.

Combating HIV-related stigma and discrimination

During the course of the review, the ability of faith leaders to influence individual and community attitudes was consistently highlighted by faith-based and secular organisations. Some faith leaders incorporated messages of compassion and acceptance into religious sermons, while others intervened at the village level – visiting individuals and households thought to be responsible for discrimination and providing accurate information in relation to HIV prevention, treatment and care. In addition, the presence of faith leaders (particularly Buddhist monks) at community meetings or during home-visits to HIV-affected households, was thought to send a strong signal to community members that people living with HIV were valuable members of the community and were not to be discriminated against.

These interventions are important because stigma and discrimination can hinder an effective HIV response. Within the context of Cambodia's concentrated HIV epidemic, national coverage of such interventions need not be a priority. However, it is essential such interventions target pagodas/mosques/churches in high-prevalence areas where significant numbers of people are living with HIV.

Engaging Buddhist nuns in HIV responses

Faith-based organisations and program participants consistently highlighted the added value of engaging Buddhist monks in government and non-government HIV interventions. The role of nuns, however, was less evident. Although monks were well represented, only one nun participated in the review. Accordingly, the current and

potential role of Buddhist nuns in the national HIV response remains unclear.

Faith-specific responses versus proselytisation

Ongoing debate in relation to the appropriateness of proselytisation within the development context is evident in Cambodia as it is elsewhere.

The review found, while some faith-based organisations separated their development work from any religious messaging, others viewed development as indivisible from spiritual wellbeing. The review did not identify any initiatives which actively encouraged community members to adopt a new religion or made their services conditional upon conversion to a particular faith. A number of faith-based organisations did, however, provide faith-specific responses to individual faith communities, although these organisations did not proselytise and their secular HIV services targeted community members regardless of faith.

It is important to distinguish between interventions which utilise religious discourse to communicate with people of that particular faith (and are therefore culturally appropriate) and activities which promote specific religious beliefs to people of other faiths. While the former may be an effective and culturally appropriate way of communicating with program participants, the later may be categorised as proselytisation.

Recommendations

Ensure HIV interventions engaging faith leaders are well-targeted and comprehensive

1. Organisations working with Buddhist monks and other faith leaders should continue to do so and regularly review (a) whether HIV interventions target higher-prevalence areas and key-affected populations within those areas and (b) whether a comprehensive package of HIV prevention, treatment, care and impact mitigation services is being provided, and c) to closely coordinate with government to enhance sustainability and avoid duplication of services.

2. Organisations working with Buddhist monks and other faith leaders should review whether appropriate HIV awareness training and capacity building opportunities are being provided to faith leaders, and identify leaders who could play a greater role in the response. This might include greater involvement of Provincial Head Monks in order to enhance credibility, sustainability and accountability. The Ministry of Cult and Religion may also look at institutionalising ongoing capacity building of faith leaders engaged in HIV interventions. This may offer an opportunity to build capacity of faith leaders in responding to other risks and vulnerabilities of marginalized families and children.

3. Organisations engaging faith leaders in HIV interventions should investigate whether target populations are more comfortable accessing support from faith leaders or from lay people and, where appropriate, engage health workers and other professionals alongside faith leaders so as to provide a range of options to community members.

4. Faith-based and secular organisations should identify opportunities to explore the (existing and potential) role of nuns in HIV programming through their engagement with pagodas, and through involving nuns in program consultations. Such exploration should first consider whether target populations would welcome support from nuns or would prefer to interact with health workers and other professionals.

Strengthen targeted evidence-informed faith-based interventions among key affected populations, their partners and clients

5. Faith-based HIV prevention programming should consist of a comprehensive package of targeted evidence-informed HIV prevention interventions designed to “normalise” condom use, particularly among key affected populations, their partners and clients. Where other organisations are already working effectively with relevant populations, faith-based organisations should build partnerships with these organisations and, where relevant, refer clients to them.

6. Faith-based responses to HIV could help create greater demand for early HIV testing, especially among key affected populations, as late testing and delayed diagnosis contribute significantly to ill health and impoverishment of affected households.

7. Faith-based organisations not currently working with key affected populations should assess the need for such interventions. Where a need is identified and no one else is providing essential services, organisations should ascertain whether relevant populations regard them as a trusted and approachable service provider, focus on developing relationships with relevant populations, and develop services to meet their needs in close consultation with them.

8. Buddhist monks and other faith leaders engaging in HIV prevention should follow relevant guidance with respect to the appropriate role of faith leaders in the HIV response. Where such guidance recommends faith leaders avoid discussing sensitive issues (such as condom use), such interventions should be implemented as part of a comprehensive package of evidence-informed HIV prevention interventions.

9. In partnership with the National AIDS Authority, faith-based organisations (and secular organisations implementing faith-based initiatives) should explore opportunities for such organisations to support the implementation of the National HIV and AIDS Communications and Advocacy Strategy 2011-2015.

Further strengthen the integration of faith-based HIV programming into a comprehensive range of health, financial, social and legal services for people living with and affected by HIV

10. Faith-based and secular organisations should evaluate (with a view to enhancing and/or scaling up) existing poverty reduction and income generation initiatives for people living with and affected by HIV, including the provision of market-driven vocational training and start-up capital for microenterprise, with a focus on vulnerable and women-headed households and households with a large number of children. Such knowledge should be shared widely.

11. Faith-based and secular organisations should further strengthen the capacity of home-based care teams to act as conduits to a comprehensive range of services for people living with and affected by HIV, including sexual and reproductive health, family planning, vocational training, income generation, psychosocial support, legal and other services.

12. Within the context of the emerging national social protection dialogue, policy makers and strategic planners should investigate the existing and potential role of faith-based actors in mitigating the impacts of HIV on affected households and protecting vulnerable households against economic shock.

13. In accordance with the national Policy on Alternative Care for Children, faith-based and secular organisations working with orphans and vulnerable children should promote family and community-based care (including kinship care, foster care and adoption), supporting families to raise their own children wherever possible, utilising residential care only as a last resort for those children who have no one who care for them.

Ensure meaningful engagement of people living with HIV in faith-based responses at the national and sub-national level

14. At the national and sub-national levels, faith-based and secular organisations should develop relationships with networks of people living with HIV, and ensure people living with HIV are meaningfully involved in HIV programming, as well as in strategic planning and monitoring and evaluation. Organisations should explore opportunities for people living with HIV to participate in prevention and treatment interventions, as well as in the provision of care and support. This may require organisations to adjust the way they "do business" in order to ensure relevance and meaningful participation.

15. Faith-based and secular organisations implementing HIV interventions should explore opportunities for dialogue with national (and sub-national, where they exist) networks representing sex/entertainment workers and men who have sex with men in order to better inform the design, reach and effectiveness of such interventions. Should a national network of people who use drugs be established, it too could be engaged.

Facilitate information sharing and contribute to national and sub-national coordination and systems building

16. Provincial AIDS Secretariats and Provincial Departments of Cult and Religion could jointly organise provincial consultative meetings on the findings of this review. This would enable participants to highlight effective initiatives omitted to date, discuss recommendations, identify emerging issues at the provincial and district levels, and jointly develop evidence-informed responses. Relevant local government, civil society, private sector and development partners should be part of such dialogue.

17. At provincial level, improved sharing of information, data and dialogue with sub national authorities would be useful to promote coordination and collaboration among faith and government responses. This would also enhance transfer of knowledge and skills and ultimately improve sustainability of externally funded initiatives.

18. The NAA and the MoCR could facilitate increased communication between faith-based organisations responding to HIV by supporting regular information exchange in relation to, for example, new or revised government policies or strategies or significant initiatives by faith-based organisations. This process might encourage greater documentation and discussion of innovative faith-based approaches.

19. Relevant secular and faith-based actors could foster regular civil society dialogue and information sharing in order to identify successful faith-based HIV interventions and lessons learned from such interventions.

Introduction

This report presents key findings and recommendations from a national review of faith-based responses to HIV in Cambodia. The review encompasses faith-based initiatives (Buddhist, Christian and Muslim) and services provided by pagodas and their members. In order to paint a comprehensive picture of the breadth of faith-based responses to HIV, secular organisations partnering with faith communities and faith leaders to promote HIV prevention, treatment, care and impact mitigation are also included in the review.

The Ministry of Cult and Religion (MoCR) introduced the Policy on Religious Response to the HIV/AIDS Epidemic in Cambodia, the first policy of its kind (3), in 2002, recognising and encouraging the role of faith leaders and communities in the national HIV response. In the same year, UNICEF launched the Buddhist Leadership Initiative in collaboration with MoCR, mobilising Buddhist monks and lay teachers to lead community-level interventions designed to increase access to care and acceptance of people living with HIV as well as building HIV resilience in communities. Despite the large number of faith-based actors in Cambodia, systematic and up-to-date information on faith-based responses to HIV across the various faiths has not been readily available. In close collaboration with the Ministry of Cult and Religion, the National AIDS Authority (NAA) established the National Faith-Based Technical Working Group in 2004to coordinate and oversee the work of faith-based partners. This review is a priority of the Technical Working Group and is designed to explore the range and depth of HIV-focussed faith-based initiatives in Cambodia, with a view to identifying examples of good practice which have the potential to be scaled up or replicated by other faith-based, secular or government agencies.

The review was implemented by the National AIDS Authority and the Ministry of Cult and Religion in partnership with UNICEF between April and August 2011.

The findings of the review are presented here with the aim of informing coordination as well as future planning and programming efforts. The report includes a description of the review methodology, and an overview of Cambodia's HIV and faith contexts. Data on the range of faith-based responses to HIV is presented, accompanied by an analysis of common themes and challenges. A number of good practices are highlighted as case studies. The report concludes with insights and recommendations to further enhance faith-based contributions to the national HIV response in Cambodia.

1 Methodology

The objectives of the review were to:

1. **Identify the number and type of faith-based initiatives focusing on HIV prevention, treatment, care and impact mitigation in Cambodia;**
2. **Determine the coverage of this work;**
3. **Collect information on organisations' policies, practices, funding and scope of activities with respect to HIV prevention, treatment, care and impact mitigation; and**
4. **Identify good practices based on agreed criteria.**

The review targeted initiatives relevant to the first objective above, and narrowed the focus to organisations that utilised a developmental approach. Participating organisations met all of the following inclusion criteria: (a) faith-inspired[2] organisations that (b) implemented HIV-related activities in Cambodia, (c) had staff located in-country and (d) consented to participate in the review. In recognition that non-faith actors also worked with faith leaders and communities, secular organisations that engaged religious leaders to advance HIV prevention, treatment, care or impact mitigation (and met criteria b, c and d) were also invited to participate.

Organisations were excluded if they met one or more of the following criteria:(a) secular organisations that had no religious charter or Mission Statement and did not directly work with religious clergy; (b) donor or umbrella organisations/networks that did not directly implement HIV-related activities in Cambodia; and (c) mission organisations or missionaries with a sole mandate for evangelism, proselytising or conversion i.e. with no development remit.

The review was designed in consultation with a steering group[3] and included four data collection methodologies:

- Literature review
- National survey of faith-based initiatives across 24 provinces (in Khmer)
- Key informant interviews with representatives of nine principal organisations in Phnom Penh (in English)
- Eleven program visits in seven provinces to meet with staff and program participants (in English and Khmer with translators)

The literature review surveyed and summarised more than 60 documents identified by faith-based and secular stakeholders and through internet searches, many with a specific focus on faith-based responses to HIV within the Cambodian context. A summative literature review was produced, the data from which informs the analysis, findings and recommendations contained within this report.

The national survey was implemented by the Provincial AIDS Secretariats (PAS) and the Provincial Departments of Cult and Religion (PDCR) after a national workshop where the survey instrument was tested and refined. During the national workshop, representatives

Image 1: The National Consultative Workshop on the Review of Faith-Based Responses to HIV/AIDS in Cambodia was held on 12 May 2011 in Kampong Cham (from left to right: NAA Director of Communications and Resource Mobilisation H.E. Dr. Sim Kimsan, NAA Secretary General H.E. Dr. Teng Kunthy, MoCR Secretary of State H.E. Dauk Narin, UNICEF HIV Specialist Ulrike Gilbert and PDCR Kampong Cham director Srey Kanoeun).

[2] *Whose mission or aims were based on or informed by the values, principles or doctrine of one or more religions or faiths.*

[3] *Composed of representatives of the NAA, MoCR and UNICEF.*

from the PAS and PDCR endorsed the inclusion and exclusion criteria and the good practice criteria which helped identify organisations and approaches for further inquiry.

Good Practice Criteria

1. Practice adheres to national guidelines and standards related to HIV prevention, treatment, care and impact mitigation (e.g.MoH National Guideline for the Prevention of Mother-to-Child Transmission of HIV, MoH National Guidelines for the Use of Paediatric Antiretroviral Therapy, MoSVY Policy on Alternative Care for Children, and the MoCR Policy on the Religious Response to HIV).
2. Practice has been formally evaluated and/or there is evidence of success/impact.
3. Organisations have received national or international recognition (e.g. awards) by governments or UN agencies for target interventions.
4. Practise is suitable for replication or scaling up and further study.
5. Methods or approaches have not been previously documented.
6. Services are not conditional upon recipients changing faith/religion.
7. Practice contributes to increased community acceptance and social inclusion of people living with HIV and key affected populations (sex/entertainment workers, people who use drugs, men who have sex with men and transgender persons).
8. Practice reaches hard-to-reach populations, including hard-to-reach women and children.
9. Practice promotes gender equity and human rights.
10. People living with or affected by HIV (and key affected populations) are actively involved in interventions.
11. Methods or approaches emphasise sub-national collaboration and information sharing.
12. Methods or approaches emphasise sustainability and local capacity building.

Key informant interviews and program visits were conducted by external consultants, accompanied by translators and NAA and MoCR representatives, using a common interview framework designed to collect data on programmatic approaches, the impact of an organisation's faith identity and the experiences of program participants.

Program visits were conducted in seven provinces selected on the basis of contextual factors, namely higher prevalence of HIV[4] and the identification of relevant faith-based responses. The selection of provinces and faith-based initiatives also sought to include a mix of urban and rural contexts. The provinces selected for field visits were Battambang, Banteay Meanchey, Siem Reap, Kampong Thom,

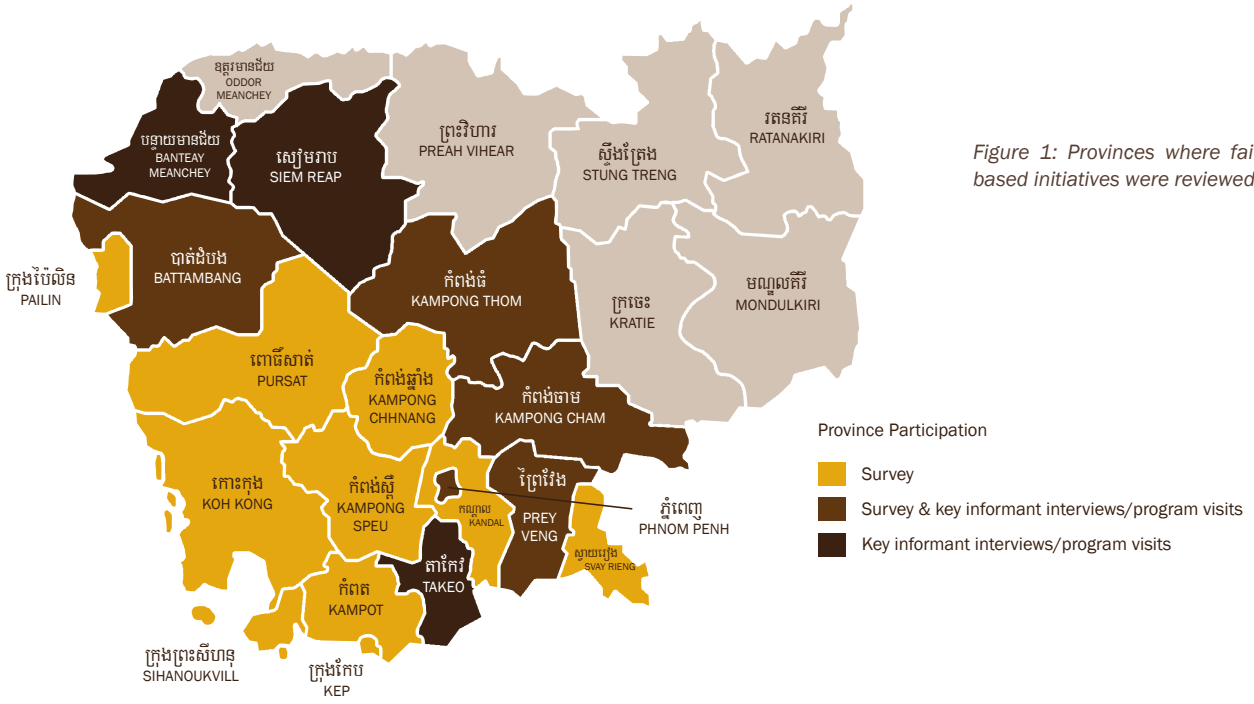

Figure 1: Provinces where faith-based initiatives were reviewed.

[4] *Seroprevalence among female sex workers (HSS 2006) was utilised as an indicator.*

Kampong Cham, Prey Veng and Takeo. In total, 11 organisations were visited in these seven provinces and interviews were held with 24 program participants (15 women, six men and three children). Additionally, nine principal organisations were interviewed in Phnom Penh.

Limitations

The literature review was conducted by external consultants and limited to materials in English. The work of some faith-based organisations (particularly the smaller ones) has gone undocumented and, accordingly, could not be included within this literature review. Despite such limitations, 64 documents were found to have relevance to Cambodia's specific HIV and faith context and faith-based responses to HIV more broadly.

The survey was administered by PAS and PDCR representatives in 24 provinces across Cambodia. However, responses were not received from all provinces. Participation in the review was voluntary and some organisations may have declined to respond. In other cases, PAS and PDCR representatives reported they were unable to identify any faith-based initiatives responding to HIV in their respective provinces. Therefore, the survey's results are based on available data and do not necessarily represent the full spectrum of faith-based responses to HIV in Cambodia.

Face-to-face interviews with program staff, volunteers andparticipants were carried out by external consultants with the assistance of experienced translators. The consultants spoke with staff, volunteers and participants and gained their insights into specific interventions and local contexts. The review methodology did not include in-depth evaluations of the various interventions. Using the good practice criteria as a guide, this report highlights six examples of good practice among the many faith-based responses to HIV in Cambodia, and acknowledges it does not provide an exhaustive or comprehensive picture.

The selection of program participants was not random as the consultants relied on organisations to identify interviewees and assist with logistical arrangements. However, the consultants did request certain principles be adhered to such as a balance of male and female participants, and an emphasis on voluntary participation.

Ethical considerations

Participating organisations were each requested to facilitate a meeting between the visiting consultant (accompanied by a translator and NAA or MoCR representative) and program participants. Informed consent was obtained from each interviewee and, during the course of the interviews, program participants were asked whether they preferred specific details to be included or excluded from the final report. While most interviewees were eager for their names and photos to be included, a small number asked to remain anonymous. Their rights to privacy and confidentiality have been respected. Program participants were each offered a small gift as a token of appreciation for sharing their time and experiences with the review team.

2 HIV and Faith in Cambodia

Faith in Cambodia

Theravada Buddhism is the officialreligion of Cambodia and Buddhist principles, traditions and institutions are said to underpin national identity(4). While precise estimates vary, all studies and censuses concur that Buddhism is the majority faith in Cambodia. With more than 95% of the population identifying as Buddhist (5) (4), Cambodia is home to more than 56,000 monks and 4,000 pagodas [5] from two distinct Buddhist schools: Mahanykaya and Thomayut (5).

Religious freedom, however, is guaranteed by Article 43 of the Constitution, and a number of minority faiths continue to play active roles in the nation's social and political landscape. There are now an estimated 482,863 Muslims (3.37% of the population) and 335 mosques in Cambodia making Islam the second largest faith community in the country, after Buddhism (4). The first Christian missionaries came to Cambodia in the 18th century, though relatively few Cambodians embraced Christianity until the influx of missionary workers and affiliated humanitarian organisations at the end of the Khmer Rouge reign in 1979. There are currently approximately 80,141 Christians (less than 1% of the population) in Cambodia. The table below shows MoCR figures for religious affiliation in Cambodia (4).

In addition, indigenous faiths are still practiced by indigenous peoples throughout Cambodia, particularly in the northeastern provinces of Ratanakiri and Mondulkiri and in the mountains of Koh Kong, though some indigenous populations have, to a large extent, assimilated into the dominant culture. Characterised by ancestor worship and veneration of the natural environment, these ancient traditions are woven throughout contemporary Cambodian Buddhism(4).

Any overview of faith in present-day Cambodia must also acknowledge the significant impact of the Khmer Rouge era on the nation's cultural and religious heritage, both tangible (such as pagodas and religious texts) and intangible (such as knowledge and traditions). When the Communist Part of Kampuchea (the Khmer Rouge) came to power in 1975, the Buddhist sangha[6] was officially abolished, senior monks were killed and others were forced to disrobe. Pagodas were destroyed, and the practise of religion was made punishable by death. Cham communities were also affected, with between 100,000 and 500,000 (estimates vary) out of a total Cham population of 700,000 perishing under the Khmer Rouge.

Religion	Members	% age of population
Buddhist Theravada	13,691,639*	95.73%
Buddhist Mahanya	34,168	0.24%
Muslim	482,863	3.37%
Catholic	9,111	0.063%
Protestant	71,030	0.50%
Kau Dai	3,516	0.02%
Bahá'í	10,008	0.07%

*** The population is assumed to be 14 million.**

[5] *MoCR estimates a total of 56,304 monks and 4,466 pagodas.*

[6] *The term sangha commonly refers to a community of ordained monks and/or nuns.*

By the time the reign of the Khmer Rouge ended in 1979, an estimated 63% of monks had been killed or had died from starvation or overwork in forced labour camps (4). Many also fled to refugee camps along the border. Khmer Rouge insurgencies and conflict continued, albeit at a diminishing rate, until 1999. In recent years, many pagodas and Buddhist schools have been rebuilt. However, the impact of the Khmer Rouge era on the sangha has been more difficult to repair. With many of the senior monks gone, in-depth knowledge and understanding of Buddhist philosophy and moral principles remains affected. This too is exacerbated by low levels of education among young men entering the monkhood, particularly in rural areas, and the high turnover of monks who choose to leave the monkhood after a few years.

HIV in Cambodia

Within Cambodia, national HIV prevalence has declined to an estimated 0.8% among the general adult population in 2010, down from a high of 2.4% in 1998(6). None the less, more than 75,000 people are currently living with HIVin Cambodia, while more than 60,000 households are directly affected by the disease (2). As the HIV epidemic has declined among the general population, it has become increasingly concentrated among key affected populations, with comparatively high HIV prevalence reported among people who inject drugs (24.4%) (7), female sex workers[7] (14%)(6) men who have sex with men[8] (2.6%) and transgender persons[9] (9.8%)(8).

Cambodia has seen a rapid scale up of care and treatment services toward the achievement of Universal Access targets. As of December 2010, there were 246 Voluntary Confidential Counselling and Testing (VCCT) sites in Cambodia (compared with 12 sites in 2000). In addition, there were 51 health facilities providing antiretroviral therapy (ART) and treatment of Opportunistic Infections (OI) in 21 provinces, 32 of these providing paediatric care. 96.7% of eligible adults and children living with HIV were receiving ART by December of the same year (9). Notably, high ART coverage among the adult population is calculated to have averted 21,497 labour force deaths and reduced Gross Domestic Product (GDP) losses by over $100 million per year for the period 2003-2009. Despite these achievements, the national HIV epidemic is projected to cause an overall decline in GDP of 16.5% between 1993 and 2020 (10).

A study on the Socioeconomic Impact of HIV at the Household Level in Cambodia (2) highlights the following individual and household-level impacts:

- **Changed household structure: HIV-affected households were twice as likely to be headed by a widow (34% versus 17%). More than one third of HIV affected households cared for a child orphaned by AIDS.**
- **Decreased income for people living with HIV:27% of respondents reported they lost their job (or other source of income) since being diagnosed with HIV. For those who kept their job, income levels were 47% lower than before diagnosis. In general, HIV-affected households earned 25% per capita less than non-affected households.**
- **Decreased income for caregivers :Over 25% of people living with HIV had a caregiver, and 18% of caregivers reported they left their jobs in order to assume caregiving duties. Those who retained their employment, saw a 50% reduction in income.**
- **Increased debt: 65% of HIV-affected households had at least one loan, compared with 53% of non-affected households. HIV-affected households were less likely to be in debt for constructive reasons such as improving their dwelling or investing in agricultural production. HIV-affected households were more likely to have sourced their loan from a moneylender (26% versus 21%) and to have paid higher interest rates (5.4% versus 4.3%).**
- **Food insecurity: 51% of HIV-affected households reported being hungry and not having enough food to eat in the previous year, compared to 35% of non-affected households.**
- **Increased child labour: Children in HIV-affected households were more likely to have a job than those in non-effected households. Twice as many girls in HIV-affected households worked compared to girls in non-affected households (10% versus 5%).**
- **Increased school absence and grade repetition:Enrolment levels among HIV-affected and non-affected households were statistically equal (86% and 85% respectively). However, HIV-households were more likely to state that children were not enrolled due to financial reasons (21% versus 15%). Children (aged 5-9 years) in HIV-affected households were more likely to have missed more than 10 days of school in the previous year than children in non-affected households (15% versus 8%). Girls in HIV-affected households were 30% more likely to have repeated a grade.**
- **Stigma and discrimination: 23% of women reported experiencing verbal abuse in the previous year as a result of their HIV status (compared with 16% of men), while 7% reported experiencing physical threats or abuse as a result of their status (compared with 4% of men).**
- **Psychosocial impacts: 65% of people living with HIV reported low self-esteem, 49% reported feeling ashamed of their status, 47% felt they should be punished and 16% reported having suicidal thoughts in the previous year.**

[7] *With seven or more sexual partners per week.*

[8] *In Phnom Penh, Battambang and Siem Reap.*

[9] *In Phnom Penh, Battambang and Siem Reap.*

Other notable contextual factors include the national population distribution which has implications for older women carers. According to David Orbach's 2007 study on Older Women and HIV in Cambodia, Thailand and Vietnam (11), older women (over the age of 50) significantly outnumber older men in Cambodia, representing 58.3% of older people. This is primarily due to the longer life expectancy of women and the legacy of the Khmer Rouge era. Additionally, the study found the majority of older people were financially reliant on transfer payments from their children(only 40% of older people reported earning an income and 5% reported receiving a pension). However, women were more likely to be widowed, illiterate and financially dependent on transfer payments.

Despite lower levels of economic stability, older women were more likely to provide care for incapacitated adult children or or phaned grandchildren and, due to their greater reliance on financial support, were more susceptible to the impacts of caring for and/or losing an adult child.According to Orbach, older women carersare likely to have lower HIV awareness than younger women. However, their training and support needs are not necessarily factored into national policies. According to Cambodia's 2004 Survey of the Elderly (12), 64% of older people had cared for an orphaned grandchild. While many older people expect to find spiritual and emotional support through the pagoda, older women carers may find few opportunitiesto do so because they are busy with caregiving responsibilities.

The national response

The Ministry of Cult and Religion introduced the Policy on Religious Response to the HIV/AIDS Epidemic in Cambodia in May 2002, the first policy of its kind (3).Targeting religious institutions, monks and laypeople, it contains broad level strategies and calls for:

- Different religions to raise awareness and promote individual behaviour change;
- Religious figures to promote compassion to families affected by HIV/AIDS and reduce community discrimination;
- Religious institutions to encourage and support the community to take care of people living with and affected by HIV; and
- The religious response to be an integral element of the coordinated multi-sectoral response to HIV at the national and local levels.

The policy is accompanied by Guidelines on the Implementation of the Policy on Religious Response to the HIV/AIDS Epidemic in Cambodia. The government held a national workshop to disseminate the policy and 63,000 copies were distributed to Provincial Departments of Cult and Religion along with civil society and development partners (13).

Overall, policy messages focus on the role of Buddhist actors in the national HIV response. Religious resource persons (Monks, Nuns, Achars, Pagoda Committee members and Buddhist youth) are seen as important partners in HIV awareness raising– specifically in relation to HIV prevention and care, and in relation to stigma reduction. Religious resource persons are considered important actors because of their access to the general population, both in terms of coverage (infrastructure) and in terms of the trust they inspire within the community.

HIV related policies and strategies

- Cambodian Millennium Development Goals (Ministry of Planning)
- Guidelines for Behaviour Change Communication Activities in Health (Ministry of Health)
- National Guideline for the Prevention of Mother-to-Child Transmission of HIV (MoH 2010)
- National Guidelines for the Use of Paediatric Antiretroviral Therapy (MoH 2010)
- National Policy on the Religious Response to HIV and AIDS (Ministry of Cult and Religion)
- National Standards for the Care, Support and Protection of Orphans and Vulnerable Children (MoSVY 2010)
- National Strategic Plan for the Comprehensive and Multisectoral Response to HIV/AIDS 2011-2015 (NAA)
- Policy on Alternative Care for Children (MoSVY)
- SOPs for Implementing ModulMithChuoyMith (MMM) for Children HIV Infected in Cambodia (NCHADS)
- SOPs for Implementing the Three I's in the Continuum of Care (CoC) Settings (NCHADS)
- SOPs for the Continuum of Care for People Living with HIV/AIDS (NCHADS)
- SOPs to Initiate a Linked Response for HIV/AIDS and Sexual and Reproductive Health Issues (NCHADS)
- Standard Operating Procedures (SOPs) for Implementing Social Care for Orphans and Vulnerable Children (NCHADS)

The policy recommends religious resource persons incorporate HIV messaging into their religious regular work.The policy emphasises religious resource persons should not turn into health educators or development workers. Rather, they should complement and support the work of these professionals. The policy recommends the work of religious resource persons should therefore be closely coordinated with the work of other government, civil society and development partners within the framework of the national HIV response, and that the other stakeholdersplay the coordinating role. The policy also recommends the work of religious resource persons should be community-oriented i.e. encourage communities to embrace and care for HIV affected community members. To date, the primary strategy utilised to realise these objectives is the provision of HIV education to religious resource persons, often intertwined with Buddhist social morality education. The initiative for engaging in HIV interventions is seen as lying with individual religious resource persons; largely independent of the opinions of the religious hierarchy(14).

Enacted in July 2002, the Law on the Prevention and Control of HIV/AIDS provides a legislative framework for HIV prevention, treatment and care, and supports the elimination of discrimination against people living with HIV. Article 10 of the Law requires the State to "mobilise individual citizens, families, organisations, monks, religious groups, and most vulnerable groups to participate in conducting educational andinformation activities on HIV/AIDS at all levels throughout the Kingdom of Cambodia" (15). Monks and religious groups are mentioned again in Article 27which requires the State to "mobilise the participation of the citizens, families, organisations, monks, religious groups and the most vulnerable groups to provide treatment, care and support to those who have HIV/AIDS all over the Kingdom of Cambodia" (15). The law provides no further guidance with respect to the contribution of faith-based actors to the national HIV response. The National Strategic Plan for the Comprehensive and Multisectoral Response to HIV/AIDS 2011-2015 (16) contains three objectives which explicitly refer to the role of faith-based actors within the national HIV response. These objectives relate to the reduction of stigma and discrimination and improved social and economic status :

The previous National Strategic Plan recommended working with religious leaders to ensure dissemination and implementation of the MoCR Policy on Religious Response to the HIV/AIDS Epidemic in Cambodia (17).

While faith-based initiatives have not featured strongly in the national policy framework, some policies do offer guidance with respect to the role of faith-based actors within the national HIV response. For example, the National Standards and Guidelines for the Care, Support and Protection of Orphans and Vulnerable Children (18) explicitly recommends implementing agencies work with pagodas, monks and other religious leaders to combat HIV-related discrimination within the community, and to promote family-based care of orphans and vulnerable children.

Strategy 3: Increase coverage, quality and effectiveness of interventions to mitigate the impact of HIV and AIDS.

Objective 2: Improve the social and economic status of PLHIV and their families, especially the most vulnerable.

Interventions:

Scale up of service provision to PLHIV and their families, including food, livelihood, psychosocial and spiritual support.

Objective 3: Expand and sustain community involvement in impact mitigation.

Interventions:

Strengthening of capacity and participation of people living with HIV in social and development activities and meaningful involvement of people living with HIV in impact mitigation interventions and decision making processes, especially those that relate to stigma and discrimination and including participation in pagoda-based committees.

Strategy 6: Ensure availability and use of strategic information for decision-making through monitoring, evaluation and research

Objective 3: Reduce as much as possible stigma and discrimination against MARPs and people living with and affected by HIV.

Interventions:

Sensitise and mobilise senior officials, law makers, opinion leaders, private sector and faith-based organisations to reinvigorate the fight against stigma and discrimination at institutional and community levels.

3 Organisational Profiles

Overview of participating organisations and departments

A total of 51 organisations in 17 provinces directly contributed to this review of faith-based responses to HIV in Cambodia. Quantitative data was collected through a national survey across Cambodia's 24 provinces, administered by PAS and PDCR, from which 41 responses were received. Building on survey findings, qualitative data was then collected through eight key informant interviews plus 11 program visits in seven provinces and one municipality (Phnom Penh). Where surveys were received from different provincial offices of the same organisation, responses were counted individually rather than grouped together.

The review included 14 Buddhist organisations, 16 Christian organisations, one Muslim organisation, five multifaith organisations, four secular organisations and 11 government departments (10 PDCR and one PAS).

No.	Organisations and departments participating in the review	Religion
1.	Association of Buddhists for the Environment (ABE)	Buddhist
2.	Brahmavihara (Cambodia AIDS Project)	Buddhist
3.	Buddhism and Society Development Association	Buddhist
4.	Buddhism for Development – Battambang	Buddhist
5.	Buddhism for Development – Kampong Thom	Buddhist
6.	Hope of Children (HOC)	Buddhist
7.	Kenkes Health Education Network (KHEN)	Buddhist
8.	Khmer Women's Cooperation for Development (KWCD)	Buddhist
9.	Lotus Organisation	Buddhist
10.	Minority Organisation Development of Economy (MODE)	Buddhist
11.	Mlup Prumvihearthor Centre (MPC)	Buddhist
12.	Salvation Center Cambodia (SCC) – Battambang	Buddhist
13.	Salvation Center Cambodia (SCC) – Phnom Penh	Buddhist
14.	Women's Organisation for Modern Economy and Nursing (WOMEN)	Buddhist
15.	Kampong Cham PDCR	Government department
16.	Kampong Speu PDCR	Government department
17.	Kampong Thom PDCR	Government department

18.	Kampot PDCR	Government department
19.	Kandal PDCR	Government department
20.	Koh Kong PDCR	Government department
21.	Pailin PDCR	Government department
22.	Prey Veng PDCR	Government department
23.	Pursat PDCR	Government department
24.	Svay Rieng PDCR	Government department
25.	Svay Rieng PAA	Government department
26.	Asia's Hope Cambodia	Christian
27.	Bridge Organisation	Christian
28.	Cambodian Hope Organisation (CHO)	Christian
29.	CARE Cambodia	Christian
30.	Caritas Cambodia	Christian
31.	Catholic Relief Services (CRS)	Christian
32.	Center of Hope	Christian
33.	Christ Centre	Christian
34.	Life With Dignity (LWD)	Christian
35.	Maryknoll	Christian
36.	Sunrise Organisation	Christian
37.	Vision Fund	Christian
38.	World Vision – Kampong Chhnang	Christian
39.	World Vision – Kampong Thom	Christian
40.	World Vision – Kandal	Christian
41.	World Vision – Phnom Penh	Christian
42.	Islamic Local Development Organisation (ILDO)	Muslim
43.	Cambodian Save Children Network (CSCN)	Mulitfaith
44.	Partners in Compassion/Wat Opot Children's Community	Mulitfaith
45.	Reproductive and Child Health Alliance (RACHA)	Mulitfaith
46.	Sihanouk Hospital Center of HOPE	Mulitfaith
47.	Save Incapacity Teenagers (SIT)	Mulitfaith
48.	Action for Health and Development (AHEAD)	Secular
49.	House of Family	Secular
50.	Mission of Generous Cambodia Alliance	Secular
51.	Save the Children Australia	Secular

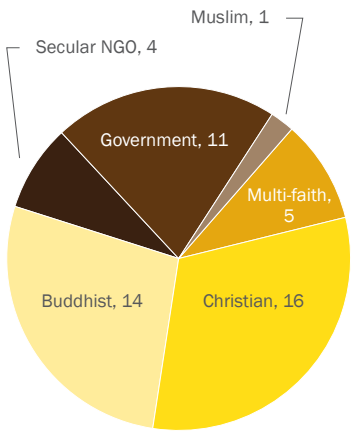

Figure 2: Participating organisations by faith identity

While the survey administered by PAS and PDCR did not gather data on every faith-based initiative in the country, findings highlightgeneral trends in relation to the nature of faith-based responses to HIV in Cambodia and underscore the added value of faith-based responses within such a context.

Awareness of national policies and guidelines

Organisations were provided with a list of national policies and guidelines and asked to indicate which ones informed their HIV interventions. The MoCR Policy on Religious Response to the HIV/AIDS Epidemic in Cambodia was nominated by 82% of respondents, while 76% of respondents stated the National Strategic Plan for the Comprehensive and Multisectoral Response to HIV/AIDS 2011-2015 informed their work.

Of the 28 organisations working with children, 21 said their work was informed by at least one of the national policies or guidelines related to children i.e. policies related to the prevention of mother -to-child transmission of HIV, paediatric antiretroviral therapy or orphans and vulnerable children. The seven respondents that worked with children but did not cite one of the child-related policies were all Provincial Departments of Cult and Religion. Instead, they stated their work was informed by the MoCR Policy on Religious Response to the HIV/AIDS Epidemic in Cambodia.

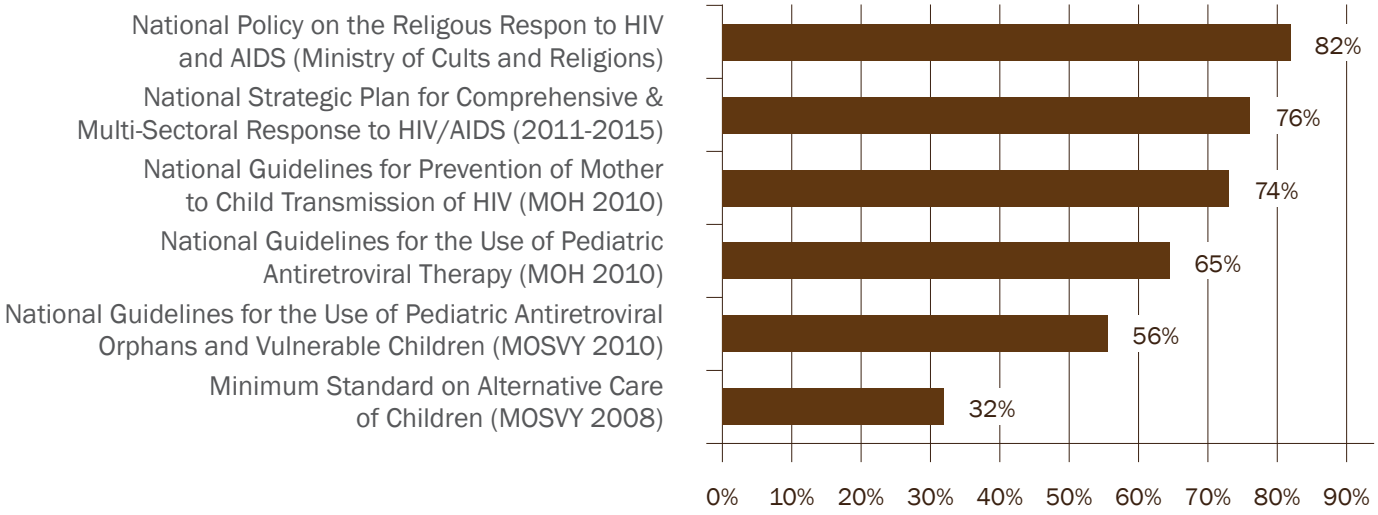

Figure 3: Initiatives informed by specific national policies and guidelines

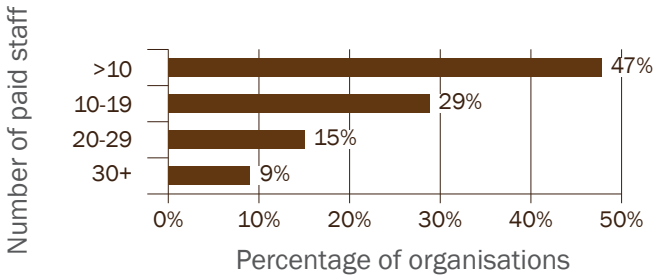

Figure 4: Paid staff engaged in faith-based HIV initiatives

Organisational capacity

Of the 41 organisations taking part in the national survey, 34 provided information on the number of paid staff and volunteers engaged in HIV interventions. The total number of paid staff was 512, making an average of 15 paid staff per organisation. The organisation with most number of paid staff (78) was the Phnom Penh office of Salvation Center Cambodia. Three quarters (76%) of surveyed organisations employed between two and 19 paid staff members. All organisations had paid staff except the Christ Center in Prey Veng which was staffed exclusively by volunteers.

The total number of volunteers engaged in faith-based initiatives was 4,769 although one organisation (RACHA) accounted for 3,069 of these, and significantly skewed the total and average figures for organisations with between 20 and 29 paid staff in the table below.

Table 1: Volunteers engaged in faith-related HIV initiatives

Organisation size	Total number of volunteers	Average number of volunteers per organisation	Average ratio of staff to volunteers
Less than 10 paid staff	296	19	1:4
10-19 paid staff	304	14	1:2
20-29 paid staff	3347	669	1:26
30+ paid staff	107	36	1:1
Number of paid staff unknown	717	143	N/A
	4769 (Total)	119 (Average)	

HIV budgets and funding sources

Surveyed organisations reported HIV budgets ranging from USD3,600 to USD400,000 per annum, with an average of USD72,000 per annum. Most organisations had HIV budgets between USD20,000 and USD60,000, while five organisations had budgets of less than USD10,000 and five had budgets over USD100,000 per annum.

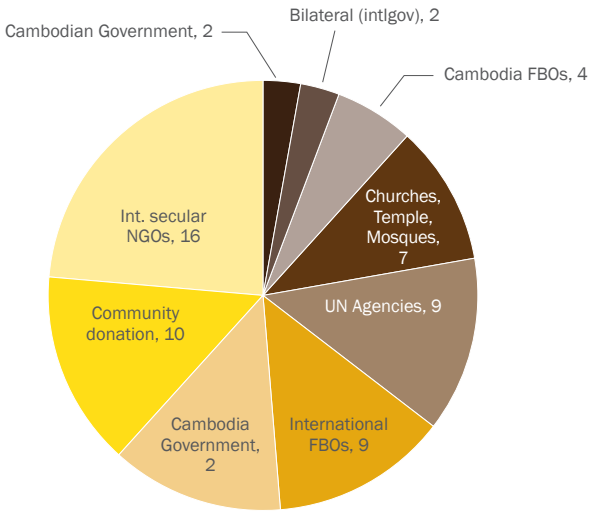

Figure 5: Initiatives receiving different sources of funding

A large proportion of surveyed organisations (16 out of 41) received funding from international secular non-government organisations (NGOs) and almost a quarter received funding from Cambodian secular NGOs. In addition, nine of the ten participating PDCRs received funding from UNICEF for the implementation of the Buddhist Leadership Initiative. This demonstrates that faith-based initiatives are well linked beyond their immediate faith networks, both within and outside Cambodia. For example, Buddhism for Social Development Action (BSDA) reported that six of its eight donors were international secular organisations including USAID, EcoSolidar, The Asia Foundation and the Affiliated Network for Social Accountability in East Asia and the Pacific (ANSA-EAP).However, for some organisations, secular funding represented a relatively small proportion of their total budget. For example, Life With Dignity (an NGO grounded in Lutheran Christian values) reported a USD4 million annual budget[10] of which 94% was from international Lutheran-based organisations and only 6% was from international secular donors[11].

Of the 41 organisations surveyed, nine reported receiving funding from international faith-based organisations while four reported receiving funding from Cambodian faith-based organisations. The survey did not ask whether donors and recipient NGOs shared the same faith. However, there was anecdotal evidence (gathered through key informant interviews and program visits) of interfaith financing. For example, when the Islamic Local Development Organisation (ILDO) was first established, it received approximately 80% of its funding from Christian organisations. Similarly, both Caritas Cambodia (Catholic Christian) and SCC (Buddhist) reported receiving financial support from CAFOD (Catholic Christian). Although there were fewer examples of non-Christian international faith-based donors funding organisations of other faiths, there was evidence of inter-faith financing at the local level. Buddhism for Development, for example, has an inter-faith policy which has resulted in a long-term scholarship program supporting local Muslim children to attend school.

Target populations and coverage

The survey asked organisations to estimate how many people living with and affected by HIV their activities reached. Thirty-one organisations answered this question and the sum of their responses was 1,104,060. Given the very high figures provided by some organisations (for example, one organisation indicated its services reached more than 400,000 people), it is likely that higher figures reflectthe total population of a specific target area, rather than the exact number of people living with or affected by HIV reached by services. Most initiatives reported reaching between 100 and 2000 people.

Respondents were also asked to indicate which categories of clients they worked with, though specific client numbers were not requested. Children living with HIV and orphans were cited most frequently by

[10] *For all activities, not just HIV-related activities.*

[11] *Life With Dignity, 2009 Annual Report*

organisations, followed by adults living with HIV, and adults and children in general. Significant numbers of organisations also reported working with rural populations, with faith leaders and with pregnant women. Four organisations indicated they worked with "male" as well as "female" pregnant women. These responses are either erroneous or suggest some faith-based initiatives engage expectant fathers in their HIV interventions. This data is worth following up with the four organisations to clarify the accuracy of responses and investigate any interventions that include men in pre and post natal initiatives.

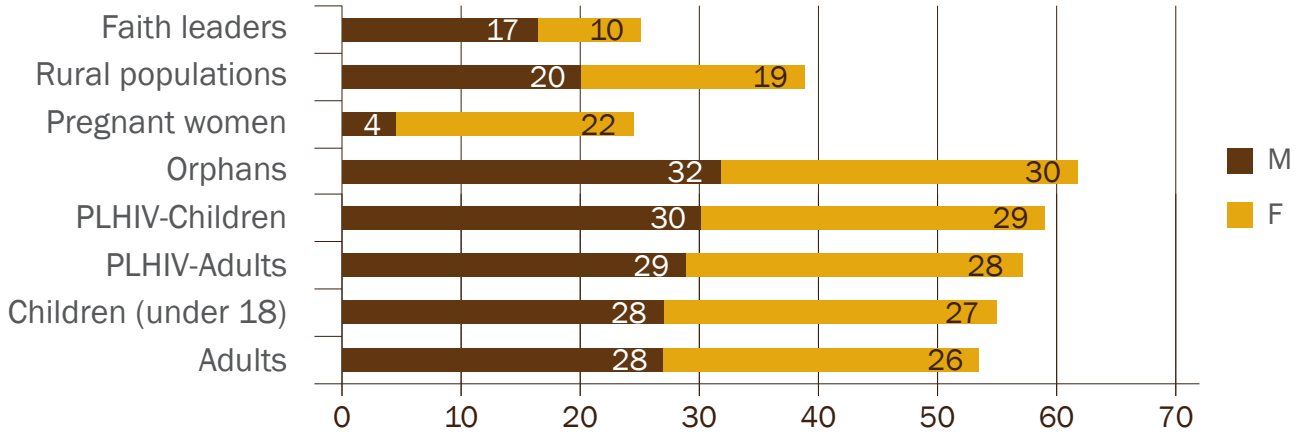

Figure 6: Initiatives working with sub-populations, by gender

Forty-four percent of participating organisations reported working with at least one key affected population. Most notably, eight organisations (including Sihanouk Hospital and Salvation Centre Cambodia) reported working with male and female drug users. In the centre of Phnom Penh, Sihanouk Hospital provides free treatment and care to patients, including women and men who are living with HIV and inject drugs. The hospital provides ART and OI services, and refers drug users to a team of seven home-based carers and six counsellors who provide psychosocial support and outreach to follow up with patients and ensure they continue to access support. Salvation Centre Cambodia (Siem Reap branch) works with more than 500 male drug users, plus 26 female drug users who are also sex/entertainment workers. However, SCC explains they do not target sex/entertainment workers in general because there are already two other organisations working with sex/entertainment workers in the area.

Table 2: Initiatives working with key affected populations, by gender

Key affected populations	Female	Male
Drug users/injecting drug users	8	8
Sex/entertainment workers	6	2
Prisoners	5	5
Sex trafficked victims/survivors	4	2
Indigenous peoples	3	3
Clients of sex/entertainment workers	2	4
Migrants and mobile workers	2	2
Men who have sex with men	0	3
Transgender persons	0	0

Several organisations highlighted the benefits of engaging Buddhist monks when providing care and support services to prisoners as monks were often allowed into prisons where lay people (including health professionals) were denied access. However, non-Buddhist organisations also worked with prison populations. Catholic Relief Services (CRS), for example, reported working with six prisons to provide HIV testing and nutritional supplements to people living with HIV.

None of the organisations participating in the survey, the key informant interviews or the program visits reported working with transgender persons.

Some organisations said they did not specifically target key affected populations, but explained they were aware some of their clients may, for example, use drugs or engage in sex/entertainment work. Often small community-based organisations, they explained they did not have the capacity to provide a full range of services to all key affected populations so did their best to ensure interventions included all community members and did not discriminate against anyone. None of these organisationsmentioned developing partnerships with, or making referrals to, local organisations already working with key affected populations.

A small number of organisations expressed a reluctance to engage with marginalised populations due to perceived safety and security risks, particularly in relation to clients who might be engaging in illegal activities such as usingdrugs or selling sex. It is possible that such perceptions are the result of a lack of understanding and experience working with key affected populations. This highlights the need for such organisations to build organisational capacity in this area or build partnerships with local organisations already working effectively with relevant populations.

Prevention

The vast majority (97%) of respondents reported engaging in HIV awareness-raising interventions, with a strong focus on PMTCT. Seventy-two percent of organisations reported implementing PMTCT activities which typically focused on awareness-raising and referrals rather thanprovision of HIV testing and PMTCT services to pregnant women.

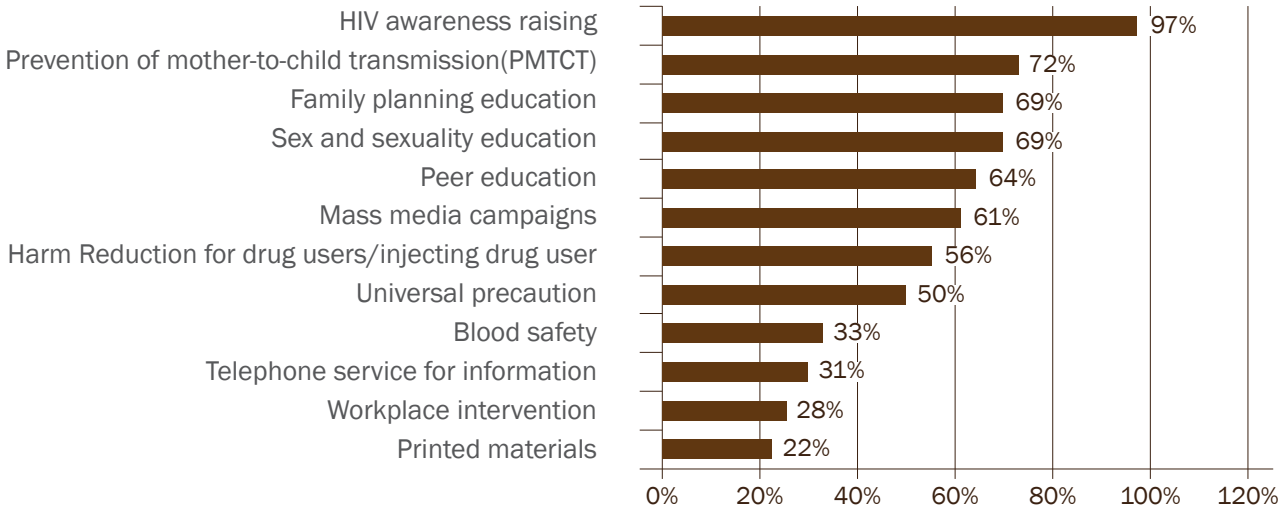

Figure 7: Initiatives engaging in different kinds of HIV prevention interventions

Faith-based organisations are sometimes characterised as shying away from sex and sexuality and family planning education, but 69% of respondents reported undertaking such activities.

In Battambang province, the Islamic Local Development Organisation (ILDO) works to raise community awareness in relation to sexual and reproductive health and birth spacing. ILDO's greatest advocate for birth spacing is a local Imam who was previously opposed to contraception due to religious beliefs in relation to the sanctity of life. Although he was initially resistant to birth spacing messages, the Imam (not pictured) turned to ILDO for advice after his wife miscarried. After discussing the process of conception with ILDO staff, the Imam concluded condom use could not harm a fertilised egg and was therefore not against his beliefs and values. The Imam and ILDO continue to work together to raise awareness in relation to sexual and reproductive health and promote birth spacing among communities.

A significant number of organisations reported engaging Buddhist monks in HIV prevention interventions. Some monks tackled sensitive issues such as sexual transmission of HIV and condom use. However, it was more common for monks to discuss HIV prevention within the context of the Five Buddhist Precepts (commitments to abstain from killing, stealing, sexual misconduct, lying and intoxication) while public health professionals provided more technical information.

The least frequently cited HIV prevention activity was producing printed materials, presumably (at least in part) due to cost implications. Many organisations were adept at documenting their work, often to satisfy the requirements of external donors, but outreach to communities was commonly undertaken through community meetings and home visits rather than leaflets and posters. This may also reflect varied levels of literacy among target populations.

Image 2: From Left to right: ILDO volunteers El Him and Huot Sarorng, with NAA Deputy Director of Communications and Resource Mobilisation Dr. Voeung Yanath and ILDO Director Sem Kalyan.

Treatment

During program visits, community members frequently referred to the financial burden of routine travel to health care centres to access ART and OI services. Accordingly, 31respondents (out of 33 who answered this question) reported providing transport support to program participants.

In Takeo province, 36-year-old Rachana[12] told how her husband passed away one year ago, leaving her with three children (aged 15, 13 and four), no regular income and no mode of transportation. After her four-year-old daughter was diagnosed with HIV, the local healthcare centre told Rachana about Partners in Compassion (a multi-faith organisation supporting adults and children living with and affected by HIV). Rachana now receives monthly home visits from a Partners in Compassion staff member, often accompanied by a Buddhist monk, and receives a wide range of support including a second HIV test for her daughter (to double-check the positive diagnosis) and R24,000 (USD6) travel allowance so she and her daughter can travel to the local healthcare centre each month.

A significant number of survey recipients (16) reported providing pre or post HIV test counselling, with Buddhist monks frequently invited to speak with community members recently diagnosed with HIV. Seven organisations stated they engaged in "ART provision" though it is likely some of these organisations supported community members to access treatment, rather than directly providing treatment themselves. While the Royal Government of Cambodia has a policy of providing free ART and OI services to people living with HIV, interviewees often referred to the additional burden of informal payments requested by healthcare workers.

Few respondents mentioned treatment literacy initiatives, perhaps seeing this as part of the ART providers' role. This might also reflect limited organisational and technical capacity in this area.

Care and support

With the increased availability of ART in Cambodia, faith-based organisations' primary focus is no longer on the provision of hospice or palliative care services. In Phnom Penh, Maryknoll's HIV response began with a hospice to care for the dying, but the facility has since been closed. The same may be said for Partners in Compassion, which has gradually shifted its focus from palliative care to education, livelihoods and community-based care, while they continue to provide residential care for orphans who have no one else to care for them.

The vast majority of respondents (32) reported providing psychological support to people living with and affected by HIV. The same number reported providing spiritual support. During key informant interviews and program visits, both staff and participants emphasised the importance of spiritual support as part of, yet distinct from, psychological support. Organisations of all faiths explained monks were generally well respected among target populations, and were therefore called on to lead meditation sessions or undertake outreach work. Most (all but two) of the 24 program participants who took part in interviews were Buddhist, and expressed their appreciation of the spiritual guidance they received from monks who helped them reflect and gain perspective on their situation and overcome the challenges of day-to-day life.

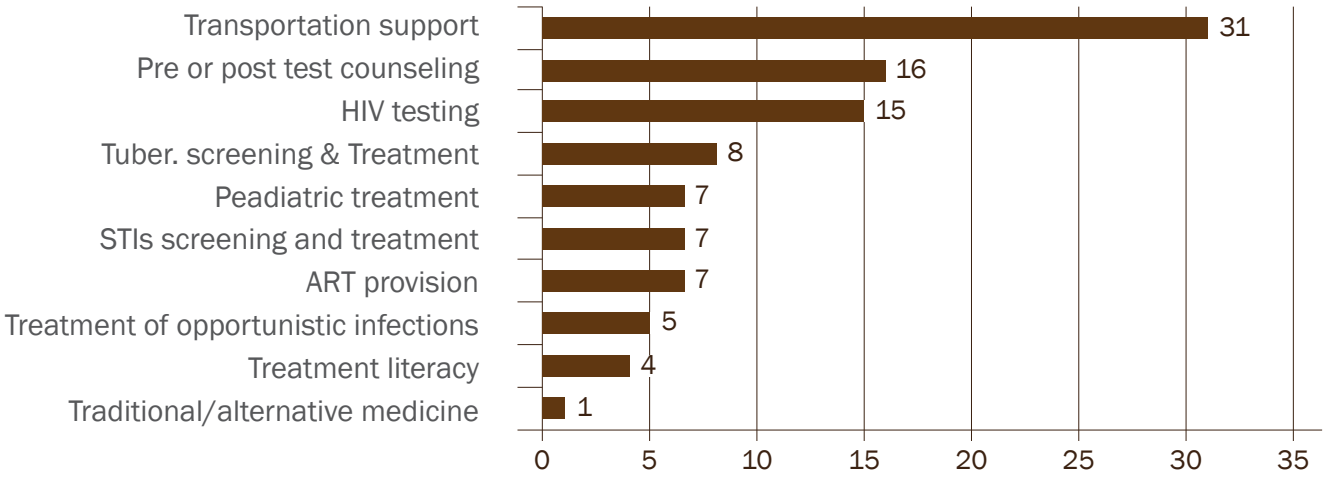

Figure 8: Initiatives engaging in different kinds of HIV treatment interventions

Three quarters of respondents reported providing home-based care services to people living with and affected by HIV. Home visits were typically conducted once or twice per month by a representative of the organisation and/or a Buddhist monk. On home visits, Home Care Teams provided basic medical treatment and referrals for PMTCT, VCCT, ART and OI services, as well as for treatment of sexually transmitted infections and tuberculosis. They also provided psychosocial and spiritual support, positive prevention education, food and nutritional support, school materials and encouragement for orphans and vulnerable children to complete basic education.

[12] *Not her real name.*

Image 3: As part of the Buddhist Leadership Initiative, the Kampong Cham Provincial Department of Cult and Religion coordinates the provision of psychosocial and spiritual support (including spiritual counselling and guided meditations) to community members living with and affected by HIV.

Such visits were also an opportunity to identify additional support needs (including vocational training or income generation) and encourage people living with HIV to access local self-help groups.

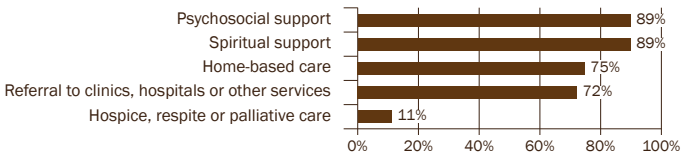

Figure 9: Initiatives engaging in different kinds of HIV care and support interventions

Impact mitigation

Material support for children to access basic education (including books, pencils and school uniforms) continued to be a priority for faith-based organisations, with 88% of respondents reportedly providing school support of one form or another. While the survey did not ask whether organisations provided travel allowances to school students, key informant interviews and program visits indicated transport costs affected access to education among rural and vulnerable households in the same way they affected access to health services.

In Kampong Thom province, 14-year-old Chenda[13] benefits from material support to attend school (six kilometres away) provided by Kampong Thom PDCR as part of the UNICEF-supported Buddhist Leadership Initiative. She works hard at school, cycling 24 kilometres per day, making two trips because she takes extra classes in physics and chemistry. She is grateful for the material support she receives from PDCR, but her problems are far from solved. She lives with her 97-year-old great grandmother and will soon finish primary school. Unfortunately, the secondary school is 15 kilometres away. Chenda has no relatives living near the school she could stay with, and she does not own the bicycle she currently uses to get to primary school. The PDCR is looking at possible solutions to ensure that Chenda can continue her education.

Over half of organisations (26 out of 41) provided food and nutrition support (including rice, salt, cooking oil and fish sauce) to HIV-affected households. Additionally, while such data was not captured by the survey, service recipients frequently reported receiving other kinds of material support such as water filters, solar panels, mosquito nets, mats, pillows, and tarpaulins. Several households were also supported to construct or renovate their home.

Image 4: Sok Chandra and her two sons in front on their home in Prey Veng province, recently renovated with support from Save the Children Australia (SCA). SCA has provided Chandra with regular food and material support (including school uniforms and books) since her husband passed away two years ago. The organisation also supported Chandra to start growing vegetables and open a road-side stall in front of her house.

[13] *Not her real name*

While the majority of respondents reported working with orphans, comparatively few claimed to operate orphanages. It seems most initiatives were in line with government guidelines to promote home and community-based care for orphans and vulnerable children, though relatively few organisations (only 9%) reported helping find foster homes for orphans. Partners in Compassion, for example, supports families to take care of their own children, accepting children into residential care only when all other options have been exhausted.

Quantitative data collected through the 24 province survey, as well as qualitative data collected through key informant interviews and program visits, highlighted the role of faith-based initiatives in facilitating vocational training and income generation opportunities for people living with and affected by HIV. 68% of respondents reported implementing income generation activities, while 59% reported providing vocational training.

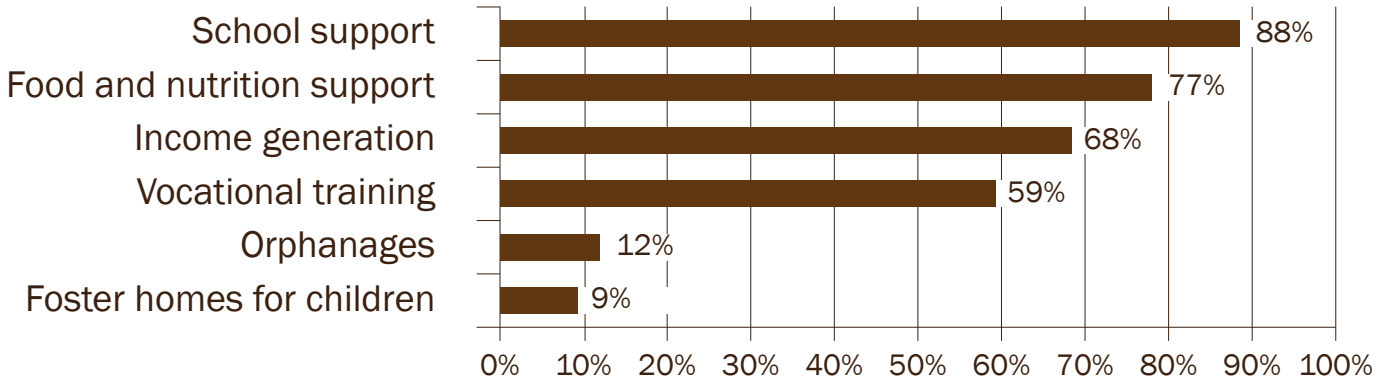

Figure 10: Initiatives engaging in different kinds of HIV impact mitigation interventions

Enabling environment

The reduction of HIV-related stigma and discrimination emerged as a priority for faith-based organisations across Cambodia, with 91% of survey respondents reportedly working to reduce stigma and discrimination. Program visits uncovered many stories of individuals and organisations affecting positive changes in community attitudes and reducing stigma and discrimination against people living with HIV. However, there were also many stories of stigma and discrimination continuing to affect people living with HIV, their families and their communities. Faith leaders reportedly played a key role in reducing stigma and discrimination because of their status within their community.

However, this does not mean community members automatically accepted the role of faith leaders as agents of social and behavioural change. Initially, both Buddhist and Muslim organisations received serious objections to their work from community members who believed faith leaders should limit their attentions to activities within the pagoda/mosque rather than venturing into the wider community. Monks were arrested and Muslim development workers were sued, in both cases for allegedly bringing disrepute to their respective faiths. These incidents were eventually resolved, however. Memorandums of Understanding were signed with various government ministries in order to clarify the role of faith leaders in the national HIV response. Trust was gradually built within the general population and community members began to see such initiatives as positive expressions of faith.

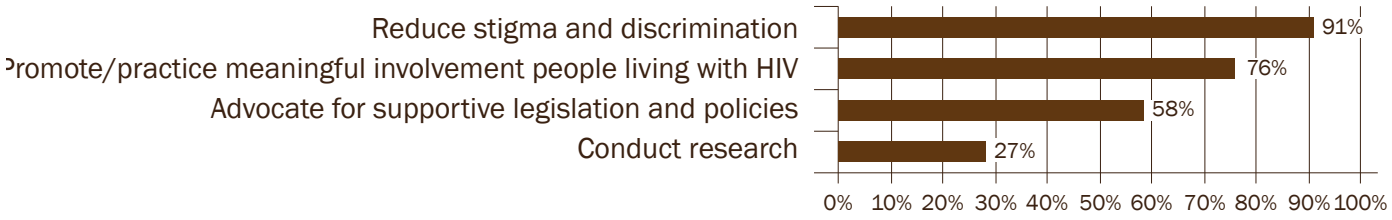

Figure 11: Initiatives engaging in different kinds of HIV enabling environment interventions

4 Examples of Good Practices

The following six examples of good practice were selected in accordance with the following criteria:

1. **Practice adheres to national guidelines and standards related to HIV prevention, treatment, care and impact mitigation [e.g. MoH National Guideline for the Prevention of Mother-to-Child Transmission of HIV, MoHNational Guidelines for the Use of Paediatric Antiretroviral Therapy, and MoSVY Policy on Alternative Care for Children).**
2. **Practice has been formally evaluated and/or there is evidence of success/impact.**
3. **Organisations have received national or international recognition (e.g. awards) by governments or UN agencies for target interventions.**
4. **Practise is suitable for replication or scaling up and further study.**
5. **Methods or approaches have not been previously documented.**
6. **Services are not conditional upon recipients changing faith/ religion.**
7. **Practice contributes to increased community acceptance and social inclusion of people living with HIV and key affected populations (sex/entertainment workers, people who use drugs, men who have sex with men and transgender persons).**
8. **Practice reaches hard-to-reach populations, including hard-to-reach women and children.**
9. **Practice promotes gender equity and human rights.**
10. **People living with or affected by HIV (and key affected populations) are actively involved in interventions.**
11. **Methods or approaches emphasise sub-national collaboration and information sharing.**
12. **Methods or approaches emphasise sustainability and local capacity building.**

While the below case studies exemplify innovative faith-based responses to HIV in Cambodia, it isimportant to note that five of the six organisations featured are non-government organisations while one is a microfinance institution. These interventions are largely (though not exclusively) funded by international development partners. In order to ensure the sustainability of such responses in the long-term, increased ownership and financial investment will be required from the Royal Government of Cambodia, in combination with ongoing institutional strengthening and capacity building within government and civil society.

Meaningfully involving people living with and affected by HIV in prevention, treatment, care and impact mitigation

While this initiative meets many of the above criteria, it is particularly relevant to criteria numbers 10 (People living with or affected by HIV are actively involved in interventions) and 7 (Practice contributes to increased community acceptance and social inclusion of people living with HIV). Practise is also suitable for replication or scaling up and therefore meets criteria number 4.

Located at the historic temple site of Wat Nokor Bachey in Kampong Cham province, Buddhism for Social Development Action[14] (BSDA) is a non-government organisation working to empower women, children (including street children and orphans) and marginalised populations (including people who use drugs) within the context of education, health, agriculture, livelihoods and social accountability. Founded by seven young monks (still attending Buddhist High School) in 2005, BSDA has grown quickly: It now has 27 paid staff and 105 volunteers (a combination of monks and lay people from different religious backgrounds) and an annual budget of USD210,000.

The organisation was established in response to criticism from nearby villagers. “The community felt that the monks would preach altruism in theory but hardly ever practice it,” the Introduction to

[14] *Formerly known as Buddhism and Society Development Association.*

the 2012-2016 Strategic Plan explains, "Deeply hurt, seven monks founded the organisation, financing it privately throughout the first three years until their work was noticed and international donors started to provide funding." (19) Buddhist philosophy, particularly the concept of metta (a selfless attitude of love and friendliness), continues to guide the overall strategic focus of BSDA as well as the day-to-day running of the organisation. However, all programming is underpinned by a firm commitment to cultural and religious diversity. The Improving Basic Education Campuchea (IBEC) project, for example, includes a Multicultural Lifeskills component where Buddhist, Muslim and Christian leaders facilitate workshops in 48 secondary schools in Kampong Cham and Kratie provinces in order to "improve communication" between students of various faiths and cultural backgrounds (19).

Image 6: Buddhism for Social Development Action (BSDA) staffs in front of their office in Kampong Cham province (from left to right: Drug Project Community Support Officer Pum Pheara, Human Resources Manager Hom Saran, HIV/AIDS Project Community Support Officer Aun Ngunheng, HIV/AIDS Project Community Support Officer Oung Ngunhen, and Deputy Director/Program Manager Chhourng Sovanna)

BSDA is part of a national network of 40 organisations implementing the Sustainable Action Against HIV and AIDS in Community (SAHACOM) project in partnership with KHANA. Targeting five districts in Kampong Cham province, BSDA works to improve the quality of life of orphans, vulnerable children and people living with HIV. Notably, all activities are led by local people who are themselves living with or affected by HIV.

BSDA currently oversees 22 support groups for orphans and vulnerable children and 17support groups for adults living with HIV, each with between 15 and 25 members. These groups are led by trained Community Support Volunteers(17 adults and 22 children) who are living with or affected by HIV and generally come from the same villages as support groupmembers. Self-help groups for adults living with HIV are peer-led by adults living with HIV, while self-help groups for orphans and vulnerable children are peer-led by orphans and vulnerable children. During monthly meetings of adults living with HIV, Community Support Volunteers disseminate information in relation to treatment literacy, nutrition, positive prevention, sexual and reproductive health and PMTCT, among other issues. Topics such as HIV prevention, child rights, and stigma and discrimination are also discussed at monthly meetings of orphans and vulnerable children. These activities are carried out in partnership with the Kampong Cham Provincial People Living with HIV Network (PPN+) in order to ensure effectiveness and sustainability.

Community Support Volunteers also provide home-based care services to 165 HIV-affected households in two districts, providing psychosocial and spiritual support and making necessary referrals to pubic clinics for HIV testing and treatment, as well as sexual and reproductive health and family planning services. Where relevant, HIV-affected households are also linked with financial services provided by Vision Fund Cambodia (a local microfinance institute). Material and food support is provided to households in need.

In addition, BSDA works to ensure participation of people living with and affected by HIV in local governance and to increase the transparency and accountability of local government institutions. BSDA staff routinely support Community Support Volunteers (both adults and children) to attend Commune Council meetings (and other meeting held at the village, commune and districtlevels) so they can communicate their social, economic and health needs to local government representatives. According to BSDAHIV/AIDS Project Community Service Officer Aun Kimseng, this strategy has already seen promising results. For example, a recent meeting between Community Support Volunteers and health centre representatives apparently resulted in health centre staff halting the practice of accepting informal payments for publicly-funded HIV services.

BSDA program staff explain they recently developed organisational policies on gender and human rights, and work in accordance with the following national policies and guidelines:

- National Policy on the Religious Response to HIV and AIDS (MoCR 2002)
- National Strategic Plan for the Comprehensive and Multisectoral Response to HIV/AIDS 2011-2015
- National Standards for the Care, Support and Protection of Orphans and Vulnerable Children (MOSVY 2010)
- Minimum Standard on Alternative Care for Children (MoSVY 2008)
- National Guidelines for the Prevention of Mother to Child Transmission of HIV (MOH 2010)

Adapting to the needs of marginalised community members

This initiative meets several of the above criteria, but is highlighted here because it reaches hard-to-reach populations, including hard-to-reach women and children (criteria 8) and because approaches emphasise sustainability and local capacity building (criteria 12). Vision Fund Cambodia has also received a great deal of international recognition (criteria 3) for its microfinance activities.

Established in 2003, Vision Fund Cambodia is a licensed microfinance institution providing financial services (savings and loans) to low

income households, including households affected by HIV. Vision Fund Cambodia evolved from a microcredit program within World Vision Cambodia in the 1990s and was later established as a separate institution, an affiliate of Vision Fund International.[15]

Targeting poor households who had otherwise been excluded from accessing conventional financial services, Vision Fund Cambodia began offering low-interest loans with a range of flexible repayment options to meet the needs of households with monthly income, as well as those with seasonal income. In addition, clients borrowing between USD25 and USD1000 were provided with free life insurance which meant, if a loan recipient died before the loan was repaid, any remaining debt would be cancelled (and would not fall toremaining family members). Families would also receive a small contribution toward funeral costs.

Operating in 17 provinces and one municipality, Vision Fund Cambodia began offering tailored financial services to HIV-affected households in Kampong Cham province in 2007, and is now operating in eight out of 16 districts. Recognising the individual and household-level impacts of HIV, Vision Fund Cambodia further adapted their financial services to meet the specific needs of people living with and affected by HIV.HIV-affected households were offered a special interest rate of 2%, compared with the standard rate of 3%.[16] However, according to Kampong Cham Provincial Branch Manager Som Kimsong, stigma surrounding the disease has sometimes caused HIV-positive borrowers to pay the standard rate rather than disclose their status.

Realising that financial services are not the only tool for economic development and poverty alleviation, Vision Fund Cambodia works in partnership with various non-government organisations and private institutions. For example, in Kampong Cham province, Vision Fund Cambodia provides financial education to loan recipients, while a partnership with the Khmer HIV/AIDS NGO Alliance (KHANA) sees loan recipients receive health education and vocational training tosupport income generation activities such as fish farming and motorbike repairing. Additional technical support is provided by Plan Cambodia and by the Cambodian Centre for Study and Development in Agriculture (CEDAC).

In 2005, Veasna and his wife Sreymom[17] approached Vision Fund Cambodia, interested in accessing credit to start a small pig farming business. They had no credit history or collateral to borrow against, and were therefore unable to access conventional financial services. They were, however, discouraged to learn that Vision Fund Cambodia also requested collateral from loan recipients. They were both HIV-positive and living with extended family members. They did not own their own home, nor did they have other assets with which they could secure a loan. They appealed to Vision Fund Cambodia, explaining that such a policy made it difficult for people living with HIV to access credit.[18] Six months later, as a result of their feedback, the policy was amended. HIV-affected households were no longer required to produce collateral when applying for a loan. Since then, Veasna and Sreymom have received five loans from Vision Fund Cambodia, ranging from R500,000(USD125) to USD1,000. The first four loans were used to establish a small pig farming business, to buy a motorbike and to purchase a block of land. All four loans have since been repaid. The fifth loan, 60% of which has been repaid, was used to build a house on the land, where Veasna and Sreymom and their three children are now living.

While Vision Fund Cambodia describes themselves as a "Christian company" operating in accordance with "Christian values", they do not provide any form of religious guidance or spiritual support to clients, nor do they keep a record of the religious affiliations of borrowers. In most aspects, Vision Fund Cambodia operates as a secular microfinance institution would, though SomKimsong is quick to point out that Vision Fund Cambodia is motivated by a desire to help the poor liberate themselves from poverty, rather than the desire for profit. He attributes this motivation to the Christian value base of the company.

Vision Fund Cambodia seeks to provide financial services to the poorest and most vulnerable members of the community, with a focus on women and children. In addition to targeting people living with HIV, Vision Fund Cambodia reaches out to widows, people with disabilities and families caring for orphans and vulnerable children. Special loans support families to enrol their children in higher education or vocational training, while others promote child rights among impoverished households. Recognising that women face unequal access to economic opportunities,and are generally more inclined to spend additional income on healthcare and education for their children, Vision Fund Cambodia actively targets women borrowers. In 2010, 88% of Vision Fund Cambodia's borrowers were women while, in Kampong Cham province, 90% of all borrowers were women.

In 2009, Vision Fund Cambodia was ranked 51st among the 100 top microfinance institutions in the world by the Microfinance Information Exchange (MIX) against criteria including outreach, efficiency and transparency. As of December 2010, Vision Fund Cambodia was providing financial services to 32 people living with HIV in Kampong Cham province. The average loan size was USD 515 and the repayment rate was 99.8%. In the future, Vision Fund Cambodia aims to establish a foundation for innovative and sustainable financial services for people living with and affected by HIV that would help remove barriers to economic opportunities for typically marginalised community members (20).

[15] *Vision Fund International is the microfinance subsidiary of World Vision. Like World Vision, it is an independent Christian non-profit organisation.*

[16] *Still substantially below the average interest rates paid by HIV-affected (5.4%) and non-affected (4.3%) households (2).*

[17] *Not their real name*

[18] *In Cambodia, only 53% of HIV-affected households own their own home, compared with 80% of non-affected households. HIV-affected households are also less likely to own basic assets such as electrical equipment, motorised and non-motorised vehicles or livestock (2).*

Providing community-based care for orphans and vulnerable children

This initiative, implemented by Partners in Compassion in Takeo province, meets several of the above good practise criteria. Of particular relevance are criteria 1 (practice adheres to national guidelines and standards) and criteria 6 (services are not conditional upon recipients changing faith).The initiative also contributes to increased community acceptance of people living with HIV (criteria 7).

With an estimated 85,000 children in Cambodia orphaned or made vulnerable by HIV, and one third of HIV-affected households caring for a HIV orphan (2), the past decade has seen ongoing debate regarding the best way to care for such children, specifically whether it is better to care for orphans in family and community-based settings or in institutions such as orphanages. In 2006, the Ministry of Social Affairs, Veteran's and Youth Rehabilitation (MOSAVY) issued the Policy on Alternative Care for Children which stated a clear preference for family and community-based care including kinship care, foster care and adoption. The policy recommends parents (or extended family members) are supported to raise their own children wherever possible, and institutional care (also known as residentialcare)isutilised only as "a last resort and a temporary solution".

Based in Takeo Province, Partners in Compassion has been supporting local families and communities to care for orphans and vulnerable children since 2001. In addition, they provide residential care to orphans where family or community-based solutions could not be found.

The organisation grew out of a partnership between San Vandin (a Buddhist) and Wayne Matthysse (a former evangelist Christian) who met while working for the Catholic Office for Emergency Relief and Refugees (COERR) in the 1990s. At the time, Vandin San was providing HIV awareness training to Buddhist monks in Takeo province, while Wayne Matthysee was working as a medic. There was little access to antiretroviral therapy at the time and both men identified the need for a special health facility, providing palliative care to those who were dying, as well as offering HIV awareness training to monks and community members. The facility was built on the grounds of Wat Opot (a Buddhist pagoda in Takeo province) in 2000. The following year, Vandin San and Wayne Matthysse formed Partners in Compassion and COERR handed over the management of the facility to them. With the gradual strengthening of the national health system and the increasing availability of antiretroviral therapy, Partners in Compassion has slowly shifted focus from palliative care toward education, livelihood opportunities and community-based care, while continuing to provide residential care (as a last resort) to orphans who have no one else to care for them.

Today, the Wat Opot Children's Community is home to 65 children between the ages of one and 19. Roughly half are living with HIV though children are never segregated according to their status. They sleep in the same rooms, eat the same food and attend the same schools, irrespective of HIV status. According to Project Coordinator Chea Phearom, the only distinctive treatment is related to the particular health needs of children living with HIV. The health of such children is monitored closely and they are accompanied to the local hospital once a month in order to receive antiretroviral therapy. All children receive age-appropriate HIV prevention education and understand there is no justification for HIV-related stigma and discrimination.

Wat Opot Children's Community goes to great lengths to support the social, cultural and spiritual development of its residents. The boundaries of the Community are intentionally porous. Children are free to visit school-friends and neighbours in surrounding villages, and welcome to receive visitors at any time. Importantly, children are encouraged to stay in touch with any extended family members (those who are unable to provide kinship care due to significant health, financial or other reasons) and visit relatives and friends during Khmer New Year, Pchum Benh and other religious and cultural festivals. Children are free to maintain their own religious beliefs and to manifest such beliefs in religious practice. Spirituality is considered essential for the development and each child and, while specific religious education is not provided, children are given the opportunity to participate in regular mediation, yoga and art classes, as well as weekly services at local pagodas and churches, though such activities are entirely optional.

While managing the Wat Opot Children's Community, Partners in Compassion works to strengthen the capacity of disadvantaged families to care for children within the home environment so as to minimize the need for residential care. In 2011, Partners in Compassion employed 12 paid staff who worked with 108 monks from 36 pagodas and 42 volunteers to provide home-based care to 475 people living with HIV and 808 vulnerable children in Bati operational district, Takeo province. Psychosocial and spiritual support is provided by monks, while volunteers provide technical information in relation to issues such as treatment literacy, nutrition and positive prevention. Necessary referrals for HIV tests and treatment, as well as sexual and reproductive health and family planning services are also made. Vocational training and start-up capital for income generation activities (such as chicken, duck or pig farming) is provided to HIV-affected households in order to mitigate the economic impacts of the disease. In addition, monks and volunteers encourage families to keep children in school, and liaise with school authorities where necessary. Food and material support (including school books and uniforms) are also provided to households in need. Chea Phearom explains this methodology is particularly effective because community members generally respect monks and appreciate guidance received from them. Where Christian households are affected by HIV, Christian volunteers are selected to provide psychological and spiritual support within a Christian theological framework.

For Partners in Compassion, the emphasis is on supporting families to take care of their own children, accepting children into residential care only when all other options have been exhausted.

65-year-old Venn[19] was struggling to care for her 13-year-old grandson when she was first visited by Partners in Compassion volunteers. She had been looking after her grandson since his parents abandoned him when he was three months old. Venn had no regular income and was having trouble feeding and clothing her grandson and paying for him to go to school. Then he fell ill and was taken to the local hospital where he was diagnosed with HIV. Soon after, Venn received her first visit from Partners in Compassion volunteers who had heard of her situation through other people in the village. A volunteer now visits Venn twice a month, providing valuable food and material support (including school clothes and books for her grandson) and a small amount of money so they can travel to the local hospital each month. The volunteer also provides psychological support and shares information on issues such as HIV prevention, nutrition and hygiene (Venn recalls knowing nothing about HIV when her grandson was first diagnosed).

Though she is grateful for the support she receives from Partners in Compassion, Venn is worried about who will take care of her grandson after she dies. She has received no news from either of the child's parents and does not know if they are still alive. She has seven other children (all grown up with their own families) but they are also poor and unable to take care of an extra family member. According to Chea Phearom, if Venn were to die before her grandson was old enough to look after himself, Partners in Compassion would speak will extended family members, as well as other families in the village, and see if they could care for the boy with the continued support of Partners in Compassion. Then, if kinship or foster care could not be arranged, Partners in Compassion would invite him to join the Wat Opot Children's Community.

Ensuring access to HIV services through comprehensive coordination

The work of Caritas Cambodia is highlighted here because it reaches hard-to-reach populations, including hard-to-reach women and children (criteria 8) and ensures sub-national collaboration and information sharing (criteria 11).

An official social development arm of the Catholic Church, Caritas Cambodia works in eight provinces across Cambodiawith its national office in Phnom Penh. Caritas Cambodia focuses on food security, community health and human rights. Caritas Cambodia provides home based care support to 1713 people living with HIV and over 5000 family members in the four operational districts of Siem Reap Province, including 12 administrative districts and 616 villages. Within Sot Nikom district in Siem Reap province, Caritas Cambodia's ten staff and volunteers work to raise awareness of HIV and STIs and encourage and supports community members to get tested. The organisation facilitates home-based care, self-help groups,livelihood interventions and a Drop-In Centre for community members affected by HIV.

Caritas Cambodia is one of three organisations implementing HIV interventions in Sot Nikom district, and has developed strong linkages with local partners. The three organisations work together to support local communities to access the District's 23 health centres. In order to avoid duplication and maximise coverage, the three organisations, in consultation with the district health authority, have agreed which health centres and communities they will each focus on. Caritas Cambodia is responsible for 14 villages and 16 health centres. Staff and volunteers regularly visit both the health centres and the villages, andsupport community members to access HIV prevention, treatment, care and impact mitigation services.

The close relationship between Caritas Cambodia and the 16 health centres results in practical cooperation which saves many lives.

Image 8: 65-year-old Venn has been caring for her 13-year-old grandson since he was three months old.

Chan Rean is 40-years-old and married to her husband Phoung Mean, a rice farmer. Rean and Mean are the proud parents of one year-old twins. When Rean was pregnant she heard about the importance of getting a HIV test and went by herself to the health centre. She took the test but did not return for her result. Health centre staff realised she had tested positive for HIV, knew she was pregnant, knew what village she lived in, and were aware that Caritas Cambodia worked in that village. Without breaching Rean's privacy and her right to confidentiality, a midwife from the health centre accompanied Caritas Cambodia staff the next time they visited her village. When the midwife found Rean, she passed on the message that her test results were ready for her to collect. This was enough encouragement for Rean to return to the health centre, collect her test results and ultimately access PMTCT services. As a result, her twins were born HIV-negative. Caritas Cambodia staff and volunteers continue to visit Ream and Mean and provide financial support so they can visit the health centre each month.

[19] *Not her real name.*

Image 9: Chan Rean is a busy mother of one-year-old twins. She accessed PMTCT services while she was pregnant, with the help of Caritas Cambodia and her local health centre.

Since Caritas Cambodia began working in Sot Nikom district, staff report an increase in community awareness of HIV transmission, accompanied by an overall decline in the number of suspected HIV cases referred to health centres each month. They also report a reduction of stigma and discrimination within the community because of increased understanding of HIV transmission and treatment options. According to Caritas Cambodia staff, before the organisation began implementing community education and awareness raising activities, people living with HIV had difficulty selling their products locally because others feared infection. Now an increasing number of community members do not discriminate against sellers they know are HIV positive. None the less, challenges remain for Caritas Cambodia staff when following up with patients who have no mobile phone and work in fields away from their home. They were fortunate to have found Reanin her village the first time they went looking for her, but many people cannot afford a phone and Caritas staff face challenges to make contact with them if they work away from home.

Caritas responded to this situation by increasingly involving volunteers living with HIV as part of the Community Home Based Care program and who can provide peer outreach at community level. Trained by Caritas, these volunteers are able to run the HBC program on their own, looking for new cases on treatment and educating them to ensure full adherence to treatment and ways to live positively with HIV. They lead self-help group meetings for people living with HIV, they speak out and are able to give testimonies at important events, and network with pagodas, school teachers and villages leaders in order to reduce stigma and discrimination. The volunteers help people to re-integrate in society through linkages for livelihood support and skills trainings. The volunteers living with HIV are important role models and provide essential support to families.

Working with diverse faith communities to reduce stigma and discrimination

The following initiative exemplifies good practice criteria 7 (practise contributes to increased community acceptance and social inclusion of people living with HIV and key affected populations) and criteria 6 (services are not conditional on recipients changing faith).

Faith-based organisations are in the unique position of being able to provide both HIV interventions that are secular in nature, as well as those that are tailored to specific faith contexts. This means faith-based organisations like the Islamic Local Development Organisation (ILDO) are able to provide secular public health messages and services to the general population, as well as reaching out to specific faith communities and leadersin ways secular organisations are not able to.

Established in Battambang province in 1993, ILDO aims to improve the quality of life of the poorest and most vulnerable members of society, with a focus on agriculture and rural development, health education, livelihood creation, gender equity and human rights education, interfaith-harmony and peace building. ILDO commenced HIV interventions in 1997andhas successfully provided HIV prevention, treatment, care and impact mitigation services to Muslim communities that had previously received little in the way of public health messaging. But it was ILDO's ability to reach out to people of all faiths that transformed the life of a young Buddhist woman named Sarorng.

After Sarorng tested positive for HIV and the people in her village began to learn of her status, the discrimination she experienced isolated and shocked her. At restaurants, proprietors would not let her sit down – they made her take the food she bought away. At shops and stalls, the sellers would not let her touch any of their products or produce – she had to point at what she wanted to buy. As she walked down the street, people would pause to let her walk ahead so they would be able to keep a distance from her. No one spoke to her.

One day, ILDO staff and volunteers came to Sarorng's village to raise awareness of HIV including how it can and cannot be transmitted (fear of contracting HIV through mosquito bites contributed to people avoiding her). At a community meeting organised by ILDO, Sarorng asked if she could speak to the gathered community about how she felt. As she told them about her isolation and the discrimination she had experienced, many people were moved to tears. After the community meeting, people gradually began speaking to her again. Even small children who were previously afraid began approaching her. Far from being bitter about the lack of understanding she had experienced, she was relieved and overjoyed to be accepted into the community again.

ILDO recognised Sarorng's bravery in sharing her experiences with her community, as well as the impact this had on reducing stigma and discrimination among those who heard her story. The organisation subsequently invited her

to speak at other community events; to provide her personal perspective and inspire others to speak out. Sarorng is now a regular volunteer with ILDO. As a Buddhist, Sarorng appreciates ILDO's policy of reaching out people of diverse faiths. However, she also appreciates its Islamic faith identity because she can see how ILDO is able to connect with Muslim leaders and communities. Since first coming into contact with ILDO, Sarorng has increased her own understanding of Islamic perspectives, particularly in relation to HIV. This, in turn, has increased her ability to relate to Muslim community members. Sarorng remains a committed Buddhist and feels that her faith is respected by her Muslim colleagues, just as she respects theirs.

Harnessing the positive social standing of monks

The following intervention reaches hard-to-reach populations, including hard-to-reach women and children (criteria 8) and actively engages people living with HIV (criteria 10).

Buddhism for Development is a Cambodian non-government organisation with approximately 150 Khmer staff working in seven provinces in the northwest of Cambodia and around the Tonle Sap lake. Based at Wat Anlongvil in Battambang province, the organisation aims to "achieve harmony between the individual, society and the environment" (21) through supporting agricultural and rural development, strengthening democratic governance and social accountability, promoting gender equity and human rights, and ensuring access to basic education and health services including home-based care and other services for people living with HIV. Founded in 1990 by a group of Buddhist monks, Buddhism for Development aims to promote socially-engaged Buddhism in Cambodia, placing special emphasis on the role of monks in community and social development.

- National Policy on the Religious Response to HIV and AIDS (Ministry of Cult and Religion)
- National Strategic Plan for the Comprehensive and Multisectoral Response to HIV/AIDS 2011-2015
- National Standards for the Care, Support and Protection of Orphans and Vulnerable Children (MOSVY 2010)
- Minimum Standard on Alternative Care for Children (MoSVY 2008)
- National Guidelines for the Prevention of Mother to Child Transmission of HIV (MOH 2010)
- National Guidelines for the Use of Paediatric Antiretroviral Therapy (MOH 2010)

Svay Sinan and her husband Loeun Visoth live in Battambang province. They were first visited by Buddhism for Development in 2005 after lay volunteers noticed Sinan was losing weight. They enquired about her health and asked her if she had thought about getting a HIV test. Sinan had not considered getting a HIV test and sent the volunteers away. The volunteers made further visits, angering Sinan, and she continued to send them away. Eventually, Sinan received a visit from one of Buddhism for Development's monk volunteers. Even though the monk essentially said the same thing as previous volunteers, Sinan's respect for monks meant that she listened more carefully to what the monk had to say and eventually heeded his advice. She decided to get tested for HIV and discovered that she was indeed HIV-positive. Buddhism for Development volunteers then supported Sinan to access HIV treatment services at the local health centre.

Sinan is now a volunteer with Buddhism for Development, providing peer support to other people living with HIV. She often finds herself mediating family disputes and providing advice in relation to sensitive matters such as gender-based violence. Sinan's role as mediator extends to her business life as well : she deals in fish and supplies small retailers.

According to Sinan, the impact of Buddhism for Development's work in her district is visible in the reduction of stigma and discrimination experienced by people living with HIV. Sinan is confident and communicates clearly. Sinan and her husband both said they would like their photos to be published in this report and would prefer their real names to be used, rather than pseudonyms.

Image 10: Svay Sinan and her husband Loeun Visoth participate in Buddhism For Development's HIV program. After encouragement from a Buddhist monk to access HIV testing in 2005, Sinan accessed HIV treatment and has become the leader of the local self-help group for people living with HIV.

5 Discussion and Conclusions

Working with faith leaders to strengthen community engagement

The ability of faith leaders to influence individual and community behaviour change was highlighted by Buddhist, Christian, Muslim and secular organisations alike. Christian and Muslim organisations worked to increase HIV awareness among their respective faith leaders, so leaders would be equipped to discuss and respond to HIV at the community level. However, as the vast majority of Cambodian identify as Buddhist, all organisations, regardless of faith, recognised the particular benefits of engaging Buddhist monks in community-level interventions, particularly in the provision of psychological and spiritual support to people living with HIV and in HIV awareness raising and stigma-reduction among the general population.

Due to their status within Cambodian society, the presence of a monk at a community meeting was thought to strengthen community participation and lend credence to social and public health messages. For example, CARE Cambodia Global Fund Program Manager Dr. Srey Vanthuon noted "a community meeting might attract 100 adults and 200 children, all chatting amongst themselves, but a hush would invariably fall over the crowd whenever a monk began speaking". Even the children would fall silent and listen carefully to what was being said. In Kampong Thom province, PDCR Buddhist Leadership Initiative Project Coordinator Hoeun Yenthy suggested the following idiom to illustrate the influential position of monks: "If a monk makes 10 statements, a person might believe seven to eight of them. If an ordinary person makes 10 statements, the same person might believe only one of them." In Prey Veng province, Save the Children Australia OVC Shelter Coordinator Meth Lorn reported: "If the meeting is [organised by the local authority], the villagers do not want to come, but when they hear the meeting is organised by the Pagoda Committee, they are willing to come." He attributes this phenomenon to the high status of monks within Cambodian society, as well as to the perception that faith-based interventions are implemented fairly and transparently, targeting the poorest and most vulnerable community members.

Organisations frequently highlighted the capacity development needs of monks, particularly those from rural areas, who often had only a basic level of education. Monks engaged in HIV interventions (particularly those working with Pagoda committees) were sometimes handed significant administration, finance and programmatic responsibilities. Accordingly, HIV interventions were frequently linked to ongoing capacity building efforts. Organisations such as Life With Dignity, CARE Cambodia, Save the Children Australia, Buddhism for Development, UNICEF and Salvation Centre Cambodia all provided capacity building opportunities to monks. Some also worked with Buddhist nuns. In addition to providing HIV awareness training to newly ordained monks, some organisations provided ongoing refresher training, recognising that the HIV epidemic and treatment environment was constantly evolving. Indeed, the advent and rapid scale up of ART and OI services and the roll out of PMTCT services has demanded all faith-based actors continually refresh their understanding of the HIV epidemic and response.

Linking religious discourse with HIV prevention messaging

Community meetings and religious sermons were frequently utilised to communicate HIV prevention messages to the general population, as well as addressing issues of stigma and discrimination within the community. On such occasions, monks used the Five Buddhist Precepts to encourage qualities such as loving-kindness and compassion, while discouraging high-risk behaviours. "The lessons compiled by the Ministry of Cult and Religion are different from the lessons compiled by the Ministry of Health," explained Kampong Cham PDCR Vice Director Chea Sareth, "In the health sector, they are talking about sexuality – in case you want to have multiple partners, you have to use a condom and they teach you how to use a condom. But we refer to the Five Precepts of the Buddha."Indeed, monks frequently expressed their capacity to provide comprehensive HIV prevention education was limited by their inability (due to cultural mores) to use words related to sex and sexuality. While some monks felt comfortable discussing sensitive issues such as sexual transmission of HIV and condom use, the majority preferred to use euphemisms or to avoid discussing such matters entirely. Accordingly, monks often teamed up with health professionals or volunteers when speaking publically about HIV. Monks would discuss HIV prevention within the context of the Five Buddhist Precepts while health or community workers tackled sensitive and technical issues.

Conversely, some faith-based organisations chose to implement HIV prevention interventions without the engagement of monks or other faith leaders, relying solely on the technical expertise of health and community workers.

While many faith-based organisations provided HIV awareness education to the general population, relatively few organisations implemented targeted HIV prevention interventions among key affected populations such as sex/entertainment workers, men who have sex with men and transgender persons, though several organisations did work with people who use drugs. Somefaith-based

organisations were reluctant to engage with these populations due to perceived safety and security risks, particularly in relation to individuals who might be engaging in illegal activities such as taking drugs or selling sex. This highlights the need for such organisations to build organisational capacity in this area and/or build partnerships with local organisations working effectively with relevant populations.

Providing psychosocial and spiritual support to people living with HIV

The vast majority of faith-based and secular organisations participating in this review reported providing psychosocial and spiritual support to people living with HIV. Such interventions would appear critical, in light of recent studies which found significant numbers of people living with HIV had experienced psychosocial and mental health issues including low self-esteem and suicidal thoughts (2).

Monks frequently provided spiritual support to people living with and affected by HIV by leading meditations, either at pagodas or during self-help group meetings. Community members explained these meditations helped them reduce stress and anxiety and deal with the challenges of day-to-day life. Community members also reported receiving moral counselling and guidance (grounded in Buddhist principles) from monks who helped them to make wise choices and feel hopeful about the future. However, monks explained some community members were hesitant to speak to them because they were concerned about using inappropriate language (terminology used to address monks is slightly different i.e. more formal than popular spoken Khmer).

In Siem Reap, Buddhist nun Ven. Duong Laing Eng is both Salvation Centre Cambodia (SCC) Administrator and Counsellor to community members who visit the office seeking support. She provides referrals to local health facilities and to the pagoda where people can meditate with the monks. Ven. Eng is also a role model to women in the community and to other nuns. She was originally a teacher but made her living as a tailor during the Khmer Rouge era. Although she survived this period, many of her family members, including one of her two children, did not. In 1979, immediately after the fall of the Khmer Rouge, she joined a pagoda. Then, as HIV began to affect her local community, Ven. Eng began providing home-based care to people living with HIV. In 2009, she began teaching herself to use computers. She learned on her own for three months until SCC sponsored her to attend formal training. Now 71-years-old, Ven. Eng continues to provide psychosocial and spiritual support to people living with and affected by HIV, motivating them to live healthily and meditate regularly.

Image 12: Ven. Duong Laing Eng is the Salvation Centre Cambodia (SCC) Administrator and Counsellor in Siem Reap.

It is not surprising that organisations working with Buddhist monks and nuns (and community members currently accessing these services) would underscore the benefits of engaging Buddhist sangha in HIV interventions. It is of course possible that some community members – those not accessing such services – are less enthusiastic about discussing personal matters with monks or nuns. Indeed, informal conversations with community members not accessing such services would suggest some people view their local pagoda as playing only a marginal role in their day-to-day lives, relegated to ritual observances during major religious and cultural festivals such as Khmer New Year and Pchum Benh. Furthermore, some community members questioned the motivations of young men entering the monkhood, explaining some took robes because of strong religious convictions, while others saw ordination as an opportunity to further their education while having their day-to-day needs taken care of by the pagoda. Such people said they would be more likely to seek advice from a trusted friend or relative, or from a health professional. Accordingly, organisations would be advised to engage health workers and other professionals alongside Buddhist monks so as to provide a range of options to community members.

Combating HIV-related stigma and discrimination

Stigma and discrimination are often cited as one of the most powerful impediments to an effective HIV response (22). Stigma and discrimination may deter individuals from accessing HIV testing services, and inhibit people living with HIV from seeking treatment, sharing their diagnosis and taking action to protect others. It may also affect their ability to access education, training and income generation opportunities. Furthermore, HIV-related stigma builds upon and reinforces other social inequalities such as those related to gender, sexual orientation and ethnicity.

Munny[20] lives in the urban centre of Battambang. He is a member of a self-help group for people living with HIV, though he and his peers have been unable to collaborate to earn an income locally. He explained community members will not purchase their wares because everyone knows they are HIV-positive and is afraid of contracting the disease. He believes he faces two options: either move to another village but risk affecting his access to treatment, or stay where he knows he can access treatment but forgo income generation opportunities. At the moment, he is choosing to stay where he knows he can access treatment. Once a monk himself, he immediately turned to Buddhism for Development for support after testing positive for HIV. While he receives much-needed psychosocial and material support from Buddhism for Development volunteers, he continues to face high levels of discrimination within the community. He preferred not to have his photograph taken by the review team and requested his name be withheld from this report because he feared causing further anguish to his family.

[20] *Not his real name*

During the course of the review, the ability of faith leaders to influence individual and community attitudes was consistently highlighted by faith-based and secular organisations. While some interviewees saw a relationship between HIV transmission and so-called deviant behaviours (such as intoxication or sexual misconduct), all described HIV as an important social and public health issue, requiring a compassionate and evidence-informed response. Accordingly, more than 90% of survey respondents reported working to reduce HIV-related stigma and discrimination. Some faith leaders incorporated messages of compassion and acceptance into religious sermons, while others intervened at the villagelevel – visiting individuals and households thought to be responsible for discrimination and providing accurate information in relation to HIV prevention, treatment and care. In addition, the presence of faith leaders (particularly Buddhist monks) at community meetings where HIV issues were discussed, or during home-visits to HIV-affected households, was thought to send a strong signal to community members that people living with HIV were valuable members of the community and were not to be discriminated against.

However, with over 55,000 monks in Cambodia (5), it would be wrong to assume that all were equally aware of the HIV epidemic and effectively engaged in community-level responses. A 2004 survey of 22 temples in Kandal province reported HIV awareness was "shockingly low among temple residents" specifically citing a fear of HIV transmission (23).

Image 11: Buddhist Leadership Initiative representatives with members of the review team at the historic temple site of Nokor Bachey in Kampong Cham province. (From left to right: Translator Heng Sambath, Kampong Cham PDCR Vice Director Chea Sareth, Venerable Phoung Sakor, and MoCR Vice Chair of Administration Chhoeum Chhad.)

Programs like the MoCR Buddhist Leadership Initiative, supported by UNICEF, have been introduced to strengthen community acceptance of people living with and affected by HIV, while increasing access to prevention, treatment and care services, with promising results. The initiative's 2007 evaluation, supported by UNICEF, found evidence of encouraging changes. For example, an overwhelming majority (90%) of junior monks stated they would feel comfortable sitting

next to a person living with HIV of the same sex, or tying a blessing string on the wrist of someone living with HIV. Between 81% and 100% of monks said that they would share household objects with a fellow monk who was HIV positive.

However, despite working in 886 villages across 10 provinces, the Buddhist Leadership Initiative reaches approximately 387 of Cambodia's 4,307 pagodas. Although this is one of many initiatives working with Buddhist monks in Cambodia, a significant number of monks continue to lack the requisite knowledge and skills to enable effective anti-discrimination interventions at the community level. Within the context of Cambodia's concentrated HIV epidemic, it is essential such interventions target pagodas/mosques/churches in high-prevalence areas where significant numbers of people are living with HIV.

Engaging Buddhist nuns in HIV responses

The review identified several instances where Buddhist monks established faith-based organisations and/or initiated specific faith-based responses to HIV (such as Buddhism for Social Development Action and Buddhism for Development). Other initiatives (such as Buddhist Leadership Initiative and Save the Children Australia's OVC program) engaged monks as community mobilisers or resource people. In all cases, there was positive feedback from program staff and from community members regarding the added value of engaging monks in such initiatives. What is less evident overall is the role of nuns in the national HIV response – their capacity and willingness to engage in HIV interventions, and the potential impact of such engagement.

The Theravada Buddhist tradition (observed in Cambodia and most of Southeast Asia) no longer offers full ordination to women. This tradition died out some time ago. In present-day Cambodia, nuns are devout laywomen who choose to live according to the Eight Buddhist Precepts (aññhasāla), reside at a pagoda, don simple white robes and shave their heads as a symbol of renunciation. Most nuns are older women who have chosen to serve fully-ordained Buddhist monks, thereby accumulating merit for the next life (4).

A 2005 report on the potential of nuns to respond to orphaned and vulnerable girls noted many nuns entered the pagoda upon retirement, seeking peace and quiet in their older age, and were therefore not ideally placed to act as carers for children (24). However, apart from the example of SCC Administrator and Counsellor Ven. Eng, little information was identified during this review with respect to the potential role of nuns in the national HIV response.

Faith-specific responses versus proselytisation

Since international humanitarian organisations and assorted missionary workers began pouring into Cambodia at the end of the Khmer Rouge era in 1979, there has been ongoing debate in relation to the appropriateness of proselytisation (or evangelising, as it is sometimes known) within the development context.

This review found, while some faith-based organisations intentionally separated their development work from any religious messaging, others viewed development as indivisible from spiritual well-being. This review did not identify any initiatives whichactively encouraged community members to adopt a new religion or made their services conditional upon conversion to a particular faith, though available literature would indicate such practices continue to exist (4). The initiatives included in this review all targeted populations in particular geographical areas, while the faith identity of the organisation and the faith(s) of community members did not influence the selection of service recipients. Rather, services weredelivered according to need.

A number of faith-based organisations did, however, report providing faith-specific responses to individual faith communities. For example, World Vision Cambodia implements HIV training among Christian communities using the Channels of Hope training model. Designed specifically for Christians, it is an intensive transformative learning approach using Biblical language and concepts. World Vision uses an adapted version for secular audiences. Similarly, the Kampong Thom Buddhist Leadership Initiative draws on the Twelve Nidānas (the origins of suffering) to encourage Buddhist community members to respect each other and avoid high-risk behaviours. In Takeo province, Partners in Compassion recruits Buddhist monks and volunteers to provide home-based care (including psychological and spiritual support) to Buddhist families, while Christian volunteers are selected to provide support to Christian households. These organisations do not proselytise and their secular HIV services target community members regardless of faith.

Hiring practices differed widely. While some faith-based organisations were staffed by people from diverse faith backgrounds, others expressed a desire to maintain the faith-identity of their organisation by recruiting, where possible, from within their faith community. For example, World Vision Senior Program Manager Mary Mohan explained, while staff were certainly not required to subscribe to the Christian religion, they were required to adhere to broad Christian principles. In addition, senior management positions were sometimes reserved for Christians, even if this meant recruiting qualified staff from abroad.

Because the vast majority of Cambodians identify as Buddhist, surveyed organisations were predominantly staffed by members of the Buddhist community.

Bopha[21] is Buddhist, though she volunteers with the Islamic Local Development Organisation (ILDO). She views ILDO as a community development organisation reaching out to community members of all faiths, but with a particular expertise in reaching Muslim leaders and community members. She is more familiar with Muslim theology and language as a result of her engagement with ILDO but its Muslim identity does not affect her otherwise.

While some people chose to adopt a new religion after coming into contact with people of that faith, this is not necessarily evidence of proselytisation.

[21] *Not her real name*

Sok Sareoum first came into contact with Cambodian Hope Organisation (CHO) six years ago when she was diagnosed with HIV. For the past five years, she has worked with CHO at Poipet District Hospital, caring for people living with HIV who have no one else to look after them. She was inspired by CHO's work and, realising their approach was based on Christian values, asked a member of staff about Christianity. The staff member referred Sareoum to a local church which she then joined. After two years, Sareoum decided to become a Christian. However, she is quick to point out that she converted to Christianity of her own volition. No one from CHO persuaded her to do so. She also remains respectful of the Buddhist beliefs of hospital patients. In addition to the practical care she provides patients, she sometimes offers spiritual support in the form of prayer. She finds most patients are not familiar with Christian prayer but many are happy for a Christian person to pray for them.

In a country where 95% of the population identifies as Buddhist and a further 3% identify as Muslim, interventions grounded in Christian discourse are sometimes viewed with suspicion. However, it is important to distinguish between interventions which utilise religious discourse to communicate with people of that particular faith (and are therefore culturally appropriate) and activities which promote specific religious beliefs to people of other faiths. While the former may be an effective andculturally appropriate way of communicating with program participants, the later may be categorised as proselytisation. This is an important distinction for observers and analysts to make when considering whether proselytisation is occurring within a given context. Of course, the responsibility for discerning the appropriateness of particular approaches also lies with faith-based organisations themselves. Such organisations must consider the distinction between interventions which are motivated by faith-based values (e.g. compassion and justice) and interventions which promote specific religious beliefs (e.g. that there is only one god). Religious values are often wholly transferable to and align with both development good practice and with the values of other faiths. It is incumbent on faith-based organisations to continually evaluate whether their interventions are culturally appropriate, given the faith identity of program participants.

6 Recommendations

Ensure HIV interventions engaging faith leaders are well-targeted and comprehensive

The ability of faith leaders to influence individual and community behaviour change was highlighted by Buddhist, Christian, Muslim and secular organisations alike. As the vast majority of Cambodians identify as Buddhist, all organisations, regardless of faith, recognised the particular benefits of engaging Buddhist monks in community-level interventions, particularly in the provision of psychological and spiritual support to people living with HIV and in HIV awareness raising and stigma-reduction among the general population.

However, coverage of such interventionsremains uneven. For example, in Kampong Thom province, Buddhist Leadership Initiative Project Coordinator Mr Hoeun Yinthy noted the initiative covered 20-30 of the province's 226 pagodas, despite being active since 2003. Within the context of Cambodia's concentrated HIV epidemic, national coverage of such interventions need not be a priority. However, it is essential interventions target pagodas/mosques/churches in higher-prevalence areas where significant numbers of people are living with HIV.

It is important to note, however, some Cambodian people view their local pagoda/mosque/church as playing only a marginal role in their day-to-day lives, and would be more likely to approach a trusted friend or relative or a health professional for support. The needs of these individuals must be factored into faith-based HIV programming.

1. Organisations working with Buddhist monks and other faith leaders should continue to do so and regularly review (a) whether HIV interventions target high-prevalence areas and key-affected populations within those areas and (b) whether a comprehensive package of HIV prevention, treatment, care and impact mitigation services is being provided.

2. Organisations working with Buddhist monks and other faith leaders should review whether appropriate HIV awareness training and capacity building opportunities are being provided to faith leaders, and identify leaders who could play a greater role in the response. This might include greater involvement of Provincial Head Monks in order to enhance credibility, sustainability and accountability. The Ministry of Cult and Religion should also look at institutionalising ongoing capacity building of faith leaders engaged in HIV interventions.

3. Organisations engaging faith leaders in HIV interventions should investigate whether target populations are more comfortable accessing support from faith leaders or from lay people and, where appropriate, engage health workers and other professionals alongside faith leaders so as to provide a range of options to community members.

The extent to which Buddhist nuns are already responding to HIV, and the feasibility of strengthening this approach, remains largely undocumented. In the course of this review, only one nun engaging in faith-based responses to HIV was identified. Earlier research found many nuns retire to pagodas in their older age so are perhaps not ideally placed to act as carers for children (24) but a more opened-ended exploration of the existing and potential role of nuns is required. The report also mentioned a cadre of younger nuns who are less likely to live in a pagoda but little seems to have been written about them within the context of HIV.

4. Faith-based and secular organisations should identify opportunities to explore the (existing and potential) role of nuns in HIV programming through their engagement with pagodas, and through involving nuns in program consultations. Such exploration should first consider whether target populations would welcome support from nuns or would prefer to interact with health workers and other professionals.

Strengthen targeted evidence-informed HIV prevention interventions among key affected populations, their partners and clients

While many faith-based organisations provided HIV awareness education to the general population, fewer organisations implemented targeted HIV prevention interventions among key affected populations such as sex/entertainment workers, men who have sex with men and people who use drugs. HIV awareness education, implemented by monks and linked to concepts of social morality, may contribute to the interrogation of gender norms which support high-risk behaviours. However, such interventions should be implemented within the context of a comprehensive package of evidence-informed HIV prevention interventions.

5. Faith-based HIV prevention programming should consist of a comprehensive package of targeted evidence-informed HIV prevention interventions designed to "normalise" condom use, particularly among key affected populations, their partners and clients. Where other organisations are already working effectively with relevant populations, faith-based organisations should build partnerships with these organisations and, where relevant, refer clients to them.

6. Faith-based responses to HIV should help create demand for early HIV testing, especially among key affected populations, as

late testing and delayed diagnosis contribute significantly to ill health and impoverishment of HIV-affected households.

7. Faith-based organisations not currently working with key affected populations should assess the need for such interventions. Where a need is identified, organisations should ascertain whether relevant populations regard them as a trusted and approachable service provider, focus on developing relationships with relevant populations, and develop services to meet their needs in close consultation with them.

8. Buddhist monks and other faith leaders engaging in HIV prevention should follow relevant guidance with respect to the appropriate role of faith leaders in the HIV response. Where such guidance recommends faith leaders avoid discussing sensitive issues (such as condom use), such interventions should be implemented as part of a comprehensive package of evidence-informed HIV prevention interventions.

9. In partnership with the National AIDS Authority, faith-based organisations (and secular organisations implementing faith-based initiatives) should explore opportunities for such organisations to support the implementation of the National HIV and AIDS Communications and Advocacy Strategy 2011-2015, with a focus on HIV prevention among key affected populations and the reduction of stigma and discrimination among the general population.

Further strengthen the integration of faith-based HIV programming into a comprehensive package of services including health, financial, social and legal services for people living with and affected by HIV

Research indicates HIV-affected households continue to face a variety of economic and social challenges. People living with HIV are often squeezed out of the workforce, while their children forgo educational opportunities in order to contribute to household income or fulfil care giving responsibilities. In addition, people living with HIV frequently experience stigma and discrimination, with resulting psychosocial outcomes (2). While a number of faith-based and secular organisations provided vocational training and income generation opportunities to people living with and affected by HIV, often in combination with psychological and spiritual support, coverage of such initiatives was relatively low. The capacity of current home-based care teams to act as conduits to a comprehensive range of health, financial, legal and social services were also under utilised.

10. Faith-based and secular organisations should evaluate (with a view to enhancing and/or scaling up) existing poverty reduction and income generation initiatives for people living with and affected by HIV, including the provision of market-driven vocational training and start-up capital for microenterprise, with a focus on vulnerable and women-headed households and households with a large number of children. Such knowledge should be shared widely.

11. Faith-based and secular organisations should further strengthenthe capacity of home-based care teams to act as conduits to a comprehensive range of servicesfor people living with and affected by HIV, including sexual and reproductive health, family planning, vocational training, income generation, psychosocial support, legal and other services.

12. Within the context of the emerging national social protection dialogue, policy makers and strategic planners should investigate the existing and potential role of faith-basedactors in mitigating the impacts of HIV on affected households and protecting vulnerable households against economic shock.

13. In accordance with the national Policy on Alternative Care for Children, faith-based and secular organisations working with orphans and vulnerable children should promotefamily and community-based care (including kinship care, foster care and adoption), supporting families to raise their own children wherever possible, utilising residential care only as a last resort.

Ensure meaningful engagement of people living with HIV in faith-based responses to HIV at the national and sub-national level

The review identified several examples of faith-based and secular organisations effectively engaging people living with HIV in programming at the provincial or district level, particularly in the provision of care and support to people living with and affected by HIV. While several organisations described close working relationships with Provincial Networks of People Living with HIV (PPN+), there was little evidence of faith-based organisations meaningfully involving people living with HIV at the national level. Representatives of the Cambodian People Living with HIV/AIDS Network (CPN+) and the Cambodian Community of Women Living with HIV/AIDS (CCW) could recall few examples of collaboration with faith-based organisations.

14. At the national and sub-national levels, faith-based and secular organisations should develop relationships with networks of people living with HIV, and ensure people living with HIV are meaningfully involved in HIV programming, as well as in strategic planning and monitoring and evaluation. Organisations should explore opportunities for people living with HIV to participate in prevention and treatment interventions, as well as in the provision of care and support. This may require organisations to adjust the way they "do business" in order to ensure relevance and meaningful participation.

15. Faith-based and secular organisations implementing HIV interventions should explore opportunities for dialogue with national (and sub-national, where they exist) networks representing sex/entertainment workers and men who have sex with menin order to better inform the design, reach and effectiveness of such interventions. Should a national network of people who use drugs be established, it too should be engaged.

Facilitate information sharing and contribute to national and sub-national coordinationand systems building

The findings of this review will contribute to an increased understanding of the range of faith-based responses to HIV in Cambodia. However, gaps remain in the documentation of responses by faith-based organisations. For example, the survey implemented by the Ministry of Cult and Religion and the National AIDS Authority yielded responses from organisations in 17 out of 24 provinces. In

addition, some Provincial Departments of Cult and Religion identified only two or three faith-based organisations in provinces where others were thought to exist. This means there are potentially significant gaps in the data because of the omission of these provinces and organisations. A comprehensive surveying may be time consuming and costly, and may not be necessary or desirable. But it is important to recognise current gaps in the data, and introduce measures which further enhance coordination and information sharing between actors in the HIV response.

To further develop a comprehensive picture of the current and potential role of faith-based actors in the national HIV response, the following mechanisms for coordination and information sharing are recommended:

16. Provincial AIDS Secretariats and Provincial Departments of Cult and Religion could jointly organise provincial consultative meetings on the findings of this review. This would enable participants to highlight effective initiatives omitted to date, discuss recommendations, identify emerging issues at the provincial and district levels, and jointly develop evidence-informed responses. Relevant local government, civil society, private sector and development partners should be part of such dialogue.

17. At provincial level, improved sharing of information, data and dialogue with sub national authorities would be useful to promote coordination and collaboration among faith and government responses. This would also enhance transfer of knowledge and skills and ultimately improve sustainability of externally funded initiatives.

18. The NAA and the MoCR could facilitate increased communication between faith-based organisations responding to HIV by supporting regular information exchange in relation to, for example, new or revised government policies or strategies or significant initiatives by faith-based organisations. This process might encourage greater documentation and discussion of innovative faith-based approaches to HIV prevention, treatment, care and impact mitigation.

19. Relevant secular and faith-based actors could foster regular civil society dialogue and information sharing in order to identify successful faith-based HIV interventions and lessons learned from such interventions.

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Annex A: Survey Instrument

Review of Faith Based Responses to HIV and AIDS in Cambodia

24 province survey by NAA and MoCR

1. Data collected by ☐ NAA/PAS ☐ MoCR/PDCR

2. Province

3. Name of organisation/department interviewed

4. Name of person interviewed

5. Contact details

6. Religious affiliation (please tick all that apply)

- ☐ Buddhist
- ☐ Christian
- ☐ Muslim
- ☐ Multi-faith
- ☐ Secular (not faith-based)
- ☐ Other (please specify below)

7. What are your organization's/department's Vision and Mission statements? (Please write below)

8. Number of employees (paid staff)

9. Number of volunteers

10. What are your organization's funding sources for HIV activities? (please tick all that apply)

- ☐ Donations from local community
- ☐ Temples, Mosques, Churches
- ☐ Cambodian secular NGOs or Foundations
- ☐ Cambodian faith based organisations
- ☐ Cambodian government funding
- ☐ International secular NGOs or Foundations
- ☐ International faith based organisations
- ☐ Bilateral (international government) funding
- ☐ UN agencies
- ☐ Other (please specify below)

11. Annual budget of organisation/department (USD) from Jan-Dec 2010 including funding from Cambodian Government.

12. What geographic area does your organisation/department cover or target? (please add number of communes/ districts/provinces in relevant boxes)

- ☐ Commune
- ☐ District
- ☐ Province
- ☐ Other (please specify below)

13. How many clients/people do your HIV activities reach? (Please estimate if exact numbers are not known and put number below)

14. Do you work with the following clients? (Please tick all that apply)

F	M	
☐	☐	Adults
☐	☐	Children (under 18)
☐	☐	Adults living with HIV
☐	☐	Children living with HIV
☐	☐	Orphans
☐	☐	Pregnant women
☐	☐	Rural populations
☐	☐	Faith leaders
☐	☐	Sex trafficked victims/survivors
☐	☐	Prisoners

F	M	
☐	☐	Sex/entertainment workers
☐	☐	Sex workers' clients
☐	☐	Uniformed services
☐	☐	Migrants and mobile workers
☐	☐	Ethnic Minorities
☐	☐	Drug users/injecting drug users
☐	☐	Men who have sex with men
☐		Transgender persons

15. What types of HIV related activities does your organisation/department engage in? (please tick all that apply)

Prevention

- ☐ HIV awareness raising
- ☐ Sex and sexuality education,
- ☐ Family planning education
- ☐ Peer education
- ☐ Harm reduction for drug users/injecting drug users
- ☐ Workplace interventions
- ☐ Telephone service for information/counselling
- ☐ Prevention of mother-to-child transmission (PMTCT)
- ☐ Blood safety
- ☐ Universal precautions
- ☐ Printed materials
- ☐ Mass media campaigns

Treatment

- ☐ HIV testing
- ☐ ART provision
- ☐ Treatment of opportunistic infections
- ☐ Tuberculosis screening and treatment
- ☐ STIs screening and treatment
- ☐ Paediatric treatment
- ☐ Traditional/alternative medicine
- ☐ Transport support
- ☐ Treatment literacy
- ☐ Pre or post test counselling

Care and support

- ☐ Home-based care
- ☐ Referrals to clinics, hospitals or other services
- ☐ Hospice, respite or palliative care
- ☐ Spiritual support
- ☐ Psychosocial support

Enabling Environment

- ☐ Reduce stigma and discrimination
- ☐ Advocate for supportive legislation and policies
- ☐ Conduct Research
- ☐ Promote/practice meaningful involvement of people living with HIV

Impact Mitigation

- ☐ Income generation
- ☐ Food and nutrition support
- ☐ School support
- ☐ Vocational training
- ☐ Foster homes for children
- ☐ Orphanages

Other activities (please specify below)

16. What commodities do you supply or distribute? (please tick all that apply)

- ☐ ART
- ☐ Treatments for opportunistic infections
- ☐ Tuberculosis treatment
- ☐ Treatment for STIs
- ☐ Infant formula
- ☐ Other (please specify below)

- ☐ Food support
- ☐ Contraceptives in general
- ☐ Male condoms
- ☐ Female condoms
- ☐ Lubricant

	YES	NO
17. Do you provide services to people who have the same faith as your organisation?		
18. Do you provide services to people whose faith is different than that of your organisation?		

19. Which national guidelines inform your HIV work? (please tick all that apply)

Informs work

- ☐ Minimum Standard on Alternative Care for Children (MoSVY 2008)
- ☐ National Policy on the Religious Response to HIV and AIDS (Ministry of Cults and Religions)
- ☐ National Strategic Plan for the Comprehensive & Multi-Sectoral Response to HIV/AIDS III (2011-2015)
- ☐ National Standards for the Care, Support and Protection of Orphans and Vulnerable Children (MOSVY 2010)
- ☐ National Guidelines for the Prevention of Mother to Child Transmission of HIV (MOH 2010)
- ☐ National Guidelines for the Use of Pediatric Antiretroviral Therapy (MOH 2010)

20. What other sources of information or guidance do you use?

		YES	NO
21.	Does your organisation/department have a policy on promoting gender equality?		
22.	Does your organisation/department have a policy on promoting human rights?		
23.	Does your organisation/department have a Monitoring and Evaluation Plan?		

24. What is an example of good practice or a unique approach in your organisation's/department's response to HIV?

25. Please list any background documentation (Annual Reports, Programme Evaluations, etc.) submitted with this questionnaire.