Prostitution and the Politics of HIV Prevention in Cambodia: A Historical Case Study

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Abstract:

Cambodia received international attention in the early 1990s when it emerged from civil war with the highest HIV rate in Asia, in which up to 60% of sex workers were infected. A massive influx of financial, human, and material resources ensued, and debates over "best practices" for HIV prevention were played out.

Over time, the politics of AIDS shifted, mirroring changes in the politics of the largest player in global health, the US. This sparked acrimonious polarization within international health policy, with direct implications for the lives of sex workers. This paper traces those debates over sex work and HIV, highlighting the example of one brothel district in Cambodia where Medecins Sans Frontieres provided services to over 300 migrant Vietnamese sex workers.

Using literature and program documentation from the time, this paper highlights how countries such as Cambodia can become vulnerable to manipulation and used to serve wider political agendas.

Introduction

For almost two decades, Cambodia has been one of the countries at the forefront of charged political debate surrounding global HIV prevention policy. Although a relatively small

country with a total population just under 14 million, Cambodia has attracted disproportionate attention from the moment the first cases of HIV were identified in 1991 by providing a crucible for the convergence of highly emotive international issues including sex trafficking, human rights, and the extent to which moral argument should guide public health practice. On the one hand, Cambodia is a success story: adult HIV prevalence has fallen from its peak of 3% in 1997 to 0.5% in 2009 and 93% of people eligible for antiretroviral therapy (ART) for HIV have initiated treatment (Buhler, Wilkinson et al. 2006, NAA 2010). But it is also an example of how a country that is heavily reliant on international funding can easily fall prey to the changing whims of donor countries, derailing evidence-based programs. This paper traces the history of Cambodia's HIV prevention policy in the late 1990s and early 2000's, focusing on how interventions targeted toward sex workers became an international battleground for ideological policy debate. The experiences of one particular program implemented between 1999 and 2002, known as The Lotus Club, are used to illustrate how these wider political forces directly affected provision of frontline health services.

Emergence of HIV in Cambodia

During Cambodia's protracted civil war and subsequent occupation by Vietnam, information on health in the country proved scarce. Sporadic reports in public health journals

described grim conditions in refugee camps along the Thai-Cambodian border (Goodman and Speckhard 1980) or discussed how health systems in countries where Cambodians were being resettled should address their health needs in culturally appropriate ways (Catanzaro and Moser 1982). Eventually health professionals gained greater access to Cambodia, at which point data on infectious diseases including malaria, TB and Hepatitis began to materialize (Denis and Meek 1992, Thuring, Joller-Jemelka et al. 1993, Hong and Sok 1997).

Throughout the conflict, images of Cambodia portrayed a wounded nation with a traumatized population that would suffer long-term consequences of the "Killing Fields" on their health and ability to function. Predictions of large-scale post-traumatic stress disorder (PSTD) and the need for significant recovery and rehabilitation were common and further galvanized the growing influx of international donors, humanitarian relief agencies, and longer-term development organizations (Mollica, Donelan et al. 1993). Cambodia itself became symbolic of vulnerability, seen to enhance its susceptibility to disease (Beyrer 1998). Thus the inevitable discovery of HIV in the country played into this image of a stricken nation and the mercy of an onslaught of modern diseases after a period of nearly complete isolation:

> *It is timely to take stock of conditions in the small country of Cambodia as it struggles to take its place after*

> *a long period of isolation. Countless Cambodians and ethnic Vietnamese have died there this year and during the past 25 years, victims of senseless killing or preventable disease. … [S]tories of suffering and killing, and of escape and survival, under the murderous regime ... are harrowing. Cambodia now has a fast growing population of around 9 million, a fifth of whom are children under 5 years old. Their health and safety are still precarious. ... Recent sample surveys show that the prevalence of HIV infection is over 50% in commercial sex workers in some areas, and about 10% in the police and armed forces. Blood donors testing HIV positive have increased from under 1% in the early 1990s to 4% in 1994. (Heng and Key 1995)*

Early signs of HIV soon developed into a rapidly growing sense of urgency (Ryan, Ouk et al. 1998, alert 1999). Reports from the mid 1990s showed rapid increases in numbers of new infections and the government issued a formal plea for financial assistance in 1996 (Plus 1996), stating that the cash-strapped government did not have adequate resources to handle the crisis. An influx of aid money followed both immediately and consistently over the following two decades; in 2010, Cambodia still relied on international donors for 90% of its HIV/AIDS program funding (USAID-Cambodia 2010).

Focus on Sex Workers

Programmatic attention soon focused on sex workers, considered among the most vulnerable citizens in a vulnerable country. Rates of HIV infection among brothel-based sex workers reached 42.4% in some surveys (NCHADS 2004), suggesting Cambodia's epidemic would follow the experience of Thailand's, which was driven by high rates of commercial sex (Celentano, Akarasewi et al. 1994, Kilmarx, Limpakarnjanarat et al. 1998). Adopting Thailand's response to the epidemic by seeking to regulate rather than eradicate the sex industry thus found favor with international organizations and donor agencies. The dramatic success of Thailand's much-lauded 100% condom use policy had only just been published (Hanenberg, Rojanapithayakorn et al. 1994, Nelson, Celentano et al. 1996), demonstrating a dramatic reduction in HIV prevalence among both sex workers and young male conscripts into the army, sampled as a proxy for the population of male clients of sex workers.

At the same time, results from the Sonagachi program in Calcutta, India, showed that a dedicated human rights approach to sex work could catalyze grassroots community activism and lead to significant reductions in HIV risk behavior within one of the world's largest known brothel districts (Jana and Singh 1995, Jana, Bandyopadhyay et al. 1998). The implications seemed evident, and succinctly stated in an early UNAIDS document bringing together best practices for targeted HIV

prevention for sex workers: “One of the clearest public health lessons emerging from the HIV pandemic is that protecting the human rights of sex workers is one of the best ways to protect the rest of society from HIV” (UNAIDS 2000):18.

The Sonagachi experience also dovetailed with the personal advocacy campaign of Jonathan Mann, who founded WHO’s Global Program on AIDS (which became UNAIDS). Mann passionately believed in ensuring that human rights of people living with HIV were respected and promoted, and highlighted the fact that the communities most at risk of HIV were also those that tended to be marginalized and excluded from society (Mann 1997, Gruskin, Mann et al. 1998). Although Jonathan Mann died in an air accident in 1998, his legacy remained strong within the global HIV response. UNAIDS thus began to actively promote empowerment and community mobilization for vulnerable groups (UNAIDS 1997). As emerging evidence continued to demonstrate the effectiveness of empowering individuals and building social capital as a means to temper the spread of HIV (Tawil, O'Reilly et al. 1999), taking a community mobilization approach dominated the early HIV prevention discourse in Cambodia.

While earlier, in 1995, the local WHO office complained that a government crackdown on prostitution in Cambodia risked driving the epidemic underground and complicating efforts to reach those most in need of services ([Editorial] 1995), the

tide had turned by the first National Conference on HIV/AIDS in March 1999. Prime Minister Hun Sen opened the proceedings and shared his keynote address with a former sex worker living with HIV, who provided a moving narrative and described experiencing discrimination. The Prime Minister publically embraced her after the speeches, a moment that was captured on camera and extensively reported in the media. The event was clearly designed to signify the government's commitment to upholding human rights, reducing HIV stigma, and adopting a harm reduction approach to HIV prevention among sex workers.

Interventions in brothel districts became the undisputed core of Cambodia's HIV programming, bolstered by behavior change messages targeting male clients and widespread social marketing of condoms (Oppenheimer 1998). At least five separate Cambodian NGO received donor support, including from USAID, to provide rights-based services to sex workers (2002). In 1998, the Cambodian Ministry of Health took the step of launching the 100% condom use policy, similar to the one established in Thailand, in which condoms were made freely available in all brothels, sex workers underwent monthly health checks, and brothel managers, rather than individual sex workers, suffered the repercussions when sexually transmitted infections were linked to their establishments. Although controversial for taking a heavy-handed and "top-down" approach (Loff, Overs et al. 2003), the policy has been

credited with the reduction in HIV prevalence observed in subsequent surveillance (Rojanapithayakorn 2006).

Yet during the early years of implementation, abuses within the system were common, including payment of bribes by brothel owners or sex workers to avoid cases of STI being documented, and demands from corrupt health authorities for fees to pay for examinations and tests that were supposed to be free (Lowe 2003). Furthermore, local governments continued to conduct occasional brothel crackdowns and "clean up" campaigns (BBC 2003), while individual police or military staff exhorted protection money from brothels and harassed, arrested, and sexually assaulted sex workers (Phal 2002, Cohen 2003). The policy also likely intensified the transition from brothel-based to more diffuse and less regular forms of sex work. These included beer promotion girls, notionally hired by alcohol distributors to sell specific brands in restaurants and bars, but who often supplemented their commissions through providing sexual services; karaoke hostesses, who served drinks and snacks to visiting customers but were usually also available for sex; and waitresses in some bars and restaurants who negotiated sex work with customers to increase their income. Women in these roles did not necessarily perceive themselves as professional sex workers and thus were harder to reach by services explicitly targeting the sex trade (Hor, Detels et al. 2005).

Case Study: Svay Pak Brothel District

Against this backdrop, the organization Medecins Sans Frontieres-Belgium (MSF) was transitioning from providing emergency post-conflict relief work to supporting longer term health infrastructure. One of its primary care clinics was situated in the village of Svay Pak, located 11 km north of Phnom Penh. Primarily inhabited by Vietnamese families engaged in fishing, farming, and small businesses, Svay Pak had also established itself as a well-known brothel district. Having flourished during the years when peacekeepers from the UN Transitional Authority for Cambodia (UNTAC) were stationed in Cambodia, by the late 1990s Svay Pak was experiencing declines in its economic fortunes as competing establishments opened closer to the capital (Busza 2005). Still, at the time when the extent of HIV prevalence among sex workers became apparent, Svay Pak had roughly 20 operating brothels and a population of over 300 sex workers (Busza and Baker 2004).

These sex workers were young Vietnamese women who were mostly in their late teenage years or early 20s, and had migrated from provinces adjacent to the Cambodian border with the specific aim of working in a brothel, which was a common livelihood strategy among poor rural households (Muecke 1992, Prybylski and Alto 1999). Most were accompanied by someone from their village, most often an aunt or other female relative, who would negotiate an advance payment from a

specific brothel (averaging US $300-400) that she would take back to the family in Vietnam. Half of sex workers' earnings from clients contributed to paying off this initial debt while half was taken by the brothel as profit. Women generally were able to pay the debt in one to two years and could then choose whether to go home, borrow another lump sum and remain in the brothel, or move elsewhere to work independently. Sex workers had experienced varying degrees of coercion in coming to Svay Pak and were not always satisfied with their working conditions; however, narrative research conducted into the circumstances and motivations behind coming to Svay Pak found that the majority perceived it to be the best option among few livelihood strategies, and acceptable in the short term (Busza 2004).

MSF's introduction of "sex worker friendly" clinical services, outreach to brothels, distribution of male and female condoms, and establishment of the "Lotus Club" as a drop-in centre and social space in which participatory peer education activities were conducted has been documented elsewhere (Baker, Busza et al. 2001, Busza and Schunter 2001, Busza and Baker 2004, Busza 2006). What is key to the approach taken by this program was that it embraced the community mobilization approach and hoped to provide social services alongside medical care in order to create a more enabling environment for change. While laudable, these aims appear naively optimistic in retrospect,

particularly as the lack of any existing sense of community identity or solidarity among sex workers living in Svay Pak's competing brothels had already been noted, e.g. in the original project proposal:

> *In order for community mobilization to take place … initial community identity must be acknowledged. … The debt-bonded context of sex work in Svay Pak places special constraints on the development of 'community' among the sex workers. Competition between brothels keeps women isolated … and the constant flux of migration limits opportunities for stable social networks. … The lack of social structures at the community-level juxtaposed with individual disempowerment limit the ability of Svay Pak sex workers to insist upon safer sex practices. (Internal Project proposal 1998)*

Nonetheless, the primary objective of the Lotus Club intervention was to implement and evaluate the process of strengthening community networks of support and demonstrate effectiveness in changing some of the behavioral determinants of HIV, namely ability to negotiate with clients, increased use of male and female condoms, and decreased vulnerability to sexual coercion and violence. The program adopted many components of successful interventions from India and Thailand, including regular social events, participatory discussions and role-plays, and skills-building workshops on

managing finances, dealing with stress, and suggesting new technologies to clients (such as the female condom) (Timm 1989, Ford and Koetsawang 1999, Evans and Lambert 2008). It also made context-specific adaptations to reflect the particularly restricted environment of Svay Pak, such as conducting some activities through outreach within brothels, and working with sex workers on the participatory development of a visual guide to ethical issues raised by the project (how to ensure voluntary attendance at activities, ensuring privacy and confidentiality, and realistic limits to MSF's involvement in sex workers' personal problems) (Busza, Hom et al. 2001).

Ultimately, however, the intervention did not prove successful when measured against most of its outcome indicators related improved work conditions, increased support structures, or reported behavioral risks for HIV (Baker, Ly et al. 2001 [unpublished]). High turnover in the community made it difficult for sex workers' to widen their social networks and for the program to maintain an engaged quorum of participants. The final report concluded:

> *The time given in this study to establish a sense of community may have been unrealistic and the seeds of community planted during the project may yet allow the sex workers to create the sense of solidarity that is needed to establish a community response to HIV/AIDS. However, it is*

even more likely that future changes to Svay Pak will result from decisions made from outside of the community, such as changing government policies attempting to control sex establishments and the flow of women across the Vietnamese and Cambodian border.(Baker, Ly et al. 2001 [unpublished])

By the end of the two year evaluation, MSF-Belgium had decided to withdraw from Cambodia following a strategic decision to focus on emergency and post-conflict settings rather than longer term development. The clinical services and psychosocial support provided through the Lotus Club were handed over to two different organizations. It is at that point that the report's prediction that "*… future changes in Svay Pak will result from decisions made from outside the community*" was fulfilled in a wholly unexpected and dramatic way with repercussions felt far beyond this one brothel district in what previously seemed like any other fishing village on the outskirts of Phnom Penh.

US Politics and its effect on HIV Policy

President George W. Bush was elected in late 2000 with the support of a coalition of far-right social conservative groups; by the time of his inauguration, it was clear that his political agenda would include close scrutiny of sexual and reproductive health programs both domestically and internationally (Greenberg 2000). One of his administration's

first policy maneuvers was to reinstate the Mexico City Policy, stipulating that no US funding could support organizations providing abortion services or even discussing it as an option for women with unwanted pregnancies (Crane and Dusenberry 2004). What came as more of a surprise, at least to the international development community that was dependent on US aid funding, was that the whole field of HIV prevention and treatment would come under scrutiny. Taking a moral approach over harm reduction, US funding for HIV privileged messages of abstinence and mutual monogamy over condom use and moved away from a focus on high-risk populations included injecting drug users, men who have sex with men, and sex workers (Kulczycki 2007).

Sex workers were re-branded by the US State Department as "victims of prostitution" (Kaiser 2003) and particular attention was given to the issue of sex trafficking. The term was not new, and in fact had been loosely used to describe the sex workers in Svay Pak in early project documents, referring to the facilitated migration of sex workers across the Cambodian border into brothels where they were not able to adequately control their working conditions. In 2000, however, the UN published the Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, which formalized the definition as follows:

> *"Trafficking in persons" shall mean the recruitment, transportation, transfer, harboring or receipt of persons, by the means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs.(UN 2000)*

This led to massive confusion within programs, many of which assumed that all sex workers were victims of trafficking and required legal intervention (Butcher 2003). US-based feminist activists opposed to sex work encouraged this conflation and pushed for withdrawal of programmatic funding for any interventions that did not attempt to remove women from the sex industry (Raymond 2001, Farley 2004).

Svay Pak became caught in the ideological crossfire and the MSF program was highlighted as a key example of how US tax-payers' money was being used to support sexual slavery. In June 2002, the House Committee on International Relations received evidence on the topic, and HIV prevention in Svay Pak was provided as an example of USAID having contravened the

2000 Trafficking Victims Protection Act (Hughes 2002, US 2002). Subsequently, an article was published in the *Asian Wall Street Journal* accusing MSF and its partners of conducting unethical interventions and research, concluding, "Those who lack the moral capacity to know that slaves need freedom should never get funding again" (Hughes 2003).

Following these and other advocacy efforts, the US government itself began to conflate *all* forms of sex work and trafficking in its Global AIDS Act of 2003, stating that "Organizations advocating prostitution are not appropriate partners for USAID" and viewing "community mobilization" and "empowerment" initiatives as thinly veiled attempts to condone sexual exploitation (USAID 2003, Masenior and Beyrer 2007). The result was a Prostitution Pledge mandating all HIV prevention programs in receipt of US donor funds to sign a statement stating their opposition to prostitution, with dramatic loss of funds for many programs (Saunders 2004, CHANGE 2005).

In Svay Pak, US funding had come to a close prior to the furor in the US. As has been documented elsewhere, however, the ongoing services became increasingly risk-adverse, and began to refuse to serve any sex workers who might be under 18 and thus potentially child trafficking victims (Busza 2006). Fear of reprisals from negative publicity surrounding sex worker projects reduced outreach services and the increase in externally-funded "rescue raids" in which NGO and police

collaborated in large scale brothel closures encouraged sex workers to "go underground," thus making access by health services all the more difficult (Thomas 2005, CHANGE and Law 2010).

Recent Developments

Under increasing pressure from the US, Cambodia eventually implemented the Law on the Suppression of Human Trafficking and Sexual Exploitation in 2008, which further reduced sex workers' contact with dedicated HIV services (Pearhouse 2008). Even the National AIDS Authority in Cambodia has openly acknowledged the damaging effects of the anti-trafficking policy:

> *... existing programs among key MARPs [Most at Risk Populations] falls short of the extent of services required to achieve sufficient scale up and coverage to avert a "second wave" of the epidemic. Successful interventions among brothel based entertainment workers have been interrupted by the Law on Prevention of Human Trafficking and Sexual Exploitation (NAA 2010):3.*

Over time, recommendations have shifted back onto a focus on targeted services for most-at-risk population, including sex workers. UN agencies again are advocating for community mobilization and empowerment approaches within the HIV response (UNFPA, UNAIDS et al. 2012), and following the

election of President Obama, the US has also reverted to taking a much less moralistic stance. Indeed, the 2012 PEPFAR "Blueprint" talks about working to reduce risk among sex workers, despite Hilary Clinton's known commitment to eradication of human trafficking, and gives Cambodia as an example of where considerable US investment has yielded impact:

> *Cambodia ... has received international recognition for scaling up HIV programs that ...have proven successful in a national HIV epidemic that is primarily sexually-driven, with the greatest burden among key population groups (e.g., men who have sex with men (MSM), sex workers (SW), and people who inject drugs (PWID)). In the U.S. government has contributed substantially to Cambodia's achievements in fighting AIDS .... Cambodia's current strategy focuses on delivering a combination prevention service package for key populations, including peer education; targeted behavioral interventions... (US 2012):11*

For Cambodia, the real issue remains one of ownership and self-determination. The country emerged from decades of conflict in which international intervention and political machinations played a considerable role, and was subsequently launched into equally politicized debates over how to address its burgeoning HIV epidemic. While it appears that the pendulum has swung back to where it was in the early 1990s,

the “Prostitution Pledge” remains as a US funding stipulation, although its legality is due to be debated in the US Supreme Court in 2013 (Sherman 2013). In the intervening years, many resources were wasted, and many sex workers needlessly harassed and driven into more precarious and marginalized positions. As a slight glimmer of hope, sex workers are becoming prioritized again just as new promising treatment regimes become available (Baral, Beyrer et al. 2012). But by definition, pendulums continue to swing, and as long as Cambodia remains heavily dependent on donor funding for its HIV programs, it may struggle to assert its own emerging priorities.

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