

Bridges of Hope Socioeconomic Reintegration Project

Report of a Follow-Up Survey
with Clients Living with HIV and AIDS



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Cover photo:

Khaet is the man in the middle of the photo wearing a pink shirt. Leang, his wife, is on the far right wearing a yellow blouse. Khaet and Leang are both living with HIV. Leang lost two of her three children but her son (not pictured here) is now doing well in school. Leang and Khaet were bridged off of Maryknoll support in February 2006. They were welcomed back to this rural Saang community by their neighbors pictured here. Bridges of Hope provided a small grant to the couple, part of which went to building a small house. Leang is now doing embroidery work and Khaet is working as a moto taxi driver.

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We would also like to salute those who were involved with the survey process. Natalie-Kruse Levy, CRS HIV and AIDS Regional Technical Advisor, provided outstanding overall assistance and technical support for the survey design, administration, and analysis processes. Shannon Senefeld provided critical technical assistance for questionnaire development, application of the quality of life index, and data analysis. Aum Sitha offered pivotal assistance in facilitating the questionnaire translation, the training of interviewers, as well as supervision of the data collection, data entry, and analysis. Michelle Lang-Alli gave us invaluable technical assistance for the nutrition component. Arturo Ang is not only the Coordinator of Bridges of Hope, but he is also its heart and soul. His enthusiasm and dedication are contagious, for which we are all so grateful. We also salute all the staff members of Seedling of Hope and Bridges of Hope who went beyond the call of duty. They provided dedicated and much appreciated service to our interviewers and clients. We also thank our client interviewers for their outstanding service, concern and attentiveness, which our clients so appreciated.

Lastly, we thank our clients, who continue to teach us. It's our goal to serve our clients better and we hope that the results of this survey will assist us to do so.

Submitted on behalf of all the staff members of the Seedling of Hope Project and its Bridges of Hope Component:

Edward J. McGovern
Project Manager
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List of Acronyms and Abbreviations

AIDS	Acquired immune deficiency syndrome
ART	Anti-retroviral therapy
Bridges	Bridges of Hope
CAFOD	Catholic Agency for Overseas Development
CPN+	Cambodian Network of People Living with HIV and AIDS
CRS	Catholic Relief Services
HIV	Human immune-deficiency virus
MMM	Friends helping friends
NCHADS	National Center for HIV and AIDS, Dermatology STDs
NGO	Non-governmental organization
OI	Opportunistic infection(s)
OVC	Orphans and other children made vulnerable by HIV and AIDS
PHA	People living with HIV and AIDS
RGC	Royal Government of Cambodia
SoH	Seedling of Hope
TB	Tuberculosis
USAID	United States Agency for International Development

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Summary

Maryknoll started the Bridges of Hope project in 2004 with the purpose of assisting people living with HIV and AIDS who had been marginalized due to illness to socially and economically reintegrate into society after regaining their health on anti-retroviral therapy. Bridges provides group and family counseling, basic training for managing a small business, apprenticeships, job placements, vocational training, small grants, health education, reconciliation with estranged families and other services required for clients to transition from being dependent upon project assistance to supporting themselves. With a view to improve the services provided by the Bridges project, a follow-up survey was carried out in October-November 2006 to understand how bridged clients were medically, economically and socially faring after returning to unassisted living. No existing baseline data was available for the surveyed clients. Bridged clients were administered surveys that collected data on basic demographics, household economics, health and nutrition, family support and social inclusion, quality of life and program recommendations. Key findings are presented below.

Household economic situation. On the whole, the household economic situation of the clients who participated in the follow-up survey was reasonable. The vast majority of clients were economically active and involved in a wide range of income-generating activities. Many more clients had engaged in activities indicative of improved economic status than activities which may indicate failure in the household's economy. A sizeable proportion started saving money, and almost all clients reported having enough money to buy food for the household and drinking water from a safe source. A substantial proportion of clients reported changing occupations—mostly due to financial reasons—from the time their Maryknoll assistance ended to the present day. Changing occupations was associated with lower quality of life scores. A considerable number of respondents reported being discriminated against because of their HIV status

Health situation. Nearly one quarter of bridged clients reported stopping their ART during the three months prior to the survey and having a treatment supporter was not found to be associated with overall adherence. Taking medication late and missing doses were both significantly correlated with declining quality of life scores. Respondents who stopped taking medication during the previous three months were more likely to report experiencing a number of health problems. There was a significant relationship between cost of treatment and poor adherence in the surveyed population. Bridged clients reported experiencing a number of health problems and symptoms associated with HIV and AIDS and ART. Most clients reported consuming a good variety of foods with adequate frequency. However weight loss and symptoms which could contribute to impaired nutritional status were also reported by a number of respondents.

Family support and social inclusion. In general clients expressed satisfaction with the support they received from their families and the role they play in their households. However, nearly 30% reported being discriminated against by their families and family discrimination was found to be a significant predictor of overall quality of life. The majority were receiving community support from health centers, NGOs, pagodas and other community groups and participating in people living with HIV and AIDS (PHA) or Friends Helping Friends (MMM) groups at the time of the survey.

Quality of life. Mental health scores were significantly lower than physical health scores among the surveyed population as a whole. There was a high frequency of requests for psychosocial support when clients were asked what type of support would be useful for them in their current situation.

Programmatic recommendations include:

Household economic situation. Explore the reasons for the high frequency of deviation from the original bridge plan and if any of the reasons can be controlled for during the bridging process. Focus on securing wage employment for clients living in urban or peri-urban settings since wage employment is a more stable source of income than micro-enterprises. Facilitate on-going technical support for clients who choose to operate micro-enterprises since such businesses frequently fail. Develop strategies for reducing HIV-related stigma and discrimination in the workplace. Examine the issues of child labor and non-attendance in school to see if there are steps that could be taken to reduce its occurrence.

Health situation. Give more thought to strategies for improving long term drug adherence. Advocate with NCHADS and health facilities providing ART as a considerable proportion of clients reported paying for what is supposed to be free treatment. Integrate nutritional assessments into care and treatment protocols and develop counseling materials, which give clear guidance on diet recommendations using locally available foods, for maintaining and improving nutrition, as well as managing OI symptoms and maximizing the effectiveness of ART. Encourage clients who have small parcels of land to plant home vegetable gardens using low labor techniques.

Family support and social inclusion. Disclosure to family, and assistance with doing it, and family counseling should continue to be a key emphasis. Assess whether or not more effort needs to be placed on minimizing occurrences of family stigma and discrimination. Actively encourage community support/involvement.

Quality of life. Consider the issue of on-going psychosocial support, along with the role (if any) of the Bridges team in providing it. Consider facilitating the establishment of support groups for bridged clients as a means of on-going psychosocial support after bridging. Administer the quality of life index to all PHA clients at the time of enrollment, annually while clients are enrolled in SoH, at the time of bridging or graduation from Maryknoll assistance and during any follow-up surveys of bridged clients. Implement a regular follow-up component, designed while taking into account the human and financial resources available for the task.

Background

Though a steady decline has been documented, at 1.6%¹ (0.9-2.6) Cambodia still has the highest HIV prevalence rate in the Southeast Asia region. Despite falling rates among sentinel groups such as sex workers and police, HIV prevalence appears to be stable at 2.1%² among pregnant women seeking antenatal care. The Ministry of Health National Strategic Plan for HIV and AIDS estimates that over 50% of all deaths among men, and 46% among women, are HIV-related³. Approximately 140,000 adults were living with HIV and AIDS at the end of 2003 and 16,000 died from AIDS in 2004.⁴

The Royal Government of Cambodia (RGC) has made considerable progress in rolling out HIV and AIDS services in the public health sector. However, much work remains to ensure both universal access to care and treatment and the sustainability of services. At the moment, the effectiveness of public HIV and AIDS is dependent on extensive support that NGOs provide to patients to access and stay on treatment and the technical assistance that NGOs make available to public health facilities. New challenges are emerging in the growing population of adults and children on treatment; these include, among others, the need for income and livelihood opportunities for people living with HIV and AIDS (PHA) on anti-retroviral therapy (ART).

The Maryknoll Seedling of Hope (SoH) HIV and AIDS project began in 1996. The project seeks to improve the quality of life of PHA and their families in target communities in three ways: 1) by improving the level of awareness and understanding of HIV and AIDS, as well as acceptance of PHA, 2) ensuring access of PHA to a continuum of care and support services and 3) strengthening the service delivery capacity of targeted Government and NGO staff. SoH has gradually expanded its continuum of care services to include awareness and education, counseling for HIV testing, clinic and referral services, home-care, hospital visitation and care, hospice, social support (food, shelter, transportation), income generation activities and socioeconomic/community reintegration services for clients on ART. Maryknoll also operates two separate projects, Little Sprouts and Little Folks, to meet the needs of children who have HIV and AIDS or have been impacted by HIV and AIDS.

During the last two years, the availability of Ministry of Health/NCHADS opportunistic infection (OI) and ART services has gradually increased. As a result, the nature of services provided by SoH has changed. Instead of providing counseling for HIV testing and OI services directly to clients, SoH now facilitates access to these services at public facilities. SoH has also altered the use of its own resources to directly support government efforts, specifically to Chey Chumneas Referral Hospital in Takhmau district, Kandal province. Another example of how SoH services have evolved is the expanding Bridges of Hope (Bridges) project.

In 2004 SoH initiated Bridges to assist PHA who have been marginalized due to illness to socially and economically reintegrate into society after regaining their health on ART. Before ART clients were quietly preparing for death, now they must think about building their new lives. Many were not able to work for several years and don't know how and where to begin again. Most sold all of their property and assets for medication; others ventured to Phnom Penh as medical migrants and existed without a stable source of food,

¹ Report on the Global AIDS Epidemic, UNAIDS, 2006.

² HSS 2003 Results Presentation, NCHADS, December 2004.

³ Ministry of Health and NCHADS, "Strategic Plan for HIV and AIDS and STI Prevention and Care, Cambodia 2004-2007." Phnom Penh, Cambodia.

⁴ Report on the Global AIDS Epidemic, UNAIDS, 2006.

shelter, income or security. Even though clients on ART are regaining their health, they often cannot go back to their previous type of employment (e.g. heavy labor), they have few skills and little education, and many have difficulties identifying viable alternatives. Furthermore, many suffered psychological pain and trauma due to the death of loved ones, stigma, discrimination and family rejection. The road to psychological health, solidarity with family and community and economic independence is a long one and many clients require assistance with this difficult transition.

Starting the Bridges project has not been without challenges. Bridges of Hope was the first systematic effort in Cambodia to address the special needs of PHA on ART to resume their roles in the larger community and there were no other specific models on which to base the approach. A major challenge was how to start the process while minimizing the stress on clients. Many had become accustomed to the standard of living afforded to them by SoH support. Others had been seriously ill for many years and had become dependent on SoH for their basic needs. In some, dependency manifested itself in low motivation, difficulty with planning, lack of resourcefulness and lack of interest in taking control or responsibility for one's life. Transition to independence requires a huge adjustment in thinking and to many it was a daunting prospect, to others it was terrifying. Some program staff were also afraid that clients wouldn't be able to manage on their own.

As a result of these factors, the Bridges project started slowly. First steps included building relationships, establishing trust and getting the buy-in of staff and clients. The first groups of clients were encouraged to see the advantages of reintegration in their daily lives and were given the choice whether or not to participate. Activities were crafted, tried and either discarded or improved upon using a process of trial and error. Two years after the project began, new clients may still be apprehensive when starting. But generally they approach Bridges with a sense of hope and excitement because they can see that their peers who have graduated are doing just fine.

Presently, Bridges provides group and family counseling, basic training for managing a small business and budgeting, apprenticeships, a job placement service, small grants and health education. Bridges also facilitates the transfer of ART services and medical records for clients who move to another province, vocational training, reconciliation with estranged families and other services required for clients to transition from being dependent upon project assistance to supporting themselves. The bridging process lasts several months; the exact duration varies, depending on the needs and capacities of individual clients. At the end of the counseling and training phase, clients prepare a bridge plan. Bridges provides small grants for capital or the purchase of equipment/supplies to those clients or family members who are starting small businesses. During the three months following the disbursement of the grant or uptake of employment, the project continues to offer social assistance (i.e. money for food and/or housing) to ensure clients are earning an income before cessation of assistance. During the same period Bridges staff make several home visits to monitor the household economic situation and the relationship between the client and his/her family and community. The approach is continuously evolving, being refined and adapted, based on the needs of and feedback from clients.

SoH and Bridges are funded by USAID, CRS, CAFOD, Maryknoll and Caritas Australia.

Rationale

During June, July and August 2006, a team of consultants undertook an assessment to generate recommendations for strengthening the Bridges project, predominantly those

activities aimed at promoting clients' economic livelihoods. One of the recommendations of the consultancy was to carry out a follow-up study of bridged clients. A number of clients stay in touch with the project, including those who are now employees of Maryknoll. But for the most part, very little was known about clients once they were bridged. From anecdotal information relayed by project fieldworkers and the small (unrepresentative) sample that was contacted as part of the consultancy, it appeared that the experiences of the bridged clients were quite mixed. Some were adhering to the plan designed during Bridges, others were not. Some were managing economically reasonably well while others were struggling. Some had been healthy, others had had frequent OIs. A handful of bridged clients were known to have died. As the number of bridged clients continued to grow and the project ramped up its efforts, it was important to take stock of the interventions and their medium-term effects on clients.

Purpose and Objectives of Survey

The purpose of the follow-up survey was to understand how bridged clients were medically, economically and socially faring after returning to unassisted living with a view to improve the socioeconomic reintegration services provided by the Bridges project. Specifically the survey aimed to:

- Determine the extent to which clients were living independently.
- Assess the general health situation of bridged clients.
- Assess the economic situation of bridged clients.
- Understand the nature of support provided to bridged clients by families and communities.
- Assess the quality of life of bridged clients.
- Determine unmet needs of bridged clients.
- Generate recommendations for how to improve the effectiveness of the Bridges project.
- Assess whether or not a formalized follow-up component is needed for Bridges.

Methods

The structured questionnaire was developed in English by project staff, translated into Khmer and translated back into English to verify the content and meaning of the questions. The questionnaire was pre-tested and revised during the training of interviewers. The questionnaire explored six main topics: socio-demographic, economic, health, family support and social inclusion, quality of life and recommendations for the Bridges project. Questions in the family support and social inclusion section were adapted from a longitudinal study of people living with HIV and AIDS being carried out by Family Health International in Battambang province. The quality of life questions were drawn from the same study and modified slightly during pre-testing in order to facilitate respondents' understanding.

Twenty former or current Maryknoll PHA clients were selected to work as interviewers for the survey. Maryknoll PHA clients were chosen to serve as interviewers with the assumption that they would be viewed as neutral by PHA respondents. It was assumed that bridged clients would be more likely to answer frankly questions about the effectiveness of the project if they were asked by peers rather than project staff. The survey was also an opportunity for interviewers to gain new skills and a supplementary income. Project staff selected interviewers based on the following qualifications: interpersonal and communication skills, literacy in Khmer, time to devote to survey, household situation

allowed interviewer to spend time on the survey, ability to spend time away from normal income-generating activities and interest in the survey. Interviewers received a 2-day training covering interviewing skills, confidentiality, the content of the questionnaire and how to administer it. Interviewers also signed a non-disclosure certificate guaranteeing they would not divulge any of the respondents' personal information. Each interviewer interviewed 5-6 bridged PHA clients. Interviewers were compensated for their time.

SoH fieldworkers and Bridges staff assisted with the survey by participating in the development of the questionnaire and survey plan, analyzing case files, selecting and supervising the interviewers, assigning bridged clients to interviewers, tracking down bridged clients, ascertaining bridged clients' willingness to participate in the survey (by phone or in person) and introducing bridged clients to interviewers. Locating the current residences of bridged clients took a substantial amount of time for three reasons. First, contact information was not meticulously recorded for all clients during the early phases of the project. Second, migration is very prevalent in Cambodia, including in the target population, as people move from place to place in search of economic opportunities. The residences of a sizeable number of clients had changed since the time of bridging. Third, in many cases Maryknoll clients were living in settlements or villages that do not have precise addresses. This was not problematic while clients were enrolled in the project as project staff visited them frequently and knew where their houses were located. However over the last two years there has been some staff turnover and these staff took with them the knowledge of how to locate some of the clients who were bridged early on. The majority of the activities related to the survey took place outside of normal work hours. As such participation of staff was voluntary and those who participated were paid overtime.

Data collection took place over a four week period in October-November 2006. When fieldwork began 189 clients had been bridged since the project began in 2004. As methodology utilized exhaustive sampling, staff attempted to contact all bridged clients for participation in the survey. A 'bridged' client was defined as a client who was no longer receiving assistance (financial subsidies for food and housing) from the SoH project. Project staff reviewed client case files and classified bridged clients by sex, last known place of residence, alive/deceased, phone number and date of bridging. Willingness to participate in the survey was obtained verbally by phone or in person by a Bridges staff person known to the client. Once verbal consent was given, the Bridges staff person introduced the interviewer to the Bridged client. A total of 150 of the 189 former clients were interviewed. Reasons for not interviewing the remaining 39 bridged clients include death of the client or inability to locate the client during the period of data collection. Surveys were administered in the homes of clients. All respondents read (or were read the contents of) and signed a consent form prior to the commencement of the interview. Names of respondents and Maryknoll ID numbers (if applicable) were recorded in order to allow for the opportunity of tracking the cohort of bridged clients longitudinally and following up their status using the same (or a similar) questionnaire. The interview lasted approximately 90 minutes. At the close of the interview, interviewers instructed respondents to contact the Bridges Coordinator if they had any questions, concerns, comments about the interview process or if they simply wanted to get back in touch.

Data was entered, cleaned and analyzed using SPSS. In an effort to encourage uniformity in the use and understanding of the term "quality of life" in Cambodia, the questions used to determine quality of life were drawn from a survey being implemented at

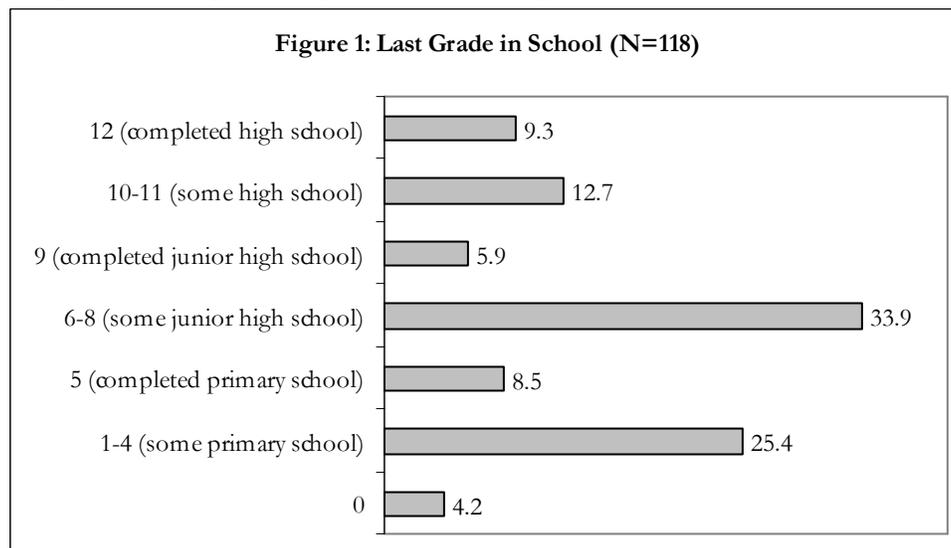
the same time by Family Health International.⁵ Responses to the quality of life questions were scored on a 0-100 scale, with higher scores indicating better results. Responses to the 22 questions were averaged to yield scores for eight domains: physical functioning, physical role, bodily pain, general health, vitality/energy, emotional well-being/role, social functioning and cognitive functioning. Three summary measures were also determined: physical health, mental health and overall quality of life. The scoring system employed was adapted from the MOS SF-36 measurement model specifically for this survey and was not tested beforehand.⁶

Findings

Socio-demographic Information

Out of the 150 surveys administered, 14 were excluded from the analysis because the respondents had not yet started ART; these clients were spouses of bridged clients on ART. Of the 136 respondents included in the analysis, 77 (56.6%) were female, and 59 (43.4%) were male. The majority of clients were between the ages of 26 and 45 with 88.9% of clients falling into this age range at the time of the survey. Slightly more than 2% were between the ages of 18 and 25; 7.4% were aged 46 to 55 and; 1.5% were aged 56 or older.

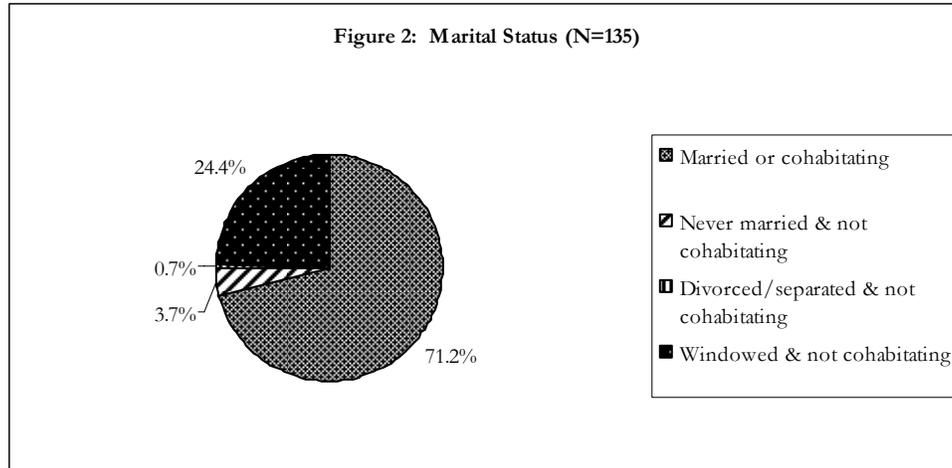
More than 95% of the surveyed clients had attended some level of formal schooling. Over one quarter (25.4%) reported attending some primary school, while 33.9% reported attending some junior high school, and 12.7% percent reported attending some high school. Only 9.3% percent completed high school. See Figure 1.



Nearly three quarters of respondents (71.1%) were married or cohabitating. A small percentage (3.7%) had never been married and was not cohabitating, while only 0.7% of clients were divorced or separated. Nearly one quarter (24.4%) were widowed and not cohabitating. See Figure 2.

⁵ Survey adapted from questionnaires focusing on ART adherence available on the Johns Hopkins University website.

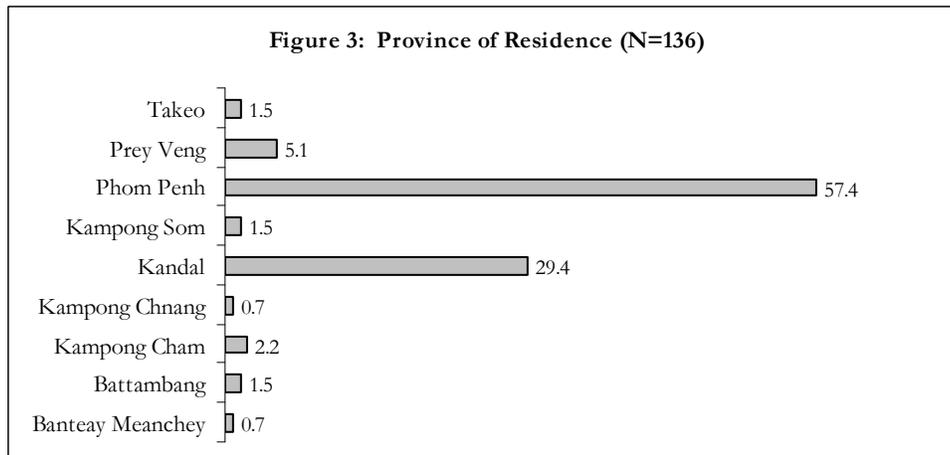
⁶ The Medical Outcomes Study (MOS) measures function, well-being and health-related quality of life of patients with chronic conditions.



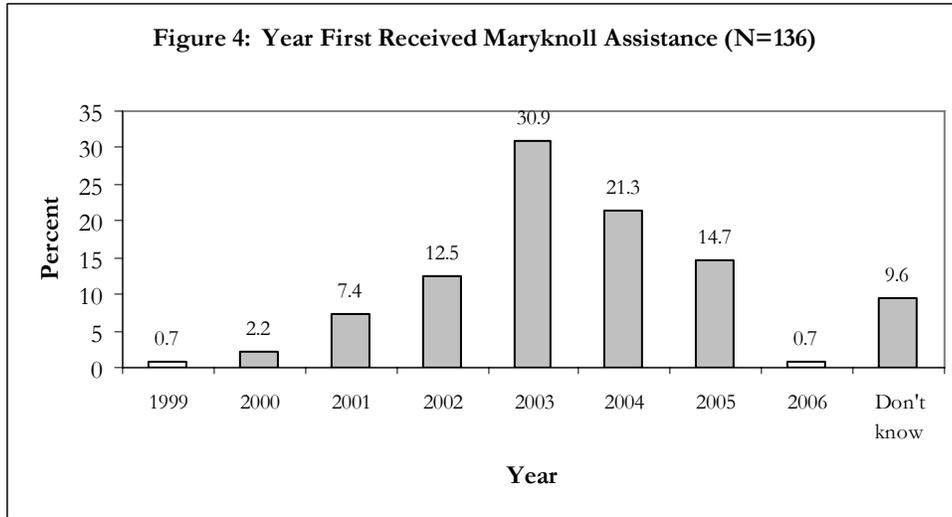
The mean number of people reported living in the household was 4.3. One hundred and fifteen (84.6%) clients reported having an average of 2.8 children. About one in ten respondents (11%) had children who had died at some point in the past. One hundred and six respondents (78%) were living with an average of 2.5 children at the time of the survey.

Eighty-three respondents (61%) reported that there were two PHA in their households, and 31.6% reported that they were the only PHA in the household. Nine (6.6%) and one (0.7%) of respondents were living in households with 3 and 4 PHA respectively.

The majority (57.4%) of the clients were residing in Phnom Penh municipality at the time of the survey. A substantial proportion (29.4%) was also living in Kandal province. The rest of the respondents were living in a variety of other provinces (see Figure 3) at the time of the interview.

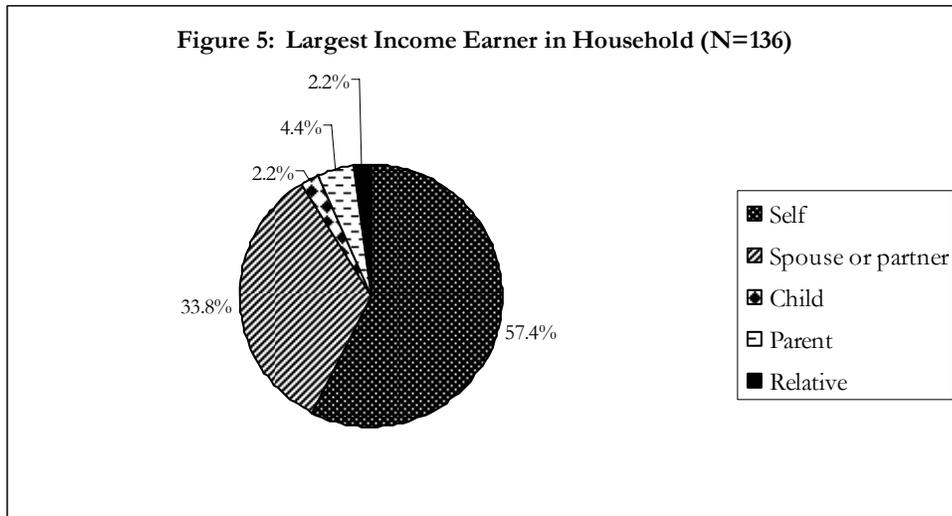


Clients reported receiving assistance from Maryknoll as early as 1999 and extending to 2006 (see Figure 4).

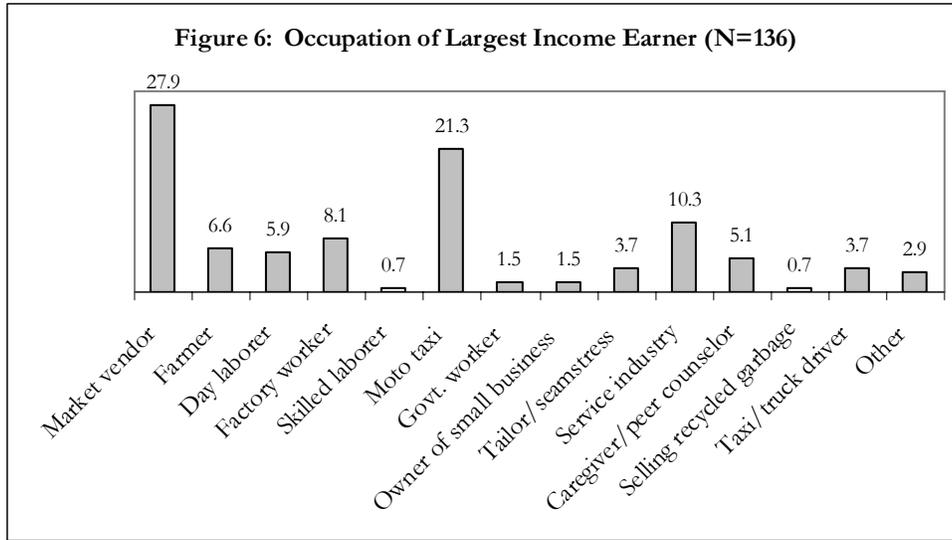


Household Economic Information

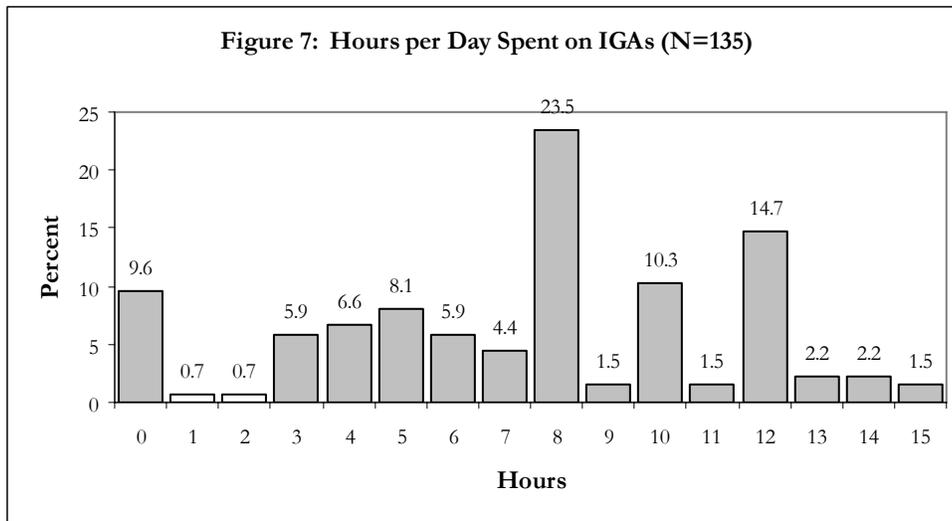
Thirty-seven percent of surveyed clients reported that they were the only working adult (aged 18 and older) living in their household who was involved in income-generating activities. However, 49% reported that there was one additional adult household member engaged in income-generating activities in addition to the respondent. The majority of clients (57.4%) reported that they were the largest income earner in the household; 33.8% reported that a spouse or partner was the largest income earner. In a small minority of households the main income earner was a parent, relative or child (see Figure 5).



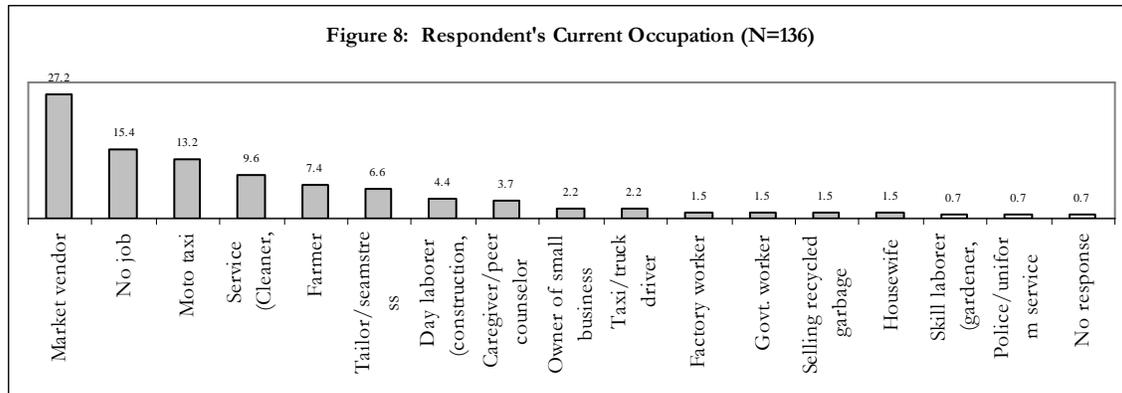
The main occupations of the largest income earner were market vendor (27.9%) and moto taxi driver (21.3%). Other primary income earners were working in a variety of occupations which are illustrated in Figure 6.



On average, respondents reported spending 7.4 hours per day (SD=3.88) on income-generating activities (see Figure 7). There was no correlation between sex of client and the number of hours spent working, nor was there any significant relationship between the number of hours spent working and quality of life.



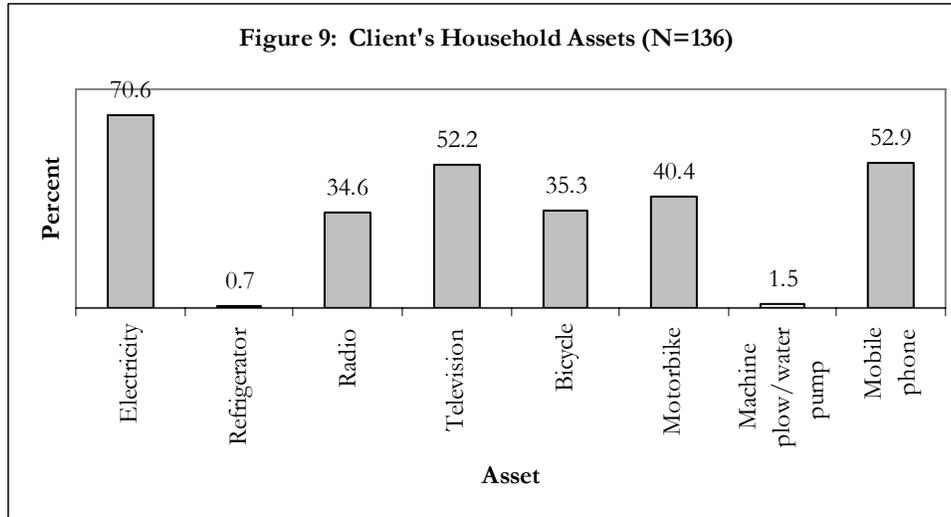
At the time of the interview a large number of respondents were working as market vendors (27.2%) or moto taxi drivers (13.2%). Twenty-one clients (15.4%) reported that they were currently unemployed as compared to 16 (11.8%) at the time that they stopped receiving assistance from Maryknoll. Figure 8 shows the range of occupations with which clients were engaged at the time of the survey.



Clients were asked whether they changed occupations from the time that their Maryknoll assistance ended and the present day. Slightly more than half of the clients (58.1%) reported that they did not change occupations, while 41.9% reported they did change jobs. The main reasons for changing jobs were financial: 63% of those who changed cited lack of money as a reason, 39% mentioned insufficient net income, 11% found a more profitable business and 2% went bankrupt. Thirty-seven percent reported that they were asked to resign from their former occupations due to their HIV status. Twenty-five percent indicated that work was having a negative affect on their health and 5% changed occupations due to illness. Other reasons for changing jobs included stopping to care for a sick relative or child (25%), finding “better” work (18%), losing space for business (9%), work being affected by seasonal factors (7%), and stopping upon request of family (5%). Changing occupations was not associated with positive or negative economic activity post bridging. Respondents who reported changing occupations after bridging had significantly ($t=2.273$, $df=134$, $p=.025$) lower quality of life scores ($x=57.9$, $SD=14.7$) than those who did not report changing occupations ($x=63.1$, $SD=11.8$).

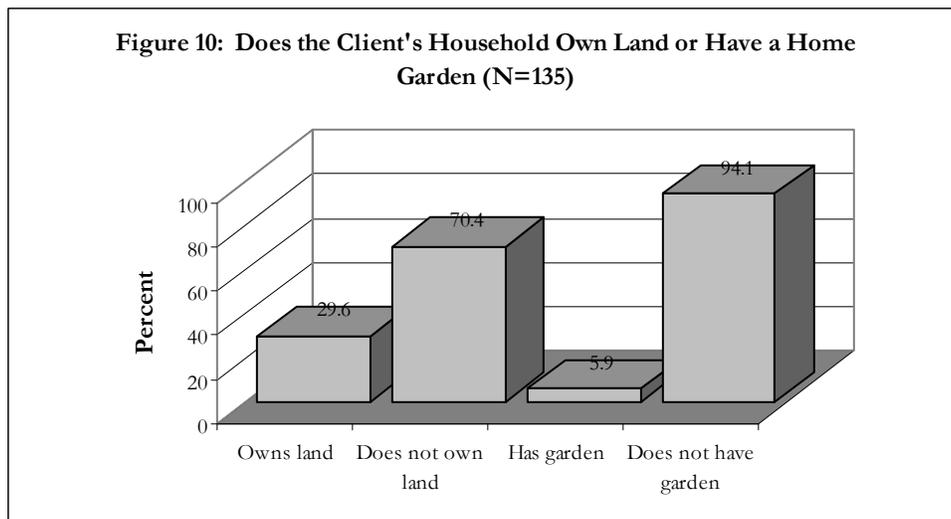
There were a total of 231 children aged six to 18 years in the surveyed households and out of these 208 (90%) were attending school. Of the 23 (10%) that were not attending school, the reasons for their absence included lack of money (25.8%), needing to work for income (25.8%), busy helping with housework (19.4%), finished grade seven already (16.1%) and married already (12.9%). Twenty-three (16.9%) of respondents were receiving monetary assistance for the costs of their children’s education from the Maryknoll Little Folks project. Receiving assistance from Little Folks was not associated with positive or negative economic activity post bridging. Respondents who received Little Folks assistance had significantly ($t=2.104$, $df=134$, $p=.037$) lower quality of life scores ($x=55.7$, $SD=13.7$) than those who were not receiving assistance ($x=62.0$, $SD=13.0$).

In order to further assess household economic status, clients were asked if they had a selection of assets at their residences. Nearly 71% of respondents indicated that they had electricity in their homes. Just over half of the respondents reported having a television (52.2%) and mobile phone (52.9%). Slightly more than one third reported having a bicycle (35.3%) and radio (34.6%). Only 1.5% of respondents said they owned a motorized plow or water pump, which is not unusual given the urban/peri-urban location of many of the residences. Less than 1% (0.7%) of the surveyed clients reported having a refrigerator in their home. See Figure 9.

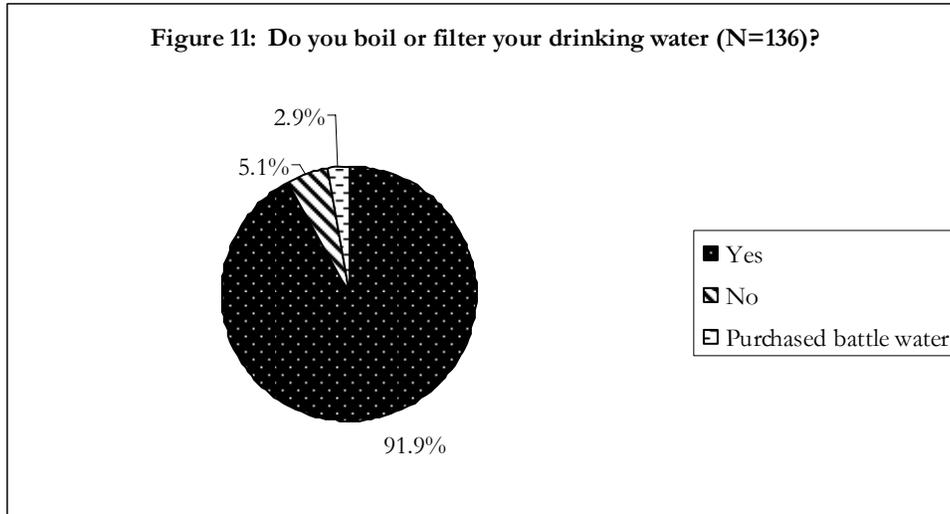


Ninety-six percent of respondents reported the monthly income of the household to be sufficient for purchasing enough food, and 80.1% and 70.6% said their households could afford health care and transportation costs respectively. Out of the 72 respondents who had school aged children and were not receiving assistance from the Maryknoll Little Folks education support program, 77.8% reported having enough money to send them to school. Only 16.2% of clients reported being able to afford other items such as clothing and furniture with their monthly income and fewer (13.2%) said they were able to set aside a small amount of money for savings.

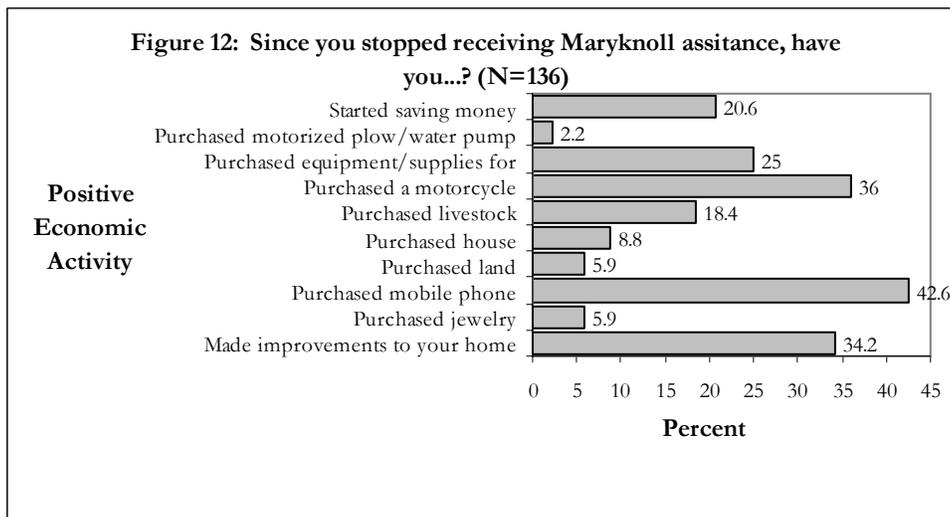
Less than one third (29.4%) of clients reported that their household owned land and only 5.9% of respondents had a home vegetable garden at the time of the survey (see Figure 10).



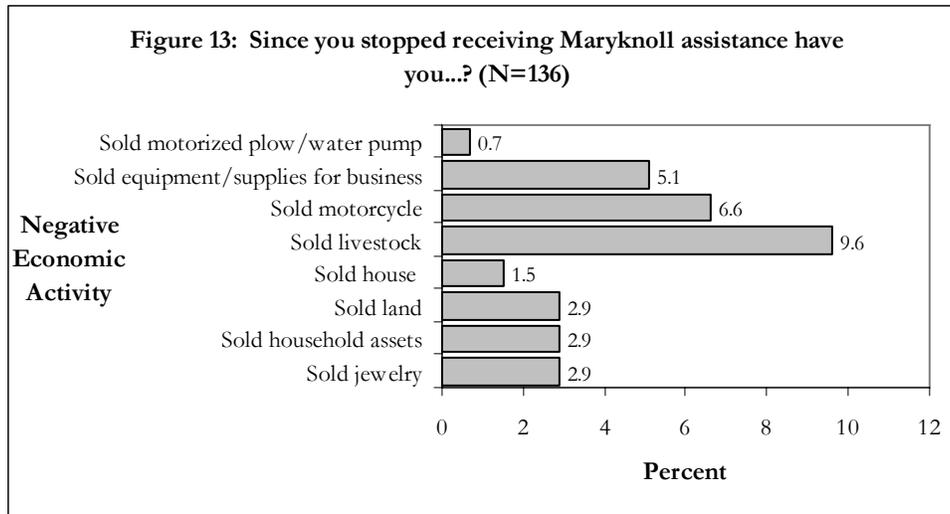
Interviewers asked clients about the source of drinking water used in their homes. More than half of the respondents (54.4%) had access to water piped to the house/plot, 27.2% used well/bore hole water and 11.8% got their water from a pond or river. A small percentage of respondents purchased drinking water from a truck (3.7%) or bought bottled water (2.9%). Out the 132 clients who drank water from sources other than purchased bottles, 94.7% boiled or filtered it before drinking (see Figure 11).



Respondents were asked whether or not they had engaged in a series of activities, selected by project staff as indicators of improved household economic status, since stopping Maryknoll assistance until the present time (see Figure 12). Nearly 43% of clients purchased a mobile phone (42.6%) and over one third purchased a motorcycle (36%) and/or made improvements to their homes (34.2%). One quarter purchased equipment or supplies for their businesses. Approximately one out of five clients started to save money (20.6%) and/or purchased livestock (18.4%).

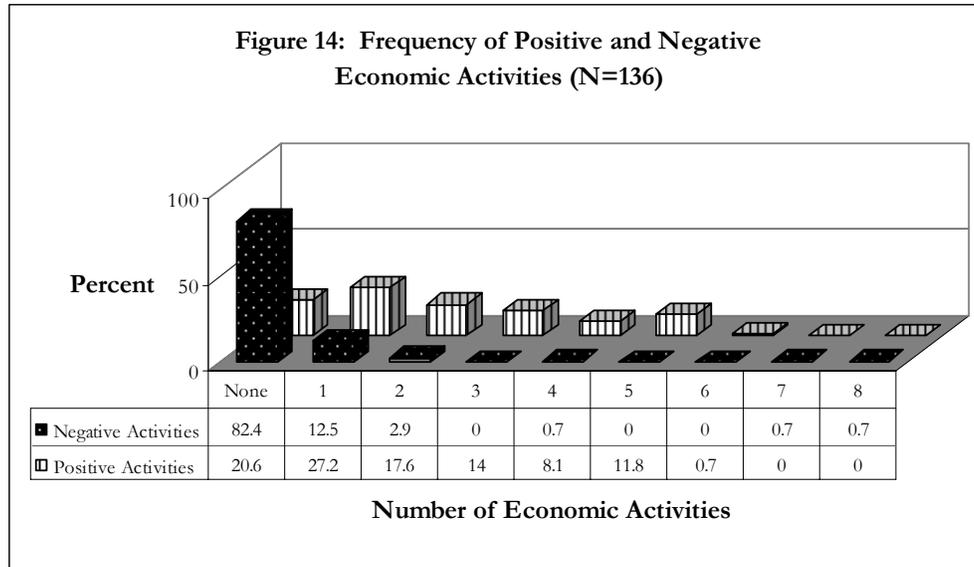


Similarly clients were asked whether or not they had engaged in a series of activities, selected by project staff as indicators of decreased household economic status, since stopping Maryknoll assistance until the present time (see Figure 12). Fewer respondents reported negative economic activity than those who reported positive actions. Out of these the most frequent responses were sold livestock (9.6%), sold a motorcycle (6.6%) and sold equipment or supplies for a business (5.1%). A small proportion of clients (2.9%) sold land, household assets and/or jewelry.



A substantial proportion of clients (39.7%) took out a loan since Maryknoll assistance stopped. From the survey data, it is not possible to know if taking out a loan was an indicator of positive or negative activity in the respondents' households and either is a possibility. There was no significant relationship between taking out a loan and the number of positive or negative economic activities. Neither was taking out a loan associated with saving money.

During analysis the economic activity variable was examined more closely to further understand clients' economic situation. Figure 14 illustrates the frequency of reported positive and negative economic activities. Seventy-nine percent of clients reported at least one positive economic activity. On average respondents engaged in 2 (range 0-6, median=2) out of a total of ten possible activities which suggests a slight improvement in household economic status in the surveyed population. Conversely, the mean number of negative economic activities was 0.32 (range 0-8, median=0) out of a total of eight possible activities. About 82% of clients did not report any negative economic activities; 17.6% reported one or more negative economic activities. The number of positive/negative economic activities was not associated with sex or marital status of the respondent. However, there was a significant yet weak positive correlation ($r=.204$, $p=.05$) between the number of positive economic activities and quality of life scores.



Health Situation

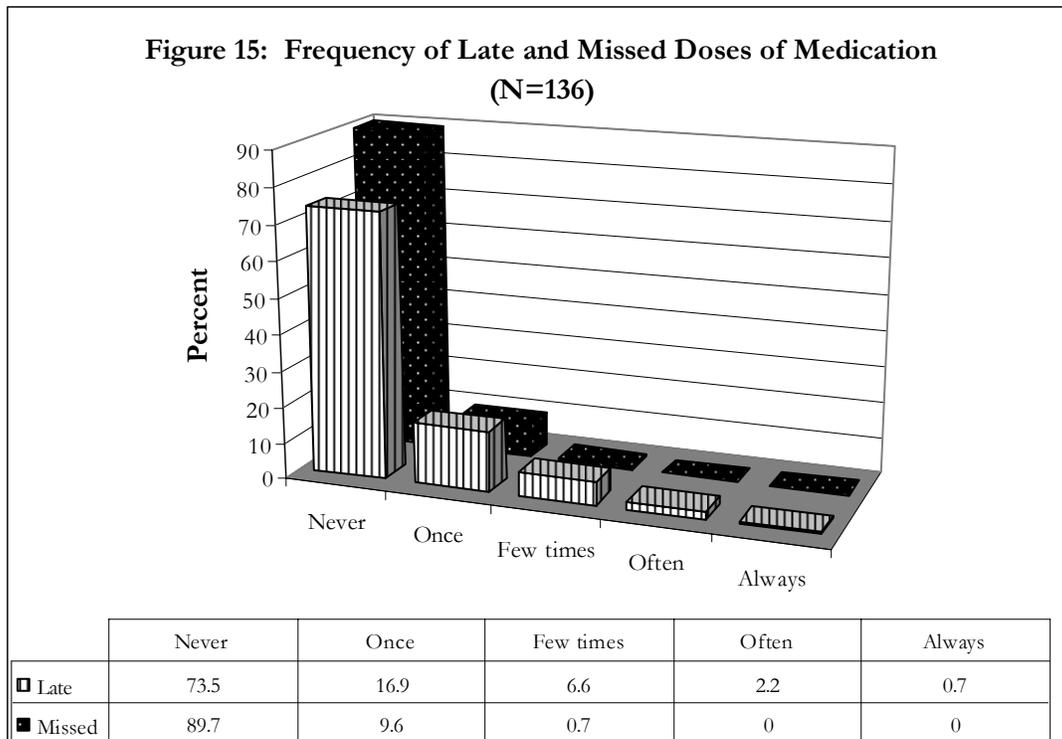
Clients reported testing positive for HIV from 1993 through 2005 (see Table 1). However, very few clients tested positive before 2000 (11.7%) and the vast majority (88.2%) tested positive from the year 2000 onwards. The date of first testing positive was not significantly associated with current CD4 counts or quality of life scores.

Regardless of when the clients reported first testing positive for HIV, no clients began ART before 2002 when 7.4% began treatment. In 2003, 22.1% reported beginning ART. In 2004 and 2005 respectively, 30.9% and 27.9% of clients reported beginning treatment. A small percentage (5.1%) began treatment in 2006. All but one client responded that they were still taking ART at the time of the survey. The initiation date of ART was not significantly associated with overall quality of life or current CD4 count.

Table 1: Year First Tested Positive for HIV and Began ART (N=136)

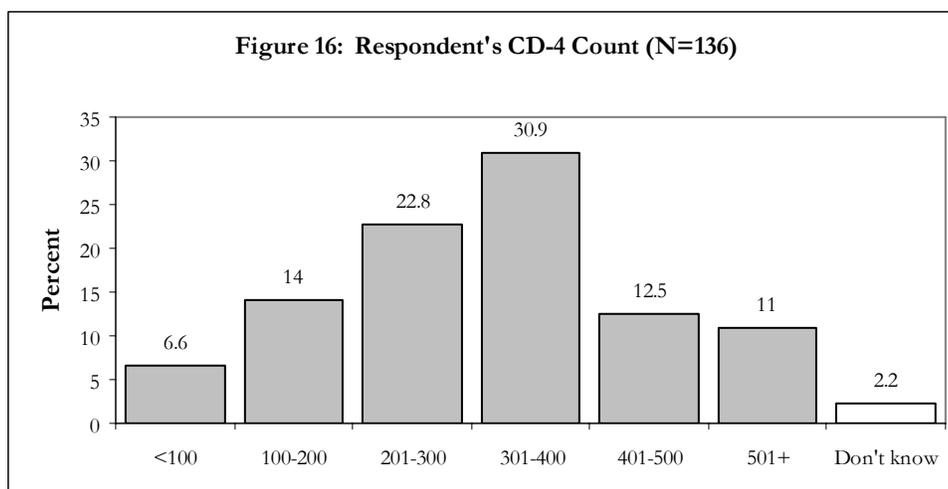
Year	First tested positive for HIV	Began ART
1993	.7% (1)	
1995	.7% (1)	
1996	2.9% (4)	
1997	1.5% (2)	
1998	2.2% (3)	
1999	3.7% (5)	
2000	15.4% (21)	
2001	12.5% (17)	
2002	14.0% (19)	7.4% (10)
2003	19.1% (26)	22.1% (30)
2004	17.6% (24)	30.9% (42)
2005	5.9% (8)	27.9% (38)
2006		5.1% (7)
Don't Know	3.7% (5)	6.6% (9)

Nearly three quarters (73.5%) reported that they never were late taking their medication in the week preceding the survey. However, 16.9% were late once, 6.6% were late a few times, and 2.2% were late often. Nearly 90% of clients reported taking all scheduled doses of their medication during the previous week. However, 9.6% reported missing one dose and 0.7% reported missing a few doses (see Figure 15). The most commonly cited reason for missing a dose of medicine was that the client forgot (11 respondents). A smaller number mentioned feeling sick (4 respondents), leaving medication at home (2) and running out of medication (1). Nearly one quarter (23.5%) reported stopping their medication at some point during the last three months. Clients who reported being late with their medication were significantly more likely to report missing entire doses within the last week ($p < .001$) and stopping their medication within the last three months ($p < .05$). Increased tardiness of dosing was significantly correlated with declining quality of life scores ($p < .001$). Missed doses were also significantly correlated with declining quality of life scores ($p < .05$).



The majority of clients (86.6%) reported that a family member or friend reminds them to take their medication. However, there was no significant relationship between family and friend reminders and overall adherence.

Clients reported a mean CD4 count of 327.4 at their last CD4 count ($SD=156.3$). The majority (53.7%) of respondents had CD4 counts between 201-400 (see Figure 16). There was no significant relationship between gender of the respondent and CD4 count. Most clients (87.5%) reported receiving a CD4 test within the previous 12 months, with the majority (65.4%) having had a test within the six months preceding the survey. Clients with higher CD4 counts were more likely to report taking their medication late ($p < .05$). However, there was no significant relationship between CD4 counts and missed dosages or stopping treatment.



On average, clients paid 11,560 Riels (approximately \$2.90 USD) for their roundtrip transport fees to obtain their medication. The majority of clients (55.1%) reported receiving their ART at no cost to themselves. However, 24.3% of clients reported paying something for their ART at their last visit. There was a significant relationship between cost of treatment and missed dosage within the last week ($p < .05$).

Almost all clients (96.3%) reported seeing a health worker in the last three months. Forty-four percent reported seeing a health worker once; 15.4% reported seeing a health worker twice in the last three months; 30.9% reported seeing a health worker three times and; 4.4% reported seeing a health worker four or more times in the last three months. Clients were asked to rate their satisfaction with the care they receive at the health facility where they receive their medications on a scale of one (not satisfied) to five (very satisfied). A considerable majority (87.5%) reported being very satisfied with the care; no client reported being not satisfied. Clients who reported seeing a health worker more frequently were significantly *less* likely to report being satisfied with the care that they receive at the health facility ($r = -.225$, $p = .008$). Client satisfaction with their health care facility was predictive of their overall quality of life scores ($p < .001$).

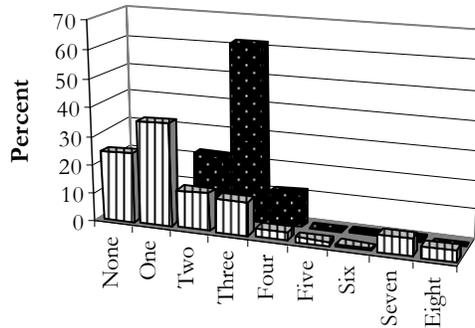
Interviewers read a list of common health problems and asked respondents if they had experienced any of them over the previous three months. The most commonly cited problem was headaches (95 respondents), followed by fever (82 respondents) and pain (72 respondents). A full list of identified issues is presented in Table 2. The presence of tuberculosis ($p < .05$) and vomiting ($p < .05$) were both significantly correlated to lower CD4 counts. Clients who reported having stopped taking their ART during the previous three months were significantly more likely to report having had symptoms of respiratory infection ($p < .05$), tuberculosis ($p < .01$), thrush ($p < .05$), loss of appetite ($p < .05$), weight loss ($p < .05$), nausea ($p < .05$), anemia ($p < .05$) and loss of body fat in the face, arms or legs ($p < .05$). Diarrhea ($p < .05$), respiratory infection ($p < .01$), skin rash or sores ($p < .05$), headaches ($p < .05$), pain ($p < .01$), loss of appetite ($p < .001$), weight loss ($p < .001$), sexually transmitted infections ($p < .001$), vomiting ($p < .001$), anemia ($p < .05$), loss of body fat ($p < .01$), and numbness ($p < .001$) were all significantly linked to lower quality of life scores.

Table 2: Conditions Experienced During the Previous Three Months (N=136)

Condition	Number of Positive Responses	Percent of Respondents Reporting Condition
Headache	95	69.9%
Fever	82	60.3%
Pain	72	52.9%
Loss of appetite	64	47.1%
Weight loss	57	36.0%
Skin rash or sores	49	33.8%
Nausea	46	33.1%
Numbness	45	27.2%
Diarrhea	37	25.7%
Loss of body fat in face, arms or legs	35	22.8%
Anemia	31	17.6%
Respiratory infection	24	17.6%
Vomiting	24	10.3%
Increase in body fat in torso, breasts or back	14	9.6%
Thrush	13	8.1%
Sexually Transmitted Infection	11	7.4%
Tuberculosis	10	5.9%
Hepatitis	6	4.4%
Swollen glands	4	2.9%
Diabetes or Insulin Resistance	2	1.5%

The majority (61.8%) of clients reported eating three meals during the previous day. Twenty-two percent said they had two meals and less than 3% of clients reported eating one meal or less. In addition, 36% of clients reported eating one snack during the previous day. Nearly one quarter (24%) did not have a snack, and nearly 40% reported more than one snack. There was a significant weak positive correlation ($r=.341$, $p=.000$) between the number of meals and quality of life scores. The complete range of number of meals and snacks taken by the surveyed population the day before the interview are presented in Figure 17 below.

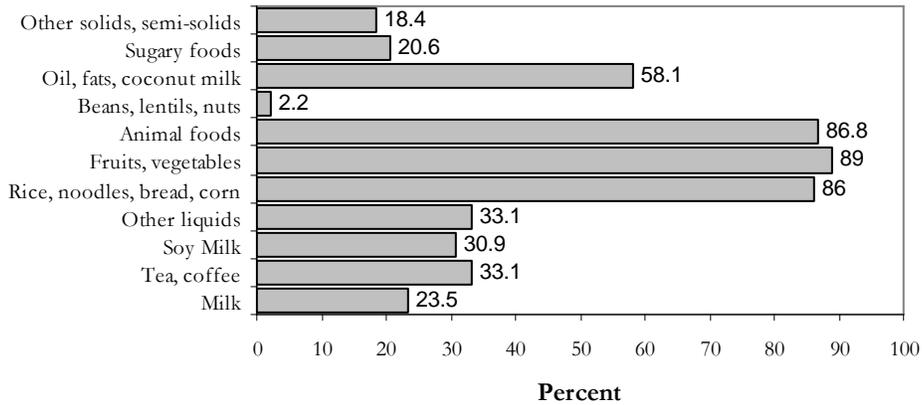
Figure 17: Number of Meals and Snacks Taken the Previous Day (N=136)



	None	One	Two	Three	Four	Five	Six	Seven	Eight
■ Snacks	24.3	36	13.2	11.8	2.9	1.5	0.7	5.9	3.7
■ Meals	0.7	2.2	22.1	61.8	11.8	0	0.7	0.7	0

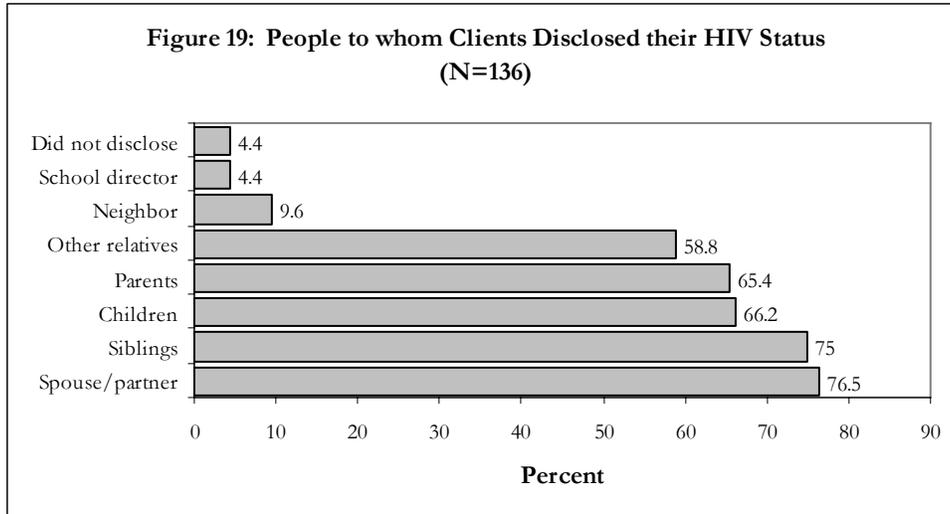
The most commonly cited foods that were consumed in the previous day included fruits and vegetables (89%), animal foods including meat, chicken, poultry, fish, frogs, insects, snails (86.8%), and rice, noodles, bread, or corn (86%). The majority (58.1%) of clients also reported eating oils, fats or coconut milk. See Figure 18 for a complete listing of food categories and the frequency they were consumed by clients the day preceding the survey.

Figure 18: Foods Eaten During Previous Day (N=136)

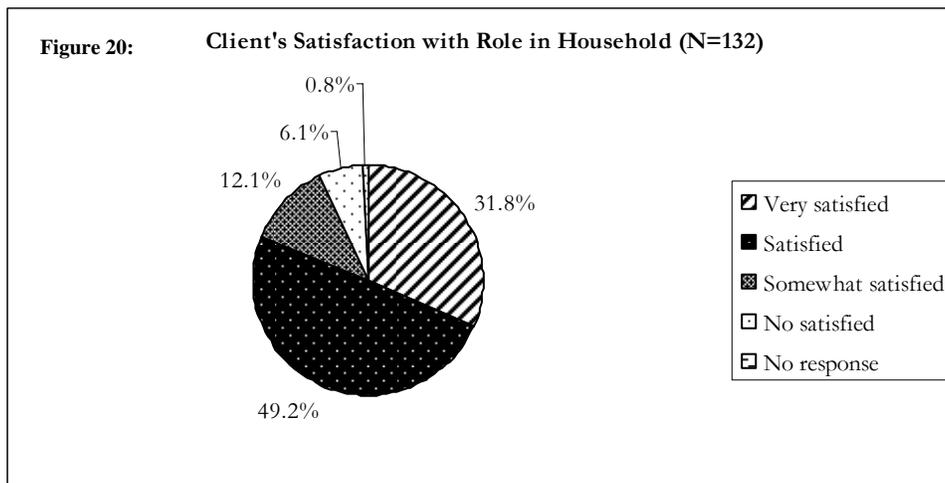


Family Support and Social Inclusion

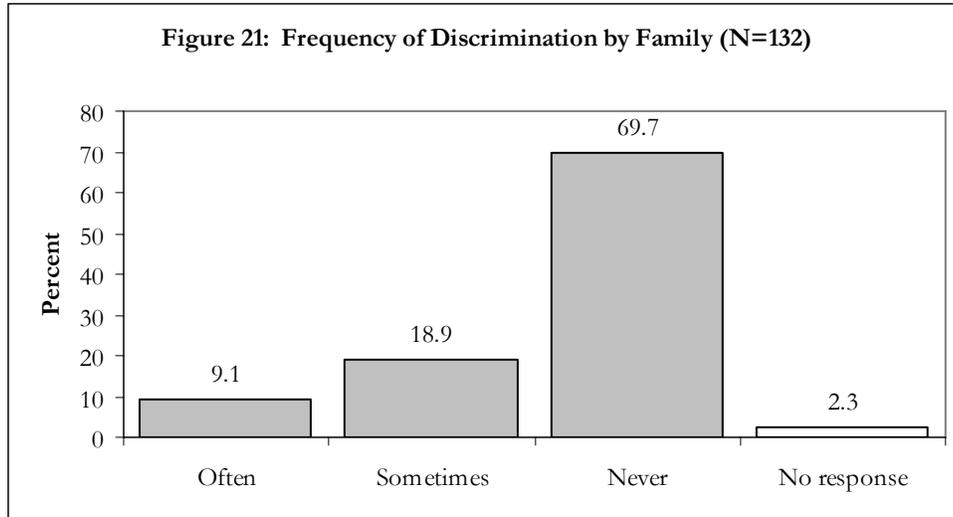
The majority of respondents (76.5%) had disclosed their status to their spouse or partner. Three-quarters had disclosed their status to their siblings. Sixty-six percent had disclosed their status to their children, and 65% had disclosed to their parents (see Figure 19). Six respondents (4.4%) did not report disclosing their status. Respondents who had disclosed their status had a significantly higher mental health quality of life score ($p < .001$).



Ninety-three percent of respondents reported being satisfied to some degree with the role they play in their households (Figure 20). Nearly half of respondents (49%) reported being satisfied with the support they receive from their families; 31.8% reported being very satisfied and 12.1% somewhat satisfied. Only 6.1% reported not being satisfied at all. The most common forms of support were encouragement/psychological support (117 respondents), physical care and support (94 respondents), and financial support (52 respondents).

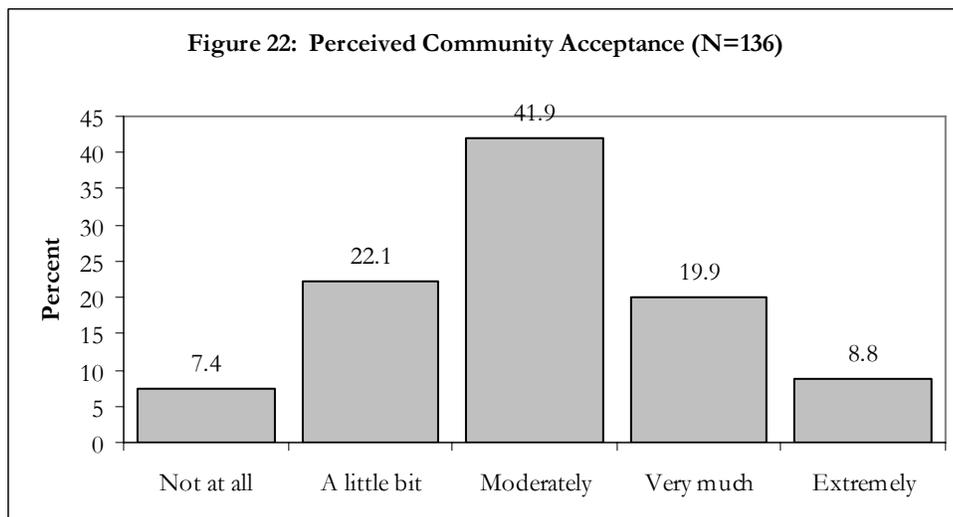


The majority of respondents (69.7%) reported never having been discriminated against by their family members because of their HIV status (see Figure 21). However, 9.1% reported being discriminated against often, and 18.9% reported being discriminated against sometimes.



The most common ways in which people felt discriminated against were family members were not visiting (24 respondents), not sitting with them (20 respondents), not touching them (18 respondents), not eating with them (18 respondents), disowning (13 respondents), hiding them so no one would know their HIV status (12 respondents), verbally abusing them (11 respondents), forcing them to leave the house (eight respondents) and physically abusing them (seven respondents). Family discrimination was a significant predictor ($p < .05$) of overall quality of life, with clients who reported family discrimination having lower quality of life scores.

Only 7.4% of respondents reported not feeling accepted by their community at all. Twenty-two percent reported feeling accepted a little bit. Forty-one percent reported being accepted moderately; 19.9% reported being accepted very much and; 8.8% reported being extremely accepted (See Figure 22). Clients with greater community acceptance had significantly higher quality of life scores ($p < .05$) and mental health scores ($p < .05$).



Eighty-six percent of clients reported receiving support from health centers, NGOs, pagodas or community groups. Clients who received this support were more likely to express higher feelings of community acceptance ($p < .001$). Seventy-four percent of clients reported participating in groups for PHA or MMM groups. Clients participating in these groups were more likely to report higher feelings of community acceptance ($p < .05$).

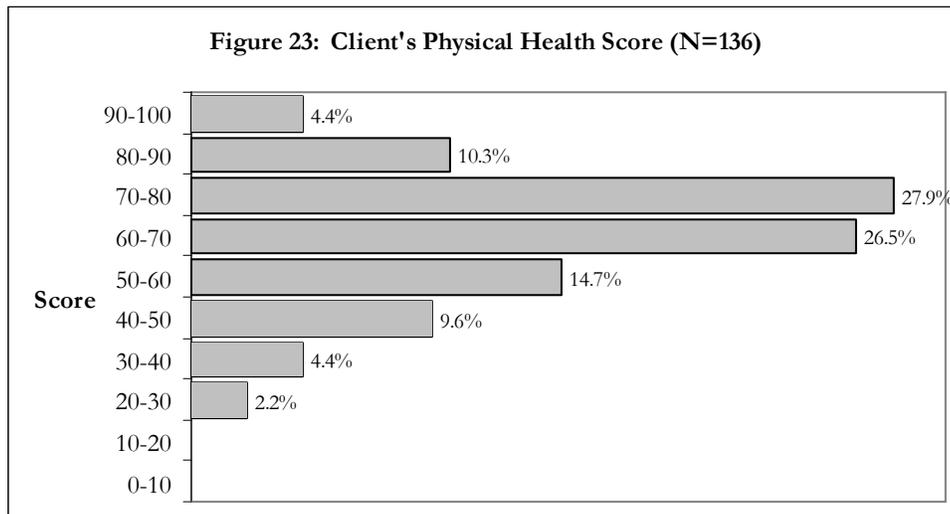
Quality of Life

Respondents were asked a series of questions about their health and psychosocial well-being. Responses to the questions were scored and averaged to determine scores for eight domains: general health, physical and emotional well-being, bodily pain, vitality, and physical, social and cognitive functioning. The scores operate on a 0-100 scale, with 0 being the worst possible and 100 being the best possible. Table 3 shows the mean domain scores.

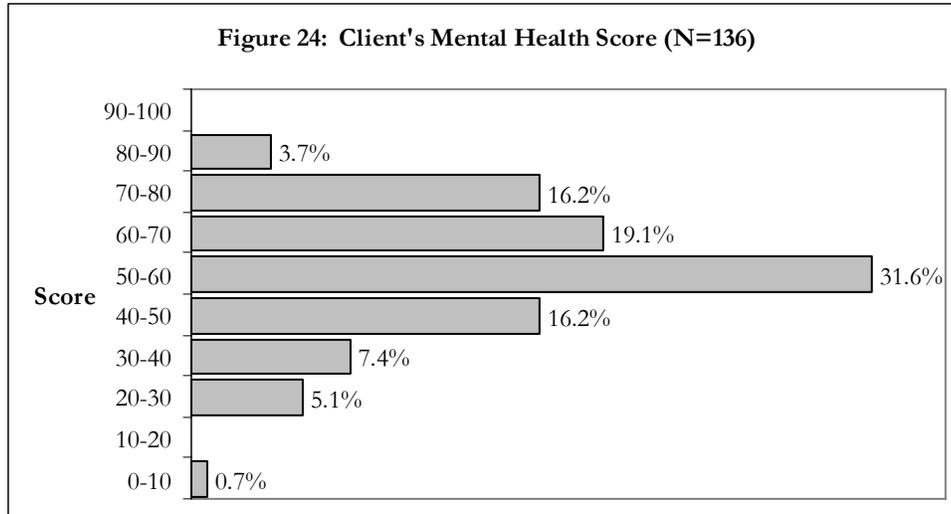
Table 3: Mean Domain Scores in the Quality of Life Index

Domain	Mean & Standard Deviation
General health	61.2 (SD=15.4)
Role-physical	52.8 (SD=36.4)
Bodily pain	64.8 (SD=24.2)
Physical functioning	73.6 (SD=22.2)
Social functioning	76.1 (SD=22.9)
Vitality	53.3 (SD=23.2)
Emotional well-being	44.2 (SD=16.1)
Cognitive functioning	55.4 (SD=22.3)

Domain scores were categorized and averaged together to determine three summary measures: physical health, mental health and overall quality of life. The mean physical health score of all respondents was 65.6 (SD=22.3). The mean physical health scores did not differ significantly between men (mean=67.0, SD=17.3) and women (mean=63.8, SD=12.9). The vast majority (83.8%) of clients had physical health scores falling between 50 and 100 (see Figure 23). About 16% of clients had physical health scores below 50.

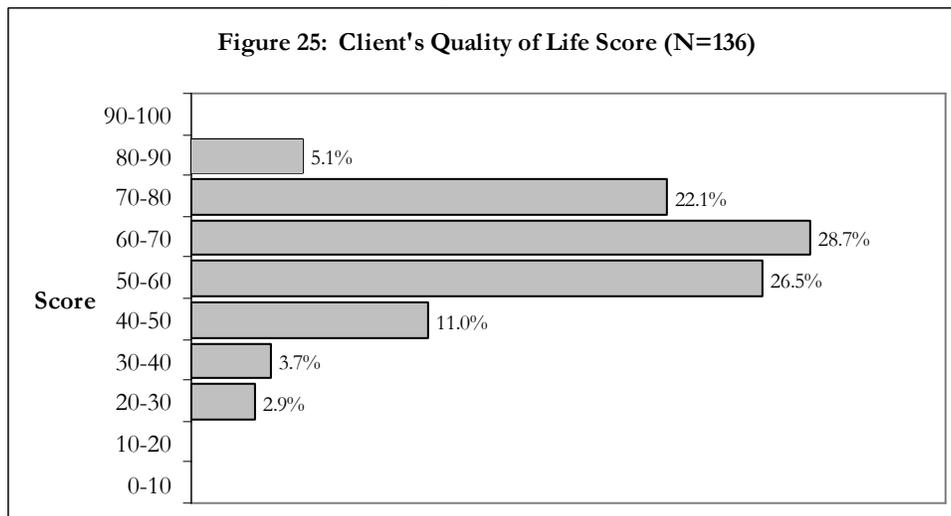


The mean mental health score of all respondents was 55.8 (SD=14.5). The mean mental health scores did not differ significantly between men (mean=58.98, SD=13.6) and women (mean=53.3, SD=14.7). Seventy-one percent of the clients interviewed had mental health scores falling between 50 and 100, while 29.4% of clients had scores below 50 (see Figure 24).



The mean physical health score was significantly greater at the $p < .001$ level ($p = .000$) than the mean score of mental health for the surveyed population as a whole. A significant positive correlation also exists between these two variables ($r = .622$, $p < .001$) indicating that those who scored higher on physical health also scored higher on mental health.

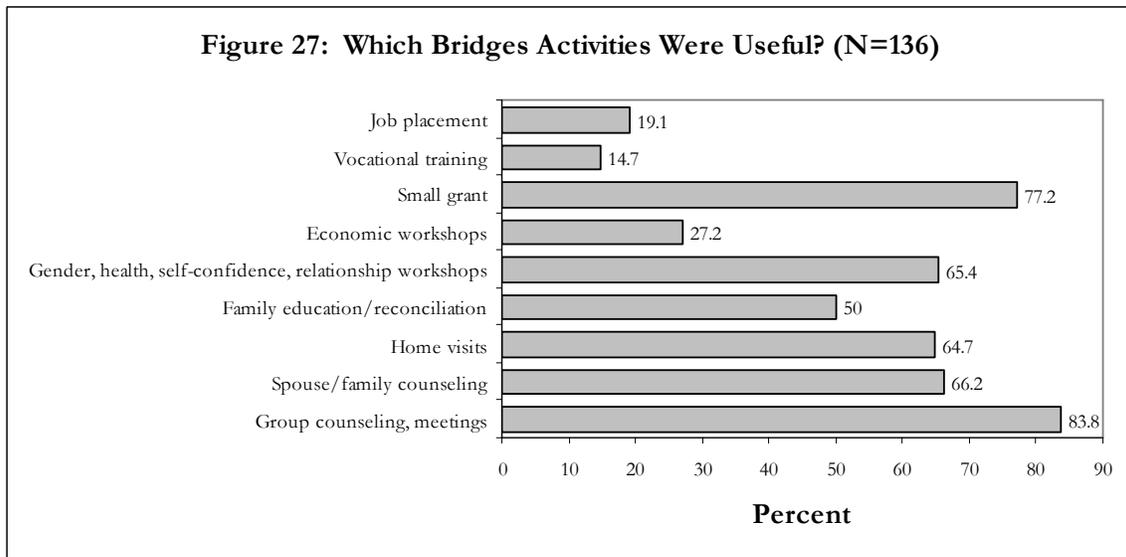
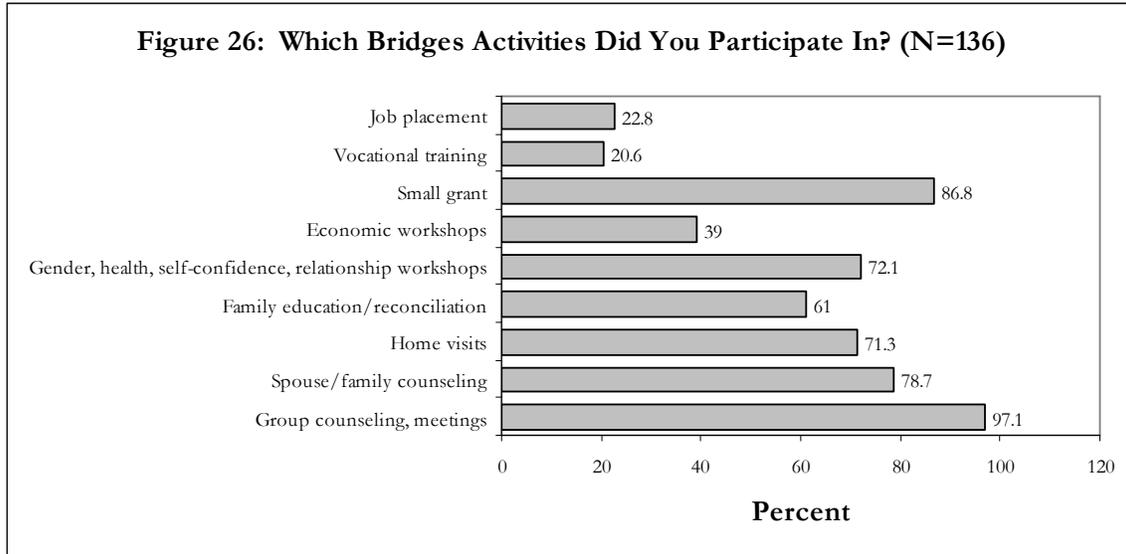
The average overall quality of life score for all respondents was 60.9 (SD=13.3). The mean quality of life scores did not differ significantly between men (mean=63.7, SD=14.5) and women (mean=58.8, SD=11.96). Eighty-two percent of respondents had quality of life scores greater than 50. A much smaller proportion (17.6%) had scores below 50.



Clients' Recommendations for the Bridges Project

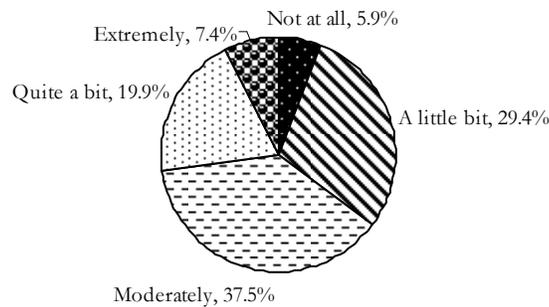
Figure 26 displays the list of bridges activities in which the respondents reported having participated. The following chart (Figure 27) shows the activities clients mentioned as being useful to them in their lives post-Maryknoll. The most commonly cited activities were group counseling and meetings (83.8%), small grant (77.2%), spouse/family counseling (66.2%), home visits (64.7%) and workshops focusing on issues such as gender, health, relationships and self-confidence (65.4%). Half of the clients reported family education and reconciliation is being useful. Economic workshops were mentioned less frequently (27.2%)

as were job placement (19.1%) and vocational training (14.7%). However fewer clients participated in these services as well.



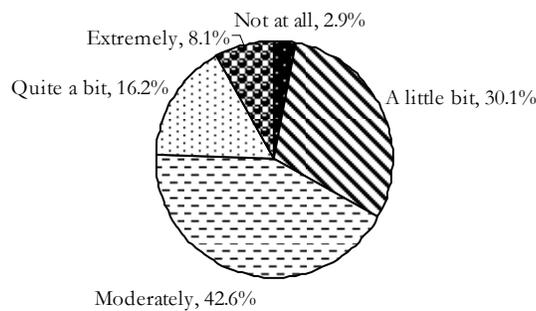
Respondents were asked if participation in the Bridges project helped them to cope with HIV and AIDS-related stigma and discrimination in the community. About 38% of clients reported that Bridges helped them to cope with stigma and discrimination moderately, 29.4% a little bit, 19.9% quite a bit, 7.4% extremely and 5.9% not at all (see Figure 28).

Figure 28: Did Participation in Bridges Help You to Cope with Stigma & Discrimination? (N=136)



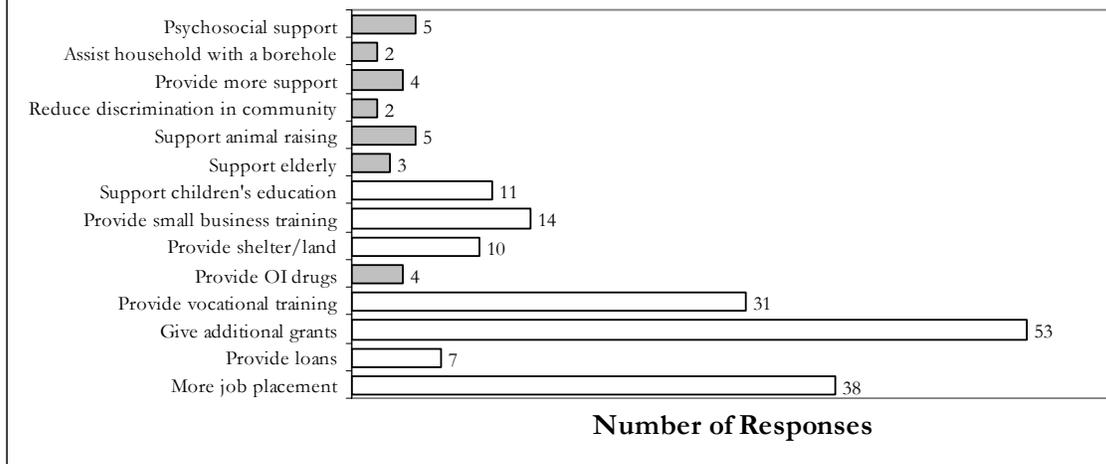
Respondents were asked if participation in the Bridges program helped them to live without Maryknoll financial assistance (see Figure 29). Nearly three quarters said that Bridges helped them moderately (42.6%) or a little bit (30.1%). About 25% said that Bridges helped them quite a bit (16.2%) or extremely (8.1%). Approximately 3% of respondents reported that participation in Bridges did not help them to live independently of financial assistance.

Figure 29: Did Participation in Bridges Help You to Live Without Assistance? (N=136)



Respondents were asked what the Bridges of Hope program could do differently to better prepare Maryknoll clients living with HIV and AIDS to live without financial assistance. The most frequent responses included giving additional grants (53 responses), focusing more on job placements (38 responses) and providing vocational training (31 responses). A full list of clients' ideas for improving the Bridges program is documented in Figure 30.

Figure 30: What can Bridges do differently? (N=136)



Interviewers asked bridged clients what type of support would be useful to them in their current situation. The most frequent replies include medical support (43 responses), psychosocial support (42 responses) and additional grants (32 responses). A full list of clients' needs can be seen in Figure 31.

Figure 31: What type of support would be useful to you at this time? (N=136)



Discussion

Clients' Household Economic Situation

Findings suggest that on the whole, the household economic situation of the clients who participated in the follow-up survey was reasonable. The vast majority of clients were economically active and involved in a wide range of income-generating activities. Very few were working in occupations commonly associated with extreme poverty such as selling recycled garbage or working as manual day laborers. Most clients were working in occupations with low skill and labor requirements. Though the majority of clients were the principal wage earners in their households, nearly half were also living with another working adult. On average clients reported spending time on income-generating activities similar to what one would expect in any working population. A substantial number of respondents reported having assets such as electricity, mobile phones, television and motorbikes. Results suggest that since bridging, many more clients had engaged in activities indicative of improved economic status (e.g. buying a phone or moto, making household improvements) than activities which may indicate failure in the household's economy (e.g. selling motorcycle, land or other household assets). Encouragingly a sizeable proportion started saving money, and almost all clients reported having enough money to buy food for the household and drinking water from a safe source.

While not the majority, a sizeable proportion of clients were living in households where they were the only economically active adult. Even though Bridges tries to identify extended family, and build the economic capacity of the family network rather than the client alone, this is not always possible for all clients. These households may not be able to withstand shocks, such as illness of the PHA, and may be more vulnerable to food insecurity and destitution. Because of the potential for increased vulnerability, the program might consider prioritizing clients who are the sole income earners for post bridging follow-up.

Slightly more clients were unemployed at the time of the survey than when they stopped receiving assistance from Maryknoll. A considerable proportion of clients reported changing occupations—mostly due to financial reasons—from the time their Maryknoll assistance ended to the present day. Other major reasons for changing jobs included being asked to resign due to HIV status and health reasons. Even though changing occupations was not associated with positive or negative activity post bridging, it was associated with lower quality of life scores.

The program should explore in more detail the reasons for the high frequency of deviation from the original bridge plan and if any of the reasons can be controlled for during the bridging process. For example, the program might work more closely with clients to analyze whether or not the occupation they wish to pursue is the best match for their skills and health situation, assess factors which could cause them to change jobs and if there are less risky alternatives, and develop contingency plans in case a change is required. Related to this issue are two recommendations which were made in a recent assessment report⁷ commissioned for the project. First, Bridges should focus on securing wage employment for clients living in urban or peri-urban settings since wage employment is a more stable source of income than micro-enterprises. Second, Bridges should consider facilitating on-going technical support for clients who choose to operate micro-enterprises since such businesses frequently fail. Linked to both of these recommendations is the need to routinely access and

⁷ “Assessing Livelihood and Enterprise Development Opportunities for the Socioeconomic Reintegration of People Living with HIV and AIDS,” Catholic Relief Services, 2006.

help clients analyze market assessment data to assure there is demand for the business/job beforehand.

Since a substantial number of respondents reported being discriminated against because of their HIV status, the program should consider developing strategies for reducing HIV-related stigma and discrimination in the workplace. This might include educating clients about the HIV and AIDS law and helping them to plan what they might do if they are encountered with discrimination in the workplace during the bridging process. The project might also consider forging linkages with legal or human rights agencies that could help support cases of discrimination. In cases where the program is facilitating job placements and apprenticeships, employers could also be sensitized about HIV and AIDS and the directives of the HIV and AIDS law in advance.

A small percentage of respondents had school aged children who were not attending school at the time of the survey. Lack of money to send children to school and children needing to work to support the household were the reasons for non-attendance cited most frequently. Furthermore, when asked if their monthly income was enough to send children to school, nearly one quarter of respondents reported that it was not. The Bridges program might examine the issues of child labor and non-attendance in school to see if there are steps that could be taken to reduce its occurrence. For example children's education status could be monitored during routine follow-up, and in cases of need families could be referred to Little Folks or other NGO programs for assistance.

In some cases bridged clients continued to receive Maryknoll assistance after bridging through the Little Folks education program. Interestingly, clients who were receiving assistance through Little Folks had significantly lower quality of life scores than clients who were not receiving such support. Since Little Folks enrollment is based on need and not automatic for the entire PHA population supported by Maryknoll, it's plausible that the Bridges clients who were being supported through Little Folks were worse off than their peers in other respects as well.

Clients' Health Situation

While PHA are active clients in the SoH program, they are supported to adhere to their drug therapy through counseling and education during home and office visits with project fieldworkers and physicians. Drug counseling for PHA and their treatment supporters (i.e. family members or friends) is a key part of all national and NGO ART programs in the country. Nevertheless, in the small sample of bridged clients, nearly one quarter of them reported having stopped their ART during the three months prior to the survey. And having a treatment supporter was not found to be associated with overall adherence in the Bridges client population. Taking medication late and missing doses were both significantly correlated with declining quality of life scores. In addition, respondents who stopped taking medication during the previous three months were more likely to report experiencing a number of health problems. These findings point to the need for a better understanding of the factors which influence drug adherence and alternative strategies for improving it. Positive deviance inquiry might be useful here. Since the essence of the Bridges project is to prepare clients for graduation from Maryknoll assistance, it may not be realistic to expect the program to continue to provide drug adherence support. Instead the project may consider other alternatives, such as facilitating access of clients to MMM or other PHA support groups and/or building the capacity of these groups to provide drug adherence support.

There is a need to look at more reporting and advocacy with NCHADS and health facilities providing ART, as a considerable proportion of clients reported paying for what is supposed to be free treatment. This finding is particularly relevant since there was a significant relationship between cost of treatment and poor adherence in the surveyed population. CPN+, local MMM groups and health center advisory committees might also play a role in advocacy and monitoring the occurrence of informal payments in health facilities.

Bridged clients reported experiencing a number of health problems and symptoms associated with HIV and AIDS and ART. It is out of the scope of this survey to suggest factors that might contribute to such conditions and further research is required to examine the role of factors like drug adherence, treatment failure, incomplete treatment of OIs, nutrition, co-infection with malaria and other infections, hygiene and sanitation have on frequency of illness. Nonetheless it is plausible that coping with these symptoms and illnesses does have an impact on physical health, mental health and overall quality of life. This hypothesis is supported by the survey findings, which demonstrate a link between experiencing several conditions (e.g. diarrhea, respiratory infection, skin rashes, headaches, etc) and lower quality of life scores.

Most clients reported consuming a good variety of foods with adequate frequency. Although diet diversity appeared to be quite good, the survey was not able to assess quantities of food consumed to determine if diets were meeting minimal nutritional requirements. It should be pointed out that weight loss during the last three months was reported by 36% of respondents. In addition, a considerable number of respondents reported experiencing symptoms which could contribute to impaired nutritional status including loss of appetite (47.1%), nausea (33.1%), diarrhea (25.7%) and vomiting (10.3%). Furthermore 40% of the group did not consume any form of fat, which helps with the absorption of some nutrients and helps to make foods more calorie-dense. Only a very small percentage of clients had a home vegetable garden.

The role of nutrition in the routine management of HIV and AIDS is not widely developed in Cambodia at present. There is a need to integrate nutritional assessments into care and treatment protocols and develop counseling materials, which give clear guidance on diet recommendations using locally available foods, for maintaining and improving nutrition, as well as managing OI symptoms and maximizing the effectiveness of ART. All clients who have small parcels of land should be encouraged to plant home vegetable gardens using low labor techniques as such gardens can contribute greatly to the quantity and diversity of produce consumed by a household. Training in home gardening might be combined with education on particular vegetables and herbs useful for preventing and managing common symptoms and conditions. Linking with programs supporting low labor, small animal-raising schemes is also recommended. In the future, project follow-up surveys should try and assess change in weight and/or body mass index, which is a better indicator of nutritional status.

Family Support and Social Inclusion

Since disclosing one's HIV status was significantly associated with higher mental health scores, disclosure to family and assistance with doing it should continue to be a key emphasis of the Bridges project.

In general clients expressed satisfaction with the support they received from their families and the role they play in their households. Nevertheless, nearly 30% reported being discriminated against by their families. Because family discrimination was found to be a significant predictor of overall quality of life, Bridges should assess whether or not more

effort needs to be placed on minimizing occurrences of family stigma and discrimination. Family counseling should continue to be a priority for the project.

The great majority of clients was receiving community support from health centers, NGOs, pagodas and other community groups and participating in PHA or MMM groups at the time of the survey. Community support/involvement should be actively encouraged since clients who received such support reported feelings of greater community acceptance and greater community acceptance was significantly linked to higher mental health and overall quality life scores.

Quality of Life

Several variables were found to be significantly associated with lower overall quality of life scores including changing occupations after bridging, receiving Little Folks assistance, taking ARVs late or missing doses during the last week, having experienced diarrhea, respiratory infection, skin rash/sores, headaches, pain, loss of appetite, weight loss, sexually transmitted infections, vomiting, anemia, loss of body fat and numbness during the previous three months, and family discrimination. Conversely the number of positive economic activities engaged in after bridging, satisfaction with health care facility, greater number of meals eaten the previous day and feelings of community acceptance were all associated with higher quality of life scores. Each of these associations is discussed separately elsewhere in this report.

Of interest is the finding that average mental health scores were significantly lower than the physical health scores among the surveyed population as a whole. Supporting this finding is the high frequency of requests for psychosocial support among clients when asked what type of support would be useful for them in their current situation. The issue of on-going psychosocial support should be considered, along with the role (if any) of the Bridges team in providing it. As part of this assessment, additional research should be undertaken to define in more detail clients' psychosocial needs and if there are any community-based outlets for meeting them. The project should consider facilitating the establishment of peer support groups for bridged clients as a means of on-going psychosocial support after bridging.

The follow-up survey was the first time that SoH and Bridges utilized the quality of life index. While the follow-up survey provided a snapshot of the bridged clients' quality of life at the time of the survey, there is no point of reference with which to compare the survey findings. Therefore, it is not possible to know if quality of life has increased, stayed the same or decreased since the time clients stopped receiving Maryknoll assistance. It is recommended that SoH and Bridges routinely administer the quality of life index to all PHA clients at the time of enrollment, annually while clients are enrolled in SoH, at the time of bridging or graduation from Maryknoll assistance and during any follow-up surveys of bridged clients. With this data it will be possible to assess change in quality of life through time and evaluate more systematically the impact of Bridges of Hope (and Seedling of Hope) program support has on clients.

It is recommended that Bridges implement a regular follow-up component, designed while taking into account the human and financial resources available for the task. The project should consider visiting all clients three months and six months after bridging. A follow-up survey, similar to the one used in this exercise, could be administered to all bridged clients after six months and annually to a sample of clients that is followed longitudinally over a longer period of time (e.g. 3 years). Routine follow-up could serve multiple purposes such as allowing for closer monitoring of clients who are less secure

economically, health-wise or socially; allowing for early intervention and support of cases that need temporary assistance; generating feedback on Bridges activities that are helpful or need to be improved; and contributing to the understanding of how to support long-term survival on ART in Cambodia and beyond.