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**COLLABORATIVELY CONFRONTING THE CURRENT CAMBODIAN
HIV/AIDS CRISIS IN SIEM REAP: A CROSS-DISCIPLINARY, CROSS-CULTURAL
“PARTICIPATORY ACTION RESEARCH” PROJECT
IN CONSULTATIVE, COMMUNITY HEALTH CHANGE. ¹**

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Abstract

We describe recent cross-cultural efforts among psychologists, medical practitioners, students, and local citizens to initiate additional health-related behaviour-change interventions in Siem Reap, Cambodia, designed to reduce the spread of sexually transmitted infections (STIs), including HIV/AIDS. The model of Participatory Action Research, originally proposed by Kurt Lewin (1946) as “action research” has guided this project since 2000. Community participation and feedback have both co-determined the goals and methodology, and have helped ensure that imported materials were culturally sensitized to local needs and technically converted for appropriate community dissemination. Specialized workshops were created to train peer-educators providing strategies for behaviour change to groups of women at high risk for HIV/AIDS. Systematic behavioural surveying was initiated in 2001 to monitor changes. Various community meetings and focus groups have led to the creation of SiRCHESI, a local non-governmental organization (NGO) to coordinate all activities and to explore the possibility of broader institutional health innovations in co-operation with other NGOs, medical practitioners, hospitals, international funding sources, government agencies– and future collaboration with Siem Reap’s local and international business sector.

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Separate pathways to “ Action Research” in Siem Reap, Cambodia

This project has assembled a collaborative, multi-disciplinary team from Cambodia, Singapore, and Canada to address an urgent community health crisis as the town of Siem Reap, the provincial capital of Siem Reap province, Cambodia, confronts a growing HIV/AIDS epidemic. Together, health practitioners, local citizens, government agencies and officials, academic researchers and non-governmental organizations (NGOs), have all been actively seeking improved intervention strategies to reduce HIV and STI infection rates. This has often involved multi-disciplinary borrowings from studies in relevant social sciences (e.g., Psychology), health sciences and practitioner specialties, and international development perspectives on building local capacity and infra-structure. Throughout the process of confronting this epidemic, it has been necessary for the external team members to learn from their colleagues about socio-cultural sensitivities when adapting educational materials and intervention strategies. In addition, the collaborative work involved solving additional technical problems of media conversion, translation and dissemination. Ongoing funding from the Elton John AIDS Foundation has been supplemented from the project's corporate donors; local and international industries and business interests will be increasingly called upon to help sustain programmes that can improve the local health situation.

For the academic researchers in the team, it was possible to find a common framework in social psychologist Kurt Lewin's (1946, 1947) “action research” model for community-based research and social change. One of us (MLW) had already applied action research in various Asian locations; these studies involved community health development, for example, designing and sustaining self-help child health programmes in rural settings (Wong, 1990;1991), designing programmes and strategies to reduce sexually transmitted diseases (STDs) in urban settings (e.g., Wong, 1998a). These in turn led to successful intervention projects for 100% condom use with sustained high levels of condom use of more than 90% and a corresponding marked reduction of curable sexually transmitted diseases among female brothel-based sex workers in Singapore (Wong et al., 1998a, 1998b, 2002). Others came to appreciate “action research” from an “armchair“ perspective in academia, after critically analyzing the historical, epistemological and experimental underpinnings and shortcomings of social psychology (Lubek, 1997, 2000; Lubek & Stam, 1995; Stam, Lubek & Radtke, 1998; Stam, Radtke & Lubek, 2000) and envisaging a more politically engaged, emancipatory and empowering brand of applied social and community work (Lubek & Wong, 2001; in press;

McCourt, 2002) . While the original “action research” perspective for social change continued to be practised by a small number of Lewin’s former students and colleagues (Cherry and Borshuk, 1997), post World War II funding policies in the 1950s favoured basic research over applied interventions (Sanford,1970); nonetheless, several variants evolved (Peters & Robinson, 1984) and with further studies in various “neighbouring areas” such as nursing, social work and education (Hart & Bond,1995) , eventually, one version seems to have increasingly gained multi-disciplinary adherents: **Participatory Action Research (PAR)** (Chataway, 1997).

Unlike the mono-linearity of laboratory research, where the experimenter controls each stage, in “action research” community participants’ feedback helps reshape the research and determine the next actions or interventions, the interpretations to place on the results, changes to the studies goals and methods, etc. Lewin’s own written descriptions of action research are either somewhat informal (1946) or inter-twined in heavy theoretical and meta-theoretical discussions (1947). However, two short passages may have captured the essence of the model: the first, his description of “rational social management” which “proceeds in a spiral of steps each of which is composed of a circle of planning, action, and fact-finding about the result of the action. (1946, p. 38). In his second article, the section on “Feedback problems of social diagnosis and action” (1947, pp. 147-153) contains a diagram showing the various feedback loops in the research and intervention process– after an initial reconnaissance of goals and means, each action step is accompanied by an evaluative reconnaissance of that action before moving on to the next step; but the evaluation may also signal a looping backwards to a revision of the original plan. Michelle Wittig (1996) described Lewin’s action research:

it eschews the traditional expert knowledge model and replaces it with a model of reciprocal knowledge between the researcher and those for whom the research is done. ...it is a collaborative enterprise, conducted in coordination with its intended beneficiaries.... [T]o the extent that the research incorporates the insights and values of its constituents, (community members and other “end users”), it is more likely to be used by them to create structural change...”(p. 6) .

Cynthia Chataway’s (1997) version of Participatory Action Research, which she used with a First Nation community in Kahnawake, starts with an initial community immersion prior to the problem definition, and then as the methods and data collection advanced, collective interpretation of results to determine whether further action should be taken, or cycling back to redefine the problem and the research process.

Michelle Fine and her co-researchers describe this newer PAR, while still remaining faithful to the Lewinian roots:

Participatory action research represents a stance within qualitative research methods; an epistemology that assumes knowledge is alive, rooted in social relations and most powerful when produced collaboratively through action. ...[PAR] has typically been practiced within community based social action projects with a commitment to understanding , documenting and/or evaluating the impact that social programs, social problems and/or social movements bear on the lives of individuals and communities. ...at its core it [PAR] articulates a recognition that knowledge is produced in collaboration and in action. (Fine, et al., in press, p 1)

Besides the Lewinian precursors, they cite recent feminists and other social activists such as Paulo Freire and Ignacio Martin-Baro.² **The latter had both, “more recently, structured a set of commitments to ...[PAR] that move Lewin well beyond the borders of psychology, into an explicit analysis of the relation of science to social inequality, community life and radical social change” (p. 3). And they define the “recursive steps” of PAR as “a dynamic or dialectical confrontation between common sense and systematic observations, followed by intensive reflection and action, engaged at the provocative borders between insiders and outsiders.... “ (p. 3)**

In our own use of the term “action research”, we suggest that any research and intervention ideas we may bring into a community and/or which are generated there collaboratively are all modifiable and even ultimately discardable– the theoretical perspective, the hypotheses, goals for change, methods, instruments, data-gathering techniques and the interpretation of results (Lubek & Wong, in press). These must meet the community’s needs for culturally- and gender-sensitive methods (see Pheterson, 1995), be subject to modification through feedback mechanisms such as consultative

discussions, interviews, and focus groups. The prioritizing of the various action goals and questions to be resolved will also depend on the community members’ perspective. The role of the external researchers should thus be research-degradable, starting out with a role of articulation and facilitation, networking, financing, and initial consultations on research design and actions, but eventually increasingly ceding their “expert” or project managerial role as local capacity is built up and local participants increasingly take over their project as community researcher/practitioners (Lubek & Wong, in press).

² Brydon-Miller (1997) also traced the history of Participatory Action Research (PAR), but only back to the 1970s, noting the influences of educational activist Paulo Freire, Marxism, feminism, and the critical theory of Habermas. However, Kurt Lewin’s earlier “action research” (1946,1947) is not cited.

Focussing on the HIV/AIDS epidemic in Siem Reap:

Some potentially explosive idiosyncratic factors

During the Pol Pot period (1975-9), approximately one quarter of the Cambodian population died in the “killing fields” or from enforced starvation. (Kiernan, 1999; Pran, 1999). As almost all Cambodian families lost relatives during this period, the genocide and uprooting reverberated and has continued to contribute to the disruption and breakup of Cambodian family and social life.³ **Much infrastructure disappeared, and medical and educational institutions shut down when the targeted killing of intellectuals and “people wearing glasses” decimated the fields of education, health care, and law. As Cambodia rebuilds, with a majority of its national budget coming from foreign donors, the tourist industry has been seen as a major source of income, estimated at \$120,000,000 per year (Puy Kea, 2002) , temporarily second only to the textile industry. The historic 9th-12th century temples of Angkor Wat are now accessible by direct international flights to the nearby Provincial Capital town of Siem Reap. As the number of tourists increases dramatically,⁴ the economy is expanding , and there is a hotel-building boom. New migrants, seeking work, arrive daily from surrounding rural locations, but for women, there are few employment possibilities in the tourism and hotel sectors. Our interviews with hotel managers, for example, revealed that women are less likely than men to find employment in the hotel industry, because they have fewer years of formal education. Literacy, along with facility in a foreign language, usually defines the minimal entry-level criteria for this industry. With no local textile factories, the only remaining urban jobs for unschooled women are as “direct” sex-workers in brothels or else as “indirect” workers in the entertainment industry: e.g., as discotheque dancers, bar and “beer promotion women ”,**

³ Several interview participants, now in their 40s, had never been married because their parents had been killed and there was no one to arrange the marriage with the potential partner’s family, according to cultural custom.

⁴ Projections from 2001, had estimated that 250,000 tourists were expected at the Angkor Wat temples in 2002, and a million projected for 2005, However, government officials recently announced that 212,690 foreigners had arrived in Siem Reap during **the first 6 months of 2002** (an increase of 75.3% over the same period in the previous year) (Puy Kea , 2002). Approximately 130,300 flew directly to Siem Reap from international locations, by-passing Phnom Penh.

masseuses and karioke singers. Because the indirect sex workers are constantly being propositioned by men in their regular workplace, they may sometimes agree to trade sex for money after work.⁵

The 140,000 citizens of Siem Reap town were facing an alarming HIV/AIDS epidemic, with 7- 10,000 persons (2001) already estimated to be living with HIV/AIDS.

Various government and NGO programmes have responded with both systematic seriological (HSS) (NCHADS, 2001) and behavioural (NCHADS,2001) surveillance programs, educational campaigns and social marketing of condoms, and a national policy of 100% condom use for commercial sex workers, which was first successfully implemented in Sihanoukville between 1998 and 2000. Additional mobilization of attention to the health arena has occurred In the national capital, Phnom Penh, where there are highly visible signs of progress and innovative programs, in part co-ordinated centrally by the Ministry of Health, the National AIDS Authority, and NCHADS (National Centre for HIV/AIDS, Dermatology and Sexually Transmitted Diseases), in cooperation with international agencies such as UNAIDS and WHO. At the provincial level, the cooperation with the Provincial Department of Health, the Provincial AIDS Office, and various provincial AIDS action committees and outreach programs have been working together on aspects of the AIDS epidemic, co-ordinating input from various ministries and from local government agencies.

In Phnom Penh, one sees campaigns of high school education (Tarr & Aggleton, 1999), a Home Based Care project (e.g.,Sihanouk Hospital Centre of Hope, in conjunction with the Elton John AIDs Resource Centre), various educational outreach programs by CARE, CARITAS, UNICEF, and Médecins sans Frontières -HBS, the social marketing of condoms by PSI, etc. There is even a small pilot program of supervised distribution of anti-retrovirals run by the Infectiology Department of Preah Bat Norodom Sihanouk Hospital and sponsored

⁵ Indirect Sex Workers, while having final say about accepting, or not, a client's offer– usually for the whole night– , may move from company to company, or be moved, e.g., by beer distributors, from restaurant to restaurant or even be rotated to other cities. According to the Ministry of Health's HSS Survey for 2000 (HSS, 2001, pg. 9), indirect commercial sex workers are defined as “women working as beer promotion girls or as bar, karaoke or massage girls”. Direct Sex Workers working from a fixed location such as a brothel generally do not choose their clients and whether or not to have sex.

by Médecins sans Frontières (FR), but this can accommodate fewer than 300 persons out of an estimated 169,000 (HSS,2001) to 200,000 persons (Reuters, 2001) living with HIV/AIDS, in the country. While Phnom Penh's programs are visibly advancing, the arrival of resources in the provinces may be too modest or too slow, as Siem Reap authorities and NGOs struggle to confront the unique and staggering social aspects of infection patterns involving both sexual tourism and a "bridging" with the local community⁶.

The PAR project in Siem Reap: From interviews to intervention via co-operative community capacity-building and the formation of a local NGO

In Siem Reap, the PAR process began when one of the Canadian researchers (IL), visiting as a tourist in 1999, was told of the local health crisis situation in Siem Reap by a local informant. In 2000, he returned to interview in depth 19 citizens and doctors about their reactions to the epidemic, and to query about the roots of the risk-taking behaviour going on in the community—excessive drinking by men and having unprotected sex with direct and indirect sex-workers known to be HIV/AIDS seropositive, and then failing to use condoms with their wives⁷ (Lubek & Wong, in press) . **Each participant related in depth their personal and often harrowing tales of surviving the Pol Pot period and subsequent years. In addition, most suggested that HIV/AIDS had first come to Siem Reap with the United Nations troops in 1991— the year that the first case of HIV/AIDS was recorded in Cambodia. At this time, brothels and entertainment venues were simultaneously established in Siem Reap. Afterwards, the international de-miners arrived to clear the nearby Angkor Wat temple areas, and tourists then began arriving in 1997. Many of these were sexual tourists, abandoning Thailand and the Phillipines for a less expensive visit to a country where the age limit for legal consenting sex acts is said to be 15.**

⁶"Bridging" will be described below in greater detail. It refers to the spread of infections among different community groups by, e.g., the married men of Siem Reap who sleep with both sex workers and then their own wives.

⁷ At the time, the researcher had brought along a theoretical perspective linking the traumatization of genocide survival to later risk-taking and self-harming behaviours. Socio- historical and psychological perspectives on devastating political events have focused upon genocide, mass rape, and uprootings, (Kren & Rappoport, 1994; Apfelbaum, 2000; Human Rights and Equal Opportunity Commission of Australia, 1997).

But the pursuit of a discussion of their past held less urgency for the 19 community members in 2000 than finding a solution to the problem of the fast-spreading epidemic in their midst. Most could name someone who had died of HIV/AIDS or complications. When asked about the future in Siem Reap and what they might do and prioritize if they “became prime minister”, they offered important insights and ideas about changing available health care and education.⁸ The fear that HIV/AIDS was a concrete reality which lived next-door or even in their own families seemed to grow in Siem Reap; by February, 2001, in our interviews and focus groups with “beer promotion women”, all (N=15) knew someone who had died recently of HIV/AIDS.⁹

The knowledge being generated in the community, and fed back, began to lead to community actions. Thus, when a summary of the results of the February, 2000 interviews was fed back to the participants at a meeting, they agreed to form a grass-roots social-action group (The Siem Reap Citizens for Health, Educational and Social Issues [SiRCHESI] as a local NGO in order to address what they had described as interlinked social, educational and medical needs in their community. Nine persons joined the discussions at this time. Based upon the interviews, it was decided to solicit international resources to create additional educational programs to prevent the spread of AIDS in Siem Reap. Two specifically vulnerable groups of women were targeted for further information

⁸ In 2000, they had generally agreed on insufficient medical facilities, treatments lacking for opportunistic infections, and that antibiotic or anti-viral medication were not available/ affordable to them, although some felt this would be available in Phnom Penh, or in neighbouring Thailand. . Extended HIV/AIDS education and sex-worker outreach programs were also stressed, along with preparation of orphanages for "HIV/AIDS babies". Married women wanted to see a change in the behaviour of men who were both unfaithful and unsafe– who had extra-marital sex and were not consistent condom users.

⁹ By 2002, the death of friends was having dramatic impact on these women: for example, during interviews in July, 2002, 7 of the 35 “beer girls” and other indirect sex workers who had completed peer-education workshops in May, 2002, were followed up with interviews in their workplace. Three spontaneously told of a local beer girl who had worked for a prominent international beer company and who had died in the past two weeks of HIV/AIDS. They all cited the same name. A fourth confirmed this account, when queried. Because there were no relatives in Siem Reap, her body was taken away by the police for cremation without any funeral service or the presence of her friends. (McCourt, 2002) . This proved an emotional topic for several of our peer-educators who discussed this as a personal sign of their own existential fragility-- although they dressed every evening in the uniform of their beer company who paid them wages, they now suddenly felt a heightened vulnerability to an anonymous, unceremonious, unmarked end.

gathering and an HIV/AIDS peer educator intervention program. Health education materials from the intervention programme for sex workers in Singapore were adapted and translated into Khmer, and in February and March, 2001, focus groups were run in Siem Reap to pilot-test and modify these. At the same time, interviews with citizens, medical and NGO personnel sought additional culture-sensitive contextual information, and assessed local knowledge and resources about HIV/AIDS prevention. These conversations in turn led to a decision to implement a more systematic survey of social and sexual behaviour of women, to help better pinpoint exact transmission patterns, further identify groups at risk, and design locally-appropriate prevention strategies (See Wong et al, 2002b).

On March 6, 2001, the second annual meeting of the local NGO was held, and 26 persons attended, including participants from 2000 and many interested health sector workers. To help the educational interventions move forward, the NGO elected an executive, a bank account was opened and discussions took place about prioritizing further educational and medical interventions. The findings from the focus groups of 2001 and other interviews were then fed back to this group, and useful ideas recorded, networking accomplished, etc. To further feed back information to others in Siem Reap who shared these concerns, we had the night before organized a bilingual community conference at the Sofitel Hotel for all government ministries and agencies, medical facilities and NGOs working on related issues (March 5, 2001); 90 persons attended and presentations were made by some of the co-authors as well as by representatives of 21 groups. One beer girl took off work to attend and take notes for others.¹⁰

Thus by March 2001, collaborative discussions were involving more local medical personnel, officials, NGOS as well as concerned citizens. Together, they helped orient the expanding research project, facilitated local data-collection, and contributed towards intervention planning. As a result, the intervention campaign

¹⁰ We learned later, that at 3 other beer promotion women had tried to attend, but were unable to get past the hotel's doormen. This meeting had a broader focus and a wider attendance among international NGOs than the regularly scheduled meetings of the Provincial AIDS Office, or the Provincial Department of Health, which bring together for progress reports and updates all the outreach workers and managers of the ongoing educational programs, e.g., concerning 100% condom use, the Direct Sex worker/Brothel program, and others. In 2001, we also tried to institute a cervical gonorrhoea testing program and as a result of the community meeting, two medical facilities began a cooperative venture, which proved short-lived due to technical problems.

would be first oriented to two target groups of women at high risk who in 2001 were not yet adequately addressed by other programs: “beer promotion women” and married women.¹¹

In terms of PAR, the continuous ongoing interviews and feedback sessions within the community over three years -- 2000-2002, permitted a pooling of awareness of the HIV/AIDS situation for married women , local men, and the workplace risks faced by the beer promotion women . By 2002, when our peer-education training workshops began for these two groups of women, many of our former participants volunteered to become peer-educators and trainers, and helped recruit their friends. By 2002, our energies in the project were all focused on prevention workshops and local capacity building; the original research ideas of 2000 involving traumatization and risk-taking were put on hold¹².

The Khmer cultural context for sexual behaviour and the actual practices in Siem Reap

Tarr & Aggleton (1999) had noted that within Khmer¹³ culture, the discourses of young men and young women regarding sexuality and the consequences of youthful sexual behaviour are strongly differentiated. According to Tarr and Aggleton (1999), premarital sex for young men is not only condoned, but encouraged: men at marriage are expected to be experienced, but young women must be virgins. Trips to local sex workers-- both brothel-based and entertainment-industry indirect sex-workers-- frequently occur as a social activity, and as such may be seen as part of a peer socializing activity. According to Wu and Grossman (2001), this pattern creates the opportunity for substantial epidemic among sex workers and their male clients. It is with the sex workers that the young men are to “experiment” and try different positions and techniques. By contrast, female exploration of their sexuality is taboo. (Tarr & Aggleton,

¹¹ It was believed that the third group, the Direct Sex Workers were already being targeted by NGOs such as Médecins sans Frontières and the Rose Centre, and the government had been planning by 2001 to expand to Siem Reap a successful pilot project for 100% condom use completed among brothel workers at Sihanoukville in 2000 (World Health Organization, 2001).

¹² About 35 persons attended the annual NGO meeting in May, 2002, and application has now been made for formal legal status as a local NGO –SiRCHESI- the Siem Reap Citizens for Health, Educational and Social Issues, with their website at www.angkorwatngo.com and www.siemreapngo.com .

¹³ While Kampuchea and Cambodia are the most recent names for the country, Khmer is an older term referring to the people of Cambodia, the language and the culture.

1999). Young women who lose their virginity are seen as being naive, and this may cast negative attention from the surrounding community onto the woman's family.¹⁴ According to social standards stemming from these conflictual expectations for men and women, indirect sex workers such as "beer promotion women" may be considered as unmarriageable and as outcasts within their community (McCourt, 2002).

Other cultural factors include the differential value placed upon the education of children by rural parents requiring their children's assistance in family farm labour, and obligations of eldest children to support impoverished families by sending home money from urban employment. The educational disparities thus created for young girls and women in turn permits fewer opportunities for education or occupational diversity; many women end up as direct or indirect sex workers. In our Siem Reap sample, McCourt (2002) reported that these women were often obliged to support their children as single mothers (40.3% of those responding in two samples) or filially obligated to send a portion of their wages back to support extended families (86.8%). They earned on average from \$85 to \$100 US monthly. By comparison, the official wages for both civil servants (teachers, doctors) and farmers is about \$20US per month.

The sexual tourists – estimated by one study (Straits Times, 2001) to number about 22% of all Cambodian tourists in 2000 – were visiting direct (brothel-based) and indirect (entertainment and restaurant industry) sex workers in Siem Reap, with inconsistent condom use. Our interviews had already revealed that local married and unmarried men were frequenting the same women with inconsistent condom use, and that condoms were even more rarely used subsequently with their stable partners and spouses. These local men with inconsistent condom use – husbands and boyfriends – served as a high-risk bridge for infections transferred from international tourists to local sex workers and hence to these men and their partners (For a discussion of bridging within epidemics, see WHO, 2001; Sopheab et al, 2001).

¹⁴Tarr and Aggleton (1999) reported that almost all of the young people they interviewed for their study regarded "*bombak muk muot kruasar*" (face of the family) and "*vong trorkaul poch ambou*" (taking care of the family reputation) within Cambodian culture as important status considerations.

National prevalence rates may not always be good indicators of the specifics of the local development of an epidemic¹⁵ For example, one United Nations report had suggested that "Despite recent statistics indicating a reduction in the rate of AIDS deaths in Cambodia", (Reuters, 2001) in 2000, " 2.8 percent of adults and 2.6 percent of pregnant women are infected with HIV."

However, statistics gathered during 2001 at the major urban health centre (Mondol Moi) in Siem Reap showed much higher rates of seropositivity among women (and men) than the national prevalence figures. In 2001 (for the first 10 months), women in Siem Reap were also at much higher risk (17.5 % overall, according to CDAG, 2001, but only 14.8% for women who were not sex-workers), and 11.3% for pregnant married women. The HSS (2001) survey of Siem Reap had already, for 2000, reported a rate of 8.7% prevalence for urban, Siem Reap pregnant women, but for two surveillance samples of men, only 3.9%. However, the CDAG (2001) data for 535 men showed a 23.2% overall seropositive rate for 2001. (About 67% of the CDAG sample for 2001 consists of married persons). About 16% (Sopheab et al., 2001) of urban men in Siem Reap had purchased sex during 2000. The traditional brothel-based direct sex-workers were 42.9% positive in 2001 (CDAG,2001) , although HSS (2001) had a seroprevalence rate of 28.7% for them. CDAG indicated a rate of 15.7% for beer promotion women and indirect sex workers, while HSS (2001) had 20.0%. . During the previous year, 19.4% of urban men throughout Cambodia had visited commercial sex workers but they reported using condoms only 72.7% of the time. In Siem Reap, 14.6% of local urban men visited sex-workers in the past year and had consistently used condoms only 61.4% of the time (Sopheab et al., 2001).¹⁶

¹⁵According to UNAIDS (2001), national averages are not meaningful in the context of the Southeastern Asian AIDS epidemic, as they do not take into consideration the uneven geographic spread of HIV. It is proposed that this is the case for two main reasons: firstly, epidemics begin as localized outbreaks before diffusing into the wider areas of the country; secondly, when the epidemic is concentrated within specific risk-groups, it is misleading to use prevalency in the general population as an indication of severity. For example, the rates of HIV infection among pregnant women are frequently used as an indicator of the prevalency in the entire population (UNAIDS, 2001).

¹⁶In 2002, for a small partial sample (N= 35, May-July, 2002) 14% of all indirect sex workers and 18.2% of the beer promotion women were seropositive. For the first 4 months of 2002, CDAG rates showed: Men overall, 20.9%, women overall, 17%; pregnant women, 15.6%, Indirect sex workers 10%, and Direct sex workers 33.3%

According to a recent behavioural survey conducted in Siem Reap during 2001 , Wong, et al (2002) found only 78% of direct sex workers interviewed (N=140) had used condoms 100% of the time with their clients; 20% used them with their boyfriends. These direct sex workers in fact differentially used condoms 50% -85% of the time with local and tourist clients, and this was significantly negatively correlated with their economic status.¹⁷ Married women (N=96) reported that only 8.7% had used a condom in their last sexual encounter; and only 3% of wives had consistently used condoms in the last week with their husbands.

A preliminary analysis of a small sample of 35 indirect sex workers (including 11 beer promotion women) surveyed in May-July, 2002, showed that 30 had answered about their paying partners and 17 answered about their non-paying partner: :

Condom use with paying partners in the usual week was ... indicated to be **everytime by 67%**, [**6.7% never**] while condom use with non-paying partners was most frequently indicated to be "never" ... by 58.8%, and only 5.9% reported using condoms everytime.....(McCourt , 2002, p. 38, **emphases added**)

Because of the bridging effect in epidemic transmission patterns, we first turned our attention to a sub-group of the "indirect sex workers" employed in the entertainment/hospitality industry at low wages , the "**beer promotion girls**" who sometimes agree to after-hours sex with tourists or with local clients who proposition them. Some of the clients are sexual tourists paying not to use condoms or to have sex with virgins; some are local married and single men who then return home and sleep with wives or stable partners. It was therefore decided to also target the **married women** in the community whose prevalence rates were dramatically increasing above the national average.

Those women who have been hired as exclusive, uniformed, promotional saleswomen for international brewing companies were often known locally as "beer girls", to both local men and women.¹⁸ Our ongoing discussions with them, as well as

¹⁷ The Sopheab et al., (2001) Behavioral Sentinel Survey also showed differences in condom use depending on combinations of marital status, location and urban/rural address. Nationwide, condom use with "sweethearts" was only about half the rate for commercial sex workers for urban males.

¹⁸ Chou Meng Tarr and Peter Aggleton (1999) described cultural attitudes toward excessive alcohol consumption by men as one of "glorification". Pressure is often put on the beer-selling women to drink (heavily) with their customers; this meant that they were often in an inebriated state should after-hours sex be agreed to, and this put them at increased risk for unprotected sex and transmission of HIV/AIDS. They are employed by Cambodian distributors for Tiger, ABC, Anchor, Singha, San Miguel, Budweiser,

with other community members and health providers had led to the decision to create cascading or pyramidal peer-training workshops.¹⁹ These would target two of the groups of women most at risk for HIV-AIDS through local bridging in Siem Reap.

Peer education workshop interventions in Cambodia: Can we culturally import and adapt successful techniques from elsewhere?

In light of the complex culturally-bound sexual practices and the socio-historical context in which the epidemic in Siem Reap has dramatically evolved, a culturally-appropriate intervention approach must be designed which addresses the individual, community and social aspects of the epidemic. Particular cross-cultural difficulties due to language barriers must also be taken into account, as we work with community members to develop an approach appropriate for these groups of women, respectful of their cultural beliefs and practices (Kral & Minore, 1999; Selby, 1999) and educational level (Asthanan & Oostvogels, 1996). Gail Pheterson (1995) also reminds us of the difficulties transporting research concepts and practices to other cultures, and the particularities of dealing with a community's sex workers, especially when stigmatised (Pheterson, 1989;1996), as the "beer promotion women" reported themselves to be. Of course, with each group of women, additional gender-based norms also prevail which must be considered. The widespread sexual double standard, discussed above, was encapsulated in her citation of a Cambodian proverb:

"A man is a diamond and a woman is a piece of cotton; when they fall in the mud, the diamond can be washed clean, but the cotton remains dirty" (Pheterson, 1996, p.11).

Early in 2002, a new government peer-educator program was begun in Siem Reap for the brothel-based sex workers, with 100% condom-use training, brothel owner

Heineken, Stella Artois, Labatt, Fosters, Beck, Leo, etc. For most, monthly wages are about US\$60, either from a \$2 daily salary to sell a beer quota (15-30 cases/month, each at \$36); more recently, some are offered a commission at \$3/case. Monthly income thus often was \$40 less than was needed to support their children and rural family members.

¹⁹ By 2001, the research team had expanded greatly, additional research questions were asked, new methods employed, partial funding was available, and planning, translating and fine-tuning of intervention strategies began (Lubek & Wong, 2001; in press). "Pyramidal" involvement is frequently used in commercial ventures such as selling Amway products, where sellers spread enthusiasm and diffuse products by recruiting and training further sellers and receiving a portion of the benefits of their "sub-contractors". It is also a form of progressive educational mentoring.

participation, and mandatory clinic health checkups.²⁰ A similar program was gearing up for beer promotion women. But in our 2001 interviews and focus groups, we had learned that both “beer promotion women ” and married women often lacked **concrete behavioural strategies** for obtaining 100% condom use from their men. And our questionnaire data , collected in 2001 and 2002 (Wong et al, 2002) examined the reasons for not using condoms; these in turn led to modifications in the educational materials. For the 140 Direct Sex Workers, for example, we found a pattern whereby **93% of these women knew** about the protective use of condoms against HIV/AIDS, and **90% then suggested to their male partners that they wear a condom**. But **only 57.8% were able to convince these men to use a condom**.

The bridging of HIV/AIDS in the community was intimately linked to the problem of the 15-20% of local Siem Reap men who were not monogamous and slept with both paid sex-workers and subsequently, their own stable partners. Wives reported they were not asking their husbands to use a condom because they “loved them” or “trusted them”; sex-workers were not using condoms because they “could not persuade their client” effectively (66.7%), or because they “loved “ (60.0%). or trusted” their boyfriend (Wong et al, 2002). Similar results may be seen for the beer promotion women .²¹

The technical, linguistic and cultural challenges of translation for an intervention: Guelph, Singapore, Sydney, and Siem Reap.

In the various stages of data gathering, analysis, creation of educational materials and intervention activities associated with this PAR there has been a constant stream of challenges jointly faced by the researchers, educators, technicians, practitioners and administrators on our team. Hovering over the whole team enterprise is the weak communication infrastructure. With phone-call and fax rates to and from Cambodia

²⁰One of the authors was escorted by a local health worker to a brothel to interview the 6 sex workers, 1 peer-educator and brothel owner. There was high awareness of the need for 100% condom use, even for oral sex. Condom-use refusal brought a call to the owner for assistance and his removal of the client. Our Khmer “behavioural strategies” audio cassette had been used in training here; we were asked for a cassette machine to permit replaying it for clients.

²¹ in a preliminary sample of 17 respondents (from 35 indirect sex workers and beer promotion women , May-July, 2002) these women explained why a condom was not used in the last sexual encounter: “Trust him” (41.1%) and “love him” (5.9%) together accounted for almost half the rationalizations for non-use; among other reasons given were that their “partner objected”(23.5%), she , “didn’t know how to persuade him” (11.8%) and “too much alcohol” (11.8%) . (McCourt, 2002).

among the highest in the world (for one of the 20 poorest countries in the world) it is a constant battle to keep communications open with a variety of colleagues in government agencies, NGOs, medical facilities, etc. E-mail addresses fluctuate; hotmail accounts go dormant if one could not afford an internet cafe. Against this background of difficult inter-communication, we add the extra research and intervention challenges of the recursive PAR perspective. Because the researcher-participant feedback loops are constantly active, on-the-spot method changes may be required.

A few illustrative examples are presented:

i) Converting the video on strategies for 100% condom use; then deciding not to use it, after all!

Mee Lian Wong and her associates (e.g., Wong et al , 1998a; Wong et al, 1999-2000) have over the years developed a series of effective health educational materials on condom use. We selected one videotape for the Siem Reap project, in which Singapore brothel-based sex workers used successful persuasion techniques to convince their resistant male clients to always use a condom for vaginal sex; if not, alternatives offered might be a massage for a lower price, or no transaction at all. Almost all the traditional reasons why men don't want to use condoms are voiced and then countered with effective, over-arching justifications for condom use, including appeals to family values and family health, keeping face in the Asian business and family community contexts, etc. The version was on VHS videotape, in the PAL standard for television.²²

²² This is common in parts of Europe, the UK , Asia, and Australia. For use in North America or Japan, a conversion to the NTSC format is necessary; for use in France, Russia, some African and South American countries, a SECAM system conversion would be necessary. What standard of video-playback equipment could we expect to find in Siem Reap? (Such equipment is often donated by international NGOs). To be sure, we took along to Siem Reap several PAL versions of the videotape, and one NTSC converted copy. PAL editing on the master tape done in Singapore could not be easily modified by technical staff at Guelph. A compatible, digitized MPEG CD-ROM version was then prepared for any emergency editing needs. As for any future DVD productions, commercial DVDs currently have both system differences –PAL-NTSC– as well as regional/zone differences --1-6 -- creating incompatibilities in playback on many region-specific DVD players and on almost all computers and laptops which are region specific. For the moment, all field interviews recorded on NTSC mini-DVD have only been copied to NTSC VHS tapes and/or audio tapes, creating potential limitations in sharing these materials.

In consultation with Khmer team-members, it was decided to transform the video-tape culturally and linguistically for use in Siem Reap. The English subtitles were changed to better fit the specific Khmer brothel situation as well as local Siem Reap cultural and behavioural patterns of sexual activities leading to HIV and STI transmission. One interchange between an older man and a woman was re-scripted as a Siem Reap husband-wife interchange; another between a beer-promotion woman and a boyfriend. Details as to whether “money was paid up front” caused other changes. The Chinese soundtrack and a few short panels with Chinese writing were replaced with appropriate Khmer formulations. However, Khmer discourse is usually longer than Chinese or English, so the video sequences were not completely in synchronization with the audio track, unless further expensive editing could be done to prolong video sequences. Time and financial constraints led to the following compromise: The final Khmer soundtrack was recorded in Singapore on audio-cassette; it could be played separately on a Walkman while the video was shown on a VCR and TV monitor, with the Chinese soundtrack turned off. Synchronization was only approximate.

In February, 2001, NGOs were shown the video-tape and were able to follow the English subtitles; several requested copies of the final version of the tape. However, beer promotion women in Siem Reap who saw the same videotape during two focus groups (N=15) paid very little attention to the images on the TV monitor. When we solicited feedback on this apparent inattentiveness to the video, we learned that the participants in fact preferred another medium of health education: the audio-recording. For many of them, coming from rural families and non-electrified homes, watching TV and/or using TV as a medium of instruction were unfamiliar activities. Only 2 of the 15 women could read, and seeing the subtitles – in English– appear on the screen was also discouraging. So they appeared neither attentive nor enthusiastic about learning about condom use from a video that had proven to be quite successful elsewhere as a health education medium. On the other hand, they had paid close attention to the Khmer soundtrack emanating from the walkman on the table! They reacted “knowingly” to sequences which reminded them of familiar clients or boyfriends. At the end of our focus groups, they asked if they could have copies of the tape to take home– they had Walkmen and they could play selected scenarios to their men. The research staff quickly huddled, found that we could get 100 copies made locally during lunch-time, and

this was the beginning of our program of mass-distribution of audio-cassettes in Siem Reap. Based upon suggestions in 2001, the audiotapes were further modified, with “announcer” sequences added in Australia by members of the Khmer Community, Inc. of New South Wales. These audio-tapes, which are being freely copied in Siem Reap, have become a core feature in the peer-education training workshops of 2002. For the moment, the video version remains on the back-burner.

ii) Redrawing and translating the peer-training manuals and cartoon booklets

Wong et al.'s (1998a) materials for giving strategies to women for convincing men to use condoms included a cartoon booklet as well as a more detailed training manual for peer-educators. These were translated into Khmer in 2001 and 2002, respectively with the help of many hands in Sydney, Siem Reap and Singapore. The various iterations of the cartoon booklet can be described. The original was published by Wong and her associates in English and then in other languages. After discussions with Khmer colleagues, this was then redrawn with familiar Khmer figures and backgrounds by French artist Bab Rethba of Paris. Computer files with JPEG images were sent back and forth between Paris, Singapore and Siem Reap.²³ The dialogue “balloons” were then carefully handwritten by team members in Singapore and in Siem Reap. We then switched to a low-tech solution to finalize the booklets in Siem Reap; occasionally the editing consisted of actually cutting and pasting revised dialogue elements onto a master copy. Although a colour cover had been designed, the cost of using simple black and white photocopying meant each booklet could be reproduced locally for less than \$0.60, of which about half was for a protective, transparent plastic covering .

As we worked through each page during focus groups with the beer promotion women in February, 2001, their suggestions were entered immediately by team members onto a copy of the booklet. Occasionally a small discussion would evolve over key questions:

²³: At one point, several pages were lost in the transfer to the Grand Hotel d'Angkor which had volunteered its internet services . Computers, we learned, which do not regularly flush their internet caches may experience trouble with an email message to which are attached 4 or 5 very large image files. Similarly, many “hotmail” or “yahoo” accounts have limited mailbox space: a few jpegs or one long text can completely fill a mailbox and cease further mail reception.

- i) Should we call the married woman the “next door neighbour” or “auntie”, meaning an older woman who looks after the welfare of younger women?
- ii) Is it better to say “sleep with” rather than to “have sex with”?
- iii) Is there one term which means “male partner” and which includes husband, boyfriend, occasional partner, tourist or local client...?
- iv) No mention of an amount of money should be made beforehand with the client.

During lunch time, we hurriedly used “whiteout” and then re-wrote dialogue, when necessary, with ink. Photocopies of the modified booklet were then collated for the afternoon focus group. Similarly, additional changes were then also incorporated from the afternoon participants, and after further consultations with other medical and NGO persons, the text and images found a stable form.

In 2002, slight changes were made to the cover. Our focus groups had pointed out that the boat did not look like a local fishing boat they knew, the metaphor of wearing “rubber life- vests” in a boat afloat among the dangers of HIV/AIDS and STIs (and, by analogy, condoms in an HIV/AIDS epidemic) was not understood. “Life-jackets” were not a common cultural item. Instead, condom-use tee-shirts were then substituted on the cover by a local Siem Reap graphics house, the boat reshaped and an oar added, and water-lilies were added to the water area in front of the Angkor Wat temples. [See Fig.1]

iii) Workshops are live: You may have to improvise.

In May, 2002, welcomed by the Salina Hotel, the authors initiated the one-and-a-half-day peer-educator training workshops. The first was for about 35 “married women” a second for 35 beer promotion women and indirect sex workers; we also presented a shortened half-day overview of the workshop to about 25 representatives of NGOs, medical establishments, government agencies, etc. We planned a series of “hands-on” activities, such as demonstration exercises to teach placing condoms on wooden model penises. We also used graphic flip-charts to teach about HIV/AIDS and sexually transmitted diseases. These materials had been supplied by the Provincial Health Department, the Provincial AIDS office and NCHADS. We built training modules around the condom-use strategies of the audio cassettes and the cartoon booklets. We used role-playing sessions to encourage active participation from the sex workers and married

women, and to facilitate the appearance and discussion of “local solutions” to condom resistance from their ‘men’. Occasionally, the men team members were asked to leave the room so that discussions of some issues could be more comfortably treated. Small group discussions were held to encourage women to talk about their problems related to condom use and to suggest solutions to them. For example, they were encouraged to solicit group answers to questions such as : “Why do the Siem Reap men not stay home at night with their families?” They then could suggest solutions to the problems they had themselves identified and discussed.

Although aware of the cultural norms and trying to remain sensitive, team members did decide that it was important to “push the envelope” if important changes in behaviour were to be made in the face of the deadly HIV/AIDS epidemic.

a) **Take this box of condoms home.** At 5 minutes before the end of the first day’s workshop for married women, one of the authors was still trying to make a point about transforming “knowledge” about why condoms should be worn into consistent condom use. Unplanned, the speaker suddenly held up a large box of Number One condoms and challenged the married women. “ Let’s try an experiment tonight. Take home one of these boxes of condoms I’ll give you. Show them to your husband. Tell him you’ve learned a lot about sexually transmitted diseases and HIV/AIDS and that this is a sure way to prevent transmission. Suggest you try using one tonight. Report back to us tomorrow morning what happens”.

The next morning we learned that about 25% of the women found their husbands immediately in agreement about using a condom. About 33% were unsuccessful and found strong resistance and even threats from their men. For the other women, discussion brought out a number of points, not all of which had been previously known to the team members. To cite just one example, for a certain number of traditional women, there was an interdiction to touch their husband’s genitals; therefore putting a condom on him, e.g., when he was drunk, went against strong cultural beliefs. This led to workshop discussions about whether the men might therefore be seeking such

intimate contact with paid sex-workers.²⁴ Future workshops and teaching materials may need some revision to better address this issue.

b) Bring beer promotion women together with married wives

In Siem Reap, the beer promotion women and the married women see themselves as groups apart,²⁵ primarily because of the wives' fear that they will lose their husbands to these younger women. In view of this, we held separate workshops for the two groups. However, we realized that at the community level, it was important to bring them together to address the problems they faced in common. In our training materials (e.g., the comic book) we deliberately stressed that they shared many of the same concerns and because of the bridging behaviour of the Siem Reap men, they were both implicated in the HIV/AIDS epidemic's transmission pattern.

During the last half-day of the "married woman's" workshop, we brought three articulate beer promotion women to talk to the married women and to demystify stereotypes.²⁶ Finally, one woman confessed she hadn't known which group to train with— until a month earlier, she had been happily married with children. When her husband suddenly left her for a younger woman, and with no financial support, the only job family friends could find her was as a beer promotion woman. So she was addressing the women from a dual perspective: 8 years as a wife; 1 month as a beer girl. And the married women were queried about how they might handle such a sudden and dramatic change in status.

²⁴ Discussions about how sex-practices changed dramatically in the 1960s in North America, and in the 1990s in Singapore alerted these women to the fact that often there could be a transfer of sexual practices from one group to another, as when "Self Help" books offered North American wives "new erotic techniques", formerly reserved for sex-workers.

²⁵ Nonetheless, at the Mondol Moi Health Centre, married women go into a front building (Family Health), while the "beer promotion women" go to the rear, to the STI clinic. (In fact, the testing equipment for both groups is in the middle)

²⁶ Some beer promotion women actually had no sex with men, but might spend time talking them through "family problems". They resented the stigma they bore in the community, when there were so few jobs open for unschooled women. Forty per cent of them supported their own children and almost 90% other family members.

c) Will you wear this Tee-Shirt in Siem Reap?

All the beer promotion women and married women who went through the training programs received a peer-educator tee-shirt and kit bag²⁷, with a peer-educator training manual, a supply of cartoon booklets, a diary, audio-cassettes, and a certificate of training, signed by all the staff. They would share the Walkman's which the supervisors lent out for training sessions.

On the back of the tee-shirt was a provocative image of a woman holding a condom worn on an upright penis. The image had first started as a poster in Singapore urging 100% condom use for oral sex. Wong et al (1999-2000) describe the evolution of this poster, PAR-fashion, as it changed according to input from the sex-workers about the sort of clear message they wanted projected. After discussions about the infrequent occurrence of oral sex in Cambodia, a Khmer translation was produced in Australia which changed the slogan to: 100% condom use for all sex. In Siem Reap, Khmer women colleagues noted that the condom was too close to the mouth and face of the woman; they asked that the woman still be pictured "in charge" and holding the sheathed penis, but that it be upright and away from the face. Once the changes were made, they asked for this to be put on the back of the "peer-educator" tee-shirt, for public display in the community. This one image has migrated across cultures and has been successively modified to meet both local sensitivities, first in Singapore and then again in Siem Reap, and to express the autonomous ideas of the women concerned. It now conveys a strong, dramatic, and vital message to the Siem Reap community about using condoms to protect against sexually transmitted infections and HIV/AIDS.

[Fig. 2]

In July, 2002, a followup was conducted with some of the workshop participants. Of seven beer promotion women interviewed in their workplaces about their post-workshop experiences, one was actually wearing her tee-shirt in the restaurant, instead of her company's uniform! She got into conversations about safe sex with her male clients in the restaurant. Another explained how she wore it on her day-job as a construction worker; at lunch time, when she received questions about the shirt, she

²⁷ Original materials donated by a corporate sponsor, Nike; additional graphics were printed in Siem Reap. Women also received, in appreciation of their time commitment, donated cosmetic kits from Shiseido or Kimarie,

lectured the men on safe sex. A third had lectured relatives at her home and a neighbour asked if he too could learn about HIV/AIDS.

Here was another PAR shift in the evolving intervention: although we had originally designed this portion of the educational campaign to involve women teaching other women, some of our first cohort of peer-educators indicated that they found it easy to also give lessons to men— that men wanted to know also about the dangers of HIV/AIDS in their community.

NGO's and Collaborative Health Promotion: Maximizing the impact.

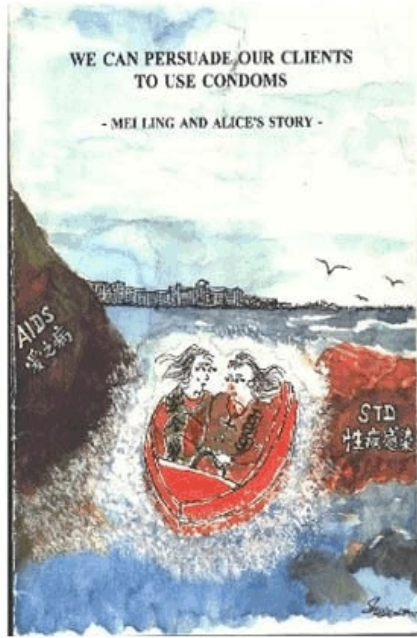
Our PAR project has evolved concomitantly with the development of SiRCHESI²⁸ a local “grass-roots” (Wittig, 1996) NGO concerned with health, education and the inter-linked socio-economic issues of the fast-expanding town of Siem Reap. In addition, we overlap with, and co-operate with, representatives from other concerned organizations and agencies, whether government departments or NGOs . Some of the larger, well-established NGOs, perhaps due to a specific project focus, head-office perspective, competition for personnel, and the transitory nature of their staff, may be less able to spontaneously adjust their HIV/AIDS prevention work to the local Siem Reap conditions. However, working with a local NGO which takes a flexible PAR approach to HIV/AIDS prevention gives greater methodological flexibility and permits added opportunities for collaborative programs. We are thus able to work with local government departments and agencies in a transparent capacity-building fashion, sharing and transferring materials and technical know-how as appropriate, running training workshops and evaluative follow-ups, etc.

But for its long-term success in having a positive effect in reducing the HIV/AIDS epidemic in Siem Reap, this NGO and the interventions it initiates must develop a self-sustainable status within the community. Part of this will involve convincing the local industries (hotel, tourism) as well as the international corporations (e.g. beer companies) now operating profitably in Siem Reap to actively support and participate in community health promotion projects. In addition, for the long-run, they may consider ways to

²⁸ The Siem Reap Citizens for Health, Educational and Social Issues has brought together citizens, medical personnel and business community representatives to focus on HIV/AIDS and other community problems..

arrange additional workplace health campaigns and career-mobilizing educational upgrading so as to provide a wider range of safer employment opportunities for the women of Siem Reap. In the meantime, we will collectively continue to educate women (and men) about reducing their risk of HIV/AIDS, and encourage them to involve others in a spreading, community outreach. We will continue to evaluate the effectiveness of the project in increasing condom use among currently targeted groups of sex workers and married women, and then expand to other groups, and perhaps other locations.

Fig.1: Transformations of "cartoon" booklet between Singapore and Siem Reap



សេរី ចង់ អាន បទពិសោធន៍ របស់ អ្នក ដទៃ ដើម្បី ទទួល បាន ជោគជ័យ ក្នុង ការ ប្រយុទ្ធនឹង ជំងឺ អេដស៍ និង ជំងឺ ផ្លូវ ភេទ ផ្សេងៗ ទៀត
(អង្គការ អេសស៊ី)



អង្គការ អេសស៊ី ភីអិលស៊ី
 មជ្ឈមណ្ឌល ក្នុង ការ ប្រយុទ្ធនឹង ជំងឺ អេដស៍ និង ជំងឺ ផ្លូវ ភេទ ផ្សេងៗ ទៀត
 Siem Reap Citizens for Health, Educational, and Social Issues
 Citoyennetés de Siem Reap pour la Santé, l'Éducation, et Les Questions Sociales

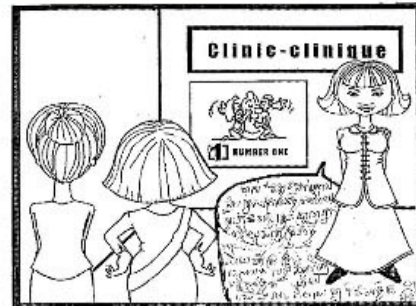


Fig.2. Poster transformations: Singapore->Sydney->Siem Reap ->peer-educator t-shirt, worn at work in the beer restaurant, and by staff at Angkor Wat tourist site.



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