CHAPTER IV

THE INTERPLAY OF HIV-AIDS, FOOD INSECURITY AND SOCIAL PROTECTION

4.1 Introduction

The interplay of HIV-AIDS, food insecurity and its social protection mechanisms are bought up clearly in this chapter by first introducing the concepts and the background in Cambodia, examining its policy apparatus together with findings from respondents from the policy-makers, donors, international NGOs as well as local NGOs.

The connection between HIV-AIDS and food insecurity however needs to be concisely explained. From a medical and health point of view, the effects of malnutrition and food insecurity reinforces the HIV-AIDS pandemic. There is a large body of evidence that supports that inappropriate intake negatively impacts on the immune system (Spool & Torino, 2008). Studies completed before and after the advent of Highly Active Antiretroviral Therapy (HAART) shows that wasting (a form of malnutrition) is a predictor of death of HIV positive individuals. Malnourishment decreases survival in patients starting HAART (Highly Active Anti-Retroviral Therapy) and ART[1] for many reasons: impairment of immune reconstitution and a prolong period of opportunistic infection risk, adverse effects on drug absorption, lower threshold for drug toxicity and decreased physical function (Spool & Torino, 2008).

In a development context, food insecurity plays a major role in resource poor and resource adequate settings. In resource-poor settings for example, there will be a decrease or no adult labor in HIV-AIDS affected households which result to orphans

[1] Anti-Retroviral Therapy (ART) refers to any drug that lowers HIV viral load, such as AZT. However, after relatively brief periods on ART monotherapy (taking one drug), people living with HIV develop resistance to the drug and their viral loads increase. Highly Active Anti-Retroviral Therapy (HAART) refers to the combinations of three or more HIV medications introduced in 1995 that lower viral load by more than 99% (down to undetectable levels). If viral load can be lowered to this level and that suppression maintained, people usually will not develop resistance

and vulnerable children who in turn may or may not be infected with HIV-AIDS. In this case, the households have less capacity to produce or purchase foods while at the same time having to procure higher medical costs. In addition, children may stop their schooling to work (Spool & Torino, 2008). Research in Tanzania showed that food consumption decreased 15 percent per capita when an adult died (Spool & Torino, 2008). Funeral costs deplete monies that could be used for food. The agricultural knowledge base of families and communities decreases as individuals with farming and science knowledge die from HIV/AIDS. Food and Agricultural Organisation (FAO) makes the connection between HIV-AIDS and the threat to rural development urging the need for a new focus on agricultural response (Food and Agricultural Organization).

4.2 HIV-AIDS and Food Security

Cambodia has the highest HIV prevalence in Asia: 1.9 percent of a 15 million population (UNAIDS, 2004). The country has been pointed out as an example of success having bought down its prevalence rate to 0.9% in 2006 (National AIDS Authority , 2008) – political will was the most important contributor together with the inclusion of civil society that helped bring the pandemic to minimal levels despite the widespread poverty and domestic political turmoil. The first case of HIV was detected in 1991 during the screening of blood and the first AIDS case was diagnosed in 1993(UNAIDS, 2004), in the same year, a National AIDS Committee was formed only to be reorganized due to the seriousness of the pandemic at that time and it became the National AIDS Authority[2] (UNAIDS, 2004). A comprehensive and multisectoral strategic plan was developed called the National Strategic Plan (NSP) that is coordinated by the NAA (Reid & Costigan, 2002).

Cambodia was one of the first to pass a rights-based approach on its Law on the Prevention and Control of HIV-AIDS in 2002; is considered to have one of the most advanced global surveillance systems among less developed countries (UNAIDS

[2] The NAA consists of a secretariat, 26 line ministries, the Cambodian Red Cross and 24 provincial committees. The role and responsibilities of NAA is policy development, strengthening partnership and coordinating the multi-sectoral responses to HIV/AIDS, mobilising resources, advocating legislative support for research on the socio-economic impact of HIV/AIDS, and reviewing and approving the Information Education Campaign programmes in all sectors.

2004). HIV-AIDS is also fully integrated into the Health Sector Strategic Plan and the goals of the national response to reduce the new infections of HIV, to provide care and support to People Living with HIV-AIDS (PLHIV), to alleviate the social-economic and human impact of HIV-AIDS on the individual, the family, community and society (UNAIDS, 2004).

While the policy environment has been one of the gains of HIV-AIDS development, enabling to bring down HIV-AIDS prevalence, financing of HIV programs in Cambodia is rising rapidly and the financial resource gap is widening (NAA 2008). The government's financial contribution comes up to 10% of the annual HIV expenditures, relying more on donors, particularly a small number of donors (NAA, 2008). More than 70% of the total HIV funding in Cambodia comes from the United States Agency for International Development (USAID), the United States Centre for Disease Control and Prevention – Global Aids Program (CDC-GAP) and the Global Fund (NAA, 2007).

There has been a shift from a health-centered to a people centered and gender sensitive approach from the top down to a bottom up approach that emphasizes human rights (Jonsson, 2006). This can be seen in its policy documents as such as the Continuum of Care Framework (CoC) and its Standard Operating Procedures (SOP) (National Center for HIV-AIDS, Dermatology and STDs, 2006) which has various support group mechanisms for PLHIVs – in particular the home-base care team which serves as an approach and entry point for food support, treatment and impact mitigation. I focused on this document because it is relevant to the issue of food security of PLHIVs when we take note that the legacy of the pandemic is the estimated 71,100 PLHIVs aged between 0-49 years old, an estimated 33,100 which are in need of ART. It is estimated by the NAA that by 2010, the number in need of ART will increase to 38,600 (National Aids Authority, 2008).

The Ministry of Health, through the National Centre for HIV/AIDS, Dermatology and STD (NCHADS) has recruited and collaborated with civil society to implement this community home-based care in Cambodia. To ensure harmonization and support the implementation of community home-based care, the Ministry of

Health has developed SOPs for implementing this activity, providing guidance on coordinating mechanism, home-based care team structure, package of home care activities, and estimated budget for operating community home-based care activities. Empowerment of the PLHIVs is also discussed in the CoC framework. It cautions that their involvement must be developed carefully to best understand and respond to the needs of other PLHIVs while recognizing their limitations in terms of poverty, illness, lack of training and discrimination. Thus their role is seen as optional and not imposed – their empowerment however is limited to active participation in service delivery as part of the community response. Acknowledging the need for socio-economic support needed by the PLHIVs, structures such as the Self-Help Groups or other initiatives can be referred to. The policy documents however are vague on what this entails and in praxis it is the NGO implementers together with funders such as WFP, USAID and other international NGOs that provides for food support and supplemental livelihood initiatives. The list of interviewees is indicated in Appendix B.

HIV-infected groups do have their own provision for food security and nutrition, under the CoC framework. Two aspects of nutrition are critical: nutrition advice and care for children and food support for PLHIVs in various specific situations either as in-patients when they arrive at the hospital, or when they are infected with tuberculosis and are in-patients or nutrition is provided for them when they are on ART during the first six months. Again there are criteria for these basic requirements: Rice (30kgs), oil (1kgs), and iodized salt (0.5kg) distributed every month (National Aids Authority, 2008) by NGO implementers.

This corresponds to what one WFP respondent told me that there is what they call a "pipeline break" wherein *"WFP supports designated beneficiaries and moves on after six months to other areas – it is assumed that the PLHIVs we support will be nourished enough...what happens though is that we have those same households that fall back to the same situation and need to be taken back"*[3]. The respondent shared that one of its implementers had noticed that its beneficiaries in the province of Siam

[3] Interviewed, July 17th, 2009

Reap were now resorting to looking for available root crops in the area in order to feed themselves. WFP admits that *"HIV-AIDS is a second priority and we are dependent on their donor priorities. In 2009, Maternal and Child Care Health was fully funded and met the targets, but in the area of HIV-AIDS it came to only 88% followed by Tuberculosis. We do not know what can happen for 2010"*. Currently, WFP has difficulty engaging with the government because of their low capacity on food security and procurement issues. However, it also runs deeper than that: *"the government knows that we cannot offer operational costs like the other UN agencies that offer them vehicles or other resources, all WFP has is food and it doesn't even go back to the state"* implying that incentives were required by the state in order to motivate its staff to work. Income generating activities are carried out, admits the respondent "*but this is the responsibility of the NGO implementer. WFP is bound by its mandate and we can only offer either food support or technical assistance*". It makes sure however that in signing its memorandum of agreement with the NGO implementer that the latter has sufficient funds to cover the livelihood aspect.

The issue of this pipeline break and challenges on food support was also echoed by USAID. The agency started its Home Based Care and Continuum of Care since 1998. At present, USAID now has 56 HBCs in the whole country. The respondent affirms that support is provided for six months only[4]. A total of $50 M/ year have been spent on HIV assistance and a maximum of that covers the HBC. In terms of sustainability, the respondent had answered that *"We encourage our partners to focus on the livelihood support since it will provide income and jobs for the PLHIVs but we admit that there is uneven progress on this and in some cases disappointing that points out to the partners' inadequate technical knowledge in carrying out tailor-made livelihood programs"*. The income generating activities of the HBC package amounts to only $30/Household. The respondent admits that "*the issue of empowerment is not injected into this process, it follows the HBC package where empowerment is not given due consideration and even then, it depends on the initiative and experience of the NGO implementer*". Currently, the agency is considering a new approach in making PLHIVs more proactive and not just dependent

[4] Interviewed, July 15th, 2009

on the NGO – it sees the ground-based mechanisms of the Self-Help Groups as that entry point. *"We have seen our funding in this category decrease by 50% in the past two years and we would need the commitment from the government to take over these responsibilities"*. Such a commitment the respondent admits will take time to foster.

NGO implementers however have apprehensions about this. *"Certainly, we would want the donors to keep funding the program because sustainability for PLHIVs is a long way off[5]"* reported a respondent from Khmer HIV/AIDS NGO Alliance (KHANA); one of the largest NGO implementers of the WFP and USAID. *"The challenge is that the food support provided to its beneficiaries is not even enough – their situation would be made even more vulnerable once the support is cut off."* KHANA has experienced this belt-tightening situation during the soaring food prices last year. WFP had to suspend its operations for three months and the respondent shared that some of its beneficiaries had to go to Thailand to find work. In terms of the livelihood program, KHANA works with other NGOs with agricultural or livelihood expertise with no coordination with line ministries – *"we coordinate with the NCHADS and NAA that is generally sufficient"*. Such limitation is deliberate because of the fears of corruption, the sense that the state cannot do anything relevant and the political underlying fear amongst NGOs against the state. KHANA also finds blame on the state since *"local authorities see the support given by NGOs and therefore do not involve themselves in the needs of PLHIVs. It is still a struggle to get them committed to integrate the needs of PLHIVs into their community plans"*. The respondent admits that this is due to the perception that those with HIV-AIDS are bound to live short lives – *"some do not know that when they regularly take their regimen and care for themselves, they can live longer"*.

Cambodian HIV/AIDS Education and Care (CHEC) an NGO partner that carries out the programs of the HBC concurs with KHANA. Support by donors is still needed because *"we realize since PLHIVs now live longer there is a burden in the future in terms of treatment regimen and food support provided to them and the sustainability of support given by NGOs but also WFP covers the most poor of the*

[5] Interviewed, July 13th, 2009

provinces because of their resource limitations[6]". This leaves out those who are chronically poor but not yet qualified to belong to the most vulnerable that other donors can potentially fund for. CHEC likewise admits that the WFP support is not enough for one family – *"it is not even enough to last one month"* – and believes that the building of assets through its micro-credit programs can help them. The maximum loan is $50 for livelihood related to chicken, pig-raising, buy and sell vegetables and they work with the self help groups to pool their resources. The respondent shares that stigma and disclosure are still problems PLHIVs face and very often the reason for the downward spiral into poverty. This means that PLHIVs would seek for treatment and the procurement of medicines and in the process sell off their assets (such as land and the like) only to be pushed to having nothing at all and finally disclose their status to the HBC team. Sustainability is seen in the strong linkage between food security, regimen treatment and livelihood support regardless if one is in the urban or rural areas but in the case of those with no land, income generating activities need to be emphasized – *"and that is not yet possible for all PLHIVs*[7]*"*

There are also holes in the HBC package in terms of transportation and accessibility to the health centers to receive their treatment and get medical check-ups as this is not covered by the NGOs.

Two local network NGOs believe the problem of food insecurity needs to have sustained advocacy among civil society. Through direct observation, I have noticed that some NGOs are "blind" when it comes to having a PLHIV staff member that can better advocate for issues – most often a PLHIV is reduced to testimonials. This is because there are very little PLVHIVs who are technically competent, work in the development sector and have disclosed their status. During the course of my research, I have met some NGOs with PLHIV staff members and except for a few, most of them need organizational support (CPN+ is one example).

HACC for example has a majority of NGO members both with big (in terms of resources) and small (the community-based organizations), most of its staff are non-

[6] Interviewed, July 20th, 2009
[7] Interviewed, July 22nd, 2009

PLHIVs and technically competent who have chosen to remain with HACC despite its organizational internal issues. HACC believes that *"donors focus more on the scaling up of treatment rather than the inadequate food"*[8] believing that PLHIVs need vocational trainings or other trainings on the appropriate livelihood support. Traditional venues for productivity such as micro-credit and the private sector still need more flexibility in the hiring or accepting of PLHIVs. The respondent believes sustainability can be achieved through the income-generating activities. As a network NGO it is advocating on a platform of (a) Advocate for the insertion of PLHIVs in the community investment plans; (b) Advocate to the government to increase the health allocation on HIV-AIDS which currently stand at 10%; and (c) Negotiate the terrain of competition between the larger NGOs and the CBOs as well as the inadequate responsibility of the latter to mentor the former. Collaborating with the government is also another issue – *"it is hard for NGOs (in this field) to support a policy advocacy unless they know that it is backed by larger agencies and in which case, there is no common position. This is hard for NGOs who have fairly good relations with government and do not want to raise issues that can seem like they are criticizing the government"*.

The Cambodian People Living With HIV/AIDS Network (CPN+) who are comprised of PLHIVs works in organizing provincial network organizations of PLHIVs throughout the country using the self-help groups. The organization acknowledges that food insecurity is a problem but that it is inter-twined with the access to treatment. *"These issues of the PLHIVs are raised during the provincial meetings with government together with other NGOs – generally the health conditions and the food security. But government works very slowly on these issues, perhaps it's due to the many technical groups and thus the mechanisms are still weak"*[9]. The respondent perceives that the government's slow response and access to civil society warrants that they "shut up" on the issues they are raising. Either way, sustainability many years after the bringing down of the HIV prevalence amongst PLHIVs is hard to achieve. *"It has become harder now because of the increasing food prices and*

[8] Interviewed, July 24th, 2009
[9] Interviewed, July 29th, 2009

economic crisis – I am getting all these anecdotal evidence from the field". The access to treatment has challenges because of the quality of the drugs (which are provided for under the Global Fund in collaboration with the government and PLHIVs under HBC program can avail of the drugs for free. Funding covers till 2011)[10], the hospital staff who dispense of the medicines do not have the proper orientation and compliance of the guidelines are weak. He has personally seen these complaints in Sian Ream about the quality and questionable expiration of the drugs yet no policy recommendation has been done about it. This is verified by one of its provincial focal points in Siam Reap who had remarked that *"advocacy in terms of improvement towards treatment for PLHIVs in the province is a struggle because of the level of hierarchy in the government"*[11].

The challenges of food insecurity and access to drug also consider the services provided by the NGO implementers. The respondent from CPN+ has heard of complaints from provincial groups which need to be validated that some *NGOs "do not give the required amount of food or even charge them for the food; in some cases the food support is delayed"* This issue is validated by reports from the Cambodian Alliance for Combating HIV/AIDS (Cambodian Alliance for Combating HIV-AIDS (CACHA), 2007) and the Deputy Director of the NAA. In the CACHA report (2007) PLHIVs in various provinces were interviewed as to the amount of food support they got. Those in Phnom Penh received 5 to 30 kilos of rice and likewise the beneficiaries in Battambang who were recipients of the WFP. But PLHIVs in Kampot who receive food support from the Cambodia Red Cross do not receive it monthly and the rations range from 17-20 kilos. "*There are criteria for how much food support is delivered by the HBC team. WFP and USAID for example recognize this but some groups not under their umbrella have their own systems which result in uneven service*"[12], said Mr Phalla.

International NGOs who also implement or fund for the HBC teams have a broader view of the structural issues on food security of PLHIVs which is reflective of

[10] Ibid
[11] Interviewed, July 27th, 2009
[12] Interviewed, August 3rd, 2009

the state's priorities in agriculture. *"The problem with the state is that they link food security to rice"*[13], said one respondent from the Helen Keller International (HKI) explaining that issues related to lack of investment in crop diversification which are indicated in policy documents (under agricultural diversification) are *"nice to look at"* does not mean anything when it comes to implementation. This is important particularly for PLHIVs who need to go beyond rice rations to supplement their diet in terms of micro-nutrients. HKI focuses on the provision of food support via the home base care teams, the building up of assets through demo farms in the communes they work with and collaborating with the commune councils to raise awareness of PLHIVs and advocate for them to be included in the development plans. The *"focus of the HIV strategy is more on prevention as indicated in the NSP and less on impact mitigation and the integration of food security; nutrition and HIV-AIDS is less understood by line ministries outside health, particularly those focused on rural and agricultural development'*. Certainly there are challenges that their PLHIV beneficiaries face when it comes to their income generating activities or agricultural-based activities. *"The lack of investment in irrigation infrastructure impedes on agricultural production and this is seen in our project areas"*. They are currently identifying and developing a data-bank of crops local to the area that can be suitably planted by PLHIVs. *"The government needs to do a lot in terms of agriculture in order for PLHIVs to go beyond just food support, and they can do this by commitment to invest in agriculture and foster that environment"*. Voluntary Service Overseas (VSO) which provides for international volunteers to work with local NGOs on a whole range of services admit that the issues related to food security among PLHIVs is *"bigger than just the provision of advisory and technical services.....it needs the political will to be implemented"*[14].

The "disconnect" between treatment, food security and nutrition worries one respondent from Action Aid who is a PLHIV herself. *"This may mean the probability of drug resistance for those taking up the first line of regimen treatment which are cheaply produced and generic; or can cause serious side effects which would mean that the HIV positive patient would have to upgrade to the more expensive second line*

[13] Interviewed, July 3rd, 2009
[14] Interviewed, July 15th, 2009

of treatment"[15]. While the drugs are provided for free under the Global Fund, if the issue of food security and nutrition isn't fully addressed and integrated together with treatment, it would mean the procurement of more expensive drugs. *"Within the context of the financial crisis, we might not see the impact now but perhaps within the next two years"*. According to Action Aid's estimates, there are currently 67,000 PLHIV in the country, 32,190 of which are addressed by ARV treatment and on the first !ine regimen treatment. There is a concern that by 2020, PLHIV might move towards the second line regimen treatment.

In an interview with an independent research who has done consultancy work with HIV-AIDS related NGOs, he observed that NGOs themselves perpetuate this dependency among the communities paraphrasing that the self-help groups were *actually "self-hopeless groups"*[16]. He proposes that rather than relying on food support to the PLHIV communities *"NGOs should also empower them instead of just saying that is no land for them (PLHIVs) to do agricultural activities or saying that the livelihood support grant that they provide is not enough, nothing will be ever enough"*. But he points that that *"how can you empower the communities when NGOs themselves are not empowered and rely on donors' priorities? This feeds into a dependency cycle"* The issue of food insecurity amongst PLVHIVs, he says, is this dependency process.

The policy makers from NAA and CARD show two different faces when it comes to the asymmetric relations with donors. Whilst CARD admits that *"people need to be more aware of what issues related to food security*[17]*"* acknowledging that it would not be able to do its technical work without the support of funders. NAA on the other hand see the support of funders likening it to *"something that falls out of the sky"* saying that donors dictate how much is spent in terms of costs and operational plan but very few will share these plans as long as it is aligned to the National Strategic Development Plan (NSDP). This is reflective in the National Spending Allocation (NSA) where expenditures of activities and resources are open and

[15] Interviewed, July 28th, 2009
[16] Interviewed July 21, 2009
[17] Interviewed July 23, 2009

transparent – *"although you can see very little difference from the 2007 and 2008 budget expenditures"* he remarked, but donors do not share these plans with the NAA. The problem he believes is that the Government-Donor Joint Technical Working Group (GDJ-TWG) is a stand-alone mechanism with no external "watchdogs" monitoring the process. Furthermore, the systems need to be streamlined because *"one can get lost in all these technical working groups"*. While it is perceived that PLHIVs are in a better position now compared to before, this does not translate to health since one has to take a look at the food and nutrition aspects. *"Exactly for how long will the food support last? Till the end of the Global Fund cycle when there is no more free ARV?"* This problem has not yet been looked into by donors and even then *"not even sufficiently advocated for by civil society"*. He believes that the Government should make strong investments into agriculture and put resources into areas such as human resource, particularly looking at PLHIVs. *"The problem is often the public perception that because they are sick, like those with TB and malaria, the state as a whole does not know what to do with them"*.

4.3 Analysis

The British epidemiologist Thomas McKeown has elucidated that progress in controlling one's illnesses cannot be attributed to vaccines, antibiotics, access to treatment alone but rather the socio-economic conditions and effects on nutrition which strongly constitute an essential health factor (Useche, 2005).

Epidemiological studies have confirmed that health expectations are directly associated with the quality of life which in turn is determined by the environmental health, nutritional status, water quality, housing, education, working conditions and emotional and psychological factors that benefit human development throughout the life cycle (Useche, 2005). In the case of Cambodia, these indicators are affected by the neoliberal paradigm. In this era, health problems have been polarized along with distribution of wealth, as born out by Paul Farmer's theory that the health of the world's poor is affected primarily by infections and violence, while the rich suffer from chronic illnesses associated with aging (Useche, 2005). As such HIV-AIDS is incubated and propagated into a system of social inequity given Cambodia's reliance

on donor support, the state of its health system and its focus on macro-economic growth.

The issue of neoliberalism and the AIDS crisis is taken up in Sub-Saharan Africa where Collen O'Manique (O'Manique, 2004) in her *Neoliberalism and AIDS Crisis in Sub-Saharan Africa*, notes that "*Neoliberalism is largely consistent with the biomedical construction of AIDS, which reduces the AIDS pandemic to its individual clinical and behavioral dimensions. What this means and is consistent with the finding is that the material conditions which acted as catalysts for the virus to thrive are obscured together with broader, structural factors that condition access to treatment and the day to day realities of the affected households where tangible impacts are felt*". She further argues that the hegemony of the biomedical framework depoliticizes disease, "removing the understanding of disease from its social context and placing it back onto the individual body." O'Manique could just be talking about the Cambodia context. This co-relates to what the respondents complained about the focus on health and the body with less emphasis on inter-related day to day concerns such as nutrition, food security, livelihoods and poverty. Furthermore, the public perception of people when it comes to PLHIVs and their productivity is based on economic perspective. The fact that NGOs have to advocate commune councils for them to be included in investment plans is another example.

The Home-Based Care approach under the CoC relies heavily on the implementation of the NGOs. The NGOs interviewed work with both donors and government in different modalities either as ensuring that community needs are being met or monitoring the status of the PLHIVs in the provinces. This shows that local NGOs work within the existing structures of governance – one can say that they are working within the neoliberal framework by fulfilling the role of service delivery on behalf of the state whilst ensuring that the mechanism are remain committed to the principles of the CoC framework. The limitation and the impact of this is that the delivery of services becomes uneven and fragmented.

4.4 Examining the issue from a Policy Perspective

This section as well as Section 4 borrows heavily from the work, concepts and references of Kristina Jonsson (2006) of Lund University whose ideas I have liberally used and complemented with my own field research to provide insights of how HIV-AIDS policies within the context asserted in this thesis are affected by globalization, and what is the shifting role of the state in this context. In summary, Table 1 below shows the policy responses of the HIV-prevalence in the Greater Mekong Sub-Region.

Country	Infection Rates	First HIV-AIDS case	Type of Transmission (Primary)	Policy Response/ Initiative Committed	Civil Society	Health Care System	Role of donors
Thailand	1.5%	1984	Sexual/Injecting Drug Use	1987/1991	Strong	High Level	Not very Important
Burma/ Myanmar	1.2-2%	1988/1991	Sexual/Injecting Drug Use	2002	Weak	Weak	Important but limited
Cambodia	1.9%	1991/1993	Sexual	1993-1995	Relatively Strong	Weak	Crucial
Vietnam	0.4%	1990/1993	Sexual/Injecting Drug Use	1987/1999	Mass organizations	Average	Important
Laos	0.1%	1990/1992	Sexual	1988/2001	Mass organizations	Weak	Crucial

Source: (Jonsson, 2006)

One can see from the table the various historical and policy context of each country in combating the disease. Cambodia's success owes itself more to the support of civil society and donors rather than its own health care system. In examining the issue from a policy perspective, one has to have a deep appreciation for the key players at hand and the role of the state and its governance in this context. Egalitarianism used to be part of the political ideology in Vietnam, Laos and

Cambodia but as it shifted towards an open economy – one with insufficient safety nets and few opportunities for the poor masses to be wealthy has resulted to societies even more unequal compared to before.

This case is especially true in Cambodia where the deep inequalities have fostered a booming development industry and the state's reliance towards development players for resources. This is reflective in the context of HIV-AIDS. Cambodia for example relies on foreign experts to developing the policies – when one scans the main dailies there are always advertisements for technical support towards project assessment, setting up systems as well as policy formulation.

In general however, political and economic history is not considered during the design of HIV-AIDS programs; rather interests inform decisions and various trade-offs influence the decision-making process. This is validated in the discussions with WFP – the state will support programs based on their own interests but so too do development players. In all the technical documents that I have reviewed, particularly the NSP with its own Costed and Operational Plan includes every option taken to fight the pandemic but the choice is reinforced by technical best interventions and international donors supporting their own preferred interventions and mandates. Obviously this has led to what the NAA has termed as "uneven" service delivery.

One element I have observed that has made the success of decreasing the HIV-AIDS prevalence in Cambodia has been the support of civil society. The area of health seems to be a relatively "safe" area to work on and enjoys the support of the state. When I mean safe, I call to mind discussions with other NGOs working on social justice and land reform that more often than not come to blows with the state because of their advocacies[18]. Perhaps this is due to the fact that health can be apolitical and moreover provide for generous incentives (i.e. donor complementation in terms of resources – something WFP admits to) but it also shows how graduated sovereignty would weigh their interests and priorities in presenting an almost contradictory picture – allowing NGOs within the health sector to have a relative free socio-political space while limiting the space of other NGOs that work towards areas

[18] Personal conversation with Katherine O'Keefe (Independent), Maia Diokno (Independent), & Tola Moeun

such as land issues and economic concessions – that affect food security of the citizens as a whole. However this space is considered relative because as the findings earlier suggest even NGOs working in the health sector are careful in how they are being perceived by the state.

While HIV-AIDS is a popular agenda, there are administrative and organizational obstacles that prevent its implementation as discussed by the respondents. This can be due to hierarchical structures that prevent for constructive criticism, that policy documents are "nice" to look at" and "for display purposes only" (as one FAO respondent remarked *"no-one cares to look at the Food Security and Nutrition Plan... once it is done, people put it in drawers to gather dust"*[19]) requiring the political will and commitment of the state, the fact that most NGOs are located in accessible urban areas while neglecting the geographically inaccessible ones as well as a weak state and bureaucracy – both NAA and CARD are policy-making bodies who admit to the dependence on donor support since both agencies are understaffed and under-resourced. Furthermore, the Cambodian culture has been described as "hierarchical, top-down oriented and insensitive to human needs (and human rights), while at the same time being unable to exercise efficient governance" (Ojendal, 2005).

4.5 Role of the State and Governance in the context of Globalization

In the context of globalization, Kinnvall and Jonsson, (Kinvall & Jonsson, 2002) points out that the process has been uneven – affecting some parts of the country while other parts remain rather untouched. The effects of globalization is not always coherent either while capital transactions are liberalized, the movement of people can be very regulated (as is the case of some sectors of civil society in Cambodia) (Barnett & Whiteside, 2002) The maturing epidemic means that while ARV are free (till 2011) it complicates policy-making and implementation as policymaking and regulation can contradict each other due to the fast-paced nature of globalization. In other words, the degree of social cohesion and inequalities links to HIV/AIDS (Altman, 2003), and societies in transition are particularly vulnerable

[19] Interviewed, July 10th, 2009

(Poku & Whiteside, 2004) due to rapid changes in society, at the same time as policymaking often falls behind.

Simultaneously, the policy-making process is more "globalized" with an increasing number of actors participating in the process. Governance as Milward and Provan (Hill & Peter, 2002) succinctly put "is concerned with creating the conditions for ordered rules and collective action, often including agents in the private and non-profit sectors as well as within public sectors. The essence of governance is its focus on governing mechanisms – grants, contracts, agreements – that do not rest solely on the authority and sanctions of the government (Hill & Peter, 2002). In a paper by Pierre and Peters (Hill & Peter, 2002) governance now has a "multi-faceted" character with international organizations taking over the roles of the government, in short non-state actors are also involved in drafting policies, introducing agendas, norms and practices. Non-official implementation of official policies is also taking place for example the use of local NGOs as to deliver the home-based care package.

"In Cambodia, we have more than 80 NGOs working in HIV-AIDS since after the UNTAC, but while we have made significant progress, after more than ten years, empowerment is not yet in sight", remarked Mr. Phalla. Cambodia saw an increase in NGOs after 1999 yet there is competition amongst the organizations that make the policy process complicated. Due to the many development actors each with their own mandates and agendas, donors can give mixed messages as well as have different incentive structures.

Although the state is responsible for the health sector and HIV-AIDS falls under this sector, due to NGOs and donors funding, this receives minimal funding from the state which presents a skewed picture of the health care system – this was acknowledged by local NGOs as well as international NGOs. The increase in funding has often resulted to limited absorptive capacity for both recipient NGOs and governments through direct observation of small funds that are coursed by UNAIDS to specific partners. The government has been increasingly used as intermediaries to fund civil society organizations playing the accountability of funds in their hands but this also means that solutions on behalf of local responses tend to be imported

(Halmshaw & Hawkins, 2004). Based on direct observation, I believe the problem lies with the way the government does not recognize individuals outside their own Ministry even if they (a) play an important role; and (b) these individuals or organizations are indicated in their own policy documents with the exception that one is a supra-national institution or will have potential resources for complementation. Another can also be due to the fact that issues related to food security and PLHIVs are considered cross-cutting and are priorities of Ministries such as the Ministry of Social Welfare, Ministry of Health, Ministry of Rural Development, CARD and even multilateral organizations like FAO. Yet there is a perception of fragmentation of agencies in Cambodia who by their very mandates and despite the numerous technical working groups find it a challenge to share each others' priorities and collaboration.

Due to issues related to accountability and transparency leveled not just against the state but also the NGOs, donors underwrite these criteria into their guidelines. This brings to a head the inherent tension between a strong public authority that can deliver action and the need for democratic openness to reduce and halt the spread of HIV-AIDS (Putzel, 2004). Effectiveness wars with legitimacy with the former associated with a top down perspective whereas the latter is more concerned with citizen and stakeholder participation (which are democratic elements). There is due attentiveness when we refer to who's voice should be heard. As Cambers has noted in Chapter 2 of the literature review "whose reality is it?"

"In terms of HIV/AIDS' impact on 'Voice' and marginalisation, it exacerbates and is in turn exacerbated by political and social exclusion" (Moran, 2004). The community is seen as "a nexus for implementation of currently popular beliefs in 'empowerment', stake-holding, and civil society which all too often are the human faces of technical fixes for many of today's problems of poverty and exclusion" (Barnett and Whiteside 2002). This can be seen the clamor for social protection by donors and several members of civil society.

Because of globalization, the state retains two features – one that is "relatively permanent, formally organized, impersonally managed and hierarchically ordered decision-making procedures" (Scholte, 2000) while at the same time navigating its

way through multilateral regulatory arrangements. In reality graduated sovereignty (Cambodia) pays face-value homage to the dictates of donor conditionalities while at the same time selectively collaborating with organizations that fit their own interests and agenda.

4.6 Transformative Social Protection

The previous section discusses the need for the community to have a "voice" which is what I propose for transformative social protection (TSP) to be able to provide. To give a briefer, social protection is defined as a range of processes, policies and interventions to enable people to reduce, mitigate, cope with and recover from risk in order that they become less insecure and can participate in economic growth (Overseas Development Institute). This includes strategies like social insurance, social assistance/social safety nets, social services, legal and regulatory protection. What is important is that social protection must complement family, community and market mechanisms for managing risk or assisting the very poor (Council for Agriculture and Rural Development (CARD); World Food Programme (WFP); World Bank East Asia Development Unit (WB), 2009). While social protection covers all sectors, there is special focus on the very poor, at risk or most vulnerable groups in social.

Currently the social protection mechanisms that exist in Cambodia are targeted toward the formal sector[20]. The clamor for safety nets can be attributed to the advocacy of the Asian Development Bank, the World Bank, WFP and the UN.

[20] The government provides for social protection by way of the National Social Security Fund which includes employment injury scheme, pensions, disability benefits, the National Vocational Training Fund, the Cambodia National Insurance Company and Social Health Protection Plan (Council for Agriculture and Rural Development (CARD); World Food Programme (WFP); World Bank East Asia Development Unit (WB), 2009). There are the scholarships for the poor, and transfers to victims of natural disasters. Donor funded or in collaboration with other ministries include school feeding (a World Food Programme and Ministry of Education, Youth and Sports), Food scholarships/take home rations (World Food Programme), Health and Nutrition Programmes (World Food Program and United Nations Children's Fund), Food for Work/Free Food Distribution/Emergency Food Aid (Asian Development Bank), Labor-based rural infrastructure rehabilitation programme (International Labor Organization), European Tertiary Road Improvement Project, and Asian Development Bank Rural Infrastructure Improvement Project Council for Agriculture and Rural Development (CARD); World Food Programme (WFP); World Bank East Asia Development Unit (WB), 2009).

There are challenges to the institution of social safety nets or social protection in Cambodia (Council for Agriculture and Rural Development (CARD); World Food Programme (WFP); World Bank East Asia Development Unit (WB), 2009). One has to consider that it is still a nation in transition. Private insurance is not viable because of the lack of markets and distrust of people in the concept which is more related to low awareness. Formal social assistance or social insurance is also costly (Council for Agriculture and Rural Development (CARD); World Food Programme (WFP); World Bank East Asia Development Unit (WB), 2009). The current existing safety net interventions exclude important vulnerable groups (migrants for example) and most interventions are food-based and limited in geographic coverage (Council for Agriculture and Rural Development (CARD); World Food Programme (WFP); World Bank East Asia Development Unit (WB), 2009). The safety net implementation run the danger of reflecting immediate priorities rather than shared longer-term vision for safety net development. The lack of a coordinative body to facilitate and monitor the implementation of policies and programs has hindered implementation (Council for Agriculture and Rural Development (CARD); World Food Programme (WFP); World Bank East Asia Development Unit (WB), 2009). In terms of funding, the budget for social safety net implementation remains low with the majority provided for by development partners and earmarked for interventions that are often implemented in parallel to the government systems.

The government reports on cost estimates and expenditures reveal a heavy reliance on international support to respond to the HIV epidemic which raises considerable concerns against the backdrop of the economic crisis since future decreases in international development assistance might be expected. At the current low levels of national financing (10%) in response to the epidemic, it is difficult to sustain successful outcomes of efforts aimed at reversing the spread of HIV in the country.

Priorities of both donors and the government are inclined more towards prevention (44.9%) that considers all the vulnerable groups in the country – thus targeting the 14 million population of the country. Care and treatment (21.3%); Social

Protection and Social Services (0.3%[21]); and Enabling Environment and Community (5.1%) are core areas for social protection and safety nets.

In the budget allocation for HIV-AIDS, the cost estimates for Cambodia's National Strategic Plan 2 (2008-2010) under the National AIDS Authority, costs were detailed and segregated into the following categories: (a) Prevention; (b) Care and Treatment; and (c) Mitigation.

Table 2: Cost estimates for Prevention from 2008 to 2010

Prevention	2008	2009	2010
Total resources needed for Prevention (to include Direct Sex Workers, Indirect Sex Workers, Entertainment Workers and Sex Workers, Men who have sex with Men, Injecting Drug Users, Drug Users, Police, Migrants, Military, Street Children, Youth, Workplace program and technical support Sexual Transmitted Diseases Management, Voluntary Confidential Counseling and Testing, Prevention of Mother to Child Transmission, Media, Blood Safety, Post-Exposure Prophylaxis, Safe Medical Injections, Universal Precautions, Prevention)	$ 51, 988,444	$ 64,902,548	$ 75,659,438

Table 3: Cost estimates for Treatment and Care from 2008 to 2010

Treatment and Care	2008	2009	2010
Total resources needed for Prevention (to include Home-Base Care, Treatment, Anti-retroviral Therapy, Laboratory Tests for ART, Support for care and treatment)	$ 11,696,942	$ 13,774,308	$ 14,195,742

[21] Upon asked how social protection is defined in this case, one of the researchers in the National Aids Authority who gathered the data answered that these were compiled from the projects done by NGOs who voluntarily submitted the questionnaires to NAA. It was added however, that the concept of social protection is not clearly defined as some can mistake it under Impact Mitigation and Care and Treatment

Table: Cost estimates for Mitigation from 2008 to 2010

Mitigation[22]	2008	2009	2010
Total resources needed (Basic Material Support and Food Support)	$ 6,212,778	$ 8,544,867	$ 10,665,444

As of 2006, use of HIV/AIDS funds is as follows:

- Prevention: 44.9%
- Care and Treatment: 21.3%
- Orphan and vulnerable children: 4.7%
- Program Management and administration: 19.7%
- Incentives for Human Resources: 2.3%
- Social Protection and Social Services: 0.3%[23]
- Enabling Environment and Community: 5.1%
- Related Research: 1.7%

Sources of Funding as of 2008

- Central Government: 10%
- Global Fund: 37%
- UN Agencies: 8%
- Other International: 5%
- Bilateral: 40%

As one can see, the area of social protection is relatively underfunded with donors making up the bulk of the funding. Yet the cost estimates shows very little increase in terms of needs for an expanding PLHIV population.

[22] Please note that in some respondent interviews' care and support together with mitigation are loosely defined as social protection mechanisms.

[23] Upon asked how social protection is defined in this case, one of the researchers in the National Aids Authority who gathered the data answered that these were compiled from the projects done by NGOs who voluntarily submitted the questionnaires to NAA. It was added however, that the concept of social protection is not clearly defined as some can mistake it under Impact Mitigation and Care and Treatment

In succeeding interviews with respondents, it was clear that the concepts related to social protection were still relatively new here in Cambodia and deemed to be an agenda taken up by United Nations agencies, the World Bank, Asian Development Bank and other bilateral in discussions with the government and with NGOs[24]. The emerging literature on social protection focuses on institutional and government mechanisms that focus on civil servants and the aging together with work done by NGOs in the area of food for work, scholarships and the like. However there is a huge gap in the understanding of social protection that seems to be limited to only international NGOs, selected donors and bilateral organizations.

The NAA respondent recalled in one seminar he had attended on issues related to safety nets and social protection that one government official had likened it to poor people walking a tightrope and the how it was necessary to provide them a "net" in case they fall. *"I answered him, why have a net for him? You are ensuring that he will definitely fall. Why not create roads for him to walk on instead?* World Vision has the same perspective *"if resources that are prioritized for direct investments into health, education and social services are diverted to social protection or safety nets, what is the use of that?"*[25] The respondent is apprehensive that taking into account the donor landscape in Cambodia, priorities will be subsumed under donor interests at the expense of areas that need more urgent funding. Admittedly enough, the respondent from CARD realizes that the issue of safety nets and social protection are still vague concepts and a firm and participatory framework has yet to be agreed on. FAO believes that in Cambodia *"the informal safety nets at the community level particularly at the commune level are still strong"* and defines social protection as either a form of charity or a response mechanism under disaster management. *"Why not build assets rather than develop safety nets?"* he asked.

USAID believes that the HBC package and the NGOs provide for social protection mechanisms, a fact that is agreed-upon by the NGOs, NAA and WFP. HACC points out also to the creating of the self-help groups and other community

[24] A National Forum on "Food Security and Nutrition under the theme Social Safety Nets in Cambodia was held last July.
[25] Interviewed, July 9th, 2009

mechanisms on the ground as social protection mechanisms for PLVHIVs. But WFP asks *"When you talk about social safety nets or social protection in the area of food security, you need to bear in mind the health and nutritional status as well as sustainability?"* Sustainability opinions both Action Aid and HKI would mean collaborating with the government on the HBC package to obtain supplemental resources under the decentralization process as well as advocating for the inclusion of PLHIVs under the commune development plans. The international NGOs together with NAA see social protection as a holistic and integrated process that addresses the issues of food insecurity of PLHIVs by investing in areas of agriculture and health. This means investing in public health systems to slowly integrate PLHIVs after the end of the Global Fund and seek for modalities in terms of drug treatment as well as examining to see how agriculture can better serve those who are chronically sick. This is not to say to do away with food support and the HBC program completely but there has to be well-thought out processes in terms of phase out of one component and the phase in of another. NAA together with HACC and CPN+ would like to see the budget allocation for HIV-AIDS to increase but under the current economic context, this might not be possible and therefore one respondent wonders *"why are they talking about social protection when the PLHIVs do not have enough to eat? Food support was inadequate to start with"*

4.7 **Analysis**

Sen (1981) pointed out that the traditional locally-based socio-economic systems are disrupted by the processes of modernization with the acquiescence of the state wherein the economy and administrative infrastructure has not yet evolved in a point where ***effective*** social protection can be provided for all vulnerable groups of society through centralized mechanisms of taxation and retribution. In the case of Cambodia, its institutions were virtually destroyed by the Khmer Rouge and the painful rebuilding process started with the arrival of UNTAC.

Certainly there is very little dispute that the home-based care program that both government and civil society collaborate on to provide the basic needs of marginalized PLHIVs are mechanisms of social protection – but how this program has

been implemented focusing on the uneven integration of food security and nutrition, treatment and economic livelihoods while giving little thought to incorporating the social and transformative role that empowerment can bring about a change in perspective on food dependency. Poverty and vulnerability are all about social deprivation as well as economic deprivation and an elaborated and nuanced understanding of social protection has the potential to address both the material needs and social inequities faced by the poor and marginalized.

Emphasis on the transformative role of social protection is potentially feasible when compared to economic social protection which implies huge public transfers of public resources to large numbers of people with various needs who are generally regarded in the economic sense has having low or zero productivity (McDonald et al, 1999). This is true in developing countries, where admittedly, governments have severe limitations in how they spent their public resources yet a transformative role has to be consistently weaved into the home-based care program rather than a stand-alone aspect.

Considering how neoliberalism has embedded itself into the systems and structures of Cambodian society – there are obstacles to this. Monetization and commodification has slowly eroded the present social cohesion and capital which forms the backbone of informal coping strategies. While neoliberalism admittedly underpins the concepts of social protection because there is very little being done to address the sources of basic inequalities wrought by an open market economy, the strategic role of transformative social protection can potentially work in favor to create a paradigm shift and erode this dominant system.

All these issues and questions have coalesced in the small district of Tuol Sambo where residents were evicted from their original area in Borei Keila.