

Ian Lubek, Helen Lee, Sarath Kros, Mee Lian Wong, Tiny Van Merode, James Liu, Tim McCreanor, Roel Idema and [Catherine Campbell](#)

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HIV/AIDS, BEERSELLERS AND CRITICAL COMMUNITY HEALTH PSYCHOLOGY IN CAMBODIA: A CASE STUDY

Lubek, Ian, University of Guelph, Canada .

Lee, Helen A. N., Staffordshire University, UK.

Kros, Sarath, Siem Reap Provincial Health Department, Cambodia.

Wong, Mee Lian, National University of Singapore, Singapore.

Van Merode, Tiny, University of Maastricht, Netherlands, and private practice, MD .

Liu, James, Victoria University of Wellington, Aotearoa, New Zealand.

McCreanor, Tim, Massey University, Auckland, Aotearoa, New Zealand.

Idema, Roel, Independent scholar, Maastricht, Netherlands

Campbell, Catherine, London School of Economics, UK.

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Abstract

This case study illustrates a participatory framework for confronting critical community health issues using “grass-roots” research-guided community-defined interventions. Ongoing work in Cambodia has imported research, theory and practice into the community of Siem Reap, culturally adapting them for particular, local health-promotion responses to HIV/AIDS, alcohol abuse and other challenges. For developing countries such as Cambodia, we recycle such “older” concepts as “empowerment” and “action research”. Community health psychology, confronted with “critical”, life-and-death issues, can adjust its research and practices to local ontological and epistemological urgencies of trauma, morbidity and mortality, when death has become the dependent variable.

INTRODUCTION

While other articles in this issue resonate to the call for “new ideas” in critical community psychology (Campbell & Cornish, this volume), the present paper champions “old ideas”, recycling concepts and strategies which can be effective in resource-challenged countries like Cambodia. During the previous half-century, progress was made in wealthier countries to reduce socio-

economic and health inequities and provide safety-nets and/or universal public health services. In still-developing countries, gender inequity, life below the “poverty level”, illiteracy, unemployment and epidemics will all require broad strategies for personal and community changes (Farmer,1999). This case study describes health promotion practices for marginalised groups facing a critical challenge--the HIV/AIDS pandemic’s sudden local arrival and onslaught, using trusted concepts such as “empowerment” and participatory “action research” (PAR) (Lewin, 1946,1947; Chataway, 1997) and “grass-roots” community participation (Lubek et al, 2002; Campbell et al, 2010).

BACKGROUND OF PROJECT

In 2000, Cambodia had the highest HIV rates in Southeast Asia, and Siem Reap’s prevalence rates made it an epicenter, with 42% of brothel-based sex workers and 20% of women beersellers HIV+ (NCHADS, 2004). SiRCHESI NGO was formed after the first author, a social psychologist, learned of the community’s vulnerable health situation, as an “accidental tourist” in 1999 (Lubek et al, 2002). Lubek, was asked to return and use his training as a “professor” to combat HIV/AIDS. He conducted a community needs assessment to investigate patterns of community transmission and determinants of sexual health. He gathered in-depth interviews guided by Lewin’s “Action Research” framework and PAR. Both advocated community immersion, continuous bi-directional feedback-loops between researchers and participants, and cross-cultural sensitivity (Liu, Ng, Gastardo-Conaco & Wong, 2008; Kerr et al, 2010). Lubek fed back to interviewees their rank-ordered, crucial concerns - HIV/AIDS, gendered educational inequalities, and poverty’s impacts on social conditions. At this meeting, an NGO, **Siem Reap Citizens for Health, Educational and Social Issues (SiRCHESI)** was formed and local stakeholders agreed to work together to educate their community members

about HIV/AIDS, though they lacked training and resources for this. Consequently, Lubek assisted with fundraising, training in health education and networking, contacting Cambodian health agencies and ministries, NGOs, and HIV/AIDS foundations, and sought international health researchers' collaboration. The latter suggested "tried-and-true" "best practices" to import into this community context. Lubek was first joined by Mee Lian Wong, who culturally re-adapted her "action research" approach and materials (Wong, 1990; Wong et al, 1998) to the Cambodian epidemic.

PROJECT ETHOS

The project's ethos and basic principles are organized around an 'empowerment via participation' framework. The project is run by community stakeholders, including health workers/educators, tour guides, entertainment workers, supported by international advisors. Day-to-day operations of 6 part-time staff and 23 community outreach peer-educators are discussed at staff meetings; goals and new directions emanate from the NGO's Annual Meetings (www.angkorwatngo.com). These followed a 1-2 day community contextualization "conference" (2001-05), bringing together all NGOs and agencies to summarize community progress against HIV/AIDS. Following the "state of the community" conference --later incorporated into the public health program-- SiRCHESI's annual stakeholders' meeting reviewed progress and discussed next year's activities and/or additional risk groups to address. Alongside PAR, a guiding principle has been an evolution through community dialogue where all participants are regarded as equals (Freire, 1970,; Vaughan, 2010).

The project constantly conducts research, so that program decisions can be informed by evidence/evaluations. In contrast to international development

projects, with proposals designed by external consultants in distant offices (Campbell, 2003), SiRCHESI's development has been organic and 'bottom up' in nature, and framed by improvisation in context rather than external blueprints (Eyben, 2009). The program seeks not only to promote behaviour change, but also to create social environments that support and enable it (Campbell et al, 2010), including its "hybrid model of capacity building" for local health services (Lubek et al, 2002). Its overarching goal is to increase vulnerable citizens' sense of empowerment and agency over their own lives. People with positive experience in controlling life changes may also be likely to take control over their own health (Wallerstein, 1992). SiRCHESI's original goals to alleviate inequities of health, education, gender and socio-economic level are all interconnected in this community, as elsewhere (Farmer, 1999).

PROJECT STRATEGIES

Building knowledge and critical consciousness through peer education

By 2003, monogamous married women and their non-monogamous husbands had replaced sex workers as the highest risk groups in Siem Reap, as HIV raced through the community, "bridging" among tourists, sex workers, husbands and their wives (NCHADS, 2004). In 2002, SiRCHESI trained a team of 23 peer educators, who continue educating increasing numbers of village men and women and entertainment workers in restaurants (Lubek et al., in press).

"Empowering" women to change their lives: career alternatives

Lee et al (2010) describe the "toxic workplaces" of beersellers and hostesses, linked to HIV risk, harmful/hazardous nightly alcohol use, sexual coercion, and violence. Their employers' unwillingness to provide "living wages" forces many to sell sex for economic survival. In order for women to escape these health

risks and to act on new sexual and health information, SiRCHESI's Hotel Apprenticeship Program (HAP) was designed to provide safer, healthier work environments, long-term career-path alternatives, and living wages for 26 beersellers (2006-8). HAP provided a literacy-training school and partnered with 9 hotels offering on-the-job mentoring. Empowered by HAP, all but two married, and all but four now also raise children. SiRCHESI monitors, through thrice-yearly interviews, the health, and socio-economic progress of this emancipated group. (SiRCHESI is considering their recent requests for a self-run, day-care centre).

Challenging negative social, community and global structures

Given that employment practices of international beer companies are a key driver of women's health risks (Lubek et al , in press; Lubek 2005), the NGO lobbied beer companies annually since 2002, with documents, emails, websites, and personal presentations, informing them of negative, local health consequences of their practices in Cambodia, while advocating economically secure, and safer, working conditions for beersellers (see www.fairtradebeer.com; www.beergirls.org).

In 2006, three co-authors joined the Provincial Health Director, taking their arguments to the medical journal, *The Lancet* (van Merode et al, 2006). Heineken scientists (van der Borgh et al, 2006) advocated emulation of their corporate strategy of free HAART-provision to African brewery workers; *The Lancet* (Editorial, 2006) supported this. SiRCHESI, concerned that the reality -- no HAART for women workers—justified clarification, published a rejoinder about “gender discrimination” in Africa and Cambodia (van Merode et al, 2006).

Dissemination of lessons learned in Cambodian health settings

SiRCHESI's local staff, international advisors, students and interns, spend much of their time "on the ground" in the community, with delivery of health education programs and related data-collection. Some findings appear in academic publications across several disciplines (Wong et al, 2003; van Merode et al, 2006; Lubek et al, in press). Many SiRCHESI team members have co-produced conference presentations, presented seminars or colloquia in community/public health programs, and the project is sometimes cited as a model case study (Campbell and Cornish, this volume; Liu & Ng, 2007; Marks et al, 2011; Stephens, 2011). Scientific journals have publication lags and this must be weighed about the urgency of knowing how the epidemic is progressing, month-to-month. In reporting the community's latest "state of health" from our longitudinal monitoring surveys and evaluating the impact of interventions, SiRCHESI often forgoes the pathway of academic, peer-reviewed, high-impact journal reports, and instead produces timely feedback to the community stakeholders, putting its latest data into the public domain through annual meetings, newsletters, websites, and "press releases", with backup statistical materials (Green & Lubek, 2010; www.fairtradebeer.com). Perhaps community health psychology should be more about the progress of the community's health rather than researcher-practitioners own career health.

STILL MORE CHALLENGES

Response from beer-sellers' global employers: Despite provision of reliable, annual data about health risks and impacts of their marketing

practices, international beer companies prove “recalcitrant” in acting on reasonable suggestions for workplace health and safety for their beer-sellers in Cambodia (Lubek, 2005). Rather than taking strong corrective actions at little cost, these companies turned to their departments of Public Relations, adept at handling “academic” claims. While the industry did create a professional association and provided a Code of Conduct in 2006, data in 2012 again show little progress (Ennis et al, in progress; Lubek et al, in press; SOMO, 2012; www.bsicambodia.com).

Shifting face of risk groups: In 2002, SiRCHESI targeted beersellers and married women as groups requiring peer-educator health-promotion outreach, and in 2003, after stakeholder discussion at its annual meetings, SiRCHESI added workshops and outreach for men, and the child souvenir vendors, exploited by touring sexual predators. Currently about 80% of outreach is to married men and women in villages; in 2012, more than 12,000 peer-educator health-promotion contacts will be completed. Government statistics saw Siem Reap’s HIV prevalence rates for sex workers drop from 42% in 2001 (NCHADS, 2004) to zero in 2008. However, anti-trafficking legislation outlawed sex-work in 2009, so this risk group disappeared underground, invisible to government HIV/AIDS surveillance or SiRCHESI’s community monitoring (Wong et al, 2003;Lubek et al, in press).

SiRCHESI’s staff, working at “grass-roots” level, identified a new community health/safety risk group. Health risk groups are often identified “top down” by international agencies defining world-wide risk categories (NCHADS, 2004; Campbell, 2003). While breathalizing beersellers in their workplaces. SiRCHESI discovered that most male drinkers drive home and that vehicle

crashes accounted for 20% of hospital beds. Perhaps SiRCHESI will study drink-driving. (Lubek et al, in press). In addition, SiRCHESI has identified: i) the need for continuous, on-going community prevention campaigns as new cohorts of teenagers become sexually active; ii) “AIDS” orphans who may need HAART; iii) the trafficking of urban street children “begging” from tourists; and iv) endemic tropical diseases with high morbidity and mortality rates.

DRIVERS OF SUCCESS

SiRCHESI remains optimistic about accomplishing its goals, expanding its work on HIV/AIDS and alcohol overuse, teach these prevention skills to others (including interns),, while looking for emerging community challenges requiring joint NGO-public health cooperation. The project harnessed expertise of external change agents, and built local skills capacity, without violating the community’s sensitivities and priorities, nor pirating staff away from public health. (Lubek et al, 2002) The “bottom up” participatory emphasis on all project activities is a result of a constant dialogue and negotiation between SiRCHESI staff, volunteers, interns, community stakeholders and international advisors. The project is relatively free to be guided by community directions, with no over-dependence on prescriptive funders. The PAR framework for health research and promotion permits a “bottom up”, or “grassroots”, organic improvisational approach. After absorbing research and practice skills from visiting academics, students and interns, SiRCHESI has also switched into “health-training” mode, mentoring up to 12 health interns each year.

Sustaining SiRCHESE's program after 13 years of successes .

The programs run on a shoestring budget, after initial startup grants ended in 2009 from Elton John AIDS Foundation and M.A.C. (Cosmetics) AIDS Fund. Community “business partners” could not take over local programs such as the HAP, while global corporations extract profits from Cambodia for their shareholders, contributing little to local health, educational and economic infrastructure, and not paying “living wages”. SiRCHESE's programs are supported by student fundraising, personal donations (www.fairtradebeer.com), selling fair-trade items, and 17-day internships in community participation.

(<http://www.fairtradebeer.com/miscdocs/brochure2013.pdf>)

CONCLUSION

SiRCHESE's “grass-roots” participatory version of critical community health interventions contrasts with “drop-down” programs from international organizations, using multi-year, multi-country programs and standardised models/methodologies. SiRCHESE remains “old fashioned” and prefers “problems” to be community-defined, and “best practice” solutions need not be leading-edge Western methodologies. Rather, best practices should be culturally-sensitized, build local capacity, and be pragmatically effective in solving critical issues in the developing world (Kirkwood, 2009). Concepts such as “empowerment” and “action research” work well in a developing community, where, seemingly long-settled issues-- gender inequity, commodification/objectification of women beersellers, illiteracy, sexual coercion, living wages—still require responses. The Cambodia study suggests that the term “critical” take on a graver meaning than “critique of mainstream practices”, one closer to medicine's patient category of “in

critical condition”; critical community health psychology might be less about qualitative or quantitative research on the benefits of sugar-free gum, and more about measuring decreases in the rates of life-threatening illnesses, where death becomes the researchers’ dependent variable (Lubek, Liu, Stam & Radtke,2009) .

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Authors:

Lubek, Ian, PhD, Professor (Adjunct), Psychology Dept., University of Guelph, Canada; and International Advisor, SiRCHESI NGO, Cambodia.

CONTACT: ilubek@uoguelph.ca

Lee, Helen A. N., PhD, Senior Lecturer, Department of Psychology and Mental Health, Staffordshire University, UK.

Dr. Kros, Sarath, MD, MSc Director, Siem Reap Provincial Health Department, Cambodia.

Wong, Mee Lian, MBBS, MPH, MD, Associate Professor, Saw Swee Hock School of Public Health, National University of Singapore.

Van Merode, Tiny, MD, PhD, Assistant Professor, Department of General Practice, University of Maastricht, Netherlands; and General MD Practitioner, Private Practice.

Liu, James, PhD. Centre for Applied Cross Cultural Research, School of Psychology, Victoria, University of Wellington, Aotearoa. New Zealand.

McCreanor, Tim, PhD, SHORE & Whariki Research Group, Massey University, Auckland, Aotearoa. New Zealand.

Idema, Roel, MA/Drs, Independent scholar, Maastricht, Netherlands.

Campbell, Catherine, PhD, Health, Community and Development Program, London School of Economics, UK.

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