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The role of NGOs in HIV/AIDS work in Cambodia

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Abstract

The aim of this study is to discuss the role of NGOs in HIV/AIDS work, but also what capability the government possesses in the field, in Cambodia. The starting-point is that the HIV/AIDS situation and the NGO community in Cambodia are unusual. The Cambodian state is seen from a weak state perspective. A policy process approach is used to see in what phases the actors are capable and incapable respectively.

I have found that both NGOs and the government take advantage of each others weaknesses and strengths. The government does not emphasise implementation due to that NGOs constitute a strong group of actors in this field. Still, in formulating HIV/AIDS sensitive policies the government is active and the Cambodian political commitment in relation to HIV/AIDS is unique in a Third World perspective.

NGOs tend to neglect the National Strategic Plan on HIV/AIDS and work after their own agendas. Further NGOs need to improve coordination among themselves and in relation to the government. There are differences between international NGOs and local NGOs in the sense that international NGOs have better human resources and more funding. Local NGOs have better contextual understanding.

Keywords: Cambodia, HIV/AIDS, NGO, policy process, weak state.

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Everybody in the UNESCO Centre Library in Macau stared at me as I suddenly laughed out loud and jumped out of the building. I had received an e-mail from the Department of Economic History, Lund University, stating that I was granted a Minor Field Study scholarship. Just over six months later I would like to express my sincere gratitude to Dr. Anne Jerneck and Dr. Ellen Carlsson who believed in my thesis idea. Also, many thanks to my supervisor, Dr. Anders Sannerstedt, Department of Political Science, Lund University, for supervision during the summer and for helping me to 'kill my darlings'.

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Aw kohn!

Lund, November 2003.

Kristina Persson

Contents

List of Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
BSS	Behavioural Surveillance Survey
CDC	Council for the Development of Cambodia
ESCAP	Economic and Social Cooperation for Asia and Pacific
HIV	Human Immunodeficiency Virus
HSS	HIV Surveillance Survey
INGO	International Non-Governmental Organisation
LNGO	Local Non-Governmental Organisation
MoH	Ministry of Health
MWVA	Ministry of Women's and Veteran's Affairs
NAA	National AIDS Authority
NCHADS	National Centre for HIV/AIDS, Dermatology and STDs
NGO	Non-Governmental Organisation
NSP	National Strategic Plan (for a Comprehensive and Multi-sectoral Response to HIV/AIDS 2001-2005)
ODA	Official Development Assistance
STD	Sexually Transmitted Disease
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
WHO	World Health Organisation

1 Introduction

> We need to rebuild our country and create social capital and a social safety net. Elements of the society must be linked to repair our social immune system. HIV leads to a *physical* immune system breakdown but people get infected because of the *social* immune system breakdown. (Interviewee)

It is estimated that 2.6% of the adult population in Cambodia is HIV infected - the highest HIV (Human Immunodeficiency Virus) prevalence in Asia, where more than 7 million people are expected to carry the virus (UNAIDS 2002, NCHADS 2003). A comparison with the giant China tells us how serious the problem is; during 2001, 30 000 Chinese died from AIDS (Acquired Immune Deficiency Syndrome) while the numbers for Cambodia were 15 000. At the same time, the Chinese population is about 90 times larger than the Cambodian which shows that Cambodia is facing an epidemic of considerable measures (Ganguly et al. 2002).

Still, Cambodia is different from its neighbours. The combination of war and revolution has not lead to the establishment of a strong state in Cambodia as in, for example, China and Vietnam (Migdal 1988:270). Cambodia is recovering from 30 years of turmoil, war and political instability. These changes have created a considerable social imbalance and the public sectors that are important in relation to health equity are to a great extent corrupt and lack physical as well as human resources (Supote S. Prasertsri 1999:124).

As a newly established democracy, the Cambodian government lacks capacity to handle the HIV/AIDS epidemic on its own. The International Donor Community is active in various sectors (Kao Kim Hourn 1999b:29). Hundreds of Non-Governmental Organisations work in different areas, stretching from humanitarian relief to governmental capacity building. About 100 NGOs work in the health sector and almost all of these are active in HIV/AIDS problematics in some sense (Interviewee). In a context as the Cambodian, it becomes important to concentrate on both selected measures and attacking structural conditions that affect and worsen the HIV/AIDS situation. Migdal (1988:xiv) argues that ‘all states have had limited capabilities at some time, or with some groups, or on some issues’. It seems like the HIV/AIDS situation in Cambodia is a certain issue concerning a certain group at a certain time.

This is a study about what capability a weak state has when facing an urgent threat as the HIV/AIDS epidemic. Further, it is a study about the

existence of an active and strong NGO community. How do these actors contribute to the handling of HIV/AIDS in Cambodia?

1.1 Topic and aim

The aim of the study is to investigate **what role the NGO community plays in HIV/AIDS work in Cambodia**. I have two vantage points for my work:

First, the current HIV/AIDS situation in Cambodia is unique. During one single decade the spreading of the epidemic in Cambodia has been faster than, and different from, in the neighbouring countries. A population already hard hit by war, weak social infrastructure and several severe developmental problems is expected to suffer extra hard from every additional obstacle for development.

Second, the NGO community in Cambodia is unusual in terms of development. In the end of the 1980's there were 20 NGOs in Cambodia, none of which was locally established. Today there are approximately 500 NGOs of which the majority are locally based (Barton 2001). This change has undergone side by side with an opening up of the country and the establishment of democracy and market economic principles (Sorpong Peou 2001:36).

When facing an issue as the HIV/AIDS epidemic, the role of the government is crucial. My presumption is that the Cambodian state has not developed its capacity as rapidly as needed when handling the HIV/AIDS epidemic and this in turn affects the role of NGOs. This will lead me to a discussion on whether the large NGO community is a vital and crucial part in the HIV/AIDS sector or if it is to be seen as an obstacle to the governmental work. To reach deep and broad understanding for what role the NGO community plays I will therefore also discuss **what the Cambodian government can and should do to attack the HIV/AIDS epidemic**.

1.2 Methodological considerations

The Minor Field Study scholarship from Sida made it possible for me to spend the summer of 2003 in Phnom Penh, Cambodia. Due to the access to the United Nations organs and a well established relation to Thammasat University I also spent some of the time in Bangkok, Thailand. Coming to Cambodia made me realise that some time had to be spent adjusting my map to reality. What I gained was a broader picture and it is definitely thanks to the Minor Field Study scholarship that I had the opportunity to

develop this understanding by being in the field; performed as a literature study, such contextual awareness would not necessarily have occurred.

The initial idea was to focus solely on the agenda setting and policy formulation parts of the policy processes in order to find out if HIV/AIDS is at all present on the political agenda and if policies are multi-dimensional and sectoral as United Nations Development Programme (UNDP) suggests (Cohen 2000). Soon, however, I found out that this approach needed to be changed somewhat. I realised that embracing all actors working with HIV/AIDS was not possible in a study of this scope and that the NGO community constitutes a specifically interesting actor to study[1]. Further, the role of the government is central since its structure and capacity in many senses determines what role other actors such as NGOs will have (Degnbol-Martinussen & Engberg-Pedersen 2003:186).

One of the things that became clear to me when coming to Cambodia was that the HIV/AIDS work is to an overwhelming extent done within the health sector - both when it comes to the government and to NGOs. My initial plan was to *not* focus on the health sector but I soon realised its importance and adjusted my study somewhat to this fact.

Finally, when brainstorming my idea with one International Donor Community interviewee, I understood that with my problem, some attention must be given the implementation of policy. The interviewee argued that to look at agenda setting and policy formulation in NGOs is troublesome because 'policies were drawn up by someone else than the ones working with the implementation, and the ones who formulated the policies are now somewhere else'.

To focus on agenda setting and policy formulation could of course have been done by studying one or a few organisations as a (multi-) case study. It should have required deeper insight in the internal organisational structures as well as analysis of their outwards approaches. The pre-understanding from reading had not provided me with this understanding and because of the limited timeframe I did not have the possibility to establish deeper cooperation with a few selected NGOs. As a consequence of these insights, the approach of the study was changed somewhat by moving the focus of the study towards implementation. However, the agenda setting and policy formulation phases are emphasised when needed.

The focus is on the role of NGOs as implementing actors, but this can not be conducted without including the activities undertaken by the government and the potential governmental regulations and conditions that other actors work under. Therefore perspectives on the NGO-government relation will be needed to understand 'the structural factors central to the epidemic' (Cohen 2000). Implementation is tied to policy formulation in the sense that the policy process is not linear and implementers should interact in a dialogue with the policy makers (Walt 1994:177).

[1] For further reasoning on this standpoint see chapter 1.1 and 3.

The study is performed as an empirical 'disciplined-configurative' study (Eckstein 1975). The aim is not to further develop theory but to explain the empirical case in the light of existing theory. I am aware that as a single-country study the inferences will likely be less secure than for a study comparing several countries (Yin 1989:21). On the other hand, it is my belief that Cambodia has a very distinctive character whereby it has to be seen through contextual glasses to completely be understood. Using an approach in which historical, political and social conditions are taken into account throughout, provides me the advantage of being able to reach deeper contextual description and find case-specific factors (Landman 2000:32, 87). I do not exclude that interesting results could have been found, and fruitful comparisons been made, if comparing the HIV/AIDS-NGO situation of Cambodia with other countries though. By such a study it could have been scrutinised what role the specific Cambodian weak state structure plays.

Creating a broad general model of explanation is not any primary aim with this thesis since one of my starting points is that the Cambodian context is special. Still, as Yin (1989:21, 47) argues, single case study results are generalisable to some limited extent and it is my belief that this study can contribute to a deeper discussion on the role of NGOs in the policy process. Further I do not exclude that the results can be applicable on other countries since a weak state perspective on HIV/AIDS is likely to also concern other developing countries with similar state and/or NGO structures.

To illustrate the complexity of the factors of explanation in the empirical result part of the thesis, the analysis will be structured around three main themes:

- What the government does - and does not do
- Strengths and weaknesses of NGOs
- Interaction between government and NGOs

The empirical findings have shown that these themes are crucial to understand what role NGOs have in implementation of HIV/AIDS work in the specific context of Cambodia.

1.3 Method and material

1.3.1 Interviews

The qualitative attempt of the study made it natural to focus on interviews. This to be able to, as Landman writes 'uncover a deeper level of information in order to capture meaning, process and context' (2000:19). Interviews can be performed in different ways and I chose to make mine as qualitative,

semi-structured with the aim to reach understanding for the interviewee's way of describing his/her reality (Kvale 1997:13). Kvale defines the interview as research method as 'a conversation with structure and purpose' (my translation). This definition was the basis when developing the questionnaire as well as to keep in mind when performing the interviews.

The questionnaire used for the interviews was structured to focus on 3 themes:

- HIV/AIDS situation in Cambodia
- Governmental action
- NGO action

Some of the questions were wide, others specific and when performing the interviews, differences in both structure and answers occurred. Some people simply answered the questions briefly, while with others, a deeper conversation resulted in discussion on much more than the questionnaire questions. All interviewees were informed of the aim of my study before performing the interview but none had access to the questionnaire beforehand.

The primary data for the study consists of 29 interviews performed in Phnom Penh, Cambodia, and Bangkok, Thailand in the summer of 2003. The choice to not perform interviews outside Phnom Penh is not a matter of cause but can be explained with two main reasons. First, Phnom Penh is the capital with most NGO main offices and government institutions. Second, due to my choice of time visiting Cambodia, practical issues complicated my study insofar as it was neither safe nor possible to travel in parts of the countryside.[2] Still, I was very accurate, asking all interviewees about regional differences. Many people I met have extensive knowledge about working in more remote areas of Cambodia and through them, I believe I have got a comprehensive picture of the overall situation.

The interviewees can be divided into the sub-groups: representatives for the Cambodian government, NGOs and International Donor Community. The motive for this division is to see if differences between the sub-groups occur in terms of views and opinions on the HIV/AIDS- and/or NGO situation. Further, it is a natural way of structuring the answers when needed and still not have to use specific names in the final report. The anonymity is important since there was no possibility letting people read the thesis in advance and as an external observer I had no way of knowing what could be considered sensitive issues.

About half of the interviews, twelve out of twenty-eight belong to NGO representatives. Among these, the majority, eight out of twelve, can

[2] The 27th of July 2003 the third democratic election was held in Cambodia. Hence government as well as NGO representatives were busy with election matters all over the country. Transportation was restricted in some areas, translators worked with the election observers and in addition much INGO and International Donor Community staff was on vactation leave.

be defined as working mainly with health issues. The others work with certain focus on women or strengthening of local NGOs. In total six of the NGOs work with specific focus on HIV/AIDS but it should be mentioned that all NGOs I have been in contact with work on it in some way. Six of the interviews were performed with government representatives and nine with International Donor community representatives. One interviewee is not to be placed in any of these groups.

More than 500 NGOs are active in Cambodia and among these about 100 work in the health sector.[3] It is impossible to cover them all in a study of this scope. I was warned by people working in Cambodia that I should expect having a hard time establishing contact with people to interview and I suspected that interviewees would not be interested in talking with me about critical issues. However, there was absolutely no problem finding people willing to talk. To the contrary everybody - and contrary to the warnings especially the government representatives - have been enormously helpful and given me not only their time, but also provided me with material, reports and statistics.

Even though NGOs are the focus of my study, it is important to get an outside perspective by hearing the opinions of donors such as UNDP, Joint United Nations Programme on HIV/AIDS (UNAIDS), World Health Organisation (WHO) and Asian Development Bank (ADB) about the work of NGOs and the government. These interviewees also constitute an important group since they are likely to work with influencing the government and therefore occupy knowledge of all levels of policy-making.

Performing interviews alone does not give the highest reliability. Relying on only one person's analysis is biased. However, about two thirds of the interviews were recorded. Having the opportunity to re-listen the material has provided me deeper understanding for complex phenomena and this increases the reliability in later analysis. The recordings were never primarily meant for quoting, but in the final thesis a few quotes have been used referring only to what sub-group the interviewee belongs when needed.

1.3.2 Secondary data

For numbers and statistics the Cambodian HIV Sentinel Surveillance (HSS) and the Behavioural Sentinel Surveillance (BSS) have been very useful. These are reports published by the Cambodian National Center for HIV/AIDS, Dermatology and STDs (NCHADS) which is the implementing organ under the Ministry of Health (MoH). The NCHADS is working in close cooperation with some NGOs and representatives from the International Donor Community such as different United Nations organs,

[3] For a broader and deeper discussion on the Cambodian NGO community see chapter 3.

ADB and World Bank and is divided into a technical, an administrational and a surveillance unit. The surveillance unit is working in a network all over Cambodia in order to publish the HSS and BSS yearly.

I collected material from different governmental institutions, organisations and research institutes in Phnom Penh. In addition to this material and the interviews, literature and articles from the Lund University libraries, the Economic and Social Cooperation for Asia and Pacific (ESCAP) library and the Thammasat University libraries has been used. Literature on the Cambodian social and political changes and International Donor Community has been valuable for widening the perspectives given by interviewees. Further, literature concerning HIV/AIDS, health policy, NGOs/civil society and has been emphasised as background readings.

1.4 Outline

In chapter two a background of the Cambodian HIV/AIDS situation is given. Chapter three contains an overview of the NGO community in Cambodia. The fourth chapter is the theoretical framework for the thesis. From a Third World viewpoint, theory on the role of NGOs in a policy process perspective is presented. In chapter five the empirical findings are integrated with the theoretical approach under three themes for analysis. A discussion on the role of NGOs in HIV/AIDS work in the case of Cambodia is drawn in chapter six. Here, also some concluding remarks are done and ideas on further research are presented.

2 The HIV/AIDS situation in Cambodia

In this chapter the first starting-point for the study - the unique HIV/AIDS situation in Cambodia - is introduced. Cultural, political and socio-economic dimensions are taken into account in a presentation of major factors explaining the rapid and uncommon Cambodian pattern of spreading of the HIV infection.

Cambodia has the highest percentage of HIV infected people in Asia; 2.6 % of the adult population - about 160 000 people - is expected to carry the virus (NCHADS 2003). Contrary to most countries, Cambodia also faces an unusual distribution among the infected. The total prevalence has decreased for a few years. What is striking though is that the yearly amount of newly infected men has decreased constantly during five years while the number of women is still increasing (NCHADS 2003). Myo Thant (1999:15, 154ff), emphasises three main factors of explanation to the pattern of HIV spreading in Cambodia: gender, tourism and labour movement.

It should be recognised that both men and women are at certain risk in a gender perspective. First of all, the population structure is distorted in Cambodia. Tea Phalla (2002) shows that the Khmer Rouge outrage has distorted the population in the way that there are very few males aged more than 45 years old leading to a considerable increase in the dependency ratio since men usually have been heading the household.[4] Due to the current population structure and a combination of socio-economic factors derived from the opening up of the Cambodian society and increased tourism, women are increasingly - directly or indirectly - forced to engage in sex work which in turn makes them more vulnerable to HIV infection (Tea Phalla 2002).

One of the main reasons to why the male - and as we shall see, in turn, the female - Cambodian population is vulnerable to HIV infection is that it is widely accepted for men to have multiple sex partners and/or to buy sex. Certain surveys show that it may not only be *accepted*, but sometimes *expected* from men to buy sex or engage in so called sweetheart relationships[5] is to a large extent affecting that both women and men turn

[4] For further reading on dependency ratio, see Todaro 2000:218f.

[5] A sweetheart relationship can be defined as a relationship 'based on a certain level of mutual trust and affection, with assumptions of monogamy' (Shroff 2003). Having/being a sweetheart should be differentiated from an ordinary boyfriend/girlfriend relationship and a recent report indicates that the term implies a great deal of complexity: 'men [...] tended to reserve the term for noncommercial sexual relationships. Women [...] described songsar [sweetheart] relationships as involving a certain degree of affection, most often sex, and often exchange of money, passing either from the man to the woman or vice versa' (PSI 2002).

increasingly vulnerable to HIV infection (Shroff 2003, PSI Cambodia 2002:14).

Sex workers constitute indeed one of the groups most vulnerable to HIV infection (NCHADS 2003). There should be a distinction made between direct and indirect sex workers.[6] While the condom use has increased considerably in the former group, the latter is expected to be exposed to great risks (Lowe 2003:4f, NCHADS 2002). The rude fact that sex workers have shown off high rates of HIV infection during the last years, has made men search for sex elsewhere than in traditional brothels. Indirect sex workers are not associated with HIV from a client perspective and men are less likely to use a condom with an indirect sex worker (NCHADS 2002). This distorted assumption makes both buyers and sex workers increasingly vulnerable and the HIV prevalence among indirect sex workers is increasing since they do not have the form of 'protection' in a brothel owner who can force the client to condom use (Lowe 2003:26). Much has been done to increase condom use among direct sex workers in recent years and a considerable decrease in HIV prevalence in this group can be seen (NCHADS 2003). This has also been confirmed when investigating the routes of transmission. From being a 'sex worker to male' issue in the beginning of the 1990's, the major routes of transmission today are rather 'husband to wife' followed by 'mother to child' (NCHADS 2003).

Labour movement/migration is a further major factor of explanation that includes many aspects of vulnerability to HIV/AIDS. Garment factories in the urban areas favour employing young girls leading to that these women often leave a traditional way of life in the countryside and by living 'a modern life' they turn more vulnerable to HIV infection (Oum Chenda 1999:53). Still, we must not forget that migration is also a key factor putting men at certain risk. For many years Cambodians have left their remote villages to find jobs in the cities or along the Thai border. Living separated from their wives makes men buy sex to a greater extent and they are thereby put at higher risk of HIV transmission (Oum Chenda 1999:53). The second dimension of the HIV problem in relation to male migration is that it also puts women at high risk of infection - a fact that becomes clear when looking at the route of transmission statistics above. When the husband returns home he is likely to transfer the virus to his wife since condom use among married couples and sweethearts is very low. Condom use among married women is expected to be as low as 1 percent (Shroff 2003).

A critical and crucial factor that contributes to the overall vulnerability of Cambodians is that the institutional and legal frameworks important in relation to gender, health, sex work, trafficking and discrimination are

[6] Direct sex workers are brothel based while the term indirect sex workers 'refers to people selling sex in settings other than brothels' such as restaurants, bars, or on the streets (Lowe 2003:5). Indirect sex workers are not necessarily selling sex on a regular basis but usually supplement their incomes when needed.

weak. In many areas laws are missing and in other fields the implementation is scarce (NGO Forum 2002b). To sum up the HIV/AIDS situation in Cambodia we can say that the Cambodian socio-economic, political and historical context makes the population increasingly vulnerable to HIV/AIDS. Infrastructural, social and juridical aspects need to be emphasised in order to change this pattern.

3 The NGO community in Cambodia

In chapter two the peculiarity of the Cambodian HIV/AIDS situation was presented. In this section the second starting-point for the study - the distinguished character of the NGO community in Cambodia - is presented. A distinction will be made between locally and internationally based NGOs and certain emphasis will be put on discussing NGOs active in HIV/AIDS/health work.

The presence of a large NGO community is characterising the Cambodian society of today to a great extent. After having endured the Khmer Rouge era in the 1970's and later a decade of Vietnamese occupation - being a Soviet supported 'pariah state' seen from the International Donor Community - in the beginning of the 1990's Cambodia was a collapsed state in urgent need of rebuilding the country (Degnbol-Martinussen & Engberg-Pedersen 2003:185, Kao Kim Hourn 1999b:22). In the end of the 1980's there were about 20 NGOs in Cambodia, all international NGOs (INGOs) working mainly in the humanitarian relief sector (Barton 2001).

Today, there is expected to be more than 500 NGOs in Cambodia. However, it is necessary to be somewhat critical to this number. The statistics of different sources vary between about 200 and 600. The official number of NGOs registered by the governmental Council for the Development of Cambodia (CDC) in 1998 is 300. Still the CDC expects that there is at least a further hundred of NGOs not registered. (Royal Government of Cambodia 1998)

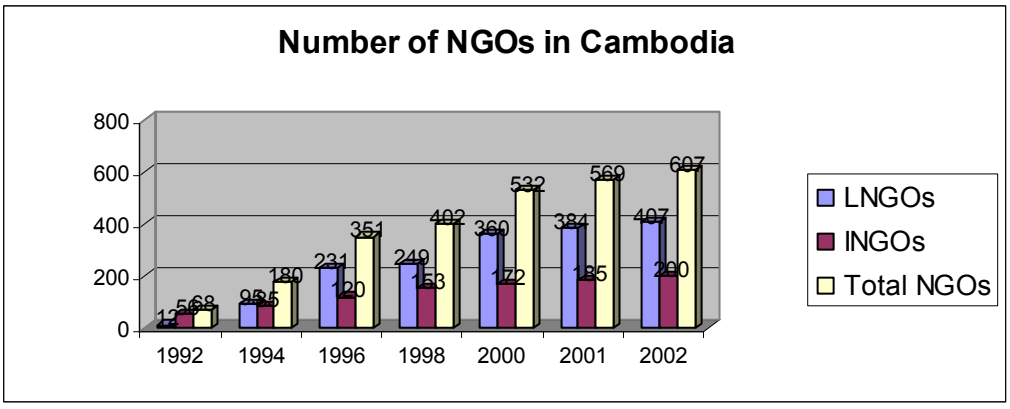


Figure 3.1 Source: NGO Forum 2002a.

The most recent number I have found is 607, counted by NGO Forum in 2001, and I assume that this is probably closer to the number of today. Concerning the number of health NGOs, the reliability of the statistics is

probably rather accurate. Both official statistics and numbers given by NGO peak bodies and coordinating NGOs show a number around 100. (Royal Government of Cambodia 1998, NGO Forum 2002a, Barton 2001)

It is hard to make fair international comparisons and by simply counting the INGOs currently active in Cambodia as in the *Human Development Report* (UNDP 2002) we cannot say that the number is extraordinarily high. However, as concluded above, during the last ten years the total number of NGOs in Cambodia has increased with several hundred percent and the health NGOs with more than 50% (Anheier et al. 2002). This development indicates a unique situation.

The main change lies in that today the majority of NGOs in Cambodia are locally based (LNGOs). Already in 1992, 70 LNGOs were created, many with assistance from INGOs or Cambodians returning from abroad after the Vietnamese had left (Bennett & Benson 1995:179). According to NGO Forum (2002a) there are now twice as many LNGOs as INGOs (see figure 3.1). Still (as illustrated in figure 3.2) it is apparent that INGOs command about four times as much financial resources as LNGOs.

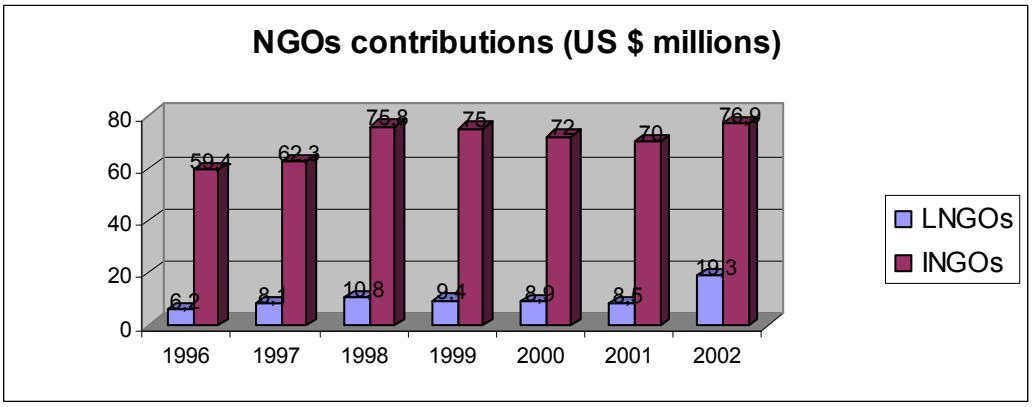


Figure 3.2 Source: NGO Forum 2002a.

It is in some way hard to distinguish a specific group of 'NGOs working with HIV/AIDS' in Cambodia. There are NGOs working with certain HIV/AIDS focus but there is no network embracing them all. The fact is that almost all NGOs I have been in contact with - the ones I have interviewed but also others - have some programme, project or other work in relation to HIV/AIDS. No specific group of HIV/AIDS NGOs exist in the statistics and reports I have come in contact with. When it comes to division by sector among all NGOs, it seems like the largest separate group is working with health, 38% (Royal Government of Cambodia 1998). It should be remembered that these statistics are a few years old and that if the number 100 is correct in the health sector the percentages should be changed accordingly since the total number of NGOs has increased with about a third since 1998. As a comparison (see appendix 1) we can see NGO Forum's (2002a) statistics indicating that about 15% of all NGO projects are within the boundaries of the health sector.

The conclusion I can draw from investigating the NGOs in the HIV/AIDS sector is that a couple of networks cover many HIV/AIDS NGOs, but not all. The participating NGOs seem to work predominantly with health focus even though the networks contribute to that several aspects are emphasised.[7] Further, the majority of NGOs tend to have some HIV/AIDS programme or project even though this is not their main focus. Most NGOs working with HIV/AIDS are based in Phnom Penh and in the provinces on the border to Thailand (see appendix 2). Six provinces lack specific HIV/AIDS NGOs (KHANA 2002).

[7] An important step - emphasised by several interviewees - in a multidimensional approach is the establishment of CPN+, the network for HIV positive people.

4 Theoretical framework

In this chapter, theory on the role of NGOs in the Third World will be presented. First the policy process perspective is introduced. In a following discussion on civil society - with particular focus on NGOs - emphasis is put on the role of NGOs in the Third World health sector.

4.1 The policy process

Walt defines a policy as something larger than a decision; a 'policy usually involves a series of more specific decisions, sometimes in a rational sequence' (1994:40). She divides the policy process into four parts: agenda setting, policy formulation, implementation and evaluation. These four parts interact and depend on each other.

Turner and Hulme (1997:79f) suggest a triangular model to understand the interactive character of the policy process. The policy process starts with a narrow problem but when evaluating the outcome of the policy, the spectrum has been broadened, leading to new connections to the former stages.

Depending on what actors are allowed on the arena, all stages of the policy process are affected. The public policy process is consequently not necessarily public all the way. Values and ideas among implementing actors - in the governmental sector as well as non state actors; from national plans to the individual level - change and affect what the results will look like. Policies are also contextual in the sense that what works in one country/system does not necessarily function elsewhere (Turner & Hulme 1997:64). In developing countries policy making - and thereby implementation - differ due to the political system.

The prevalence of health issues on the agenda and in policy formulation is tied to, what Walt (1994:42) calls, high or low politics. Waylen, on her part, makes similar distinctions but simply uses the term 'masculine politics' as high politics (1996:13). While high politics focus on long-term matters, public issues, such as national interests and values, low politics is to be seen at a micro level. Among low politics issues are normally health, women and human security (in comparison to national security) found. Still, Walt concludes that e.g. health policy can get high political status when in a crisis or when getting a lot of attention in media. Could the same be valid for HIV/AIDS in a specific context as the Cambodian? Or is such an issue 'so low' that it does not even occur on the

agenda? This is to be investigated in the empirical part of the study. In the next sections, the role of NGOs in the policy process will be emphasised.

4.2 NGOs and civil society in a Third World Perspective

NGOs and civil society are terms sometimes used interchangeably. My opinion, supported by theorists such as Kao Kim Hourn (1999b:23) and Degnbol-Martinussen and Engberg-Pedersen (2003:143), is that there should be a distinction between civil society and NGOs. The term civil society can be defined as follows:

> Civil society is one of the three "spheres" that interface in the making of democratic societies. It is the sphere in which social movements express themselves through such diverse organizations as trade unions, cooperatives, service organizations, community groups, youth and women's organizations, academic institutions, media and church-related organizations. Civil society organizations [...] are helping to redefine the role of the state and the quest for new forms of governance. (UNDP 1993)

According to Kao Kim Hourn (1999b:23) civil society is a broad term embracing:
- NGOs
- Political parties[8]
- Independent media
- Trade unions, and
- Think tanks and research institutes.

NGOs are consequently a part of the civil society. Often referred to as the 'third sector', NGOs are working side by side with the government - the first sector - and the private - second – sector. However, many theorists insist that the role of NGOs has changed so much during the later years that they should not be seen as a third sector (Tandon 1992). Uphoff (1995:17) argues that NGOs are located between the public and the private sectors. The general role of NGOs is described by Gordenker and Weiss (1995b:546f):

[8] However, Kao Kim Hourn adds in a footnote, that it is questionable whether political parties should be seen as part of the civil society. When I met Kao Kim Hourn I asked about this and he concluded that the best general definition of the term civil society probably should be 'non-governmental bodies not seeking political power'. Thus political parties are excluded. Still it is ambiguous. We turn into a complex reasoning since political parties not currently in position of power can be an important force in driving policy in the same direction as other civil society actors. However, we cannot neglect the fact that they seek power and are likely to put this aim above others. To make a clarifying distinction - NGOs are often founded with the aim of questioning or supplementing the government, to be parallell actor. Political parties seek to constitute the government.

> Most NGOs probably exist to influence, to set direction for, or to maintain functions of governance or to operate where government authority does not. [...] In failed states [...] NGOs take on some normal governmental programmes.

Even though using the term NGOs as a uniform term, it must be remembered that NGOs are not homogenous in any sense. In addition to the differences in area and scope of focus, size, origin, mission and geographical range vary. Further, in terms of funding, NGOs differ a lot. Some depend on governmental funding while others have a policy of not accepting such grants at all (Gordenker&Weiss 1995b:545, 552). A fact that may be interesting to analyse in the high-low politics perspective is that Gordenker and Weiss (1995b:546) conclude that NGOs focusing on HIV/AIDS do not rely on governmental funding to any large extent. Is this because NGOs in these sectors ideologically refuse governmental funds or since they are not prioritised by the government?

In the Western World, NGOs have played an important role in strengthening the civil society in various ways. Salamon (1994:112) explains the overwhelming interest in forming NGOs during the last decades with that 'ordinary people [...] decide to take matters into their own hands'. This is indeed true to a certain extent, but when applying a Third World perspective further aspects must be added. First, the kind of governance sets all basic conditions for what kind of civil society that will be created. In e.g. an authoritarian regime, no NGOs running democratisation programmes will be established, no matter how much will there is on the grass root level (Turner & Hulme 1997:65f). Second, we must remember that when developed countries were developing, the state was usually somewhat capable to handle issues traditionally considered 'public'. The two public main tasks are health and education and the responsibility of the state has been wide and the tasks of the state have been clearly defined (Anheier 2001:69). This is not the case in most recently established democracies where NGOs and the private sector are important players also on what traditionally is seen as the public arena. An abrupt turnover to democracy and market economy, as has been the case in Cambodia, contributes to an initially weak and unstable state whose tasks are neither clearly defined nor always contextually feasible (Kao Kim Hourn 1999b:17).

Applying a policy process perspective, we find that while the civil society as a whole has been active mostly in agenda setting and policy formulation matters in the Western world, while in developing countries NGOs often work with implementation (Gordenker & Weiss 1995a:377). This does not exclude that NGOs active in the Third World are, and should be, important in matter of advocacy issues (Degnbol-Martinussen & Engberg-Pedersen 2003:146). When addressing e.g. gender and freedom of speech, NGOs are extremely important in new democracies where the state

often is not capable of absorbing and operating all dimensions related to functioning as a democracy. To explain how it turned out like this; Salamon (1994:109) talks about NGO tasks as 'formerly unattended or left to the state'. I want to stress the distinction between these two forms. While health service, the legal system and state finances were - even if poorly or inappropriately - handled by the state in many former communist states, issues such as environmental protection, certain health issues and freedom of speech in most former non-democratic regimes have been ignored. Other issues such as HIV/AIDS are fairly new in its context and both NGOs and the state may start paying attention to related problems. Today NGOs are active in several dimensions of various tasks in developing countries.

Something that complicates the analysis of the legitimacy of NGOs is the internal structure of NGOs. How can we be sure of that NGOs themselves are democratically governed? Who is to overhaul NGOs' internal structure? Is it legitimate that organisations run by interest often are operated by the same people who set the structure? We must ask ourselves whether it is ethical that it is possible that hierarchical, non-gender aware, religiously driven organisations are active in work for deepening democracy. (Gordenker & Weiss 1995b:553)

In a country where the state itself is democratic and capable, the problem is less likely to occur. A state that is capable enough can set conditions for NGOs and select which organisations to contract. Thus, the implementation of policies will be done in line with a national policy that also NGOs have to follow. In a weak state, however, it is not likely that the government can and/or will set these conditions (Gordenker & Weiss 1995b:547). In such cases, NGOs can set conditions and do not necessarily have to work in line with national policies. Thereby, NGOs can neglect contextual issues that they have no understanding for and hence disregard a good national plan.

On the positive side, NGOs can play an important role in developing new and/or transform existing bad plans (Degnbol-Martinussen & Engberg-Pedersen 2003:157f). The flexible and independent character of NGOs can hence be both an obstacle and an advantage. As we have seen, this problem is multidimensional and very complex. In a country with a weak state structure, NGOs working on e.g. advocacy, democratisation and educational issues should be cheered to affect the progress in a democratic direction. Such development cannot exactly be government supervised.

4.3 NGOs in the Third World health sector

The case of Cambodia is complex. All NGOs working with HIV/AIDS are to some extent active within the health sector since they work with a disease, and many NGOs working with aspects of HIV/AIDS are members of the health NGO alliances. Further, the governmental implementing

organ, the NCHADS, lies under the MoH. Consequently, all NGOs working with HIV/AIDS who want to cooperate with the government must deal with the MoH and/or the NCHADS.

Walt (1994:97) points out that, to understand decision making and policy formulation in the public sector, 'we have to look beyond government'. Many interest groups affect policy making and the linkage to how implementation is to be done is crucial. From a market economical perspective it is definitely positive that the state does not have monopoly in the health sector (Tandon 1992, Jareg & Kaseje 1998:822). Still, even the most notorious advocates of market economy have to look beyond principles and admit that the public sector plays a major role in certain areas such as when combating an epidemic.

Todaro (2000:50) points out that the Third World has to handle health related problems different from what the Western World has ever experienced; unhealthy drinking water, high maternal and infant mortality rates, malaria and other insect borne diseases, no health service infrastructure, 90% of HIV infected people living in less developed countries. The list of specific Third World health sector challenges is extensive since infrastructure and institutions in relation to health look different. Thus a Western view on attacking health issues is not entirely applicable. In a speech on economic implications on HIV/AIDS, Myo Thant, ADB concludes:

> The public sector is, also, in principle at least, the entity most able to adopt a holistic view of the epidemic, utilize a long-term perspective and prepare appropriate responses by harnessing all resources within the nation state. (1999:155)

It must be remembered, though, that in general, the private sector or NGOs in the Third World health sector can without doubt be an important force in certain areas such as improving efficiency and quality in implementation of health service. Traditionally, health NGOs in the Third World have worked mainly with assistance to the very poor in primary health care (Jareg & Kaseje 1998:820). Especially where the public sector is not capable of managing the implementation itself, the government is dependent on the approval and assistance from other participants when implementing policies. However, during the last years, health sector NGOs have also been important in concentrating on selected measures such as epidemics, reproductive health issues and illegal aspects of health service (Interviewee).

These facts lead us to the formulation of policies in the health sector. In a context where the government is not capable of implementation, but relies on NGOs and the private sector as supplement, the government cannot simply neglect these participants in policy formulation. The policy formulation process becomes very complex and may be slowed down a bit with many interest groups involved. What is positive with a variety of

participants is that hopefully, also a variety of aspects will be taken into account in health policy formulation. Not only pure health NGOs may be interested in health policy and this fact is positive in the way that it contributes to how critical aspects such as e.g. gender or HIV/AIDS can be taken into account to a greater extent.

When analysing the interaction between government and NGOs in the health sector, many questions arise. Will a variety of participants in itself increase the government's competence in the area or not? It should be pointed out that this is not necessarily similar to extending the government's responsibility in the area, but the capability to handle its tasks in a competent way. Will NGOs disregard a weak government while running their own races? Will governments acquiesce or try to suppress NGO activities? How can we be sure that needs assessments guide the actions of a weak state or NGOs with individual internal organisational agendas? To summarize: Who will be driving policy?

5 Results

In this chapter the findings from the empirical study are presented in three main themes. First, the work of the government is discussed. Second, strengths and weaknesses of NGOs in the HIV/AIDS work, and differences between LNGOs and INGOs are examined. The third theme concerns the interaction between the government and NGOs in the HIV/AIDS sector.

5.1 What the Government does - and does not do

5.1.1 Political Commitment

The Cambodian government responded quickly when Cambodia started to face the HIV/AIDS epidemic and the first action to combat HIV/AIDS was taken in 1991 when a National AIDS Programme was set up. During the following years, the governmental response was raised further and a multi-sectoral and dimensional view on HIV/AIDS work was developed. This act of political commitment was taken in 1999 when the National Aids Authority (NAA) was established. The role of the NAA is to coordinate the governmental response to HIV/AIDS in a multi-sectoral way and make sure that Gender, Human Rights and other socio-economic aspects are taken into account in policy formulation. (Royal Government of Cambodia 2001:69ff, NAA 2001:26)

The NAA has developed a National Strategic Plan (NSP) for 2001-2005 which is focused on a multi-sectoral response to HIV/AIDS and compared to earlier plans this one is not health focused to the same extent but has a broader approach. To ensure the multi-sectoral perspective the NSP specifically points out the role of several ministries with great importance in relation to HIV/AIDS (NAA 2001:28, 30).

Several of the interviewees with experience from work in other parts of the world conclude that the Cambodian government is explicitly doing a good job in relation to its capacity in terms of putting HIV/AIDS problematics on the agenda. Compared to e.g. some African countries, the government of Cambodia admits that there is a problem to solve and welcomes external actors to help. We can conclude that the governmental strengths have been recognising the HIV epidemic and work in order to develop policies. However, there is still a lot left to be done and further need of policy development is not something that is critical specifically in the case of HIV/AIDS.

Interviewees also indicate that there is still a long way to go in the implementation of governmental policies. This is an indicator on that what is stated on the surface is not necessarily taken care of. There are numerous examples on policies that are not fully implemented; HIV/AIDS in education covers only five provinces and voluntary test centres exist in only 50% of the provinces even though this is one of the so called priorities (Interviewees).

To mention a government policy that has been successful and rather satisfactory implemented, the 100% Condom Use Project among sex workers is a good example even though it is not implemented in the whole country yet.[9] It should be remembered that when it comes to HIV/AIDS it is not as easy as saying that a policy has to be implemented in the whole country, though. As one interviewee told me:

> HIV/AIDS is different. You want to be on the front-line and target the most vulnerable places and people. It is not as with development sectors where you want to spread evenly.

The Cambodian government seems not to have been quite on the front-line. It has addressed certain important vulnerable groups and provinces, but not practically put real effort in combating the spreading of HIV. The official recognition of the problem is the crucial starting-point to an opening up for external actors and this is definitely one of the main strengths of the Cambodian government. During the latter term of office both the NAA and for example the Ministry of Women's and Veteran's Affairs (MWVA) were established. Such initiatives show that there is a will to address HIV as a multi-sectoral and dimensional issue and that HIV/AIDS has climbed some steps on the priority list (Interviewee).

Even though HIV/AIDS is meant to be included in the work of all ministries and even though the NAA exists, it has been clear to me that the health sector, and thereby the MoH, holds a major position in the practical work that is done. The NCHADS, the implementing organ responsible for HIV/AIDS, lies under the MoH and is the governmental institution that the majority of the NGOs interviewed seem to cooperate with. The work of the NCHADS and the MoH will be investigated closer in the next section when discussing the role of the health sector.

5.1.2 The public health sector

The majority of interviewees argue that the public health care system is weak. The current situation is that there is an extensive awareness of that the overall health situation of Cambodians must be improved. The MoH has its own three key priorities: Malaria, Tuberculosis and HIV/AIDS of which

[9] For further information on the 100% Condom Use Project, see Lowe 2003.

the two latter are closely linked since many HIV patients also get tuberculosis (KHANA 2002:2). This actually makes health become a high politics issue in the sense that the government has recognised and planned actions to fight these diseases. Still, the governmental health sector is not capable of fully managing the implementation part.

Statistics show that the Cambodian government finances only 41% of the total public services in the country and only 22.5 % of the total health sector. Official Development Assistance (ODA), in both these cases, add up to more than 50% while NGOs contribute with the rest. (World Bank 1999) This example indicates a very special situation and one NGO interviewee points out that usually NGOs get some financial assistance from the government while in Cambodia ministers on the contrary are begging to NGOs for money. Gordenker's and Weiss's (1995b:546) hypothesis about NGOs not relying on governmental funding is consequently verified in the case of Cambodia and the case shows that governmental ways of prioritising are to blame rather than NGOs' ideological considerations.

During 1998-2000 only 3.9% of the total Cambodian government spending went to the health and education sectors (UNDP 2003). These numbers equals that the government spends US $1 per year per capita on health and education respectively and should be compared to ODA adding up to US$ 30 per year per capita (Ibid.). These basic facts affect how the access to HIV prevention and care will look. Not that the state budget or ODA should finance only the health sector, but there seems to be a distorted prioritising. For the formal part, many of the social and political sectors that are important especially in relation to health seem to be corrupt, or at least not favoured to a great extent by decision-makers (Several interviewees). When facing an issue as the HIV epidemic this fact becomes even more visible and serious. It is one thing to develop multi-sectoral policies with assistance from the International Donor Community but something different to implement them.

One of the main advantages of the public health sector in terms of HIV/AIDS work is that there is already a public network of Operational Districts and health centres covering the whole country (Royal Government of Cambodia 2001). One Interviewee points out:

> The accountability and responsibility of public health services must increase. [...] If the government gets efficient it will cover the whole country. I am not criticising the government, I *do* recognise their role. If they just do well their impact will be big, much larger than the NGOs'.

Still, the quality of the public system is known to be very low both in terms of skilled staff and physical resources. Interviewees give examples of health centres that are closed or used for only private activities; a fact that decreases the chance of getting access to care for HIV/AIDS patients. Adding to the already tough situation for this group of patients are in is the widespread stigmatisation making it less likely that these seek and get care.

Interviewees say that the public sector is characterised by corruption and discrimination making HIV/AIDS patients less likely to get the treatment they need from the public system. Instead Cambodian people have the preference of, in one way or another, finding money to finance private health consultations. A consequence of people urging money for health care is that they tend to turn in to actions such as engaging in sex work, take children out of school or selling their land (Interviewee).

Many interviewees view the lack of human resources in the public health system as one of the key issues for Cambodia to work on in order to be able to build a capable state on the whole. This is valid for the public health sector on several levels that affect the HIV/AIDS work. The staff in health centres in the provinces is seldom well trained and wages are extremely low. Well educated doctors look for work abroad or possibly in Cambodian private or NGO clinics where salaries are higher.[10] Still, raising wages is an ambiguous solution. In a country where it is almost impossible to save up money without engaging in illegal activities or some kind of corruption, increasing salaries will to some extent even weaken the public system further. The doctors getting higher salaries leave the public sector as soon as they have saved enough money to start a private clinic and the public sector is back on a point of having unskilled staff (Interviewees).

One NGO interviewee points out that the effects of the weak public health system are especially troublesome in relation to HIV/AIDS. There is a large lack of midwives and female nurses in the health centres which in turn makes women - which is the group in which HIV is spreading fastest at the moment - not seek health service there. Since Cambodian men are not familiar with issues related to reproductive health and sexuality, the knowledge of related issues such as HIV/AIDS stays low. Even government representatives admit that NGO clinics is probably the best option for these women but the NGO system does not cover the country as the public health system whereby access to a clinic is very limited. (Interviewee)

In the same way as increasing salaries is not a solution of a problem in the long run, to suddenly increase funds for the Cambodian public sector is not a way to strengthen it. As stated earlier, in a regional comparison Cambodia is among the countries getting most ODA/capita. Only Lao PDR and Mongolia received more and it should be remembered that these countries have very small populations. Still Cambodia has not managed to solve certain basic health problems, e.g. reducing infant and maternal mortality which are among the highest in the world. Not to say that there is not a need for further funding, but simply injecting money into the government has not been successful in solving basic health problems and there is a risk that it is only feeding corrupt activities. There is of course a

[10] A monthly salary for a medical doctor in the public system is about 20 USD and other health staff positions are paid about 10 USD monthly. A decent salary would be about 100 USD in remote areas and about 200 USD in Phnom Penh. One Interviewee gives an example on two people working with the same tasks in the NCHADS and a large INGO respectively. The NCHADS employee earns 3500 USD per year and the INGO employee gets 25000 USD.

clear distinction between HIV/AIDS and basic health issues not least in terms of funding. Still similarities exist since many basic health problems concern HIV infected people to a great extent since they get opportunistic infections.

It is obvious that the public health sector does not have enough resources - physical and human - to fully embrace all its tasks. This conclusion seems to be valid not only in relation to HIV/AIDS though and there is a huge need of overall strengthening the system. While the public sector is not capable of implementing policies, NGOs constitute an important actor that will be scrutinised in the next section.

5.2 Strengths and weaknesses of NGOs

NGOs are fairly new on the Cambodian scene and this should not be forgotten when putting them against the wall. In conformity with the NAA and the NCHADS established not even 10 years ago, the main part of the NGO community has not been in Cambodia for longer time.

The fundamental advantage of the large NGO community in the case of Cambodia is that all actors can focus on what they do best and together they should be able to cover all areas needed; a variety of actors can contribute to a variety of work. This is not surely the reality though. The regional spreading of NGOs is not as good as desired and this means that some parts of the country get no NGO assistance while a few provinces are crowded with NGOs overlapping each other (Interviewees). One interviewee points out that NGOs are rather inflexible in terms of adjusting their agendas to the NSP and that they decide where and when to work rather than letting needs assessments guide. This is also the comprehensive picture I have got, but it should be mentioned that there are examples of NGOs working thoroughly with regards to the actual needs.

The current trend is that NGOs are going into the field of AIDS care from being mostly focused on HIV prevention (Interviewee). Care is a major issue since the Cambodian health care system is weak and cannot handle all patients who need help. The need of NGOs in this sector is definitely massive since there is a lack of skilled Cambodian public health service staff and functioning health centres. In total, Cambodian hospitals cater 9000 beds (Interviewee). About 160 000 people are HIV infected and 20 000 of these have reached the stage of AIDS. The NGO assistance is valuable not only because of the extra physical resources but also in terms of improving quality of the care in a system where human resources are weak. With NGO staff overhauling and assisting governmental work, corruption is often reduced and HIV/AIDS patients get access to the care they need. NGO staff also contribute to that discrimination is decreasing and overall quality in the care system is improved (Interviewee). Although, some interviewees argue that in some senses the changed focus of NGO

work is bad since NGOs seem to forget about HIV prevention and other HIV/AIDS related areas.

The NGO involvement in AIDS care is still not enough to help all HIV infected people with the service they need. One of the solutions has been to develop a system of home care. It started as a pilot-project in 1998 initiated by the NCHADS and several International Donor Community actors (Wilkinson 2000:11). Today the Home Care system is maintained by the NCHADS working closely with the Cambodian NGO Alliance KHANA. The 40 partner organisations work together with staff from the governmental health centres in teams visiting families affected by HIV/AIDS to give care and support (Interviewee). The Home Care system has both medical and social aspects. Data on the extent of the Home Care system differs. According to the *KHANA Annual Report*, the Home Care system runs in 3 provinces while one interviewee argues that 15 provinces are covered (KHANA 2002:5, Interviewee). Home Care can be seen as a must in the context of Cambodia and it is a positive step in order to help HIV/AIDS patients as well as improve the overall health situation by adequate information.

A strength of NGOs often mentioned by interviewees is the capability of quickly adjusting to changed circumstances which means that implementation can be done quickly and efficiently once there is a policy; an ability important in relation to HIV/AIDS. This is definitely true but it is necessary to add the fact that NGOs usually work in small scale which facilitates implementation compared to operating a whole country covering governmental projects. Further, it should not be forgotten that this flexibility can also be negative since NGOs are not committed to long-term work and can decide to stop or leave whenever they want to. Even though the Cambodian government is not the most capable one, it 'will always have to be there' (Interviewee).

All NGOs have to follow the Cambodian NSP, but there is evidence showing that NGOs often work after their own agenda in sense of implementing policy in a different direction than the NSP stipulates. Especially in the case of INGOs there can be a conflict between the headquarter agenda and the Cambodian NSP. The differences between LNGOs and INGOs will be investigated closer in the next section.

5.2.1 LNGOs and INGOs

A major strength of INGOs is experience from elsewhere. INGOs can make use of what has been done in other countries and they often have a network for exchanging results and strategies for HIV/AIDS work. Further, INGOs have stable financial resources and can adjust quickly to different circumstances.

From many of the interviews I get the impression that there is a danger of that many INGOs will leave Cambodia in the near future. The decreasing HIV prevalence has made INGOs feel that there is not much left to be done. NGOs have requirements from head offices to present results on a regular basis and this is not easy when it comes to long-term work such as in the health sector. For sure, it has been easy to present the decrease in HIV prevalence to head offices but this is not the same as embracing the whole problem area of HIV/AIDS in the long run. As one INGO interviewee with long-term commitment points out: 'Donors tend not to have a long-term approach. When working with HIV/AIDS commitment is long-term. 2 years is not enough'.

Whether Cambodia does not need more assistance in combating HIV/AIDS is, as one interviewee points out, depending on how you look at it. Compared to the hardest hit developing countries, Cambodia faces a positive trend when simply measuring prevalence. Compared to Western Europe however, Cambodia faces an epidemic of considerable measures. This should be kept in mind even if it is not completely fair to compare the case of Cambodia with neither Europe nor Sub-Saharan Africa. As concluded in chapter two, the history of Cambodia has distorted the country's foundations and made it highly vulnerable to every obstacle hindering development.

One important area where INGOs contribute is strengthening LNGOs to develop the local capacity. By doing so, the INGO expertise, funds and organisation advantages can be utilised in order to build Cambodian capacity and it is more likely that a long-term approach is assured. LNGOs' major advantage is knowledge of the surroundings, the culture and the language well. This is a valuable strength which is very important in relation to HIV/AIDS. People need contact with someone understanding them and the gap to INGOs can be big. (Interviewees)

The most visible difference between LNGOs and INGOs is the considerable difference in financial resources (see chapter three). According to NGO Forum (2002b), INGOs possess more about four times as much money as LNGOs even though LNGOs are twice as many in numbers.[11] The consequences of this fact cannot be neglected. Further, INGOs are mainly situated in the capital and a few other provinces while LNGOs working with HIV/AIDS cover the majority of provinces (see appendix 2). The distribution of resources is thereby distorted to a great extent. It is indeed true that the problems related to HIV/AIDS are big in the capital and in border areas but also remote areas need help.

[11] Numbers concerning NGOs in the HIV/AIDS sector have not been found due to that it is hard to define such a group. More information on this reasoning is to be found in chapter three.

5.3 Interaction between government and NGOs

The government is slowly developing capacity when it comes to policy formulation and the HIV/AIDS policies developed by the NAA can be said to be multi-sectoral and dimensional. I concluded in earlier sections of this chapter that many NGOs as well as the NAA, the NCHADS and the MWVA are fairly new on the Cambodian arena. The governmental organs have had limited time to adapt to its tasks - even though an inflow of ODA - and considering the lack of human resources, they are having a more difficult task compared to INGOs with experience from elsewhere and the LNGOs who get assistance from INGOs and the International Donor Community. However, turning to implementation the situation is different. No actor is capable of taking full responsibility and the work has its foundation on collective work and that everybody is doing their small part (Interviewee).

There are few examples of NGOs working with other ministries than the MoH and thereby with the NCHADS. Among the NGOs interviewed for my study, only two say they cooperate with an other ministry and only one NGO interviewee say that the NGO cooperates with the NAA.[12] There are probably several reasons to this. First of all it is costly for the government to negotiate with masses of NGOs. With more than 100 NGOs active in the health sector and another at least 400 NGOs, the cooperation must be structured somehow. Many interviewees say that NGOs tend to overlap and work in the same fields without coordinating the efforts. Further, NGOs tend to focus on current 'in fashion' areas instead of spreading evenly over Cambodia and in all HIV/AIDS related fields. Not surprisingly the most remote areas get least service both from NGOs and the public sector.

In the case of HIV/AIDS, NGO alliances have been established to improve coordination and, as a naturalness, many member NGOs belong to the health sector. Consequently it is natural to cooperate with the governmental health sector. The advantages of structuring and shaping the cooperation are cost effectiveness and also the possibility to better coordinate actions. What has to be questioned is whether the multi-dimensional and sectoral approach is emphasised. Cambodia has an abundance of actors working with HIV/AIDS issues in different fields, which in itself contributes to a multi-sectoral work. In trying to get a comprehensive picture of the actions on HIV/AIDS care and prevention in Cambodia, I have understood that there is no perfect actor. Neither is there any single typical leading actor. Still, we shall see that INGOs possess a very special role.

[12] It should be mentioned that several UN organs have established partnerships and cooperation with other ministries than the MoH. E.g. UNESCO work with the Ministry of Education and UNDP with the Ministry of Transport and the MWVA. To analys these cooperations is outside the scope of this study though.

Determining the structure of cooperation are to a great extent financial resources. The large INGOs have enormous budgets in a Cambodian perspective and there is a danger for the government when dealing with these INGOs since it may not be able of saying no. Several interviewees indicate that the government does not officially set particular conditions on INGOs but that INGOs set their own working conditions. Still, for the particular reason that the Cambodian government is not capable of implementing policies itself, it is an advantage that INGOs with experience from other countries can contribute to a strengthened civil society of Cambodia.

Cambodia shows characteristics of a weak/failed state.[13] One of the signs of this is the need of strengthened human resources since the people in the positions of handling funds are not always prepared and/or skilled for such responsibility (Interviewee). A proper governmental handling of resources seems to depend on individuals' capacity and commitment rather than on guidelines in the formulated policy. In chapter four Gordenker and Weiss (1995b: 546f) were cited arguing that: 'In failed states [...] NGOs take on some normal governmental programmes'. This situation is verified in the case of Cambodia.

INGOs started to give Cambodia attention during the 1980's in order to effectively target problems of immediate need. After the Vietnamese left in the beginning of the 1990's, INGOs also got involved in other fields. Later, suddenly in the middle of the 1990's, HIV/AIDS showed up as an other urgent issue and NGOs - both the INGOs and now established LNGOs - acted quickly. It is obvious that NGOs can constitute a strong force in a weak state not least since they are quick in adapting to new situations. Strained, it can be said that it is rather easy for INGOs to attract funding for issues that are 'in fashion'. Head quarters seem to be willing to quickly assign resources when field offices present certain needs or results (Interviewees). Such facts explain to a great extent how INGOs can drive and affect policy and how governments consequently stay weak. LNGOs are not favoured with an overseas office sending money. Still a handful of LNGOs cooperate with INGOs and thereby get access to funding. To sum up, the tendency today is that the government takes advantage of the fact that NGOs take a lot of the responsibility for implementation. At the same time NGOs take advantage of the weak Cambodian state structure. Especially INGOs tend to make use of their favourable position of funding when it comes to driving as well as implementing policy. No common policy for HIV/AIDS work exists.

[13] It should be mentioned that the term 'failed state' was used by Madeline Albright describing Cambodia during a press conference in 1993 (Kao Kim Hourn 1999a:5).

6 Discussion

In this chapter the roles and capabilities of the Cambodian government and the NGO community in HIV/AIDS work will be discussed. The discussion takes its starting-point in what factors are crucial in the specific case. When possible, differences between the groups of interviewees will be stressed.

Walt (1994:3) argues that a multi-dimensional problem also requires a multi-dimensional approach. Health issues in the third world are such issues and HIV/AIDS is without doubt one of these. Both endogenous and exogenous factors affect if a proper approach is to be effectuated when formulating and implementing policies in a certain case (Ibid.:26). Proceeding from the starting-point that Cambodia is a weak state, the handling of HIV/AIDS is not performed as desired. However, the empirical evidence indicates that the problem is not as simple as saying that the government is *in*capable and the NGOs are capable.

The structure of the political system in the particular context often sets the conditions for how HIV/AIDS will be treated. In the case of Cambodia there was no functioning political system when the HIV/AIDS epidemic started to spread. As I have concluded in earlier chapters, the internal situation in the beginning of the 1990's with a fragile government and a society in need of a complete remodelling was problematic. No single issue could get all the attention needed from the government. Exogenous aspects such as war, the current regional order and the ODA situation consequently determined what was to be done to a great extent.

According to its capacity, the Cambodian government still took some positive measures in the 1990's. Through the establishment of the NAA it has been possible to develop a comprehensive approach to HIV/AIDS and enforce policy development. This act is rather unique in a Third World perspective and the political commitment from the Cambodian government is excellent in comparison with many other countries hard-hit by the HIV/AIDS pandemic. The NAA is important in order to attack all dimensions of HIV/AIDS and to get away from the health sector focus but still the NAA is a non implementing organ and some interviewees do not agree on its importance. A multi-dimensional and multi-sectoral NSP does not necessarily lead to multi-dimensional and sectoral implementation. In fact, a governmental NSP does not guarantee governmental implementation.

In chapter four, the importance of a capable, but not necessarily dominant public sector was declared. The case of HIV/AIDS in Cambodia shows that this need is to be emphasised. It has nothing to do with

hindering private or NGO alternatives but is a necessity in order to establish a capable institution taking the long-term responsibility. Developing the implementation capacity is an extremely important step for a weak government in order to not depend on ODA and not have to handle donors and/or NGOs making the policy process more complex by running their own races (Ibid.:159).

To sum up, the Cambodian government has managed well, in relation to its capacity, in putting HIV/AIDS on the agenda and in formulating HIV/AIDS sensitive policies. But the implementation - neither the own or the one of other actors - is not coordinated and overhauled.

The establishment of a functioning public sector will gain credibility and trust and such an institution can set appropriate conditions with regards to the local contextual understanding on its partners as well as hinder bad NGOs from misdirected actions. In the case of HIV/AIDS, a capable MoH will, and must, screen among and/or coordinate its partners but also listen to important advice given from NGOs with important external perspectives; NGOs do not manage coordination themselves (Ibid.:91ff). Cambodia has several challenging health problems to combat and HIV/AIDS is tied to many other health issues such as Tuberculosis and maternal and child mortality. The health issue is an issue that will always exist and the government is the only actor involved with a true long-term commitment. NGOs *can* commit themselves to long-term work but they can also change their plans over time. Further, for the sake of effectiveness it should be preferred in most countries to make use of the existing governmental health service network when working with providing service for the whole country (Interviewee). This is valid also in the case of Cambodia where a network, albeit humble, exists.

INGOs with valuable knowledge gained from working in other countries can be important in building Cambodian capacity. To sum up, it is not necessary that the government has to have the main responsibility for all components of HIV/AIDS work but it needs to maintain its governmental functions such as regulation of the private and NGO sectors and making sure that a long-term approach covering the whole country is granted (Myo Thant 1999:155, Walt 1994:43). Still it should be remembered; the development of a capable public health sector is important, though not the solution of HIV/AIDS problems in Cambodia.

Government staff putting ODA in their own pockets. Corrupt lawyers. Medical doctors taught in French but who cannot speak French. Health centre staff that does not let HIV/AIDS patients in. International Donor Community interviewees give countless examples of why human resources are one of the weakest links in the rebuilding of Cambodia as well as in combating HIV/AIDS. Among some of the government representatives, on the other hand, there seem to be an overconfidence in increased ODA; a sign in itself of a non-raised understanding of development. On all levels of the society improving the educational level is needed; on the grass root

level people must learn how to read and write in order to be able to profit from HIV prevention and information. Higher up, people in charge in the public sector must develop capacity to handle large sums of money and understanding for the policy process. (Kao Kim Hourn 1999b:62)

For immediate humanitarian relief assistance INGOs are probably extremely important. However, this is not the case only in Cambodia and not only in the case of HIV/AIDS; whenever an unexpected serious problem hits a country there is need for external assistance. As I concluded above, many government representatives seem to put a strong belief in ODA of various kinds. Also many NGO interviewees view international funding as crucial. LNGOs argue so which is not surprising knowing their financial situation (see figure 3.2) and their often limited experience of development work. What is surprising is that INGOs seem to think they are irreplaceable and that Cambodia would go under without them. This conclusion leads us to discuss what role NGOs play in long-term work.

One of the clearest results of the study is the lack of self-criticism among NGOs. LNGOs overall seem to have no proper system for evaluation. INGOs tend to never find any bad sides with their work. As two interviewees answer when asking about their weaknesses:

> NGO cooperation has only good sides. There are no problems. (LNGO)
>
> We are good for Cambodia; we are not doing anything negative. If we did they should not let us work here. (INGO)

Answers like these indicate that there is a need of capacity building among LNGOs and development of better understanding for Cambodia among INGOs. INGOs have no deep contextual understanding for Cambodia and many of them do not reflect over the weak state structure making it fairly impossible for the government to resist ODA or hinder 'bad' NGOs. One International Donor Community interviewee indicates that INGOs sometimes come to the Cambodian government with an own compiled plan for which they want to get approval of implementation. The government has a hard time negotiating with the INGOs since if it does not approve, the INGOs may leave the country and resources decrease. The government consequently does not tend to criticise the work of INGOs.

To sum up, Cambodian institutions are weak and unstable and the existence of other actors - and primarily a quickly growing NGO community - sets conditions on the government. It is thereby possible and positive that actors with developed capacity can influence all levels of policy making. However, there are also considerable risks with giving NGOs the power to run their own race. In a country crowded with NGOs of different size, origin and mission, there is a danger that religious, ideological or other underlying aims will overshadow work that should be guided by needs assessments. Only by an overall strengthening of the

governmental capacity, when it comes to implementation, NGOs will need to work in line with the NSP. In addition, the poor implementation of law in all areas important in relation to HIV/AIDS needs to be improved.

On the other hand, LNGOs need to develop their human resources and improve their financial situation in order to play a stronger role in the Cambodian civil society. By combining LNGOs' contextual knowledge with INGOs' experience from elsewhere, Cambodia can avoid repeating its own and others' mistakes. Such direction of development needs improved coordination of NGOs though.

Walt (1994:117ff) argues that NGOs traditionally worked with focus on the poor in the welfare and humanitarian relief sector. Today a movement from doing to influencing is perceptible. Instead of being 'COME'N GO's' when it suits NGOs and there is an urgent need for help, NGOs can work with long-term commitment. In the case of HIV/AIDS this means that NGOs without doubt should work with it, but there is a need of further spreading of the resources between regions and sectors in Cambodia. The whole NGO community could constitute an important player on the Cambodian arena in capacity building in terms of keeping democratic development upwards and in advocacy INGOs can play a key role in strengthening the LNGOs. Consequently the multi-sectoral and dimensional approach would be strengthened.

A question that occurs naturally when analysing the case of Cambodia is whether the results from the empirical study apply to the NGO community in general or only to the ones working with HIV/AIDS. My opinion is that many conclusions probably can be drawn for the main part of NGOs working in Cambodia but that the basic data of a study of this scope is too small to make wider reliable generalisations from.

6.1 Concluding remarks

Is HIV/AIDS high or low politics in Cambodia? The answer is probably both. When it comes to agenda setting and policy formulation, HIV/AIDS is high politics. Cambodian politicians realise that it is an issue not to be ignored. On the other hand, the implementation part of the process is not prioritised by the government. As it is today, the variety of actors contribute to a relatively overall multi-sectoral and dimensional handling of HIV/AIDS.

HIV/AIDS in Cambodia should be seen in the context of the overall national health and education situation. Overall poverty reduction and strengthening of health care and the educational system is of great importance.

Neither NGOs nor the private sector can be forced to take long-term multi-sectoral and dimensional responsibility for HIV/AIDS work. Consequently there is a need of a strengthened public sector. In the same

time, the NGO community itself should take a moral responsibility and improve coordination. Established networks should be developed and focus should be on strengthening LNGOs capacity.

There is a tendency that INGOs are sometimes too sensible to what is 'in fashion' in order to attract funding. Hence the ways in which strategies are implemented are not consistently related to the NSP. The Cambodian weak state structure is partly to blame. In order to improve the situation, the implementation of law must be improved and human resources in the government and in LNGOs must be strengthened. Self-criticism among NGOs in relation to HIV/AIDS work must increase and INGOs must not misuse the structural conditions with the possibility to disregard the government.

Increased funding is not in itself the solution of HIV/AIDS problematics. Much of HIV/AIDS work is about human resources. Although, for LNGOs money is still an issue and their funding needs to be increased as well guaranteed in the long run. LNGOs need to develop capacity in order to become an opposite pole to the weak state structure. Then LNGOs can play a key role in HIV/AIDS work in fields such as discrimination, stigmatisation and equal access to information and care on the grass root level.

When developing theory on the role of NGOs, the importance of context specific characteristics cannot be emphasised enough. NGOs work with different issues in different fields in different stages of the policy process in the First and Third World respectively. As a consequence of this, a proper scrutinising of the roles of LNGOs and INGOs is needed. The case of Cambodia shows that these work under different conditions, having different strengths and weaknesses, different advantages and disadvantages.

6.2 Further research

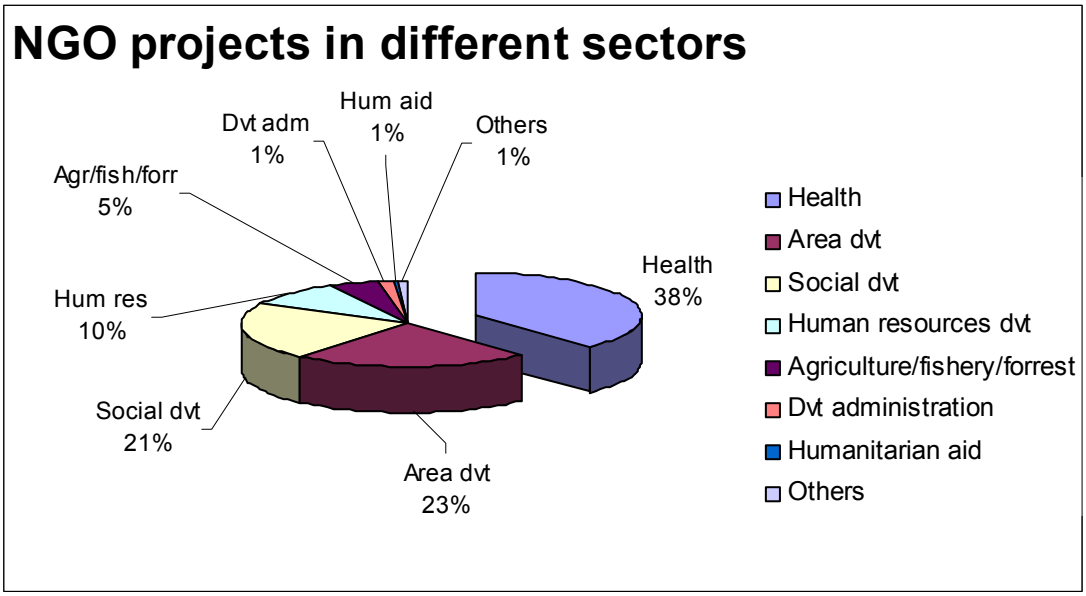
The empirical findings show that NGOs constitute a group of actors with a very special character in Cambodia. It has become clear that coordination of NGOs is insufficient not only in the case of HIV/AIDS. An important as well as interesting idea for further research is to study the HIV/AIDS NGO alliances as well as other NGO coordinating bodies. Scrutinising of NGO cooperation can hopefully lead to knowledge about how coordination can be improved.

This thesis has dealt with NGOs but it should be remembered that NGOs are only one group of actors. It would be interesting too see what role other non-governmental actors such as International Donors play in HIV/AIDS work. Such a study would hopefully complement this one and contribute to a broader understanding of how HIV/AIDS is approached.

As indicated already in chapter two, a study comparing Cambodia with other countries hard hit by HIV/AIDS and/or with a large NGO

community would be interesting. In such a study deeper understanding of the meaning of the Cambodian weak state structure could be reached.

Appendix 1

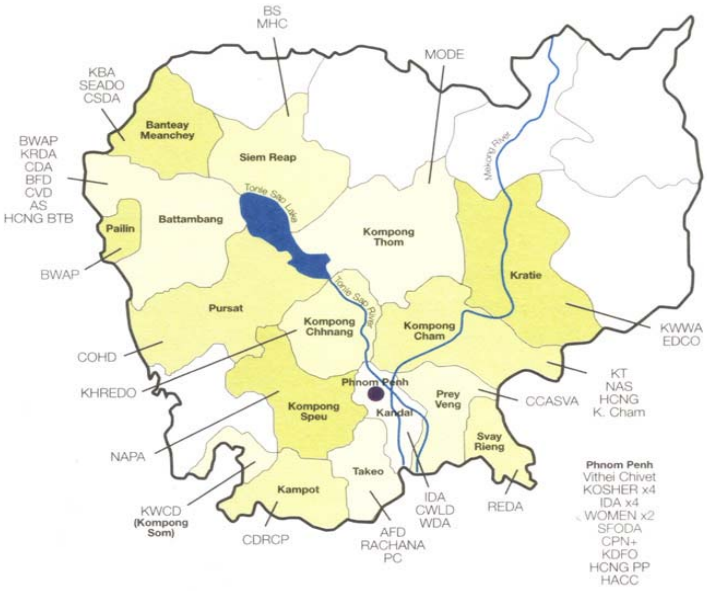


NGO projects in different sectors. Source: NGO Forum 2002a.

Appendix 2

The maps show that five provinces bordering Laos, Thailand and Vietnam in the North and the Northeast lack NGOs. This is also valid for one province in the Southeast bordering Thailand. The aim with the second map is showing the borders.

HA



Regional spreading of NGOs in the HIV/AIDS NGO Alliance KHANA. Source: KHANA 2002.

Map of Cambodia.
Source:
http://www.geocities.com/thailandsidan/map/cambodia/cambodia_pol_97.jpg

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