10 HIV/AIDS and Alcohol Risks in Cambodia: Confronting Challenges and Policymaking through Research-Guided Actions

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HIV/AIDS COMES TO CAMBODIA

The Khmer Rouge period (1975–1978) saw up to 25 percent of Cambodians die in "the killing fields" or from starvation. Devastation to national infrastructures, family and social life, culture, and the elimination of educated professionals including doctors and teachers were not alleviated when the Vietnamese then occupied Cambodia for the next 11 years. The Paris Peace Accords in 2001 defined the rebuilding of the Cambodian state and the United Nations moved international personnel to Cambodia to separate warring factions and prepare for elections in 1993. UNAMIC (United Nations Advance Mission in Cambodia, 1991–1992) brought 1,100 personnel and was replaced by UNTAC (United Nations Transitional Authority in Cambodia, 1992–1993) with over 22,000 foreign soldiers, police, and so on, including contingents from sub-Saharan African nations already in the throes of their own HIV/AIDS pandemics (UNAMIC,1992; UNTAC,1996;Yeager & Kingma, 2005).

The first documented case of HIV/AIDS in Cambodia was reported in 1991 (Saphonn et al., 2004; NCHADS, 2001). With the arrival of UN soldiers, there was an increase in brothels, discotheques, and beer gardens serving "Rest and Recreation," contributing to the spread of the virus

into the community and leaving a sex industry to greet international deminers removing landmines from potential tourist sites in 1993 and tourists to Angkor Wat temples from 1997 (NCHADS, 2001; Chaya, 2006). Cambodia saw an increasing number of tourists from 354,000 in 2001 to 2,900,000 by 2011. Many were "sexual tourists" who infected young persons who they believed were less at risk for HIV/AIDS and STIs, or sought to be cured of HIV/AIDS by sleeping with "young virgins" (Lubek & Wong, 2003; Wong et al., 2002).

By 1998, HIV prevalence was 42 percent for commercial or brothel-based "direct sex workers" (DSWs), 19 percent for beer-sellers and other "indirect sex workers" (IDSWs), 6 percent for police officers, and 3.2 percent for antenatal care women, according to the HIV Sentinel Surveillance report of the National Center for HIV/AIDS, Dermatology, and Sexually Transmitted Diseases (NCHADS, 2001). From 1993 onward, the Royal Government of Cambodia confronted HIV/AIDS, creating structures of governance, research and surveillance, and policymaking. Respectively, these were the National AIDS Committee (NAC), NCHADS, and the National AIDS Authority (NAA). Saphonn et al. (2004) commented: "With full support from the top policymakers, good leadership in program management, and the commitment of the public health program officers, the HIV/AIDS prevention and care program in Cambodia has been successful, despite its resource constraints." The pandemic was regularly tracked through HSS reports and behavioral surveillance surveys at two- or three-year intervals (NCHADS, 2001, 2004, 2007). By 1995, there were health centers and clinics for "voluntary confidential counseling and testing" (VCCT) or "CDAG" in French (*Centres de Dépistage Anonymes et Gratuites*) (Saphonn et al., 2004). Chaya (2006) notes that "transmission of the virus in Cambodia was accelerated by a mobile and poor working population, and entrenched gender inequalities that led to a pervasive sex industry. HIV/AIDS prevalence peaked in 1997 at 3 percent . . . and then fell to 1.6 percent in 2005." She singles out the 100 percent condom use program (CUP) in brothels, begun in 1998. "The Cambodian response had the right ingredients for success. It was quick and strategic. It used local data to engage local policymakers. The 100 percent CUP garnered commitment and involvement at many levels (policymakers, local authorities and the owners of sex establishments)" (p. 1). But alongside public health successes, there were also concerns about the further spread of the virus (Tarr & Aggleton, 1999; UNAIDS, 2001), especially with Cambodia being described as having the highest rate of HIV/AIDS in Southeast Asia (NCHADS, 2001). The successful 100 percent condom-use pilot program

in Sihanoukville (World Health Organization, 2001) was a turning point for concerted action and was rolled out in other provinces, including Siem Reap by 2002.

In Siem Reap Province, the Provincial AIDS Committee (PAC) and Provincial AIDS Office (PAO)—both coordinated by Dr. Sarath Kros—intervened with local brothels after the introduction of the 100 percent condom policy. Between 2001 and 2008, regular meetings and workshops with all stakeholders were held and HIV prevalence rates for brothel-based sexworkers fell from 42 percent to zero (unpublished CDAG data, Siem Reap Province, 2011; NCHADS, 2007). Using data from NCHADS, the NAA (2010, 2012) reported an estimated national HIV prevalence of 0.9 percent in 2006 and 0.7 percent between 2008 and 2010, predicting a prevalence of an estimated 0.6 percent of the adult population in 2011 and 2012. Thus there have been significant reductions of prevalence in Cambodian risk groups, although some challenges remain. This chapter describes how progress in public health in Cambodia has combined government research, surveillance, and monitoring efforts, and proactive policymaking with interventions from NGOs and community-based stakeholders. In particular, we focus on SiRCHESI's community-based and research-driven programs, favoring "participatory action research" (PAR), which engages community stakeholders as equal partners in the research-intervention process. Since 2000, SiRCHESI staff and peer educators, academic researchers, students, and interns have co-created gender- and culture-sensitive interventions, interfacing research, data-gathering, and policymaking about HIV/AIDS, with added emphasis on the correlated risks of alcohol overuse (Liu & Ng, 2007; Lubek et al., under review).

THE NGO "SIRCHESI" IS FORMED TO CONFRONT HIV/AIDS IN SIEM REAP PROVINCE

In 1999, one of the authors (IL) wandered, unawares, as a tourist into the Siem Reap pandemic hotspot and was challenged by local residents to "do something about HIV/AIDS" as a professor and researcher. Returning in February 2000, he met health workers from the PAO, the Provincial Health Department, the Provincial Hospital, and from NGOs. To understand the pattern of transmission and its local impact, he conducted a community needs assessment through 23 in-depth, semistructured interviews with key informants. Three community concerns emerged and were fed back to participants at a community meeting. The most frequently mentioned and highest prioritized threat was the risk of acquiring HIV/AIDS. Second

were the gendered educational inequities that sent women to entertainment sector jobs with high risks (including HIV/AIDS). The third concerned social issues around poverty and low salaries, both for rural farmers and civil servants such as doctors and teachers, putting all at Cambodia's 2001 poverty line (Lubek et al., 2002).

It was agreed that an independent Cambodian NGO could be formed in which local citizens and health providers would deliver a research-guided HIV/AIDS prevention program in Siem Reap. A team of external researchers, practitioners, advisors, experts, students, and interns would be founded: together, they would locate and introduce "best practices" to confront HIV/AIDS, review previous research, design methods appropriate for this "tourist community" and its idiosyncratic transmission patterns, and locate necessary funding. The three community priorities helped name the NGO—the Siem Reap Citizens for Health, Educational and Social Issues (SiRCHESI). Local citizen stakeholders (including tourguides, orphanage workers, teachers, beer-sellers) joined with health providers (midwives, nursing assistants, health educators, and medical doctors) to address, as SiRCHESI, the community health and development issues associated with rising HIV prevalence rates and related educational, gender, and economic inequities. With input from visiting researchers and support from original "startup" funders (University of Guelph, 2000; Elton John AIDS Foundation, 2000–2003; M.A.C. AIDS Fund, 2003–2009), SiRCHESI evolved as a community-based, nonpolitical, nonreligious, nonprofit, nongovernmental, research-guided health-promotion organization.

At the time, there were few locally generated research initiatives in Siem Reap to guide health interventions. It became important to pool all NGO research and interventions with practices from the public health infrastructure, coordinating activities and preventing duplicated efforts.

The Ministry of Health was not sufficiently budgeted to implement all research, surveillance, and intervention projects. So a number of international NGOs and agencies, and local NGOs such as SiRCHESI, stepped up to gather needed data and implement needed programs. Each NGO tackled a small part of the epidemic—SiRCHESI, RACHA, and Doctors Without Borders (Médecins Sans Frontières) took on HIV/AIDS prevention education; CARITAS took on home-based care, especially concerning tuberculosis; AFESIP rescued trafficked sexworkers; CARE worked with the beer industry on improving workplace conditions; PSI did social marketing of condoms; and ESTHER and Doctors Without Borders began antiretroviral therapy (ARVT) distribution in 2004. Two foundation-sponsored private hospitals (Angkor Children's Hospital and

Khanta Bhopa Jayawaraman VII Hospital) monitored pediatric HIV/AIDS, and the latter, by 2006, had organized a maternity ward to prevent mother-to-child transmission. An example of the "umbrella" provided by government agencies to NGOs was the bringing together by Dr. Sarath Kros of the two independent ARVT-providing international NGOs (ESTHER from France and MSF from Holland/Belgium). Following their separate presentations at the SiRCHESI HIV/AIDS conference in 2004, Dr. Sarath Kros invited them to occupy the same pavilion of Chronic Disease on the grounds of the centrally located Provincial Hospital; here, all persons living with HIV could convene for testing, monitoring, and receiving medication.

Qualitative in-depth interviews with key informants (Lubek & Wong, 2002, 2003) corroborated the quantitative conclusions of the HIV/AIDS surveillance studies (NCHADS, 2001) and local serology data from VCCT. In 2000, health workers in Siem Reap referred to the "bridging pattern" for HIV transmission in Cambodia. Local women were selling sex to tourists (some of whom offered extra money not to use condoms); some of these women were brothel-based, full-time DSWs while others were part-time IDSWs, employed and underpaid in the entertainment industry and forced to accept propositions to exchange money for sex. These included beer-sellers paid by breweries and distributors to market international brands, massage workers, dancers, and karaoke singers. By 2006, a new group of women called "hostesses" were being hired by individual restaurants; customers would invite them to sit and drink for the evening. For all of these women, there were the pressures of economic necessity to sell sex in order to fill the "wage gap"—about 50 percent (McCourt, 2002; Green & Lubek, 2010; Worrell & Kunthear, 2012). After drinking, condom use is reduced among beer-sellers (Pagnutti, 2006; Lubek, 2012) and other men and women.Women with multiple partners/clients and reduced condom use, and men (who may be their husbands/partners or clients and who, in turn, have multiple partners) are all at increased greater risk for spreading STIs and HIV in the community (NCHADS, 2001). As part of this "bridging pattern," those not using condoms 100 percent of the time may retransmit infections to both tourists and local partners. Men who have frequented commercial sex workers may return home and infect (monogamous) wives/partners. For HIV, newborns also are put at risk through mother-to-child transmission at birth and/or through nursing(Wong et al., 2003).

While most HIV infections are through heterosexual sexual acts, sensitive vigilance about other transmission pathways has been implemented. At SiRCHESI's first men's HIV/AIDS workshop in 2003, men who had sex

with men (MSM) identified themselves to staff, but privately. Within a year, the NGO Men's Health Cambodia was formed and attended SiRCHESI's annual HIV conferences. Government and SiRCHESI's VCCT interviews, questionnaires, and counseling processes were modified to reflect the possibility of same-sex relations, as were the government's surveys. Until recently, little or no transmission was through needle-sharing in Siem Reap. However, since 2007 NCHADS has been monitoring harm-reduction needle-exchange programs in Phnom Penh (NAA, 2012). In 2012, Siem Reap's VCCT testing first included 303 "drug users" in addition to 526 MSM.

USING PARTICIPATORY ACTION RESEARCH (PAR) FOR COMMUNITY HEALTH INTERVENTIONS

At the originating community feedback meeting in February 2000, research results from the needs assessment were "fed back" using participatory action research (PAR). SiRCHESI adopted this framework so that grassroots community concerns could be integrated into community and research-driven HIV/AIDS interventions, with those programs systematically monitored and evaluated by its community members and researchers. SiRCHESI's early applications of PAR (Lubek et al., 2002; Lubek & Wong, 2003) were guided by classical, historical accounts of action research (Lewin, 1946, 1947; Lubek, 2000), the updating of PAR by Chataway (1997), and Mee Lian Wong's community public health work (Wong, 1990–2004). Decisions were shared among researchers and community participants about whether to go directly forward to the next step or backtrack and revise the research practice or community action step in the light of new evidence. Researchers and participants became equal partners throughout the PAR process: design, variable selection, instrument creation, data gathering, data interpretation, and community application (Denzin, Lincoln, & Smith, 2008). The participants in SiRCHESI's PAR community needs assessment had vivdly described the breadth and depth of the community health challenges: HIV/AIDS and STIs, but also endemic malaria, tuberculosis, encephalitis, dengue fever, and opportunistic infections (from diarrhea to pneumocystis) that all were devastating their community. They were aware, from their personal losses, of the increased community mortality rates. Onto these critical health concerns they interwove discussions of gendered educational inequity and illiteracy, poverty, violence, and sexual coercion. This PAR community dialogue would set the agenda for SiRCHESI's researcher-practitioner-stakeholder collaborations in community health promotion for more than a decade.

In 2001, Dr. Mee Lian Wong of Singapore brought to SiRCHESI her expertise in community preventive medicine. She helped design health-promoting, behavior-monitoring questionnaires for sex workers, beer-sellers who occasionally sold sex, married women, and local men. She helped formulate health promotion focus groups, culturally adapt health education materials for nonliterate women, and design and orchestrate training workshops to launch an extensive peer educator outreach program beginning in 2002. Short courses in public health research skills and behavioral and health promotion interventions were provided for several SiRCHESI staff at the National University of Singapore. SiRCHESI's "grassroots" community goals were to prevent HIV/AIDS transmission and increase condom use in identified high-risk groups. The strategy was to provide a supportive and enabling environment by increasing self-efficacy and skills in negotiating for safer sex behaviors and reducing barriers to increased condom use. Immediate and long-term effectiveness of the health interventions and the changes in condom use and safer sex behavior were evaluated. Local NGO members, once trained, would deliver health services and also collect data.

SiRCHESI developed a "hybrid model of NGO capacity-building" to avoid taking professionals away from public service (Lubek et al., 2002; Lubek & Wong, 2003). Under this model, SiRCHESI's Cambodian staff worked part-time (usually 13 hours per week, after their regular jobs ended) for a "living wage" salary, while keeping their public health jobs, 40 hours a week, often for only $1 per day in 2000. This provided effective "capacity-building" (Kirkwood, 2009), since all health intervention skills learned with SiRCHESI—for example, health promotion workshops with pre-post questionnaires—could also then be implemented by the government agencies during the week. Both the nature of Cambodian "nonpolitical, nonreligious, nonprofit" NGOs and the fact that staff may also hold full-time public service positions requires a certain neutrality concerning data-gathering and intervention activities. The new draft NGO Law of 2012 contains possible "defamation" charges for criticism of the government, its leaders, and its policies. However, the independent international advisors, as outsiders, do not share the same constraints and are able to cite SiRCHESI's data, speak freely to the press, and suggest policy changes. This division of labor works well. Many SiRCHESI research articles and conference papers have up to 25 co-authors, indicating the involvement of local and international researchers/practitioners at all steps of the PAR process; by contrast, after legal advice, only one author (Lubek, 2005) was listed on a paper strongly critical of the beer industry's lack of action against HIV/AIDS, particularly company

"X." They were industry leaders with an effective HIV/AIDS policy for their international workers, but despite repeated requests, it was not being extended to Cambodian women beer-sellers deemed to be doing "promotional advertisements" rather than "work" (van Merode et al., 2006). Some readers hypothesized that "X" might be Heineken.

Throughout SiRCHESI's period of PAR implementation, there had been ongoing calls for cultural sensitivity for PAR community projects (Fine et al., 2008; Liu et al., 2008), as well as Smith's (1999) advocacy for indigenous community partnerships and Kerr et al.'s (2010) community action study. These acted as reminders for researchers looking at HIV/AIDS, alcohol, and other public health challenges to be sensitive to ways in which the researchers, practitioners, and participants with different cultural and resource experiences might require further communication to reach a shared understanding of the community health and social challenges. For example, in community health promotion projects using a "social ecology" approach, Jakubowicz et al. (2012) remind us that successful implementation of policies geared toward social and behavioral change will relate strongly to their fit with local values and practices. This approach has been used in public health community development situations as interventions on alcohol and tobacco use (Panter-Brick et al., 2006; Richard et al., 1996) through to more broadly based concerns with social well-being and integration for groups such as Muslim youth in the West (Jakubowicz et al., 2012). Such approaches can prove contentious, as they require researchers to see the world from the perspective of the "target" whose behavior is to be changed. They can produce rich and detailed insights into the orientation of communities, but may challenge the political morality of governments faced with implementing the programs. In Australia, the "Grim Reaper" television advertisements of the early 1990s were aimed at reducing the spread of HIV and drew on widespread and deeply embedded community fears about epidemics. The approach prods policymakers and governments to recognize the spread of the disease outside the boundaries of the gay and intravenous drug user communities, thus moving to a safe-sex and safe-injection model of interpretation and intervention, much to the discomfort of conservative social groups (Sanson, Havighurst, & Zubrick, 2011). For multicultural societies such as Canada, Australia, New Zealand, and South Africa, public health researchers and practitioners must maintain vigilance about any systemic barriers or "health gap" (Russell & Wenham, 2010; Robson & Harris, 2007) for indigenous or minority groups, especially concerning HIV/AIDS (Spicer et al., 2010), or for a neo-colonial "parachuting in" of interventions not "owned" by the local community stakeholders,

which in fact may prove to be culturally dissonant (Campbell, 2003). However, Kerr et al. (2010) found a number of positive rebounds from their community health action research with indigenous Maori in New Zealand.

SiRCHESI's PAR activities kept the above caveats in mind as local members and visiting researchers, students, and interns tackled HIV/AIDS and alcohol problems and related issues. During its first four years, SiRCHESI focused on a series of interrelated community challenges all linked to the HIV/AIDS pandemic and sought ways to disseminate results quickly; websites were developed to inform community and global stakeholders, health (policy) decision makers, and the research community working on HIV/AIDS prevention. This last step sometimes involved going beyond the NGO's own "nonpolitical" mandate, so data were communicated to relevant national agencies and ministries, international and global businesses, trade unions, the press, humanitarian organizations, and conferences where health research and policy change concerns were intertwined.

By 2003, after a decade of public medical service in Siem Reap, Dr. Sarath Kros became part-time program director of SiRCHESI, while maintaining his full-time public service function, part of SiRCHESI's "hybrid capacity building" project (Lubek & Wong, 2003). SiRCHESI organized annual HIV/AIDS conferences from 2001 to 2007 (see www.angkorwatngo.com), which permitted all local stakeholders and other NGOs to report their ongoing community projects and performance statistics for the year. International researchers and the secretary-general of the NAA addressed these conferences, as did stakeholders from risk groups such as the Angkor Wat young vendors and local beer-sellers. (At the 2004 conference, representatives of a major global brewer were rebuked after their paper presentation by the NAA official for not providing antiretrovirals to women beer-sellers; only engineers [all men] at the brewery in Cambodia received HAART.) In keeping with the goals of NGOs to be "socially degradable" and to fade out when their task is finished and local capacity is strengthened, SiRCHESI's conferences morphed into regular large meetings of the PAC. Data-sharing mini-conferences were organized, with more frequent exchange and planning meetings. Thus SiRCHESI's innovative research dissemination practices, sharing local data and coordinating activities, were successfully passed on to, and augmented by, the public health service.

The "Health" Anomaly of Closing Brothels

The NGO–government cooperation may be contrasted with possible health-related policy disconnects between government ministries and/or agencies. In many countries, including Canada, debates go on about

HIV, hepatitis C, and overdose prevention within the community of intravenous drug injections. For example, should supervised harm-reduction injection sites be made available in a community versus strict policing and punishment of all illegal drug use? In Cambodia, legislation has had negative effects on HIV prevention efforts as it has made it more difficult to reach out to a major risk group—women and girls who sell sex. Since the removal of brothels it has become more difficult distinguishing between those who for the most part sell sex and those who sell sex only occasionally. This will further complicate the task of conducting surveys such as the HSS and BSS in a rigorous manner (NAA, 2012, pp. 30–31).

In Siem Reap, in 2009, 80 "direct sex workers" (DSWs) were among the 4,691 persons seeking VCCT testing; in 2010, 32 were tested among 4,122 persons; but by 2011, only 3 DSWs were tested out of 4,768 and 6 DSWs out of 5,789 in 2012. Tolson (2012a,b) summarized the changing places for sex work and its surveillance for HIV/AIDS prevention. She suggests that the 21.7 percent HIV prevalence rate for beer-sellers (1995–2003; van Merode et al., 2006) seen a decade ago was in part influenced by customer migration from brothels to entertainment venues, which were seen as less risky. Harm reduction efforts by government and NGOs, with supportive funding for these campaigns, had reduced prevalence significantly by 2008 (under 5 percent). However, funding and campaigns may now shift after implementation of the Law on the Suppression of Human Trafficking and Sexual Exploitation began in 2009. Tolson (2012a,b) suggests that the closing of brothels drove brothel-based workers into beer gardens and clubs, and swelled the ranks of restaurant "hostesses" who now have to sit and drink with customers. With direct sex work driven underground, it is difficult to monitor such behavior and employ harm reduction campaigns.

The Double Threat of HIV/AIDS and Alcohol in Cambodia and Elsewhere

Many local public health workers were already engaged with Dr. Sarath Kros in Siem Reap well before SiRCHESI's formation; in 2000–2001, Ian Lubek, Mee Lian Wong, and student Meagan McCourt (2002) joined with other SiRCHESI members to start peer-educator training for HIV/AIDS prevention outreach. In 2002 80 Siem Reap citizens attended workshops (Lubek et al., 2002; Wong et al., 2003) to become peer-educators, and 23 have remained with SiRCHESI as its health outreach workers for villagers and entertainment workers. From SiRCHESI's earliest workshops and

workplace interviews (2002–2004), concerns were raised that HIV risk was linked to consumption of alcohol by beer-sellers of global brands (McCourt, 2002; Lubek et al., 2003). Correspondence was addressed to several international brewers requesting they provide HAART (highly active antiretroviral therapy) for their infected female workforce and change workers' remuneration to a living wage so they no longer turned to occasional sex-selling. Shortly before its beers were withdrawn from Cambodia, an executive for an Australian brand said: "We can't have prostitutes selling the national icon!" (personal communication, 2004). In 2002, with the arrival of HAART in Cambodia, contact was made with Doctors Without Borders who were starting a pilot project to implement HAART in a Phnom Penh hospital. They agreed to include HIV+ Heineken beer-sellers—then estimated to be 20 percent of their workforce of about 200. Heineken's negative response was unexpected (Lubek, 2005). In 2005 and 2006, three major brewers (Heineken, AB-INBEV, Carlsberg) each rejected recommendations for a living wage and HAART when presentations were made to management at their European headquarters.

Because beer-sellers had become a high-risk HIV group in Cambodia, with prevalence rates around 21.7 percent between 1995 and 2003 (Green & Lubek, 2010; van Merode et al., 2006), the PAO and NGOs in Siem Reap increased efforts to provide health promotion workshops and peer-educator outreach to teach about alcohol overuse as well as HIV/AIDS, STIs, and reproductive health. Heavy drinking takes place in entertainment venues. SiRCHESI's data (Green & Lubek, 2010; Lubek et al., 2009) showed beer-sellers and hostesses drinking between 4 and 10 standard units daily—an average of 5 units equal to 5 glasses, or 1.5 liters of beer. They drank 27 days a month. These are well above WHO standards of harmful and hazardous drinking (Babor et al., 2001) and U.S. government guidance to women to drink no more than 1 glass a day, no more than 5 days in a week! Other methodologies by nonindustry researchers show similar findings (e.g., SOMO, 2012); APHEDA/ILO (2011, p. 74) reported as many as 10–12 cans of beer drunk per shift. Each study above by independent researchers or those that were industry-sponsored (e.g., Klinker, 2005) describes pressure from customers and/or management to sit and drink harmful amounts of alcohol. Overuse of alcohol, with decreased judgment and inhibitions, may counteract any positive impact of health promotion and harm reduction campaigns for condom use. With excessive drinking and economic pressures to sell sex in the entertainment venues, condom adherence decreases, increasing the likelihood of both STIs and HIV in entertainment workers. Lubek (2005) and APHEDA/ILO

(2011) argue that alcohol abuse is linked to the perceived fulfilling of their job descriptions: "Salaries are generally set so low in the entertainment sector that workers, in order to earn a living wage, need to earn tips and, therefore, agree to sit, drink, and entertain the guests in anticipation of supplementing their wages" (pp. 73–74). Green and Lubek (2010) argue that insufficient wages and the "required" drinking with customers put extreme pressure on the women to make impaired and unsafe decisions about exchanging sex for money. Some sexual acts are not negotiated as 38 percent of beer-sellers report coerced sex acts in the workplace (Bury, 2005). After changes in the law in 2009, Cambodian researchers have lost the distinction of DSWs and IDSWs; selling sex is now illegal and health-related government agencies and NGOs must now regroup their activities and shift their focus to the behaviors and serology of a broader category of "entertainment workers."

Outside Cambodia, the correlation between increased risks for HIV/AIDS and alcohol overuse is also documented. Overuse of alcohol may result in reduced condom use after drinking (Fisher, Cook, & Kapiga, 2010), decreased adherence/effectiveness of HAART after drinking (Schneider et al., 2012), or reduced immune system response for persons living with HIV/AIDS (Neuman et al., 2012). HIV/AIDS and chronic alcohol dependency, taken separately or together without proper intervention, may present life-shortening risks and require major health system resources. Zablotska et al. (2006) found that "alcohol use was significantly associated with inconsistent condom use and multiple sexual partners in both sexes. The use of alcohol before sex increases HIV acquisition. A reduction of alcohol use should be incorporated into HIV prevention programmes" (p. 1191). Parry, Rehm, & Morojele (2010) review strong evidence of a "causal linkage between heavy drinking patterns and/or alcohol use disorders and the worsening of the disease course for HIV. Of all years lost through death and disability that can be attributed to alcohol, 10 percent for men and 28 percent for women can be directly attributed to alcohol's impact on the progression of HIV in infected individuals" (p. 81). Rehm et al. (2012), after an extensive meta-analysis of the relation between alcohol and the likelihood of unsafe sex, suggest that alcohol consumption should be included as a major factor in HIV preventive efforts. As mortality and morbidity may be high in resource-poor locations or among disadvantaged populations, Neuman et al. (2012) argued that "a network of direct discussion is needed between people living with HIV/AIDS, medical personnel treating HIV and/or addictions, epidemiology researchers, as well as policymakers and treatment planners" (p. 11).

The public health response in some countries was twofold: developing a national policy to organize public health campaigns against HIV/AIDS and a national policy on alcohol. In multicultural societies, additional research was required and sensitivity shown to situations in which minority groups would be at greater risk for preventable illness, including HIV/AIDS and alcohol overuse (Russell & Wenham, 2010; Grierson et al., 2004; Robson & Harris, 2007). In neighboring Thailand Kawichai et al. (2005) reported the arrival of HIV/AIDS in 1988, and by 1991–1992, VCCT clinics were opened in all government health clinics. HIV/AIDS reached its peak with prevalence at 44.6 cases per 100,000 population in 1998, which decreased to less than 10 per 100,000 in 2009 (Wibulpholprasert, 2012). The 100 percent Condom Campaign for direct and indirect sex workers contributed to the success in bringing the prevalence down. Thailand's modern alcohol policy movement started in 2001. The Center for Alcohol Studies was set up in 2004. Findings on the social cost of alcohol-related problems and the systematic review of alcohol laws of other countries led to the Alcohol Beverage Control Act, B.E. 2551 of 2008 and the National Alcohol Policy Strategy in 2009 (Thamarangsi, 2009). In Cambodia, there is not yet a coordinated national alcohol control program. It is suggested that strong national policies about HIV/AIDS and alcohol will add to the health services "toolbag" of knowledge and actions to be used to protect health and reduce harm to Cambodians.

SIRCHESI'S PRIMARY VS. SECONDARY HEALTH INTERVENTIONS

"Primary interventions" prevent communities from acquiring HIV infections by protecting them from common sources of the infection; "secondary interventions" may be health promotion programs designed to reduce and prevent the further transmission of infection, once it is already present in the community. SiRCHESI does not conduct "tertiary interventions," which may include medical treatment programs (e.g., ARVT or HAART) once an epidemic is already established. These were brought to Siem Reap in 2003 by the international NGO Doctors Without Borders (MSF) and France's ESTHER, supervised by the PAO, and are now implemented by the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria.

SiRCHESI's primary intervention—the Hotel Apprenticeship Program (HAP)—was launched in 2006, with follow-ups still ongoing. In two staggered cohorts, 30 women were selected (N=14, Cohort 1; N=16, Cohort 2) who were at risk for HIV/AIDS from "toxic" environments at their beer-selling workplaces (Lubek, 2005; McCourt, 2002; Schuster, 2006, Pagnutti, 2006).

They left their jobs to train at SiRCHESI's school for safer, healthier careers as hotel workers. The program guaranteed "living wages" for up to two years with frequent monitoring of their progress and changes through questionnaires and interviews. With their written consent, each individual student—26 completed the program—could be followed longitudinally with repeated measures, currently for over seven years (see, e.g., Pollock, 2008; Lee et al., 2010).

SiRCHESI's secondary interventions include health workshops with pre- and postworkshop intervention questionnaires for various risk groups and the collection of data by peer educator outreach health promotion teams. These provide yearly trends on community health awareness, HIV knowledge, and HIV-risk reduction behaviors using multiple cross-sectional community samples of some high-risk groups. Voluntary in-depth questionnaires have been made available after VCCT testing for up to 560 persons each year (Wong et al., 2003).

While international researchers, interns, and student volunteers originally brought the "research language" into the community, SiRCHESI's staff began to offer a formal, 17-day internship program that teaches all the community health research and intervention techniques now used in Siem Reap; 3 interns participated in 2012, 8 in 2013, and up to 12 can be accepted in 2014.

Generally, SiRCHESI's local data, when compared with international research, showed broad agreement that infection rates, risks, and prevention outcomes were related to predictor variables of gender, poverty, and illiteracy (Farmer, 1999; Lewis, 2008; Wong et al., 2003). But the "bridging pattern" of HIV transmission was in part a unique research finding, which drove SiRCHESI's prevention strategies toward various groups, especially local men. Of prime importance to this PAR research has been the mapping of the development of the epidemic across time.

LOCAL DATA COLLECTION CONCERNING SIRCHESI'S HEALTH PROGRAMS

Using community participation in both health interventions and the research programs attached to them, a rich core of longitudinal research findings about this community's response to the HIV/AIDS pandemic helps guide the continuing community-health campaigns.

Community Sexual Health Behavior and HIV/AIDS Monitoring

SiRCHESI's interviewers since 2001 annually conduct up to 560 in-depth structured questionnaire/interviews with four risk groups, $N = 140$ each

at the local VCCT clinic: married women and women receiving antenatal care checkups, direct sex workers (brothel-based until 2009), indirect sex workers (entertainment industry workers including beer-sellers), and men. These interview/questionnaires probe how demographic, economic, gender, and workplace factors impact health behaviors and risk-taking indicators (e.g., consistent condom use, selling of sex).

Alcohol as a Risk Factor in HIV/AIDS Transmission and as a General Community Health Risk

SiRCHESI collects interview data about healthy or risky behaviors and breathalyzer samples from women working in the entertainment industry (as well as their customers). Levels of drinking and sexual risk-taking (2004–2013) of the beer-sellers of different international brands sold in Cambodia are compared among the brands (or brand "families," as almost all are owned by about six global conglomerates). As well, comparisons are made with restaurant hostesses sharing their workplaces. Various health and safety indicators of the beer-sellers are examined before and after the institution in 2006 of an industry code of conduct for safely selling beer by a group of companies, Beer Selling Industry Cambodia (BSIC), controlling 80 percent of the market (SOMO, 2010). Besides extensive pre–health workshop questionnaires for beer-sellers and hostesses, postworkshop assessments are made about what has been learned about HIV/AIDS and alcohol risks and strategies for avoiding them. Furthermore, SiRCHESI collects, in field settings, demographics and nightly drinking behavior indicators alongside breathalyzer scores for blood alcohol concentration (BAC) of beer-sellers and men in beer-gardens. Almost 2,000 interviews have been conducted since 2004 for the women at risk (Ennis et al., 2012).

By 2005–2006, SiRCHESI's HIV/AIDS research had shown that alcohol abuse was a factor in unprotected sex, leading to higher risk for HIV/AIDS (Lubek, 2005; McCourt, 2002; Pagnutti, 2006; Schuster, 2006). The increased workplace health hazards for these women, due to both their customers and managers, are expressed in measures of alcohol overuse, coerced sex, and physical abuse; all research sources agree, whether industry-financed studies (Quinn, 2003; Bury, 2005; Klinker, 2005; CAS, 2009), independent studies (International Labour Organization, 2006; Moller & Yean, 2001; SOMO, 2007, 2009, 2010, 2012), and in research conducted with SiRCHESI (McCourt, 2002; Schuster, 2006; Pagnutti, 2006; Lubek, 2005; Lubek 2009a; Lubek et al., 2009, Green & Lubek, 2010, Ennis et al., 2012).

Green & Lubek (2010) summarized SiRCHESI's research about workplace health, safety, and financial security of over 900 Cambodian beer-sellers (2004–2010). Findings showed women constantly were pressured to drink on the job, only 1 percent abstained, and the quantities they drank, averaging six glasses of beer nightly, put them physically and psychologically at risk. Selling beer in 2009, no matter which international or local brand, put Cambodian women at risk for HIV/AIDS, alcohol overuse, violence, harassment, and sexual coercion. Well into 2009, beer-sellers had little recourse to their shift supervisors for help, company transport home at night was not uniformly provided, and many women were followed home by customers. Company health and safety training was generally "too little, too late." In fact, SiRCHESI concluded (Lubek, 2009a; Green & Lubek, 2010) that BSIC's code of conduct has had little impact on worker health and safety. There was no overall industry health improvement in any reduced nightly alcohol consumed or in BAC as a result of the BSIC code (Worrell & Kunthear, 2012).

SiRCHESI's Peer-Educator Outreach Program

SiRCHESI (since 2002) monitors the demographics and condom use behaviors of Siem Reap villagers and city-dwellers and entertainment workers. The data are gathered monthly by 23 trained peer-educators, reaching just 880 persons in 2002, but by 2012, 11,910 persons in that year. These data help SiRCHESI to reorient, as needed, the teaching strategies and materials about local health conditions and also to decide whether any groups are underrepresented or are showing lower condom-use rates.

SiRCHESI's Hotel Apprenticeship Program (HAP)

SiRCHESI's staff conducts regular job-satisfaction inventories and a longitudinal series of follow-up questionnaires and qualitative interviews (every four months) about life transformation of 26 women who, between 2006 and 2009, participated in a career-changing primary health intervention. SiRCHESI's data showed that gendered inequity in the Cambodian educational system led nonliterate women to unsafe, unhealthy, and high-risk employment situations in the entertainment industry (Wong et al., 2003).The Hotel Apprenticeship Program removed beer-sellers from "toxic" entertainment industry workplaces and trained them for safer, two-year job commitments in the hotel industry, paid at a "living wage" in upwardly mobile career pathways (Lee et al., 2010). SiRCHESI's school

(2006–2009) offered an intensive eight-month program of Khmer literacy, English, and health, social, and life skills, alongside daily "mentored" hotel work. Students were monitored throughout their study (Pollock, 2008; Lee et al., 2010) and SiRCHESI continues to monitor their progress in the community to this day. When leaving the beer industry and training for hotel work, women ceased alcohol use and occasional selling of sex, and their health knowledge, self-esteem, and job satisfaction all increased during the school period.

Capacity Building and Knowledge Transfer for SiRCHESI's Community PAR and Interventions

Throughout its research-driven health interventions, SiRCHESI continued to use its "hybrid capacity-building model"—as explained above—to transfer research and intervention skills from international researchers and advisors to NGO members and then back to the community's public health workers and peer educators, and finally, full-circle, back to visiting student interns from developed countries. Through SiRCHESI's websites (e.g., www.beergirls.org, www.fairtradebeer.com), press releases, publications, and presentations, knowledge may be transferred within the local community, Cambodia's health system, and perhaps to national and global health and business policymakers. Recently Kirkwood (2009) gave a more favorable evaluation of local NGO SiRCHESI's long-term community implantation of health intervention and research skills as compared to an international NGO's internationally funded two-year project in Laos. Abandoned when the money ended, the latter didn't leave a continuing community program.

The above five grassroots projects are interlinked and help guide and/or evaluate SiRCHESI's health promotion, harm prevention, and risk reduction activities, as well as those of the public health sector. The research and practice components are parts of the PAR model, which encourages research-derived evidence to guide practice and points to policy options. When VCCT data showed an increase in the HIV prevalence rate among married women that peaked in 2003 at 35 percent, and a near-identical rate of 33 percent for local men, possibly their husbands, contrasting with a decreasing rate of 30 percent for the brothel-based sex workers, these findings were quickly turned into PAR interventions as additional efforts in peer education and workshops were aimed toward men. The community's "bridging pattern" of infection is significantly affected because of multiple partners used by approximately 25 percent of local men (NCHADS, 2001, 2004).

In 2003, SiRCHESI added research questionnaires and health workshops for men and ramped up its peer-educator HIV prevention outreach program.

ONE SMALL PROGRAMMATIC STEP FOR SIRCHESI: HOW CAN AN NGO IN CAMBODIA MOVE FROM HEALTH PROMOTION TO ADVOCACY AND POLICY CHANGE?

SiRCHESI's data collection about the HIV/AIDS epidemic in Siem Reap uncovered the risk-increasing factor of alcohol overuse and the consequent lack of a corrective response from global brewers to the institutionalized workplace health hazards of their beer-sellers (Green & Lubek, 2010). This local, autonomous, HIV/AIDS research/intervention NGO works hand-in-hand with the public health service, and also educates international and global health (and development) interns about working in resource-challenged environments. SiRCHESI's health workshops and outreach program are among the contributing community interventions that have positively affected increased condom use and helped decrease HIV prevalence significantly in risk groups such as beer-sellers (Lubek, 2012). But SiRCHESI has been limited in its ability to "make data matter" in the local context and beyond. A "debate" has been waged in the Cambodian and international press about the problems of alcohol overuse and workplace dangers for the beer-sellers. On the one hand, SiRCHESI (Green & Lubek, 2010), Dutch NGO SOMO (2010, 2012), APHEDA/ILO (2011), and certain ethical shareholders' groups (e.g., VBDO in the Netherlands) suggest dangerous/hazardous nightly overuse. On the other hand, industry-sponsored research and websites (CAS, 2009; Indochina Research, 2011; Quinn, 2003; Bury, 2005; Klinker, 2005) and www.bsic.com.kh present research that does not paint as negative a picture of the entertainment environment and the pressures to drink to harmful excess. In Cambodia, there has been little visible movement toward basing an alcohol policy on research, in contradiction to the very proactive steps begun two decades ago to combat HIV/AIDS. Preliminary analysis of the alcohol industry in Cambodia shows ownership by a small number of prominent persons (SOMO, 2010). Cambodia has not yet adopted legislatively the measures concerning "socially responsible drinking," high school education, drunk-driving campaigns, designated drivers, roadside breathalyzer testing, alcohol taxation, and age restrictions seen elsewhere where the same global brands are marketed.

In Cambodian national policy and planning documents, there is little acknowledgement of the role of alcohol in the HIV/AIDS challenge or as

a health issue. Examination of the Strategic Plan for HIV/AIDS and STI Prevention and Care in Cambodia 2001–2005 (Ministry of Health, 2000), or Cambodia National Policy and Strategies for Prevention and Care of Sexually Transmitted and Reproductive Tract Infections (STI/RTIs) 2006–2010 (NCHADS, 2007), the National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS 2006–2010 (NAA, 2006), or the National Strategic Development Plan for 2009–2013 (Royal Government of Cambodia, 2010) discloses few references to beer-sellers, alcohol, or beer as a co-factor with HIV/AIDS. There is a committee of parliamentarians in Commission 8, "Health Care, Social & Veterans' Affairs, Youth Rehabilitation, Labor, Vocational Training & Women's Affairs," who might prepare legislation concerning HIV/AIDS, alcohol and drug risks. Members of this committee visited the Global Alcohol Policy Conference in Bangkok in 2012,which covered the thorough and well-defined policy of Thailand's Alcohol Beverage Control Act, B.E. 2551 of 2008 and its National Alcohol Policy Strategy of 2009 and how they had evolved with research guidance (Thamarangsi, 2009).

A "direct approach" to policy change, in which SiRCHESI or other NGOs supply data on harmful nightly drinking and HIV/AIDS risk-taking to the government or to the drinks industry, does not seem to lead to alcohol policy changes that improve health and reduce risks concerning alcohol (Green & Lubek, 2010; SOMO, 2012). But for the past two decades, HIV/AIDS research from NGOs and government researchers has in fact informed those policies, as Cambodians have confronted the mortality of HIV/AIDS and its social consequences. In Cambodia, alcohol sales increase annually, and nightly drinking by most beer-sellers and hostesses has not decreased (Green and Lubek, 2010; Ennis et al., 2012). Global companies target Cambodia specifically and South East Asia generally for further annual sales increases; Cambodia is said to lag behind the consumption rates of their Southeast Asian neighbors. SOMO (2010) has looked at the ownership structure of the drinks distributors and breweries; most are (co-)owned by wealthy business entrepreneurs or tycoons ("Okhna"). In working at the interface of HIV/AIDS and alcohol overuse as health risk factors, there do not seem to be any noticeable barriers to HIV/AIDS policymaking, using data supplied by NGOs and/or government agencies. However, there may be less political urgency for alcohol-related health data to directly inform national policy.

An "indirect approach" may see data from NGOs affecting policy changes by involving third parties who provide advocacy and activism beyond the mandate of Cambodian NGOs' nonpolitical/religious/profit

stance. International advisors and non-Cambodian academics can send data to international audiences; to local/global activists concerned with health, labor, and human rights; to trade unions, industry shareholders, the press, and/or judicial entities/tribunals such as various labor tribunals or OECD contact courts. With PAR as its adopted framework, SiRCHESI's international advisors felt that health interventions must be guided, monitored, and evaluated by research. But the road from research data to policy change has been largely indirect and trial-and-error. Under the new "NGO" draft law, it is difficult to find the boundary between political actions or government policy criticisms, which could be treated as actionable defamation, and suggestions for social changes to improve health, safety, and well-being and reduce harm and risk (LICADHO, 2011). Local SiRCHESI staff, working part-time,who may also be full-time public servants, therefore largely abstain from any advocacy activities, leaving such statements to the international advisors and non-Cambodian academics.

One example of a recent "indirect approach" includes debates about Cambodia's role in ASEAN. One external SiRCHESI member took part in regional events to shape policy by joining the ASEAN Women's Caucus meeting in February 2012, prior to their Summit in Cambodia (April 2012). The Women's Caucus gathered suggestions from participating NGOs focusing on women's issues, delineating specific concerns that would affect the most marginalized workers (including beer-sellers). Their recommendations were submitted at the Women's Forum in March 2012 and were covered by the local media (Nimol, 2012).The SiRCHESI NGO opted not to include its name on the official list of 69 NGOs due to concerns regarding the NGO Draft Law. However, SiRCHESI's website and advisors' recommendations to increase salaries to a living wage and to advocate for free assembly for workers within unions were still able to be put forth behind closed doors (Michelle Tolson, personal communication, June 5, 2012).

Another example of an "indirect approach" involves attempts to bring data from SiRCHESI's various "Alcohol Risk and HIV/AIDS" studies to the attention of those who could implement workplace health and safety policy changes, whether globally, nationally, or even at the level of the local community. International advisors have been annually sending SiRCHESI's data to the CEOs of the global beer industry since 2002 (Lubek, 2005; Green & Lubek, 2010). In 2005 and 2006, Lubek personally presented the data to company executives and directors at the headquarters of three of the largest global brewers: AB/INBEV (formerly Interbrew) in Louvain, Heineken in Amsterdam, and Carlsberg in Copenhagen. Since

2007, the Dutch NGO VBDO (Association of Investors for Sustainable Development), representing Heineken's sustainable and ethical shareholders, has brought SiRCHESI's data about Cambodian beer-sellers (along with summaries from SOMO, 2007, 2009, 2010) to the attention of the CEO and all shareholders during the Heineken Annual General Meeting, sometimes instructing its advisees to abstain from voting for the board of directors (e.g., VBDO, 2007, p. 10).

Various suggestions for policy change addressed to the global brewers have been posted on www.fairtradebeer.com by international advisors:

- Correct all salaries to the "living wage" level, so that part-time sex work ceases, reducing risk for HIV/AIDS.
- Provide free HAART (antiretroviral medications) to their beer-sellers from the beer companies themselves, and extend this to hostesses.
- Provide timely "first day" training about reproductive health, workplace behaviors, alcohol, and HIV/AIDS risks for all beer-sellers and hostesses.
- Recognition by all international brewers and local distributors that women beer-sellers are workers under the Cambodian Labour Code, eligible for all international company benefits and local labor rights.
- An end to forced workplace alcohol consumption.

A more recent "indirect approach" sees SiRCHESI's data passed by international advisors to other advocacy groups like trade unions. Greater action by trade unions, a relatively new concept in Cambodia, is a possibility. In August 2010, some of SiRCHESI's peer educators who work with beer-sellers joined with representatives of the Cambodian Food and Service Workers Federation (CFSWF) and APHEDA to recruit, at a workshop on workers' rights, 63 new union members and elected SiRCHESI peer-educator Ms. Phaal Sophear as president. SiRCHESI's data on workplace health and safety and the risks to health caused by workers not having living wages were all provided to the union's national office and to new Siem Reap members at the workshop. In August 2011, the CFSWF workers at Angkor Beer, a BSIC brand owned by Carlsberg, went on strike to claim several years of contracted but unpaid overtime and holiday pay, which the ILO Arbitration Council had ruled should be paid to the women. During the strike, the press in Cambodia and Denmark sought data from SiRCHESI and opinions about "the two-dollar strike" (Titthara, 2011; Kragballe, 2001). Six hundred Angkor beer-sellers each got a settlement of $320, about one half-year's pay. By using media advocacy to highlight how poverty and the work environment have impacted on the beer

sellers' health, SiRCHESI's data had an indirect effect, being used by the unions, the beer companies, and the press, when combined with electronic networking, as evidence for an action or a settlement. When Carlsberg unfortunately retaliated against strike leaders and formed a "house union" to undercut the CFSWF union, Tolson submitted two stories that ran in the United States (Tolson, 2012a) and locally in Khmer (Tolson, 2012b) summarizing the health data of SiRCHESI alongside other reports from labor organizations in support of the concerns put forth from CFSWF. The international story was rerun on trade union blogs to be shared with other unions. This illustrates the active, nonacademic uses that research data can have when disseminated via websites. Following further press coverage of the aftereffects of the strike, CFSWF recently launched a new campaign in April to get the remaining beer companies to acknowledge overtime and holiday pay as Carlsberg now does. At least one major brewery in Cambodia (Cambodia Breweries Ltd.) has been reported to have quietly followed the Carlsberg lead for 800 sellers, while Heineken, in contrast, has reduced its workforce from 2011 by 80 percent (personal communication, Mora Sar, president, CFSWF, June 2012) and was scheduled to stop using beer-sellers as a marketing tool by 2013. However, in late 2012, Heineken bought Asia Pacific Breweries, employing over 800 Tiger Beer sellers in Cambodia. They are being monitored during 2013.

SiRCHESI's data have helped create change for the underpaid beer-sellers through an indirect process that had other groups in industry and the trade union movement take action and award the equivalent of a half-year's wages. Of course changing the remuneration policy of one global brewer is not the same thing as creating a health-promoting national policy for alcohol to go hand-in-hand with the already effective policy mechanisms in Cambodia for HIV/AIDS. SiRCHESI continues its efforts to "make data matter" to improve Cambodian public health.

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