CHAPTER 6

GENDER AND HIV/AIDS

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GENDER AND HIV/AIDS

Cambodia at a glance

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<th>Indicators</th>
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<td>National HIV prevalence (percent)</td>
<td>2.6</td>
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<tr>
<td>Number of people living with HIV or AIDS, 2002</td>
<td>157,483</td>
</tr>
<tr>
<td>Number of women living with HIV or AIDS, 2002</td>
<td>75,448</td>
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6.1 Status, trends and issues

The first case of HIV infection in Cambodia was reported in 1991, and the rate of transmission rose rapidly through the decade. The estimated reporting rate of HIV in Cambodia is low, at 8 percent, indicating that the problem is likely to be much greater (Cambodia Human Development Report, 2001). Cambodia has the highest HIV/AIDS prevalence rate in Southeast Asia, though the epidemic rate has decreased in the past few years. The virus is mostly spread through heterosexual contact.

Since 1997, the national prevalence rate among adults has shown a steady decline (Figure 6.1), from 3.3 percent to 2.6 percent (National AIDS Authority and the National Center for HIV/AIDS, Dermatology and STDs, 2002; Cambodia Human Development Report, 2001). The number of people living with HIV or AIDS declined from 210,000 in 1997 to 157,483 in 2002, of whom 82,037 are men and 75,448 are women (NCHADS, 2002). In particular, there has been enormous progress in curbing transmission of HIV between sex workers and clients. This has been achieved largely through programs on increasing condom awareness, access and quality, providing treatment for sexually transmitted infections, ensuring stakeholder involvement (for example brothel owners and police), and effective program management at brothels.

Notwithstanding the impressive decline in prevalence, attributed to both a decrease in new infections and due to AIDS-related deaths, the epidemic still poses a major threat to human development in Cambodia (NCHADS, 2002). There is still a possibility that the epidemic may evolve rapidly and unpredictably (UNGASS, 2003). At risk in particular are women in long-term stable relationships, within marriage or outside of it (UNGASS, 2003). A new prevention strategy is needed to continue the downward trend of the epidemic. Finally, significant numbers of people are living with HIV in Cambodia, and the need to expand access to care, support and treatment to men and women is urgent.

6.1.1 New infections decreasing among men, leveling off among women

The number of new HIV infections annually appears to be on the decline since 1994 among men, and since 1996, among women (HSS, 2002). However, the data on new infections are limited, as there is no surveillance among men who have sex with men – and a small study by Family Health International showed a 14 percent incidence rate of HIV infection in this population. The number of men currently living with HIV has been declining since 1997 and, while the number of women currently living with the virus continues to increase, it is beginning to level off (Figures 6.2 and 6.3). In Cambodia, high-risk groups include commercial sex workers and their clients. The HIV sentinel surveys have gathered data from groups such as the police, military and sex workers, as well as women seeking antenatal care services.
To explain the progression of the epidemic over the past ten years, the following paragraphs focus on direct sex workers and pregnant women receiving antenatal care.

### 6.1.2 Prevalence among sex workers has decreased as condom use has increased

Transmission from sex workers to clients accounted for significant proportions of HIV infection in the 1990s. In 1998, slightly less than half of the commercial sex workers were living with HIV. Perhaps the most marked decline is the prevalence among sex workers, from 42.6 in 1998 to 28.8 in 2002. Some of this decline can definitely be attributed to deaths (CHDR, 2001). But condom use by customers or sex workers has increased consistently, reaching close to 90 percent in 2002 (NCHADS, 2002). In the past five years, condom use programs have aggressively promoted prophylactic acceptance in brothels, resulting in a sharp increase in reported use (Figure 6.4). There are still anecdotal reports, however, of clients beating sex workers who insist on using condoms.

There is little room for complacency as younger and newer sex workers enter the industry. Education on HIV prevention will need to continue. Further, there continues to be demand for non-brothel sex work, as fears of HIV are becoming more widespread. Condom use among indirect sex workers (young woman who work as “beer girls”, karaoke singers, etc. but are available for sexual services) is still only around 56 percent, indicating that much more needs to be done to increase condom use in these groups (NCHADS, 2002). Of greater concern are reports of violence and gang rape with direct and indirect sex workers, which obviously preclude condom use (PSI, 2002; GAD-C, 2003).

*I am a sex worker to feed my family. There is nothing else I can do, otherwise my family will suffer. I am suffering from AIDS and might die before my family can look after itself. This is a terrible situation to be in, but I can do nothing about it… I think this must be the lot of the poor.* A woman in her late 20s, cited in the participatory poverty assessment report (ADB, 2001)
6.1.3 Prevalence is decreasing among women seeking antenatal care

Prevalence among pregnant females seeking antenatal care, especially in the 15-24 age group, is considered a suitable proxy for new infections and for the movement of the epidemic into the general population. The National Center for HIV/AIDS, Dermatology and STDs (2002) estimates that approximately 45 percent of pregnant women receive antenatal care (compared with 38 percent estimated by CDHS, 2000). HIV prevalence among pregnant women receiving antenatal care appears to be leveling off, at about 2.6 percent (see Figure 6.5).

Figure 6.5: HIV prevalence among women seeking antenatal care

Source: NCHADS 2002
Prevalence among pregnant women varies by province, the highest located among provinces near the Thai border (Figure 6.6) where migrant workers and mobile populations gather. Fifty thousand Cambodians work in Thailand as construction workers, farmers or seafarers (PATH, cited in UNGASS, 2003). Prevalence is also high in Ratanakiri province, possibly due to the population’s mobility.

**Figure 6.6:** Regional HIV prevalence among pregnant women seeking antenatal care

![Regional HIV prevalence among pregnant women](image)

*Source:* HIV sentinel survey 2002

Infection among pregnant women is highest in the 15-19 age group (Figure 6.7).

**Figure 6.7:** HIV prevalence among pregnant women

![HIV prevalence among pregnant women](image)
6.1.4 The routes of HIV transmission are changing

Although transmission of HIV along all routes is decreasing, mother to child, and husband to wife transmissions are not decreasing as fast as other transmissions and therefore women and children form an increasingly large percentage of those that are vulnerable.

Figure 6.8: Route of HIV transmission over time

![Graph showing route of HIV transmission over time]

Source: HIV Sentinel Survey, 2002

6.1.5 Women in direct and indirect sex work are still at risk of HIV transmission

Estimates of the number of women working as commercial sex workers varies, but may be up to 100,000 (UNDP 2001). Many of the women in sex work have been forced or tricked into that profession. While data is not available, there is some concern that the age of sex workers may be decreasing. The Behavior Sentinel Survey (BSS) 2000 indicated that a significant proportion of men among high-risk groups (military, police and motorcycle taxi drivers) have visited a sex worker at some point in their lives: 17-30 percent in the past year, and 8-20 percent in the past month.

Recent studies (PSI, 2002) also indicate a range of situations in which paid sexual work takes place, including long-term relationships with “sweethearts”. Sweetheart relationships are based on a degree of mutual trust and affection, with an assumption of “monogamy” on the part of the woman and the man, who is typically married to someone else (PSI, 2002).

These factors make it difficult for both direct and indirect sex workers to negotiate condom use during sex work. Social marketing campaigns appear to have contributed to increased condom use among clients and direct sex workers, but efforts need to continue to maintain and increase the levels of condom use among both clients and direct and indirect sex workers.
6.1.6 Married women are more at risk

Married women are increasingly at risk of HIV transmission, and it is among this group that the epidemic could spread rapidly. Condom use among married women is only 1 percent. Condoms are associated with a lack of trust and infidelity and also with disease. Asking a husband to use a condom implies that infidelity is suspected. Discussion on contraception among married couples is low, with most women bringing it up once or twice in a year or not at all with spouses (CDHS, 2000). Condom promotion among married couples has been limited.

6.1.7 Strong gender stereotypes influence male sexual behavior

Strong gender stereotypes about sexuality and sexual behavior underpin the evolving epidemic in Cambodia. Cambodian society frowns upon premarital sexual activity, and virginity among girls is considered essential before marriage. The society values attributes such as demureness, submissiveness and a lack of knowledge about sex among girls. Girls who are not virgins before marriage are considered to be “fallen women”, and are stigmatized. At the same time, some Cambodian men regard visiting sex workers and sex outside marriage as part of male bonding (GAD-C, 2003), acceptable when away from home and part of the attributes ascribed to masculinity. Peer pressure to visit sex workers is high in some groups of men. Current definitions of masculinity encourage men to nurture dominance, power and promiscuity, thus negotiating condom use within such a context is challenging for all women. Thus, to be effective, interventions will need to address definitions of masculinity and social norms of male sexual behavior.

6.1.8 Women shoulder the burden of care and support for people with AIDS

The burden of caring for AIDS orphans usually falls on aunts and grandmothers, creating extra demands on their time and resources, especially in poor families. Married women who are infected and whose husbands succumb to AIDS end up taking care of them while simultaneously getting sicker themselves as the disease progresses in their own bodies. While data on girls discontinuing education specifically to take care of a family member with AIDS is not available, many studies indicate it is a common occurrence (Bredenburg et al, 2003; Velasco, 2002). Most Cambodians do not have access to antiretroviral therapy (ART) drugs or even to regular treatment of opportunistic infections. Treatment of these infections, such as pneumonia, diarrhea and toxoplasmosis, is thus available only at home for the majority of Cambodians. All of these infections require significant attention and constant care by women and girls in the household.

6.1.9 Access to treatment is limited

Antiretroviral therapy drugs can be bought without a prescription at pharmacies and from wholesalers in Phnom Penh and a few other places. The cost of ART drugs has varied over the past few years. Currently, prices in pharmacies in Phnom Penh vary from US$40 to $50 per month, while a study undertaken in 2002 quotes prices of US$60 per month in the market, and up to US$600 for triple therapy (UNCT, 2002). These costs are prohibitive for the majority of Cambodians. Some NGOs are providing ART to people living with HIV/AIDS, requiring them to pay a small amount or for free, but the reach of these programs is very limited.
Even if ART is available in rural areas, under the current health system women will have difficulty accessing the treatment because of their generally poor access to health services. Further, many women do not get tested for HIV until quite late, which means that they will be unlikely to access appropriate care and support at an earlier stage of the illness (UNCT, 2002). Another concern is that intermittent use of ART or use of counterfeit drugs may increase drug resistance (UNCT, 2002). Women with lower levels of education who live in remote areas and who are poor are likely to be the most vulnerable.

The use of the prophylactic drug, nevirapine, has proved effective in reducing mother-to-child transmission. However, access to drugs and services by pregnant and post-partum women remains challenging.

### 6.2 Government Policies and Strategies

In 1991, the government established a National AIDS Program and provincial AIDS Committees were established in 1994. More recently, the government set up the National AIDS Authority (NAA) and the National Center for HIV/AIDS, Dermatology and STDs (NCHADS) to monitor and manage the national response to the epidemic. NAA is a multisectoral agency composed of representatives from all 26 line ministries. It coordinates all key activities of the line ministries, makes policy recommendations and ensures information exchange and dissemination. Many efforts have helped craft its broad-based, multi-sectoral approach. For example, the Ministries of Rural Development, of Education, Youth and Sports and of Defense have strategic plans on handling the HIV/AIDS issue. The Ministry of Women’s and Veterans’ Affairs is also implementing HIV/AIDS activities, and the Ministry of Social Affairs, Labor, Vocational Education and Youth has plans to start activities. NCHADS is responsible for the national sentinel surveillance systems and also develops plans and programs for HIV/AIDS prevention.

The strategic plan for HIV/AIDS and STI care and prevention for 2001-2005 provides approximately US$6.5 million per year, almost exclusively channeled through the health sector, to support activities. A number of bilateral donors, multilateral agencies and NGOs have active programs in HIV/AIDS prevention and additional funding, especially for care and support, is awaited. A national plan to provide access to care and support and treatment along a continuum has been developed, has been developed, and includes free RT. However, while the numbers receiving the free treatment are increasing the progress is slow.

The health ministry plays a critical role in the provision of HIV/AIDS-related services. At the provincial level, health departments and AIDS committees set policy and coordinate and implement prevention activities.

In view of the high costs of chronic illness for the poor, especially women, the National Poverty Reduction Strategy identifies four priorities for poverty reduction: i) extending the continuum of care to the poorest groups to enable them to access appropriate and low-cost treatment; ii) targeting fishing communities and migrant workers with community prevention programs; iii) ensuring a significant political commitment to HIV/AIDS prevention and care; and iv) strengthening budget decentralization and provincial and district structures.