Policies and politics underlying the path for universal access to treatment against AIDS in Cambodia

Frédéric Bourdier*

Working Paper No 18

2006

Centre for East and South-East Asian Studies

Lund University, Sweden

www.ace.lu.se

*Frédéric Bourdier is Anthropologist at the Research Institute for Development from France. Currently he coordinates a research programme on health policies in Cambodia (fredericbourdier@hotmail.com)

WORKING PAPERS IN CONTEMPORARY ASIAN STUDIES

General editor: Professor Roger Greatrex
Assistant editor: Nina Brand

Publications in this series:

1. Is the world Ready for a Coherent ASEAN+3? / Cesar de Prado Yepes / ISBN 91-975093-0-2
2. Renegotiating Gender and Power: Women's Organizations and Networks in Politics – The China Women Mayors' Association / Qi Wang / ISBN 91-975093-1-0
3. Re-evaluating Preventive Diplomacy in Southeast Asia / J. Michael Tivayanond / ISBN 91-975093-2-9
4. The Role of Law in Contemporary Indonesia / Mason C. Hoadley / ISBN 91-975093-3-7
5. Closing the Digital Divide: Southeast Asia's Path towards a Knowledge Society / Hans-Dieter Evers and Solvay Gerke / ISBN 91-975093-4-5
6. De-colonising Indonesian Historiography / Henk Schulte Nordholt / ISBN 91-975093-5-3
7. Path Dependence, Change, Creativity and Japan's Competitiveness / Cornelia Storz / ISBN 91-975093-6-1
8. China Regaining Position as Source of Learning / Jon Sigurdson / ISBN 91-975093-7-X
9. Prospering on Crime: Money Laundering and Financial Crises / Guilhem Fabre / ISBN 91-975093-8-8
10. Implementing anticorruption in the PRC – Patterns of selectivity / Flora Sapio / ISBN 91-975093-9-6
11. Shaping the Future of Asia – Chiang Kai-shek, Nehru and China-India Relations During the Second World War Period / Guido Samarani / ISBN 91-975726-0-8
12. The Consumer Citizen in Contemporary China / Beverley Hooper / ISBN 91-975726-1-6
13. Defining Southeast Asia and the Crisis in Area Studies: Personal Reflections on a Region / Victor T. King / ISBN 91-975726-2-4
14. Women in Politics in Thailand / Kazuki Iwanaga / ISBN 91-975726-3-2
15. The Return of Piracy: Decolonization and International Relations in a Maritime Border Region (the Sulu Sea), 1959-63 / Stefan Eklöf / ISBN 91-975726-4-0
16. Youth and the State in Contemporary Socialist Vietnam / Phuong An Nguyen / ISBN 91-975726-5-9
17. In the Ancestors' Shadow: Cultural Heritage Contestations in Chinese Villages / Marina Svensson / ISBN 91-975726-6-7
18. Policies and politics underlying the path for universal access to treatment against AIDS in Cambodia / Frédéric Bourdier / ISBN 91-975726-7-5

This working paper is published by the Centre for East and South-East Asian Studies, Lund University. The views expressed herein, however, are those of the author, and do not represent any official view of the Centre or its staff.

ISSN: 1652-4128
ISBN: 91-975726-7-5
Layout: Petra Francke, Lund University, Information Office
Printed in Sweden by Lund University, Media-Tryck, 2006
© Frédéric Bourdier

Abstract

From February 2006 in Cambodia, national health deciders and international agencies are re-organizing a new health policy agenda consisting of the promotion of free access to antiretroviral treatment (ART) for all the infected persons having less than 200 CD4 counts throughout the country (soon it will be less than 250 CD4). Such a decision is definitely a step foreword if one remembers that HIV positive people have been totally denied ARV treatment till 2001. With the exception of Thailand, Cambodia is the first nation in Asia and South-East Asia adopting such a health delivery coverage, having in mind that it is one of the poorest countries in the region, with at least 80% of the population living below the poverty line. Unlike in Brazil ten years ago, universal access represents a challenge not only from a health perspective but also from social, political and economical perspectives.

The paper intends to present quickly the evolution of the health situation related to HIV/AIDS treatment, before focusing on some hidden concepts underlying the public process, run by local planers and outsiders, whose common aim is to "put the treatment first for every body", according to the classical rhetoric of medicine accessible for all, including the most deprived.

A fair statement, clad in compassionate slogans, remains however insufficient if the drugs delivery system is not elaborated within a sustainable approach (quality of care, diversity of drugs protocols, socio cultural considerations, training of medical staffs, etc.). We also may wonder whether the new deal concerning universal access reflects other policies and politics like the ones tacitly expressed by persons or groups who, aware that a health system is a political system, know that a health focus on the epidemic will create both national and personal prestige, and attract donors for other development issues in a country still under economic perfusion.

Contents

Introduction 1

Context of the collective research in Cambodia 3

Methodology and perspectives of approach 5

Path for universal access to treatment:
political issues and controversial implementation 7

For a political anthropology of health development 21

Introduction

The analysis of public intervention represents a constitutive dimension for the interpretation of the policies and projects of development. In this perspective, it is a thematic for investigation as a whole. It becomes scientifically relevant to be loyal to the theoretical and methodological innovative aspects related to a politico-anthropological insight, if one of the aims of a research is to contribute through long term field enquiries to a better understanding of institutional and social processes operating in the public policies for development, specifically within a particular representative sector related to health. Subsequently, institutions as well as actors of development become a subject for investigation together or separately[1]. In this paper, which is presented as an introduction to a further broader analysis having a more systemic overview, I decide by choice and also by constraint (insufficient data available at the stage of the enquiry), to concentrate on individuals and not on institutions, even if social developers are part of institutions and reflect to some extent, but not always, the main ideologies of the agency employing them.

Deciders, planners, politicians, implementers and other individuals are part of a chain of social actors. And each link of the chain not only interacts with other social actors but lives, develops particular convictions and rationalities, and finally engages in various personal strategies mixing professional responsibilities, personal well being and spiritual sustenance. Even if a reflexive consideration is not yet prevalent in developing agencies, such preoccupation appears more and more relevant in the field of political and anthropological sciences, considering the fact that, despite the energy devoted to generating the right policy models in development (at every levels of intervention and in different domains of action), little attention is given to the relationship between these models and the practices and the events that they are expected to generate or legitimize, as David Moose argued in a paper recently published[2]. The author remind us that understanding the relationships between policy discourse and field practices has been hampered by the dominance of two opposing views on development policy that can be characterized as follows[3]. On the one hand there is an instrumental view of policy as rational problem solving, directly shaping the way in which development is done. On the other hand, there is a critical way of analysing

---

[1] Jean-François Baré (ed.), *Paroles d'experts. Etudes sur la pensée institutionnelle du développement* Paris, 2005, Karthala.

[2] David Moose, Is Good Policy unimplementable? Reflections on the Ethnography of Aid Policy and Practice, *Development and Change*, 2004, 35(4) : 639-671.

[3] David Moose, ibid, 641

the socio-political dynamics that sees policy as a rationalizing discourse concealing hidden purposes of bureaucratic power or dominance, in which the true political intent of development is hidden behind a cloak of rational planning. From my own point of view adopted in this paper – which does not take into account the larger scope of the analysis undertaken by Moose considering not why but how development is made – I intend to do justice to the complexity of a specific policy-making undertaken in Cambodia, by showing how and under which circumstances this so-called policy is in fact interconnected with other logics of developments having little, or even nothing, to do with the proposed goals of the initial target which is the path to universal access to treatment against AIDS.

I have divided the paper into three parts. First I shall briefly introduce the collective programme. This introduction provides the contextual framework of what will be developed afterwards, specifically the rapid scaling up strategy of antiretroviral treatment. Second, I shall explain the main approaches that have been implemented for the field work. Far from being a methodological digression, it shows how the data collection has been conditioned, insofar as any production of knowledge strongly depends on the way one manages to obtain information. In other words, the choice of a suitable methodology adapted to the socio cultural realities and to the numerous and ambivalent social actors' "ways of planning, thinking and doing" remains vital if we want to penetrate the concepts underlying the development process. Lastly, I shall focus on the path to universal access to treatment against the epidemic. This theme has been chosen because it is the new given strategy of the Cambodian national government, resulting from the latest policies of the UN System[4]. Because of its actuality, it becomes a relevant matter of investigation. Our purpose here is less to provide a mere description of the agenda of the universal access strategy, framed in a consistent official policy than to analyse the way the Khmer national government shifts its policy from its "let's wait and see" mood of four years ago to one of the most aggressive statements promoting "free treatment for all". In other words, how and why a specific government has been in a position to change its health policy, and what does it mean in terms of development impact?

[4] Quite a few countries have been involved in the 3 by 5 strategy launched in 2004 by the WHO, and actually in the universal access policy encouraged by the WHO, as well as other United Nations bodies. We will focus here specifically on the Cambodian issue, without assessing what it represents as either a representative model or a typical feature of what is going on between international developers and national deciders.

Context of the collective research in Cambodia[5]

Without considering the unorganised private and non-formal sectors, antiretroviral drugs have been officially available in Cambodia since 2001. At that time, a few hospitals in Phnom Penh and subsequently in the provinces launched proper care-cum-drug-delivery centres for a limited number of AIDS infected persons. The potential strategy of universal access to HAART (highly active anti-retroviral treatment) was not yet on the agenda, not even thinkable or debated, when this research was launched in early 2004.

It was the time of the 3 by 5 strategy within the UN. This strategy was a global initiative under the technical leadership of the WHO that aims to provide 3 million ART treatments by the end of 2005[6]. To reach this goal, the Global Fund for HIV/AIDS, malaria and TB was supposed to give financial support at the country level.

In the course of time, interactions between external donors, multilateral agencies, non governmental organizations (NGOs), national bodies and civil society have been repeatedly reformulated. This led to the crucial questions of national management and, to some extent, local governance. In spite of foreign assistance, Cambodian institutions were supposed to be more actively involved in the decision-making processes. They have been as well in charge of proposing their own health guidelines, dealing with external funds and distributing them to the various NGOs involved in care and treatment, knowing that more than 90 NGOs are presently working in the field of HIV/AIDS. In Cambodia, more than 3,500 persons came under treatment at the end of 2004 (but without GF money and mainly with private money from NGOs like Médecins sans frontiers France and Belgium/Holland), 7,600 in August 2005, and more than 10,000 in December 2005.

In this context, the main objective of the present research was to analyse the policies and strategies for the distribution of ART drugs currently existing in Cambodia and to see to what extent and under which conditions this implementing process is going to increase over the long term, and eventually be progressively taken as a model for a sustainable and relevant national health care policy. This objective has been divided in two subordinated aspects:

---

[5] The programme is named: "The politics and policies for the extension of ARV drugs in Cambodia: perception, implementation, obstacles and impacts". Only some of the scientific orientations of the research programme that are directly related to the topic of the paper are presented.

[6] World Health Organization, *Treating 3 Million by 2005, Making it happen, WHO Strategy*, Geneva, September 2003, World Health Organization, 55.

1) First, the identification of the anti-AIDS organisation system, of its potential capacity and ability to follow on a middle and long-term basis HIV infected persons. We started with an observation of its complex functioning: policies and politics, operational constraints, evolution and stability of the multifarious strategies of decisions and interactions with the social dynamics. Even though we focused on what is happening on the Cambodian government side, special attention has been given to external interferences. We kept in mind that the country still remains under economic and political dependence (International donors, aid institutions, multilateral agencies, etc.). We choose to consider these factors in order to take into account acceptances, re-appropriations, structural obstacles, resulting conflicts and potential benefits that such huge international cooperation may generate.

2) Second, we wanted to know about the feed-backs to the patients of the national policy, through a long-term concrete follow up of the beneficiaries. An attentive examination of the discourses, perceptions and practices of both HIV infected persons and medical staff regarding access to treatment enabled us to go beyond the rhetoric of the planners, developers and deciders. We aimed at determining socio-medical criteria conditioning access to treatment, having in mind that these identified criteria may lead to a sustainable adherence related to the ARV drugs in the country.

3) In order to have a more systematic overview, we observed the various strategies of care implemented not only in hospitals but outside the health structures within the society itself (care continuum, home-based care, community care, ART procurement).

Initially, the main location of the program was in Phnom Penh, specifically for the political and anthropological analysis related to public health policies and interventions. Most of the decisions and implementation processes were taken, in fact, in the capital city. But due to the decentralisation of access to therapy to reach the 3 by 5 target, we extended our activity out of Phnom

Penh, into four provinces (Siem Reap, Takeo, Kampot, Kandal). The extension of our work enabled us to integrate into our research a geographical and social comparative dimension. We wanted to follow the evolution of how international and national guidelines, along with policy planners' interferences, were *de facto* decentralized and implemented outside the capital in provincial cities and in rural districts. Everywhere, non governmental organisations contributed directly with the government - sometimes separately - to the geographical extension of care and treatment.

Methodology and perspectives of approach

The first scope of our investigation has been devoted to understanding on which basis health policies are decided and whether consequently they have been implemented in a similar perspective or with some adjustments, taking into consideration political, socio-cultural contexts and provincial public health specificities. For this purpose, policy planners, deciders, health development specialists, representatives from multilateral agencies, external donors, NGOs as well as members of the civil society became, *de facto*, our privileged interlocutors.

In the second phase, we decided to collect feed-back from people living with HIV/AIDS. The first group of individuals with whom we developed on-going relationships has been infected persons and their families. These individuals have not all been receiving ART from the official sector: they may have been refused or rejected from public hospitals or are not yet eligible for help from NGOs (as a member of their active file). Other contacted persons whose attitude and discourse are extremely relevant to understanding people's voices were the those who participated, in different manners and to different degrees in civil society's efforts, sometimes through associations, for advocacy or, more strongly, as activists who claim the right for the whole infected population to receive the treatment.

How do we organize our research? The team is composed of a group of ten researchers, half of them Khmer and the other half foreign advanced students, with different assignments and terms of time (from six months to three years). The present research is therefore a collective one, based on an interdisciplinary approach including public health, anthropology, sociology, political economy and political science. It aims to strengthen a local research team recruited from Phnom Penh University. Each student develops a particular topic. The first concentrates her efforts on providing an overview of

the ART delivery system in the private sector, through analysis of the international pharmaceutical network, marketing strategies, and linkages with local providers and doctors. The second focuses on the emerging mobilization of social groups - specifically among people living with AIDS - in their expectations for more equal access to ART. Two other persons, acting as key research assistants for establishing various contacts with the infected patients, are following different categories of people receiving home-based care, either from government institutions or with autonomous support associations.

The IRD French team has integrated five French contributors. A student in medicine and anthropology is identifying how the selection process to receive ART is elaborated in a given urban health infrastructure. A Ph D fellow in Anthropology is focused on the socio cultural representations related to ART among health professionals and the general population. She intends to reveal the vernacular social construction of the medicines and the meaning of "what is a treatment" for the infected people. A French-Khmer scholar in anthropology is working on the social and spiritual involvement of Buddhist monks. She is providing an account of the formal linkages that the religious organizations establish with the national AIDS policy. Another Ph D fellow in anthropology is analyzing the involvement of the "experts-patients". Experts-patient is an expression formulated at the international level to denote the contribution to the improvement of the struggle against the HIV epidemic by employing - and professionalizing – HIV infected persons. Apart from coordinating the research activities, I focus on discourses and practices from politicians, planners, deciders, social actors, public health experts and doctors in charge of various organizational aspects and operational assignments related to HIV/AIDS care and treatment, including drug procurement and the distribution system at the national/international level.

These contributions are going to provide new facts and figures on the quickly changing situation of Cambodian HIV/AIDS policy. Each personal research project complements and strengthens the others. Thus we develop together a multi-centred complementary approach, so as to provide a comprehensive understanding of the social and political dynamics underlying the fundamental issue related to care and treatment. In order to avoid research that could be criticized as existing in isolation, we undertake a political-anthropological monitoring. This means that we develop an interactive partnership – even if not always on formal grounds - with some of our interlocutors who are usually highly specialized but do not have an

opportunity to grasp the broader comprehensive socio-political and medical insight that *we* hope to reach.

Qualitative inquiries are systematically privileged according to classical anthropological methodology. With our interlocutors who are health professionals, we try to let them speak not of what they are supposed to do but how they manage to apply their expertise into action. This is a side of themselves that generally they are not used to revealing. Concerning laypersons, we regularly meet them, strengthen the trust, encourage intimate relationships, follow their quest for treatment access and quality of life, and enable them to speak about what they perceive as their own personal concerns. Sometimes - if we can - we act when we are confronted with situations that need to be changed[7]. In such cases the research eventually becomes a struggle. We have decided that we stand on the patient's side and we help them to receive what they are normally authorized to receive either from the government or from a NGO.

Otherwise, we do not "perform" focus group discussions or rapid assessment procedures (quick quantitative enquiries) because we are far from convinced of their relevance for scientific research. Constructive interpretations of data depends on a long term analysis emanating from observation, oriented enquiries and, whenever possible, "participative involvement".

It would be too long to provide in detail the methodological background. But this preliminary presentation leads me to introduce the topic that raises should raise debate and concentrate the attention of all health developers. With the exception of Thailand, for the first time in Asia, a country – small, disorganised and poor – has oriented its policy towards universal access. Let us analyse this important, timely and extremely sensitive issue.

Path for universal access to treatment: political issues and controversial implementation

Cambodia is categorized as one of the least developed countries in the world with an estimated GNP per capita of US 280. For the last 20 years the Khmer territory, with 13 millions inhabitants as of 2005, has been

[7] For instance, one religious NGO which established a rescue home for infected mothers and children was preventing access to care and treatment for the mothers (they were just waiting for them do die, before taking the orphans into a so-called "new family" taking the form of an international orphanage). Many patients started to ask us to support them in lobbying to receive proper attention, or not to be discriminated intentionally by medical staff.

rebuilding its whole societal environment as well as a health system dismantled by war. Nowadays guerrilla warfare is over, administrative efforts are being undertaken, development assistance has made substantial progress (at the same time as suffering serious drawbacks in every sector), and political stability prevails, even if a proper application of democratic values is still in the pipe line. Cambodia is a country in transition. Institutional mechanisms, including the health system have to be elaborated with new infrastructures and regenerated human resources. But these components are scarcely apparent in spite of the massive aid and a potential internal capacity that have been obstructed by vote-catching, social and political nepotism. A middle class has emerged quickly along with an upper class (composed of politicians, high ranking persons and the top military) that has managed to take advantage, for their own profit, of the so-called development inputs.

Within a decade, socio-economical inequalities have increased, corruption has become rampant and the gap between rural and urban areas (mostly Phnom Penh) has widened. More than 70 % of the population remains in villages in very poor living conditions[8] (far from NGOs and public amenities) and the migration flow to the capital is tremendous.

The average minimum salary of 30 US dollars per month for those employed in government jobs or in the factories concentrated around Phnom Penh (run by foreign companies) allows, with great difficulties, a single person, but not at all his family, to survive decently. Debt is the major vernacular strategy to temporarily overcome this problematic socio-economic configuration[9]. Needless to say, health complications aggravate the generalized debt process[10], and various pieces of research and unpublished reports compiled by doctors working in NGOs offering treatment have noticed that people living with HIV/AIDS are one of the groups which is most victimised by this bogus solidarity system[11].

In terms of health and development, the government's overall strategy, in agreement with the external donors, is to improve equity and accessibility to essential health services to rebuild confidence in the public health sector.

---

[8] Data on poverty in Cambodia is controversial. For instance, the Cambodian Economic Survey in 1999 was carried out in two rounds of interviews. The first round resulted in a headcount poverty rate of 64%, the second 35,9%. Needless to say, both those statistics (even the more optimistic) reflect more an intention to show a very particular representation of the socio-economic reality than to identify, with adequate tools, a representative sample of the population.

[9] Oxfam Hong Kong, *Women agenda for change: the debt bondage*, Phnom Penh, 27 October 2004, 57.

[10] Maurits Van Pelt, Health Consultant, personal communication (Phnom Penh), 2005.

[11] Interestingly, a "key" UN report hardly considers the primordial impact of debt that lead to an increasing poverty. See: Bloom D.E. *et al.*, *Health, Wealth, AIDS and Poverty. The Case of Cambodia*, Geneva, 2001, UNAIDS, 34.

Despite widespread poverty, many Cambodians still opt to pay for private sector services rather than use what is perceived to be a low quality public health sector, where services are supposed to be free, but where patients have regularly to pay money under the table and are ill-treated. The apparently equitable strategy is formulated by people who have the know-how to design a politically correct policy supposed to attract international funds. In reality, it remains pure rhetoric, elaborated with fashionable and attractive concepts like "best practices", "community participation", "ethical inputs", etc. Besides a few exceptions (coming either from a particular public hospital, a NGO programme, or both together), it hardly appears in the field. They are neither the social commitment nor the political willingness to strengthen and clarify such vague political assignments so that they can be effectively implemented. The declarations remain on the paper they are written on.

In spite of a few constructive changes, the socio-economic and health situation has been more or less the same for the last ten years, at least in terms of equal distribution. It is in this context that the HIV epidemic burst out and spread quickly in the country. Sentinel surveillances revealed that from 1997 Cambodia was experiencing the highest prevalence and incidence of HIV/AIDS in the Asian-Pacific Region. In spite of different statistical estimates (due to different methods of calculation), it was roughly estimated to be 2,6 % at that time[12].

Until 2000, the only activity that was implemented to fight the epidemic was prevention, even at the level of the NGOs sector, with very few exceptions. However, it was estimated that 18,900 new infections of AIDS occurred in 2002 (apparently less than in the previous years) and that 157,000 people lived with HIV/AIDS (also less than before, and probably because many had died). Care and treatment finally became major issues to be considered, after ten years of silence. But it still remained for too long a time nothing more than a topic of endless office discussion.

A change in policy does not occur simply. The right for people to have a chance to access to treatment has been a fight. Civil society was neither invited to participate in the debates and decisions (not even as an observer) nor was it allowed to present any claim. Such mobilisation would have been interpreted with acrimony as a sign of irrelevant protest by ignorant people unaware of the structural constraints prevailing in the government administration and in the international luxury bureaux. On the other hand, international agencies,

[12] NCHADS, *Cambodia's Behavioral Surveillance Survey 1997-1999*, Phnom Penh, 2001, Ministry of Health, 29. ; NCHADS, *Report on Sentinel Surveillance in Cambodia*, Phnom Penh, 1999, Ministry of Health, 63.

including the WHO and other UN bodies, did not provide any support to access to treatment prior to 2000. According to them, it was too early. The country was not prepared, even though many people – we will never know the exact number amount – were dying of AIDS every day. One can remark that even if a given country is not yet sufficiently prepared, international agencies along with the government are supposed in the meantime to take some necessary steps in order to prepare the country to absorb a new health policy. But this not been the case, at least for the UN, the Asian Development Bank and other bilateral entities, in which most of their numerous consultants repeat that their mandate (which parallels their professional recognition within their own agency) was to go in the same direction as the country policy (whatever its drawbacks and incoherences), and eventually to strengthen it, either through advocacy, planning reinforcement or, last but not least, by designing attractive written policies, irrespective of their proper adequate implementation. This remained, at the most, a second priority.

Only a few medical NGOs (at first two, then three at the beginning up to 2003) had the initiative and the courage to welcome infected people. I say *courageous* because some of them have been threatened by public health officials, even by international experts. With a qualified staff, their own drugs procurement and distribution system, these NGOs managed however to show that HIV persons, including those among the poorest, were fully able to observe the constraints of regularly taking the treatment, in accordance with the given prescription.

It was proof that the statements of international officers were full of preconceived ideas (among them: prevention is more important than care, treatment is not cost/effective, people are not responsible, etc.[13]).

Little by little, both officially appointed Khmers[14] and the community of expatriates in charge of monitoring and evaluating the AIDS policy emerged from their air-conditioned offices and discovered a social reality that they were not aware of, leading to the conclusion that it was possible to treat as well as prevent. The constructive efforts undertaken by a few NGOs members generated a precedent.

---

[13] Bourdier F., *The Extension of HAART Drugs Delivery in Cambodia: from Socio-Medical to Political and Economic Challenges*, Chang Mai (Thailand), 10-12 November 2003, Paper presented at Chang-Mai Conference on « Social Sciences and AIDS in South-eastern Asia: research inventory, priorities and on going perspectives », 15.

[14] Not all of course. Some of them – including the NCHADS director – encouraged the first NGOs to show the way (by including care, treatment and prevention) that the country could afterwards follow.

Once faced with a concrete reality, it created a precedent because neither the government nor the international community involved in Cambodia's affairs could continue to encourage a strategy strictly based on prevention since the care component has been proved to be feasible. It would be regarded as a conservative policy, in comparison to what had been achieved apparently with success by foreign NGOs (some of them considered by medical activists).

On the one hand, it was the perfect moment for those officially in charge of the struggle against the epidemic to elaborate a real care and treatment policy. And to control it. No question of allowing a mushrooming of private, isolated drug-distribution centres that, according to some deciders (either outsiders or local), would do what they want to do, with their own ideological statements, even if they had been the care pioneers.

A health system is a political system. In that respect, it became a challenge for some decision makers, strongly supported by their government and international agencies, to emerge as the leading persons, possessing the capacity, and sufficient power to be "operational" (as it was termed) for the launching of a planned policy, perceiving care and treatment as a human and medical priority.

Negotiations between the Ministry of Health, more precisely with the Institution in charge of the struggle against HIV/AIDS, and private NGO entities have been, however, more complex than it seems. The numerous guidelines were scarcely adapted to medical and social contexts[15]. The public sector lacked human resources and adequate health establishments, while some NGOs structures have field experience and were more technically and medically advanced. So the first needed the second to receive basic teaching, monitoring and expertise: training in infectious diseases, and increased skills in the public health and equipment planning needed for a better following up.

On the other hand, it is true that the NGO centres were concentrated in a very few locations (there were only three in the country, principally in Phnom Penh). This means that infected patients, whenever they could, would migrate from their distant native or living places to find somewhere to stay in cities, which were synonymous with medical hope and recovering health. One of the concerns of the government was to avoid this migration and to organize, step by step, a better spatial integration of health services so as to respond to the medical demands of the infected population.

[15] By way of comparison, a small country like Cambodia has written many more guidelines than huge countries like Brazil. Size does not reflect the complexity, but one may wonder whether repeated and compartmentalized guidelines generate clarity or obscurity for those who are supposed to follow them.

In order to know where the establishment of drug distribution centres should receive priority, more than one hundred HIV voluntary test centres have been created[16]. They are not spread evenly over the country (some provinces have been forgotten without any apparent reason, apart from the fact that nobody wants to go there) but concentrated in most of the populated areas. Along with deployment of screening facilities, the government started for the first time in 2004 to establish HIV/AIDS clinics, based in provincial referral hospitals and specifically in places viewed as "hot spots", where the epidemic was supposed to be more prevalent than in other low-incidence zones. In most cases, the appointed provincial health secretaries who used to work quite independently from the central board in Phnom Penh started to receive, under government supervision, financial support, regular training from international agencies like CDC, FHI, MSF Belgium and Holland and also from emerging local and efficient NGOs like CHC (Cambodian Health Committee). *Paradoxically, the geographical decentralisation encouraged by Phnom Penh increased the control of public health institutions from the capital over the provinces and reinforced a process of centralisation.*

Furthermore, there has existed a financial prerequisite to implementing the new national policy. The country has been in a position to regulate and draw up a middle plan with the Global Fund. This agency created in 2001 - based in Geneva and relying on international donations – operates as a financial instrument, not an implementing entity. It makes available and leverages additional financial resources. It supports programmes that evolve from national plans and gives priority to Cambodia which has been one of its important beneficiaries. Cambodia has now seen over two years of the implementation of Global Fund programmes, including those which involve the distribution of ART medicines. Currently, 101 million dollars of grants provided in four rounds of funding, have been approved for the HIV/AIDS component alone. This is not only because the HIV prevalence was high: other countries experiencing more desperate situations do not receive anything, or much less. It is because Cambodia has managed to show clearly – at least on paper – its national plans and priorities, in accordance with what

[16] Even, in fact, if the screening of the people is not strictly aimed at providing treatment to them. For developers, a trend to propose systematic HIV testing also justifies the partial outcome of a care policy. It is something visible, without an evident outcome, undertaken independently and without a proper follow up. For instance, local actors who are in contact with the newly identified infected population remain doubtful of the impact of the HIV test, which acts as a death sentence (when someone is declared positive) if there is no guarantee of a proper follow up and treatment as soon as it becomes necessary. In other words, screening which is supposed to be at the crossroads between prevention and treatment remains a first (and partial) act, and not the complete aspect of a more general implementation programme, leading to the universal access of treatment for those who need it.

was perceived as being adjusted to its socio-epidemiological context and political capacity of local management.

To receive grants, it needed a core structure that was well established, ie. a local public-private partnership which develops and submits grant proposals, and later on oversees the implementation of funded programmes (17 programmes were devoted to AIDS in the last round in 2005), including some run by medical foreign NGOs. Subsequently, this new funding mechanism has five major socio-political, organizational and medical implications:

1) First, it creates the inevitable gear stick for whoever is in the driving seat for organizing an apparently sustainable huge programme for delivering treatment to an increasing population who need it.
2) Second, it reduces duplication of programmes at the ministerial level.
3) Third, NCHADS which is the national authority in charge of implementing HIV/AIDS programmes, and mostly the operational aspects of care and treatment, **now** has the control over other entities – including NGOs – willing to receive money from the Global Fund. NCHADS evaluates the feasibility of each programme proposed by what is called a sub-recipient, but the latter has to comply with the national guidelines elaborated by the national body in terms of geographical location, ART protocol lines, continuum of care dimensions, number of persons to be treated, and so on.
4) Fourth, the Global Fund participates in strengthening the cohesion between national deciders and representatives of multilateral agencies, while private local entities find themselves more and more dependent within a new hierarchical order in which they are not in a position anymore to negotiate as before, even if according to their experience with sick persons they feel the necessity of articulating macro-logical or external constraints imposed on them by contextual situations, for instance the issue of treatment lines.
5) Fifth, this international funding mechanism has generated efforts towards accountability for the resources committed and disbursed regularly by rounds, as well as towards a new type of adequate supervising system for the programmes implemented. This point is of extreme importance in terms of health management and forecasting, if one remembers the poor organisation and "zero degree" level plan adopted in different ministries. Many health experts maintain that the positive results of this necessary management aspect were unthinkable five years ago. Nonetheless, this point has to be mitigated. The Global Fund established mechanisms for transparency by creating bodies such as the Principal Recipient (PR) and the Sub-Recipients (SR),

but due to local corruption, the diversion of money may still occur however because there is no proper follow up and no adequate tracking system on how the national government uses and distributes money.

One of the special features I would like to emphasize is that the present HIV/AIDS care policy in Cambodia depends on many actors, having different interests, ideologies and convictions. They manage, in addition to an image of harmonized plan, to set their own hidden agendas. It is a very simple and evident observation but this point has to be taken into consideration to understand the diversity and complexity of its functioning. Even if we cannot identify all sections involved in care activities, we can infer that due to their number, they need to be organized and properly articulated, which is not always the case.

International agencies constitute a big family – sometimes with naughty sons and daughters or uncles who can be re-educated by convincing arguments - in spite of apparent conflicts and disputes regarding topics that definitely are not the most important concerns for the future of the populations supposed to be the beneficiaries. Many meetings, think tanks and seminars are related to practices they want to put a name on (rather than implementing concretely) and concepts they use (one of the purposes for the discussions found in their agendas is to decide upon about which word should be employed in the numerous guidelines that only a few persons read (and are in fact allowed to read[17]): stigma or discrimination? capacity building for who? community participation or mass participation? empowerment of who and why? etc.).

As a financing institution, the Global Fund relies upon its partners to provide technical assistance and support. Agencies like DFID (the English bilateral agency for cooperation), the World Bank, UNAIDS, WHO and all the other UN agencies try – or at least try to demonstrate that they are trying - to work with contradictory agendas side by side. Apart from some drawbacks, depending on external and internal constraints due to health actors' mandates and due their professional and personal strategies, there has been however a relative consensus in Cambodia with regards to the scaling up of antiretroviral treatments. The WHO has played a distinctive role by providing normative leadership on international standards for medical responses to AIDS. On the other hand, challenges by health specialists have

[17] Quite a few social observers, health actors belonging to the NGOs sector and even to the public sector told us they have not been in a position to obtain some of the guidelines they expected to read, in spite of their repeated requests.

been well documented, specifically the ones elaborated by the MSF campaign to essential medicines[18]. Another criticism has been formulated by reputable private physicians. Unfortunately, some medical NGOs argue that it is impossible - and even dangerous - to give a standardized first line treatment to all infected people, even if they are from a poor country like Cambodia[19]. Reiterating the words of the well-known physician and researcher G. Montagner, a respected authority in the domain of HIV/AIDS, some specialists in infectious diseases say nobody can encourage that a second rate system of medicine should be taken as a model.

In terms of adequate objectives to be promoted, and due to the opportunity offered by the Global Fund resources, the WHO and the UNAIDS secretariat set an urgent challenge for the country : the "3 by 5" target of providing ART to 3 million people living with HIV/AIDS in low and middle-income countries by the end of 2005. This corresponds to treating just half of those in need. Such an objective started to be put in practice in 2004 in Cambodia, with the unconditional approval of the Khmer authorities. It means that at least 10,000 infected persons should receive a treatment by the end of December 2005.

It was not clear at that time if the number of 10,000 was in fact half of the people who needed treatment (in 2006, the figure has been denied, and has reached only 17,500 which is the figure given in a recent WHO/UNAIDS report[20]). There were definitely more, according to many specialists, but they were invisible. No doubt, epidemiological data was better calculated in Cambodia than in some other countries, for example in Africa or in some neighbouring countries such as Laos and Vietnam, but they remain estimates and mathematical extrapolations. They were based on sentinel surveys during the prevention campaign in some of the believed risk populations at that time. They remain social constructions. This has a drastic implication, not only in terms of pure epidemiological investigations but also in terms of lives to be saved, insofar as the deciders, willing to show that their country could reach the international « 3 by 5 » objective, came to an implicit agreement that to have no more than 10,000 people under treatment was not really essential. A strange, subjective public health decision…

---

[18] Médecins sans Frontières, The Effects of the 2005 Trips Implementation deadline on access to Medicines, February 2005, 3 p.; Médecins sans Frontières, Clinical AIDS care Guidelines for Resource-poor Settings, Brussels, March 2001, First edition published by MSF Belgium, 159.

[19] Dr. Didier Laureillard, personal interviews, Phnom Penh, 2004 and 2005.

[20] World Health Organization & UNAIDS, *Progress on Global Access to HIV Antiretroviral Therapy. A report on "3 by 5" and beyond*, Geneva, March 2006, World Health Organization, 83.

Whatever the mathematical model elaborated for estimating the number of people to be treated, the scaling up of HIV treatment has resulted in a rapid intervention. It has been quick and disorganized. At any cost, the government wanted to deliver treatment, free of charge, at about twenty places in the country. Nobody can deny that the intention was non-ethical but it has been poorly prepared. It could have been better planned long ago. Doctors' training came late, with a very limited time, while some AIDS specialists had already asked the deciders if for years they could contribute to the dissemination of their knowledge. They have never been heard. Assistance has been refused by NGOs. Also, most of the infrastructure run by the public health sector was – and still is – in a desperate state and without needed materials. Many patients were reluctant to visit government centres and tried without success to be accepted by well equipped hospitals (because they were overbooked) run by important NGOs or, if they had sufficient money, to go to private doctors who had established lucrative anonymous AIDS clinics.

The deciders concentrated on a deadline. It was perceived as a result per se to reach the target suggested by UN agencies. The world was keeping an eye on Cambodian efforts. Strangely, the challenge was to find sufficient people. Propaganda appeared in some provincial referral hospitals: "Come if you are infected, we welcome you and you will receive quickly the proper drugs", or "if you know someone infected, bring him with safety, you will receive feed-back". Some NGOs on a good footing with the government, participated in the "mass identification" of infected persons. They used trucks to bring county-side people first to be tested and then, if positive, to be treated "without delay", as a few volunteers used to say. During the last six month period before the deadline, observers used the term "hunting" to describe the intensity of the movement to locate infected people. On the other side, doctors in charge of the scaling up of HIV treatment in particular provinces were constantly under pressure by the officials in charge of the target objective in Phnom Penh. Some doctors were anxious about being fired if they did not fulfil the quota of persons to whom they should give treatment. Some accepted play their role, while some have been more cautious and did provide treatment immediately, without adequate and normal physical examination and without proper clinical tests that take normally between one and two months. It was said – and confirmed in a few areas - that Khmer people could receive ART within one or two weeks after being declared positive, which is a medical absurdity.

Other doctors, feeling that they had no choice if they wanted to keep their professional positions – or hoped to receive promotions – complied. They did not want to verify if the receipt of quick standardized treatment can be dangerous, even in case of opportunistic disease. For instance, a few persons co-infected with TB and AIDS started both medications at nearly the same time and could not survive because of the effects of the medication.

These drawbacks have been considered as "side-effects". Infected people in danger and those who could not take the treatment due to complications have been tacitly accused of endangering the success of the drug distribution system. They did not comply with the system while, normally, one could expect that the system should comply with people's needs. Not the contrary.

Finally, in early January 2006, Cambodian developers have been tempted to claim that they got the Nobel Prize for the "3 by 5". Without any doubt, the challenge was believed to have been overcome. In fact, nearly half of the patients received ART through MSF centres and without direct contact with "3 by 5" initiatives[21]. The country could show that at least 12 000 infected people will continue to live with drugs (36% of the people needing it), *forgetting* about those who died because of the rapid course of treatment action, *forgetting* about ambiguous follow-ups, *forgetting* about tremenduous lack of the basic aminities in the health services, *forgetting* also that social and economic conditions that have caused the collapse of the public health system could not be corrected overnight …

From a scientific point of view, any analysis should be balanced, but such a basic sociological principle, called symmetry, has rarely been taken into consideration by stakeholders and most of the health politicians in Cambodia. The main argument is that "a health system in formation cannot deal with best practices at the beginning but they will come, little by little" or "we need to build more building capacity", or "cultural commitment", and so on. Sadly, inadequate health care infrastructures and shortages of trained workers, inadequate diagnostics and discrimination still hamper public health efforts. And little attention is given to these key factors either by international agents or by national actors. There is a shyness/reluctance/refusal to understand the reasons behind and a lack of involvement to find appropriate strategies to mitigate them

The current bottlenecks to this rapid scale up have never been approached or considered of public health importance. For instance, it is known that

[21] Moreover, the WHO in Geneva did not recognize it: Cambodia mentioned previously that about 23,000 people needed to be under treatment (end of 2004) while a more accurate epidemiological source mentions 35,000.

many people died with inadequate treatments and insufficient care, but ironically they have been registered as beneficiaries of the "3 by 5" by both the government and the UN agencies. The side-effects of a political public health orientation are totally neglected and it is even considered dangerous to analyse them; according to some developers, it could reduce its positive impact and discourage internal and external promoters of the national policy. In fact, these are arguments that show more respect for the well-being of the health planners than the people who are supposed to be the beneficiaries. We may wonder who is supposed to develop who…

Whatever the results, the positive outcomes of the almost reached target of "3 by 5" have been taken as granted. Strangely within a few weeks in Cambodia, the scaling up for "3 by 5" belongs to the past. It was an objective, not a policy. It was a preliminary step to initiate a broader perspective that will receive the favours of the world: the universal access to treatment. Now, the entire Cambodian health policy operating against the epidemic wants to demonstrate to outsiders, including to the donors, that it is possible in a constrained setting to provide treatment free of charge to everybody who needs it. We have to stop for a while and try to understand, apart from the public health statements and the humanitarian values, what are the hidden and apparent ideas underlying such a decision.

These ideas go far beyond HIV/AIDS issues and even health development. One of our theses is that Cambodia has hardly been in a position to fulfil the requirements of the external donors - whatever the reasons. It has been regularly (and recently) seriously challenged for its incapacity to improve the well-being of the whole society, including health issues. The country is under economic pressure and external experts have analysed the situation too narrowly and blindly, identifying the endemic corruption as an agent of destruction. Cambodia cannot justify its acts with its own Asiatic logic to Westerners. It is not only a question of communication: it is due to a broader attitude linked with socio cultural, political-economic representations and local practices that are not in accordance with a so-called and expected universal perception of "doing things in that way".

It means, for the deciders, that the particular Cambodian logic will neither be believed nor understood. To fill the gap between the donors and the recipients, the country needs however to show it can unavoidable overcome internal drawbacks, otherwise a part of the aid could be cut. Little by little, donors and implementers are accused to entertain a system that does not function. So they have to react as well. At this very particular moment, the HIV/AIDS care programme comes along. On the one hand, the more registered HIV positive persons, the more money could

be asked from the donors. It became a cash guarantee to maintain a health development programme, even if the money received did not reach the victims of the epidemic. One the other side, it was presented as a progressive achievement that is successfully working, something that can even be taken as a model for neighbouring developing countries.

It means that the implementation of a universal access to ART policy comes with two implications. First it is perceived as a rescuing lifebelt for other development programmes (including other interventions related to health care) that are not yet functioning if such a very sensitive humanitarian programme can be successful, it can anticipated that other interventions will also be successes. It will have a therapeutic effect. It will show that Cambodia can do it.

Second, it complies with a consensual conception of a progress strategy. We need to pause for a while and go deeper into this point. In order to have a better comprehension of this second point, we need to expand the perspectives of ongoing development issues in the country. Along with the millennium goal encouraged by the UN and other huge foreign aid donors, combining a great diversity of scopes, health issues, and mostly HIV/AIDS interventions, are parts of a large package which has to fit in a broader conceptual acceptance of development in Cambodia. This conceptual approach of development is ideologically presented nowadays in a homogeneous way by most of the international agencies. It is supposed to respond to some targets and achievements that can be reached, according to stakeholders, by specific ways. Those specific ways have to follow some "methods of doing" (or the state of the art): this is what the developers call "good practices".

Good practice is not only technical advice. It represents a particular "way of doing" that deciders and developers have integrated as adequate values. In other words, they respond to the expectations coming from above, certain that it is the "appropriate one". Of course, consideration of bottom line requirements is mentioned, but such negotiation hardly exists in practice. Flexibility on behalf of the people is tacitly linked with potential disorder.

There is an interesting number of key-words attached to "good practices", and not only by chance. Programmes funded by outsiders will receive money only if they include them all, at least on paper. Among the most important ones we can routinely identify are : participation, governance, sustainability, socio-economic improvement for the poor, antidiscrimination, etc. All these key-words are concepts and not activities, but they are presented as activities,

and subsequently as testimony of adequate planning if eventually there is any success.

For instance, an idealist UN development text we find in many reports and documents states that: "Participation (a first indicator) means that the civil society constitutes with the State and the market one of the three components involved in the construction and the maintenance of an adequate governance (a second indicator). It can be done if civil society's actors contribute to socio-economic activities and behave as a group liable to influence public policies, in particular in favour of the poorest (a third indicator). This ideal description of the societal and political functioning is a prerequisite for a sustainable development (fourth indicator) in which representatives of the population are supposed to act without prejudice (a fifth indicator)".

All these indicators are included in the discussions about universal access, in a similar way. It seems, therefore, that there is a pre-configuration of the universal access policy (becoming a rhetoric) that nobody can apparently criticize at the intentional level, but that does not respect the minimum of medical, social and even political requirements.

When Brazil started in 1996 giving ART to all the infected population who need it, there were probably less national guidelines, international interferences and "key words" falling out of the sky. There were drugs in adequate quantities and qualities, sufficient doctors were correctly appointed, there were well-equipped centres, public health specialists, trained paramedical staff, voices from local NGOs, continuous campaigns linking care with prevention and HIV testing were provided simultaneously. The deciders stimulated representatives of the civil society (in different positions) to act as a force of opposition, and the government wanted to have a watchdog. The result was that the country managed to make it.

In Cambodian, the necessary ingredients to prepare the programme in the same way are neither constituted nor interlinked. An order is supposed to be respected, while existing improvements are not articulated correctly. In such conditions, how is it possible to ask a newly trained doctor, earning 35 dollar a month, to take care of 250 AIDS patients in an isolated provincial town with no existing referral system, and working in one of the worst hospital settings you can imagine?

For a political anthropology of health development

The path to universal access is a new policy, still in process. We cannot draw any conclusion yet. Other facts and figures can interfere, and we have not yet observed them because it is something under construction. The future will give us new keys to understanding, but I am not sure that decisions have been taken only to alleviate the suffering of the infected population. One of the paradoxes that mentioned previously is that more drugs given without proper preparation led to more deaths.

The health policy decisions in Cambodia have been an opportunity to pour prestige and to inject refreshing consideration for developers associated in Cambodia's affairs, either national or outsiders, whatever their geographical and professional backgrounds. One cannot put them "in the same basket". They do not share similar ideas but, generally speaking, a common trend can be formulated: they act without an adequate understanding of the social and economical context. A relevant health policy can be based on theoretical and discursive argumentations, but it cannot be in a state of levitation removed from the local dynamics. Developers should visit the field and remember that people exist, and have something to express, or at least to show through their behaviour and ideas, for their improvement. Otherwise their tragic social reality remains something abstract. We come back to this evident notion stipulating that "we need to understand first in order to act".

On the other side, there are positive expectations. With free universal access to ART, the government expects to modify a common world-wide perception that Cambodia cannot absorb development challenges. It is engaged in a challenging policy but just the fact "of being engaged" is a sign of voluntarism[22]. Not all poor countries did the same. Maybe, after all, the HIV policy for universal care and treatment can act as a stimulator for other development goals and it will be consequently a constructive point. But we have the right to wonder whether the choice of intervention to promote

[22] We do not mean that planners and developers are ignorant of the whole reality. They prioritize their own perception of the reality, along with their own personal concerns that may have nothing to do with the expected outcomes for the beneficiaries, namely the poor and the deprived population. They definitely realize the lack of basic health infrastructures, the challenges and numerous obstacles they face in the elaboration of their project, once it has to be implemented. They know they are surrounded by numerous social dynamics liable to prevent the outcome of their policies, even if they have the tendency to argue they are right (they have knowledge) and that the population is wrong in terms of knowledge, attitude, behaviour, etc. They are even aware of the gap between discourse and practice as well, even if they have the tendency to maintain deliberately such a discrepancy because it justifies the continuation of their assignments. But whatever the policies, written through recommendations, they do not show any direction to implement the projects. See: UNAIDS, *Scaling up towards uiversal access to HIV prevention, treatment, care, and support. Cambodia country report*, Phnom Penh, February 2006, 38.

treatment to everybody has been justified through acceptable contextual medical, socio-cultural, economic and political realities, or with meta-logics having little to do with health and the anti-AIDS goal as a whole *but with the quest for the accreditation of the country*, mostly for its governance that everybody from outside is viewing through distorted glasses.