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HIV epidemic in Cambodia, one of the poorest countries in Southeast Asia: a success story

'While poverty greatly contributes to the spread of the HIV epidemic, we should not use it as an easy excuse for being incapable of curbing it.'

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"Sok Sen's younger brother cannot be more than 3 or 4 years old. He is exhausted, subdued. For a full hour he seems on the verge of tears, but his big eyes never water. They just stare back at me and I back at them. They seem to be asking me why – why are both of us here, why are his parents dead, why is his face a sea of scabs – a side effect of the antiretroviral drugs that are meant to be making his life better. This is the face of the AIDS epidemic in Cambodia. It swept through the sex workers, to the men who used them, to their wives and now to their children…However, despite the awful reality of all AIDS orphans and the almost complete absence of any structure to deal with them, it is somewhat miraculous that all these patients are on anti-AIDS drugs, over 10,000 in Cambodia now, a number that is increasing fast [W WELLS, PERS. COMM.]."

In 1997, Brazil became the first developing country to offer free and universal access to antiretroviral treatment (ART) to all Brazilian AIDS patients. The combination of AIDS treatment programs with extensive HIV-prevention programs led this country to, in effect, curb the HIV epidemic, and limit the effect of AIDS on societal structures and Brazil's economy by 2001. When calling Brazil an example for many other countries in the developing world, skeptics often point to the fact that this country, with a gross domestic product (GDP) similar to that of South Africa and a similar disparity in wealth [101], isn't quite as poor as some of the countries in sub-Saharan Africa where many earn a salary of US$200/year. The argument used to be that poverty prevents a country from curbing the HIV epidemic. However, while poverty greatly contributes to the spread of the HIV epidemic, we should not use it as an easy excuse for being incapable of curbing it. Cambodia is one of the poorest countries in Southeast Asia. Its citizens on average make US$0.88 per day. Yet, watching the fight against AIDS in Cambodia succeed, proves that the footsteps of Brazil can be followed and that, even in very dire circumstances, the HIV epidemic can be curbed, eventually maybe even contained.

In 1990, the World Bank predicted that Brazil, a large developing country ranking 72nd on the Human Development Index, would have 1,200,000 HIV-infected patients within the next 10 years. At that time, Brazil counted only approximately 10,000 HIV-infected patients. This prediction by the World Bank was a wake-up call for the Brazilian government which embarked on a determined, dedicated path to curb the impact of AIDS in Brazil. As a result of their actions, the HIV prevalence rate was halved to 0.6% by 2001. Brazil also became the first country in the developing world to offer free and universal access to ART to all AIDS patients in need at a time when funding by the Global Fund wasn't available, and the US President's Emergency Plan For AIDS Relief (PEPFAR) didn't yet exist.

The Brazilian recipe for success included five pillars, each pillar essential in its own right, yet insufficient by itself: early action,

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very strong governmental leadership and commitment, the involvement of an active civil society and balanced HIV prevention and AIDS care.

The first pillar for success was 'early' action, action at a time when the HIV prevalence rate was only 1.2%. The epidemic was young but on the verge of moving from high-risk groups into the general population. In 1990, the HIV epidemic in Brazil was in a similar stage as the one in South Africa. Unfortunately today, this statement is not true any longer with South Africa being home to the highest number of HIV-infected patients in the world. Waiting to act until an epidemic has ballooned out of control makes the effort to contain it not only more difficult logistically and more costly; it also puts a much greater strain on the capacity of those systems to be used for combating the issue.

Very strong governmental leadership and commitment were equally important in Brazil's success. The role of a government is to provide leadership, a national strategy, policies and empowerment to its people. This is exactly what the government in Brazil did, realizing its central role, while recognizing that implementing programs had to be done in a decentralized fashion by a civil society which has direct contact with the at-risk populations. By 2002, loans by the World Bank had been effectively used by the Brazilian government to finance more than 1780 HIV-prevention activities by nongovernmental organizations (NGOs). Brazil's targeted prevention campaigns were, however, not only aimed at high-risk groups such as sex workers, men who have sex with men and injection drug users, but also at the general population which was subjected to open and direct prevention messages.

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Many often suggest that the open attitude towards sex in the Brazilian culture has fuelled the HIV epidemic. The opposite has proven to be true. Instead, the lack of a taboo surrounding sex has allowed for clear and explicit messages to be delivered to all, from young people to seniors. Contrary to beliefs held by the US government, Brazil recognizes that sexual activity is part of human nature. Abstinence from sexual activity may be pursued by individuals based on religious motivations, or as a personal choice and as such, it needs to be respected. However, as the basis for a national strategy against a public health problem, which is what an epidemic is, the Brazilian government needed a practical public health approach based on science and embedded in rationality, not an approach based on ideology. As a result, even in a country that is being held in a strong grip by the Catholic church, the uptake of condoms amongst Brazilians grew from a meager 3% in 1997 to 78% by 2001, a number that is equivalent to that in Western Europe and the USA.

In the end, the HIV prevalence rate was halved to 0.6% in Brazil within 5 years. Some may point out that a decrease in HIV prevalence rates is frequently caused by an increase in AIDS death rates as patients move from being HIV infected, to having AIDS and dying. But for Brazil, this argument doesn't hold, given that its government didn't only focus on HIV prevention, but rather started offering free access to ART through its public healthcare system, to all AIDS patients who need it.

In 1988, health was declared a constitutional right in Brazil. By 1996, a law was passed guaranteeing free and universal access to ART to all who need it, through the public healthcare system. However, in order for this law to become a reality for suffering AIDS patients, Brazil needed to scale up its healthcare system in addition to obtaining a reliable supply of effective antiretroviral medications at a price the government could afford. Large-scale training programs were organized for healthcare personnel and a structured referral system for HIV care was set up. Clinics were accredited and a network of laboratories created.

National treatment guidelines written by a committee of Brazilian HIV experts determine which ARTs may be given first line, second line and beyond. The latest scientific advances within the international HIV arena are noticed, but decisions on what is best for Brazil are made locally. And the medications themselves are obtained through a mix of local production and purchases of discounted brand name drugs. In 1997, as protease inhibitors became available in Brazil, the cost of the national treatment program skyrocketed. As a result, the viability of the entire initiative was called into question. Wishing to fulfill the law which guaranteed everyone access to free ART, the Brazilian government caused grave international concern by issuing compulsory licensing, a World Trade Organization-endorsed mechanism by which patented medications may be produced locally in case of a national emergency [1–3]. It should be kept in mind however that Brazil has yet to break any patent law to date. Instead, it has locally produced those medications which didn't have patent protection in Brazil before patent laws came into effect in 1999. For those medications that are protected, the Brazilian government has successfully negotiated price reductions with the patent holders. As a result, the price of treatment has gradually decreased over the years, allowing more patients to receive medications without significantly increasing public health expenditures. In 1999, US$336 million was spent to treat 75,000 patients. By 2000, total expenditure decreased to US$250 million, while the number of patients treated increased to 110,000, and today, that same amount treats approximately 150,000 patients.

This in-a-nutshell is Brazil's story [4]. It was not easy to implement this strategy successfully, but Brazil managed to do it regardless. According to UNAIDS, there are 129 countries in the developing world that now have a HIV prevalence rate similar to the one in Brazil in the early 1990s. The economy in some of these countries is similar to Brazil's, others have much higher levels of poverty. As mentioned in the introduction

however, poverty indeed greatly fuels the spread of the HIV pandemic, but it cannot be used by us as an excuse to lose the battle against HIV and provide care to all of those in need.

In 1975, Cambodia, a country of 9 million people at the time, fell prey to Pol Pot's regime. As Westerners, we mainly watched as the Khmer Rouge killed approximately 20% of the population or 1.7 million people within 4 years. Anyone who was suspected of having received education or who was seen as contributing to the economy, was arrested and murdered. Institutions were abolished. Family structures disrupted. Beyond the horrifying humanitarian implications of the actions taken by the Khmer Rouge, their activities resulted in a country without systems, a country that had to be built up from the ground when Pol Pot was finally ousted in 1979. Even an education system had to be rebuilt. But how would one build an education system if there are no teachers to teach? And how would one build institutions in a society when there is little access to formal education? While it is still one of the poorest countries in Southeast Asia, Cambodia is gradually managing to undo the damage and to recreate a society with structure and institutions. Cambodia's success in the fight against HIV sets a solid example of how even poor countries in some of the worst circumstances can manage to follow in Brazil's footsteps, as long as the above described, five pillars for success are taken care off.

At 1.9%, Cambodia is home to the highest HIV prevalence rate in Asia. In support of its fight against HIV/AIDS, the country does receive funding from international donors, including the Global Fund, but not from the US Government's PEPFAR initiative, even if Cambodia very recently was designated 'a PEPFAR country' for other than funding reasons.

'Cambodia's success in the fight against HIV sets a solid example of how even poor countries in some of the worst circumstances can manage to follow in Brazil's footsteps'

As HIV prevention programs were implemented across Cambodia over the past 10 years, the HIV prevalence in antenatal clinic attendees has gradually declined from a high of 2.82 in 1999 to the current level of 1.9%. In this country as well, the activities of an active civil society have supported government policy by implementing targeted prevention and care programs. The HIV epidemic in Cambodia was largely driven by sexual transmission; hence the government in Cambodia did effectively institute a 100% condom use policy. The effectiveness of the condom policy was significantly enhanced by simultaneously providing programs targeting behavior change and sexually transmitted infection (STI) management through monthly check-ups for STIs [5].

However, despite the fact the HIV epidemic in Cambodia became stabilized, the number of patients needing access to AIDS care increased over the years as patients progressed from being HIV infected to having symptoms of AIDS. The estimated national adult AIDS incidence increased from 12,414 in 1999 to a range of 15,553–15,794 in 2005 [6]. The importance of providing antiretroviral medication and care cannot be underestimated. Many economists have made the argument that prevention activities are more cost effective than treatment. Reality however, has shown us that the uptake and impact of prevention activities is closely linked to the availability of HIV care, including antiretroviral medication. Aside from that, provided that patients take their antiretroviral medication diligently (every day for life) and that the medication remains effective, AIDS almost becomes more of a chronic disease with which patients can grow old. This treatment effect mitigates the impact of the disease on societies as HIV-infected professionals, including teachers, healthcare providers, farmers and others, continue to contribute to their societies and economies, raising their children and building their country. In addition, Brazil has shown us that providing treatment indeed cuts the cost of HIV to the public healthcare system. And the final pro-treatment argument points to recent data that a HIV-infected patient is less likely to transmit HIV if his viral load is undetectable (meaning that he is on effective therapy).

In 1999, only three AIDS patients were receiving ART in Cambodia [7]. But thanks to dynamic government leadership, this country managed to put 2311 patients on treatment by the beginning of 2004, increasing this number to 10,537 by September of 2005. This amounts to 38% of adults eligible for ART in Cambodia [8]. And the scale-up continues rapidly. Some clinics are being set up with just US$1000 in funding, and within the initial month, have 100 patients in care.

A major break through came in 2003 when Cambodia received funding from the Global Fund to start providing free ART to AIDS patients, through its public healthcare sector. Previously, ART had been provided mainly through the private sector or clinics managed by NGOs, for example, Médecins Sans Frontières, Hope Worldwide and others. Under the strong leadership by the Ministry of Health in Cambodia and National Center for HIV/AIDS, Dermatology and STDs (NCHADS), a continuum of care (CoC) framework was developed for Cambodia.

The CoC framework eloquently integrates care at the district level hospital with support at the community level, involving all stakeholders to ensure optimal HIV care and prevention within Cambodia's limited available resources. The importance of 'within Cambodia's limited resources' cannot be stressed enough. All to often do we, Westerners, project our own resource-rich backgrounds onto developing countries not realizing that by doing so we are trying to set up programs that are not sustainable in the long-run, and hence delaying, in effect, access to HIV prevention and treatment for millions. Many studies have proven that HIV care can be delivered effectively in the poorest settings on earth. Services provided through CoC include voluntary confidential counselling and testing (VCCT), prevention of mother-to-child transmission (PMTCT), outpatient services, support groups for People Living with HIV/AIDS (PLHA), preventative and curative tuberculosis therapy, HIV care and ART. A study presented at

the *International AIDS Conference* in Bangkok in 2004 concluded that the success of a CoC framework is contingent upon strong and continuous coordination during program development and implementation to ensure that stakeholders' respective strengths were used most efficiently [9]. Within the CoC framework, every stakeholder has his specific responsibility, and all stakeholders together create access to HIV care and prevention in Cambodia. The stakeholders do not only include the Ministry of Health, NCHADS, local NGOs such as RACHA and international NGOs such as Family Health International and CARE International, but also healthcare workers and clinic directors, representatives from the provincial AIDS offices, district health officers, PLHA self-support groups (such as 'friends-help-friends centers'), home-based care teams, village volunteers, religious leaders and other nonhealthcare community members, families and religious leaders (e.g., Buddhist monks) [102]. Aside from linking HIV-infected patients with healthcare services and giving them a platform where their opinions can be voiced, the decision to implement a CoC strategy also resulted in the upgrading of the skills of the healthcare staff, the set up of drug supply and tracking mechanisms, the scale-up of laboratory services and the creation of home-based care at the village level. And as such, all pillars Brazil used were implemented in Cambodia too.

When thinking of who should receive credit for Cambodia's success against HIV/AIDS, a country that is still recovering from the tragedy imposed by the Khmer Rouge, the right answer of course is 'all of those involved'. But in order to get all these groups to work together towards a common goal, a very dynamic leader is necessary – and in Cambodia this visionary, practical leader is Dr Mean Chi Vun, Director of NCHADS and Deputy Director General of Health.

Mean Chi Vun is an understated man who has a solid grasp on how Cambodia will succeed in its fight against HIV/AIDS. He is a true visionary, has a very practical mind focused on results and is a strong leader. His team at NCHADS is equally dynamic. Cambodia has many international partners. Anyone who wants to make a contribution to the plight of Cambodia against HIV has to pass by him. Having worked in Cambodia for some years, it has been most striking to watch how, under Vun's leadership, assistance by international NGOs is welcomed as long as their activities support the national strategy and respect the locally available resources. In determining the strategy against the HIV epidemic, Vun, in discussion with all stakeholders, has paid special attention to setting up the systems that would support the long-term delivery of AIDS care rather than providing temporary patchwork remedies. Funding takes a back seat over a national strategy, integration and collaboration. Thus far, this stance taken by Cambodia's leaders has paid off nicely with Cambodia joining the ranks of those able to curb the HIV epidemic. And the field of international development would benefit greatly if it took this lesson to heart across the board, and much beyond HIV/AIDS.

The best way to think about curbing the HIV epidemic within a country is by comparing it with a large puzzle of which all pieces are essential yet not a single one sufficient. All pieces of the HIV puzzle need to be put together at the same time, as a collaborative effort between stakeholders, with an emphasis on efficiency and under strong leadership by a true visionary. And if we – the international community – would indeed respect local needs, expertise and leadership, if we would provide true support and assistance to national endeavors, there is no reason why all of us together cannot curb the HIV pandemic.

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