

**8th International Congress on
AIDS in Asia and the Pacific (ICAAP) Meeting**

**Bridging the Gap between SRH and HIV
in Cambodia:**

A Discussion of Cost and Benefits

Speech
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Introduction

Today I have been invited to share with you my experiences in Cambodia, where I have been working for over 10 years to link the needs for sexual and reproductive healthcare with the growing demand for high-quality HIV/AIDS services.

I have been asked to speak to you about the costs and benefits that are involved with bringing SRH and HIV programs together, and provide answers to questions of program linkages, such as "*Where should we link?*", "*What should be linked?*" and "*What can't be linked?*".

In answering these questions, I will first provide a brief overview on the current HIV epidemic in Cambodia and demonstrate how this has driven the need for integrated SRH and HIV services in my country. I will also highlight the following areas for your consideration :

- Focal costs and benefits for service providers to meet the growing demand for linked SRH and HIV services
- Cost and benefit considerations from a client perspective
- RHAC experiences by linking its SRH and HIV services

I. The Current HIV Epidemic in Cambodia

Although Cambodia has observed the declined of HIV prevalence among general population (from 1.9% in 2003 to 0.9% in 2006), particularly the STI prevalence remained un-touched. According to STI survey conducted by NCHAD in 2005, the STI prevalence among female sex worker is still high as 24% while the police group is 3.2% despite the promotion of 100% condom use program in brothel. Yet knowledge about STI symptom and prevention remain relatively low compare to HIV/AIDS and family planning. Through RHAC evaluation survey conducted in 2005 revealed

that knowledge about STI symptom among young people is only 42,6% and 23.2% doesn't know how STI can be prevented while the knowledge about HIV prevention is as high as 96.4%. The statistic on abortion rate is floppy and Maternal Mortality ration still 472/100,000 and the under five mortality is 85 per 1000 live birth.

The demographic trend from high risk to general population . The declining rates of HIV prevalence in the last 10 years
Note here that the health system is the weakest in rural areas where the majority of the population lives.

Discuss briefly here "Why are housewives and their children the fastest growing population to be HIV positive?" Is it because the HIV prevention efforts have been focused on high-risks groups and not made available to the general public? Is it because of poor resource at health infrastructure at the periphery? List these factors as they will need to be addressed in cost-benefit considerations. Insufficient of the service delivery, the service designed for the high risk group but the general population have hard or no where to go.

II. Focal Costs and Benefits for Service Providers

Given the Cambodian context I just described, it is evident that Cambodian healthcare providers are facing increasing demands to provide fully integrated or, at the very least, linked SRH and HIV services. In this section, I will describe both the provider-incurred costs and the benefits to be gained with linking these essential health services.

A. There are **several key provider costs** that must be considered when linking SRH and HIV services:

(1) Staff: Healthcare providers must have the technical capacity to provide SRH services, such as ANC, FP and STI services in addition to HIV services, such as prevention counseling, VCCT, PMTCT, treatment for OI and other referrals for care and treatment of HIV infection. Significant investments are required to hire additional staff and/or providing them with clinical training and counseling to develop the human resources and capacity necessary to take on the integration of services or link SRH to HIV services in some cases. A major cost here probably modest or marginal, add more time on consultation combined with IEC material

(2) Infrastructure: Another area that requires significant investments is in developing the health facility infrastructure. Additional space is often required and existing facility space may need to be modified or renovated to ensure that HIV services are provided within private and confidential settings. Laboratory services will need to be adapted to handle HIV blood samples and additional equipment and supplies will be required. For facilities without laboratory services, preserving and transporting specimens to referral labs

and obtaining the results will need to be factored into overall costs for providing these services.

(3) Time: To provide SRH and HIV services to clients, staff will need considerable more time during each client visit and hours of operation may have to be increased to accommodate clients that cannot reach clinics and health centers during regular hours of operation. Other time considerations include staff absences at health facilities to attend technical trainings so that health providers are skilled in integrating or linking SRH and HIV services. Staff may also be displaced during infrastructure development and staff may be required to transport lab specimens or accompany clients for referral services.

(4) Financial costs: At the base of all these staffing, infrastructure and time considerations are the very real financial costs that are involved with linking SRH and HIV services. The ability to expand or link services to include additional service components may be limited by funding agencies, such as donor priorities, or the organization's own ability to recuperate costs.

B. The key provider benefit to be gained when linking SRH and HIV services involves the economy of scale.

(1) Economy of Scale: With increased client volumes, the overall costs to deliver services decreases, which translates into a cost reduction for the clients themselves. In a few minutes I will discuss the factors that contribute to RHAC's ability to increase client volumes, which leads to this overall reduction in the costs of integrated HIV services and SRH services.

III. Cost and benefit considerations from a client perspective

With 85% of the population living in the rural areas and 43% of the population living on less than a dollar a day, clients face considerable costs to access health services. As I will demonstrate, these clients also have the most to gain from integrated or linked SRH and HIV services.

A. There are several key client costs that must be considered when linking SRH and HIV services:

(1) Lack of services: With the majority of Cambodians living in rural areas, the closest health facility is often the government health center. Within Cambodia's current public health system, the peripheral or rural level is the weakest link in the chain of public sector health services. It is common in Cambodia that government health centers face chronic staff shortages, lack medical supplies and drugs, lack sufficient facility space, and have limited hours of operation. These factors contribute to a lack of available services and a limited ability to link SRH and HIV services within the public health

sector. All of these factors increase client costs and limit their access to services.

(2) Travel costs: With a lack of services available in peripheral health centers, clients have to pay-out of pocket for transportation costs to access health services. In some cases, women face security issues when traveling long distances to access SRH services in regional towns . They often need to be accompanied by their husband or other family member.

(3) Time and other opportunity costs: The need to travel long distances to access health care services and the need to be accompanied by a husband or family member involves significant opportunity costs within the household. The time and the expense involved with traveling to access health care displaces the time spent generating income for the household, whether conducting commerce or working on the farm. Additional opportunity costs include displaced household tasks such as child care, food preparation, collecting water and other resources for the household.

(4) Financial costs: At the base of all these client cost considerations are the very real financial costs that are involved with accessing SRH and HIV services. Even if health providers are able to integrate SRH and HIV or create linkages between these services, clients may not seek health services due to lack of money or competing priorities for the limited household income.

B. The main client benefits to be gained when linking SRH and HIV services involves reducing the overall opportunity costs involved when seeking health services. These include: Enhance confidentiality aim to reduce stigma attached and invisible from outside and a one stop shopping with building awareness and important for other services like ANC ,FP, PMTCT, TB and Child survival.

(1) Travel costs: Integrated or linked services reduce the out -of-pocket costs involved with traveling to multiple facilities to access health services. This is the concept of "one-stop shopping" where the client can access all services at one facility.

(2) Time and other opportunity costs: "One-stop shopping" also reduces the time involved with traveling to multiple clinical sites and waiting for health services at each facility. The time-savings gained with integrated or linked services can be spent generating income for the household and conducting daily household tasks.

(3) Financial costs: At the base of these time and travel considerations are the very real financial savings involved with accessing SRH and HIV services. The cost per services provided is slightly going up adding more sources to the same client, the cost going up and the more services provided.

IV. Linking SRH and HIV services at RHAC Clinics

With all these cost and benefit considerations in mind, RHAC has been able to successfully reduce the overall costs involved with providing integrated SRH and HIV services, while maximizing the benefits for clients who come to RHAC for healthcare.

Client volumes steadily increased after RHAC integrated HIV services into its package of SRH services. As a result at RHAC served 279,755 in 2006. Integrated SRH and HIV services attracted clients to RHAC clinics and health posts. With increased client volumes, the overall costs to deliver services decrease, which translates into a cost reduction for the clients themselves.

RHAC uses a **synergistic approach** to successfully link SRH and HIV services. Elements of this synergistic approach include:

- **Full integration:** HIV education and services an aspect of all clinical services and outreach programs.
- **Client-centered care:** RHAC's approach to client-centered care focuses on the **rights of the clients to make informed decisions** about their health care, which increases access to both SRH and HIV
- **Increasing male involvement** at RHAC. Reproductive health and HIV services at RHAC meet the needs of both women and men, especially in the area of premarital screening, FP and ANC services and PMTCT, as well as increased STI testing and treatment for men. In 2006 male clients are 40,898.

V: RHAC support to Government Health Centers:

To address the need for linked SRH and HIV services at the peripheral level of the health system, RHAC has begun supporting to government health centers in linking SRH and HIV services. This is being accomplished in the following ways:

On the provider side

- Screening criteria for eligible health centers. Given the limitations at most health centers, RHAC does not want to overburden facilities of limited staff to build in referral system between HC to Hospitals for lab and further services.

On the client side

- Covering the cost of travel and user fees for the poor to access services

Conclusion

In this presentation, I have discussed key costs and benefits involved with linking SRH and HIV services in Cambodia. Given that each country has a unique set of conditions that influence the ability to link SRH and HIV services, I have outlined the main cost considerations for both providers and clients so that you can weigh each of these relative to your own program and country context. Here I will summarize the following key points to answer the questions of *"Where should we link? What should be linked? What can't be linked?"*

Where should we link?

- Rural areas and urban areas with high concentrations of poor households, where the health needs are high and opportunity costs limit access to services.
- Peripheral health centers can be linked to referral hospitals for improved access to lab facilities and treatment services.
- NGO activities with government health facilities to strengthen the health sector overall.

What should be linked?

- ANC services can be linked to PMTCT services
- Family planning can be linked to VCCT
- STI and RTI treatment can be linked to VCCT
- Health education messages can include information on HIV prevention, VCCT services and the importance of PMTCT and TB

What can't be linked?

Facilities that lack adequate staff and infrastructure

Based on the potential statistic buy integration HIV/AIDS to Sexual Reproductive health is hope to see the decline of MMR and STD and unwanted pregnancy that can be reduce of abortion and increase the generale awareness of the population which are still an issue of Cambodia that aren't improved very much.

More bank to the buck – more cost effective approach.

