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DRAFT

A Background Paper on HIV/AIDS in Eastern Europe and Central Asia.

Prepared for the Director, The White House Office of National AIDS Policy.
8/25/00

The Problem

The increasing prevalence of intertwining issues such as HIV/AIDS, STDs, tuberculosis, alcoholism, and drug use in Eastern Europe and Central Asia have significant health, socio-economic, geo-political/security implications for these regions.

HIV/AIDS - a devastating epidemic picking up speed

According to the latest UNAIDS data, 1999's steepest rise in new HIV infections worldwide took place not in Africa, but in the former Soviet Union.

In Eastern Europe and Central Asia, HIV/AIDS was a relative latecomer but in recent years HIV prevalence rates have increased dramatically, with some Eastern European regions having the fastest rates of new infections worldwide.

A new report issued in July 2000 by UNAIDS estimates that the number of people living with the virus in the former Soviet Union and Eastern Europe has more than doubled in the past three years. HIV-positive people in the region now number 420,000, up from an estimated 170,000 cases three years ago. Belarus, Kazakhstan, Russia, Ukraine, and Moldova are considered the most affected countries at this time.

Many places are experiencing a rapid increase of injecting drug use, especially among young people. This gives HIV the opportunity to gain substantial footholds quite quickly.

Drug injecting is still the main risk factor driving HIV/AIDS in Eastern Europe and Central Asia, though sexual transmission is recognized as a significant factor as well.

In the countries of the former Soviet Union, the HIV epidemic continues to be concentrated heavily in injecting drug users. The absolute number of cases has remained small in many countries so far, but overall the growth has been rapid. The majority of new HIV infections are caused by unsafe drug injection and are occurring primarily in two countries: the Russian Federation and Ukraine. Drug injecting is becoming common among unemployed young people in many of the industrial cities of these countries. And because of the way drug solutions

are prepared in the region, there is also the risk that the solutions themselves are contaminated with HIV; thus, even if clean equipment is used, there is still the possibility of transmitting the virus.

In Ukraine, the number of diagnosed HIV infections jumped from virtually zero before 1995 to around 20,000 a year from 1996 onwards, with about 80% of them in injecting drug users. As HIV spreads and new infections occur, the total number of people living with HIV continues to grow, reaching an estimated 240 000 at the end of 1999, compared with 110,000 just two years earlier.

In the Russian Federation, the virus has been introduced into networks of drug injectors in both large and small cities where HIV was previously unknown. In Moscow city and region there were 7,000 new cases of HIV reported in 1999 alone--three times as many as in all previous years combined. While about 130,000 Russians are thought to be already infected with HIV, recent estimates of the number of injecting drug users in the country range between 1 and 2.5 million. Obviously, many more infections may still occur in this group, apart from the risk of further spread of HIV into other parts of the population.

In any country with a large and growing drug injecting population, coupled with unsafe drug-injecting practices, a fresh outbreak of HIV is liable to occur at any time. This is especially true of the countries in Eastern Europe where the HIV epidemics are still young and have so far spared some cities and sub-populations.

Indicators that HIV infection is occurring through sexual transmission are available as well. For example, in the past five to six years, syphilis cases among girls who are fourteen or younger have increased thirty-fold in some Russian regions.

Rising HIV infection rates are often coupled with rising rates of other STDs. As a co-factor, the presence of an STD increases the chance of becoming HIV infected from unprotected sex with an HIV infected person.

What's behind this?

Many factors can drive an HIV/AIDS epidemic. Among them is economics. As experienced in most Eastern European countries, economic hardship has lead more individuals toward illegal drug use and prostitution. Many drug injectors also have unprotected sex, and STD prevalence among them is high. Thus, their sex partners are also at risk of HIV, regardless of whether they use drugs, thereby facilitating transmission to the "general population." Moreover, weak and/or transitioning economies and inadequate political will render it difficult for governments to develop, fund and sustain effective anti-HIV/AIDS campaigns.

In some areas of Eastern Europe there is already strong overlap between drug injectors and sex workers, who will also have clients from outside the drug-injecting community. For example, out of a small sample of 103 sex workers arrested on the streets of the Russian city of Kaliningrad, a third were known to be IDUs living with HIV. The city reported that four out of every five women treated for HIV-related illness at the regional AIDS center make a living as a sex worker.

Tuberculosis (TB): one of several HIV/AIDS co-factors

HIV/AIDS co-factors such as tuberculosis and STDs are important to address in the overall context of HIV/AIDS. For example, the incidence of TB in Russia has been escalating rapidly. The Russian mortality rate for TB is 16.9 per 100,000; the U.S. rate is 0.5. One-tenth of the prison inmates in Russia have TB, and reportedly, 850,000 to one million Russians are in prison. These estimates are generally considered underestimates of the actual numbers.

Other countries in the region

Other Eastern European and Central Asian countries should also be considered. Risk factors and patterns must be assessed and addressed in these areas as well, if HIV/AIDS is to be effectively controlled. For example, Romania has the greatest number of pediatric HIV/AIDS cases in Europe. HIV transmission has occurred primarily in health care settings through infected blood products and contaminated equipment and syringes. In other nations, such as the Czech Republic, initial cases have occurred primarily via homosexual/bisexual transmission, followed closely by heterosexual transmission.

Why should everyone be concerned?

There is no doubt that the warning signs for a widespread injection drug use and/or sexually-transmitted epidemic of HIV exist in many areas of Eastern Europe. Although levels of HIV infection in the general population remain low at this time, the testing of pregnant women, blood donors, and others suggests that the virus is becoming increasingly common in society as a whole. And we are now witnessing dramatic increases in other sexually transmitted diseases, especially syphilis, in the general population. From negligible rates of around 10 cases per 100,000 people in the late 1980s, new syphilis infections have shot up into the hundreds. The Russian Federation, which had an annual rate in the single figures in 1987, recorded over 260 cases per 100,000 people a decade later.

The rise in new cases of STDs and the mixing of injecting drug users with other groups and segments of society indicates that the risk of HIV spreading rapidly throughout the general population in Eastern Europe is very real.

Why should policymakers be concerned?

Those concerned with issues such as geopolitics, economics, global and national security as they relate to Russia and Eastern Europe, must also consider these fundamental health and public health realities. National epidemics of infectious diseases and the devastating illness they cause stand to undermine long term solutions to a country's political, economic. and security issues. This is true for Russia and other countries of Eastern Europe and Central Asia. This is especially true for the devastating patterns of illness created by HIV and AIDS.

With respect to health and healthcare, well-constructed evidence-based planning and action taken now can assist Eastern Europe in averting what is now happening in Sub-Saharan Africa. Many African governments concede that they are so overwhelmed with care issues of those already HIV-infected that they have very little ability to meet this demand, let alone support public health scale HIV prevention efforts. Life expectancy in some African nations are predicted to drop by over 20 years during this decade, with work forces and family structures being decimated, and the effects of HIV/AIDS consuming increasing amounts of governmental and non-governmental resources. Resources that otherwise could be applied elsewhere, in other sectors, to grow economies and strengthen countries.

August 25, 2000
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Asia and Near East Bureau's Suggested Itineraries for the President's Office of National AIDS Policy Mission to Asia.

Overview of HIV in Asia

With almost half the world's population, Asia currently has 20% of the world's HIV infections and is projected to have the greatest number of HIV infected persons by 2010 (estimates range from 30 to 40 million). The epidemic in Asia is diverse and is driven by different conditions than in Africa or other parts of the world. The HIV epidemic in Asia began in the most marginalized populations, spread largely through commercial sex and intravenous drug use (IDU). Widespread poverty, trafficking in women and girls between and within countries, population migrations, cheap drugs, and the low status of women are factors propelling the epidemic through Asia.

The dynamics of HIV infection differs across regions within Asia. In the southeast Asia/Pacific region, especially Indonesia, the Philippines, Korea and Japan, HIV is spreading but rates remains low (less than 0.3%). In the south Asia subcontinent, HIV infection is spreading through the southern and northeastern states of India, where prevalence rates exceed 2% of women attending antenatal clinics. Thailand was the first country in Southeast Asia to recognize and confront the epidemic, and, while concerted public health efforts have produced a steady decrease in the number of new infections, more than 2% of adults are living with HIV. The most explosive HIV epidemic is now occurring in Cambodia, where 4% of the adult population is infected. It is clear that HIV is spreading from areas of high concentration into the general population and across international borders.

Real opportunities to prevent an HIV pandemic exist in Asia. USAID has focused interventions targeting the most vulnerable groups with:

- awareness and prevention programs
- condom social marketing
- appropriate treatment of sexually transmitted infections
- development of care and support programs
- capacity building for policy, surveillance, and training.

It is critical that interventions be scaled up *now* to slow the evolving epidemic in Asia.

Suggested Focus of the ONAP Mission to Asia

The purpose of the ONAP mission will be to:

- Understand and experience the unique Asian context in which affected communities – sex workers, intravenous drug users, people living with AIDS, and their families—confront the HIV epidemic.
- Investigate the extent of the AIDS crisis in the most severely effected countries, especially as it relates to children affected by AIDS
- Gather lessons learned from successful interventions in policy, prevention, and care and support.
- Promote leadership and policy dialogue both at home and abroad.

Suggested Countries to Visit

India: Due to its large brothel-based sex industry and huge population, is expected to have more HIV infected individuals than any other country in the world. Response by the Government of India (GOI) was slow, especially in the first decade of the epidemic. NGOs stepped in to fill the void. The Government, through the National AIDS Control Organization (NACO), has recently announced a new 5-year plan of action on AIDS. The ONAP-sponsored delegation will visit with government, NGOs and People Living with AIDS (PLA) groups to understand the Indian experience, perspective and culturally appropriate solutions.

Thailand: In the last decade the Thai government's actions to prevent the spread of HIV are considered a model for the region, if not the world. Instituting a "100% condom use in commercial sex policy" has

resulted in significant increases in overall condom use, decreasing number of visits to sex workers and steadily declining HIV incidence (new infections) nation-wide. With one of the strongest economies in the region (especially prior to the Asian financial crisis, from which Thailand is slowly emerging), high level of education and the political will to address the epidemic, Thailand has developed a myriad of programs to address the epidemic and its consequences: broad scale awareness and prevention activities; care and support to HIV affected children and families; wide-spread treatment of AIDS-related opportunistic infections; counseling and testing for every pregnant woman and the provision of AZT if positive; job placement for HIV positive persons. The ONAP Mission will visit a variety of organizations involved in HIV/AIDS activities and share lessons learned from the Thai experience.

Cambodia: Cambodia has the highest HIV prevalence rate (4.04%) in Asia. The epidemic has spread rapidly and AIDS is now a visible reality for the Cambodian people and their government. This year the Royal Government of Cambodia (RGC) endorsed a "100% condom use in brothels" policy and has made clear and public statements about the threat of HIV to the country's long term reconstruction and development after 3 decades of war and occupation. Government response to the epidemic has been constrained by lack of resources, a devastated infrastructure (roads, rail, schools, hospital and clinic facilities), limited human capacity to undertake awareness and prevention, treatment or mitigation activities. International donors are active in HIV prevention activities, and USAID is the leader in this effort.

What follows are three possible itineraries:

For a seven day mission, focus on India:

Option One Visit Delhi and Chennai, Tamil Nadu. In Delhi meet with key policy makers and donors. Visit a wide range of NGOs responding to HIV among the urban poor. Tamil Nadu had one of the first states to address HIV and now, in collaboration with USAID, has a state-wide program showing impressive results. Visit a rural-based prevention project.

Option Two Visit Delhi and Mumbai, Maharastra. (Delhi as above.) Mumbai is the most cosmopolitan of Indian cities, with the most visible sex industry, in the state with the greatest burden of HIV in India. The State of Maharastra is undertaking, in collaboration with USAID, an ambitious prevention program in four cities in the state. Visit a rural-based prevention project.

For a 12 day mission include Thailand and Cambodia in addition to Option One or Two.

- Thailand has the most mature epidemic in Asia and has been called a "model" country for it s response to the epidemic and to those living with HIV/AIDS. Meet with community volunteers and AIDS activists to learn which lessons can be adopted/adapted for other countries in the region and the world.
- Cambodia is the hot spot for HIV in southeast Asia, with the potential to spread HIV into lower prevalence countries like Lao PDR and Vietnam. Despite a devastated infrastructure and a nascent government, HIV prevention activities are targeting a wide range of communities, including the military and police forces.

DRAFT ITINERARY – ONAP DELEGATION

India **Major Holidays in October (Government offices closed)**:
Oct 2, Monday: Gandhi's birthday
Oct 7, Saturday: Dusshera
Oct 26, Thursday: Divali (Festival of Lights)

Three itineraries:

1. 7 days Delhi-Chennai
   or
2. 7 days Delhi-Mumbai

3. 12 days Either I or 2 plus Bangkok, Thailand and Phnom Penh, Cambodia

India

Trip One **Delhi and Chennai, Tamil Nadu**

Day I Fly to Delhi

Day 2

Afternoon: Arrive in Delhi, meet with USAID/Embassy staffs/Science Attache
Briefing on HIV in India and GOI, Business, Scientific and USG response/activities

Day 3

Morning: GOI Response: Meet with National AIDS Control Organization (NACO), Ministry of Health and Social Welfare, and other GOI agencies for update on HIV in India

Donor roundtable: Meet with WHO,UNAIDS/UNDP, DfID other donors on their current activities on HIV prevention.

Afternoon: Visit Salaam Balaak Trust, NGO working with vulnerable boys and girls living in or abandoned at the Delhi train station. The Trust provides a drop-in center, resting place, HIV prevention education and attempts to search for families to re-unite child.

or

Visit Sharon Project, a drop-in center for injecting drug users (IDUs) and sex workers in Delhi: Unlike Africa, several countries in Asia (in India, the State of Manipur and urban centers like Delhi, and in Burma, South China and Vietnam), are experiencing rapid escalation of HIV prevalence in IDUs communities. The Sharon project provides counseling for coping with addiction, counseling and testing for HIV, needle exchange (not funded by USAID), and care for people with HIV.

or

Visit research institute doing HIV research/vaccine development/AIDS care: India has world-class research talent. India is engaged in the worldwide vaccine development initiatives and is doing research in virology, epidemiology and behavioral aspects of HIV.

or

Visit Council of Indian Industry: an organization of private business and industries engaged in workplace AIDS prevention activities.

Day 4

Morning: Visit a model Slum Dwellers HIV Prevention Project by an NGO called CASP-PLAN. For the last three years CASP-PLAN has been targeting youth and their parents for HIV and STI prevention through peer counselors, development of Information, Education and Communication (IEC) materials about HIV and STI, and has conducted program evaluation.

Afternoon: Visit the United Nations International Development Fund for Women (UNIFEM) to discuss issues of women and child trafficking in India, and throughout the South Asia region for the sex industry. UNIFEM is the organization supported by USAID and the Embassy to increase awareness and understanding of the issue of trafficking and of the profile of its victims. UNIFEM is mapping trafficking patterns within India and across its borders with emphasis on identifying highly vulnerable communities, and working with Indian NGOs to link them to regional networks to improve coordination.

Meet with women's NGOs doing micro-credit and training programs for vulnerable women. In order for women to have options other than sex work, women need vocational and business training to succeed.

Day 5 Fly to Chennai

Afternoon: Meet with Director of Tamil Nadu AIDS Cell, Tamil Nadu Health Minister and other officials

Visit Chennai TB Research Center (ICMR premier institution on TB, but will need clearance from GOI to visit) to address the growing problem of TB and HIV co-infection. India has one of the highest TB burdens in the world and with increasing HIV infections, the need to appropriately treat patients with these co-infections is growing.

Or

Visit to Prakriti, community based AIDS service organization. Prakriti recently participated in a briefing on Capital Hill sponsored by Congressman Jim McDermott, called "The Effects of Health on India's Development." Their spokeswoman, Lalitha Kumaramangalam, spoke eloquently about the tremendous stigma and discrimination facing PLA in India. Participate in a forum on issues facing people living with AIDS in India.

Or

Meet with Indian Network for People Living with HIV/AIDS (INP+). Participate in a forum on issues facing people living with AIDS in southern India

Day 6

Morning: Visit APAC's (USAID Mission program) Highway HIV Prevention Project, which is influencing significant behavior change in truck drivers, their helpers, factory workers and sex workers along the major routes through Tamil Nadu through peer education, STI treatment and condom social marketing. Visit rural APAC outreach sites.

Afternoon: Meet with women's NGOs doing micro-credit and training programs for vulnerable women

Or

Visit YRG Cares, an NGO leader in research, care and treatment of HIV patients

Or

Meet with Tamil movie star(s) promoting HIV prevention. Maharastra has Bollywood, Tamil Nadu has "Chennai-wood". South India has a distinct, but just as popular, movie tradition. Meet with a popular south Indian movie star to discuss HIV and youth.

Day 7 Return to US

Trip 2 Delhi and Mumbai, Maharastra
(days 1-4 are same as above)

Day 5

Morning: Fly to Mumbai. Meet with Director of Maharastra AIDS Cell, Maharastra Health Minister and other officials. Maharastra has the greatest burden of HIV in India and has an active State AIDS Cell. Discuss the latest data for Maharastra and Mumbai and mother-to-child-transmission issues and research.

Afternoon: Meet with Mumbai movie star(s) promoting HIV awareness and prevention. Finally Bollywood is finding a voice on AIDS! A few popular movie stars have begun to make HIV a priority issue among youth. We will try to have a photo-op and interview with a movie star promoting HIV/AIDS awareness.

Or: Mission divides into 2 groups

Group 1 visits ASHA, a comprehensive care clinic in Mumbai's red light district. The Kamatipura district of Mumbai covers a huge area, home to thousands of sex workers. The NGO provides treatment for sexually transmitted infections and other health problems to 50-60 sex workers and 150 men every day.

Group 2 visits Mumbai-based NGO doing HIV care and support and programs with children and families affected by AIDS.

Day 6

All day: As per ONAP request, visit rural site outside Mumbai (TBD by USAID mission).

Day 7 Return to US

Trip 3 **India, Thailand and Cambodia**

Thailand

Day 7 Fly to Bangkok

Afternoon: Briefing at Family Health International's (FHI) Asia Regional Office for discussion of the national response to HIV in Thailand and USAID's ANE Regional Asia program.

Day 8

Morning: Meet with Embassy
Meet with Thai AIDS Business Coalition, PLA groups

Afternoon: Visit NGOs doing grass roots prevention and care and support activities, organizations working with vulnerable children

Day 9

Morning: Meet Thai legislators supporting improved HIV policy in Thailand. While Thailand has led the South East Asia region by responding with (relatively) early and innovative intervention programs, discriminatory policies are still in place. We will try to meet with some newly elected legislators working for policy reform.

Afternoon: Travel to Cambodia

Cambodia

Day 10 Travel to Cambodia (if not able to do on day 9)

Afternoon: Met with Mission/Embassy staffs
Meet with Ministry of Health, National AIDS Authority, National Center for HIV/AIDS, Dermatology and STDs (NCHADS), and other line ministries involved in HIV prevention

Day 11

Morning: Visit military/police peer-to-peer training. In Cambodia and other countries in Asia, military and police personnel have increased HIV rates. This is a unique program working with Cambodian military and police in HIV prevention. Recently UNAIDS/USAID sponsored a strategic planning and training workshop on HIV/AIDS/STI prevention held in Siem Reap, Cambodia where this program was presented. The workshop was attended by officials from the Ministries of National Defense, Interior, Health, National AIDS Authority/Committees from Lao, Vietnam and Cambodia, as well as and NGOs and Donors working in Cambodia. Attendees endorsed the program, requesting that it be translated into other languages and made available to military and police department throughout South East Asia (30-minute drive outside of PP).

Afternoon: Visit NGO outreach site in Phnom Penh. There are several projects ongoing with sex worker communities and vulnerable children and orphans. We will visit at few of these projects to talk with outreach workers about the escalating AIDS situation in PP.

Day 12 Return to US

HIV/AIDS and Tuberculosis in Asia and the Near East

I. Summary

HIV/AIDS:

- Between 1991 and 1998, the total number of HIV/AIDS cases in Asia (excluding China) increased from 675,000 to 6.7 million (about 20% of the worldwide total). An estimated 40% of these HIV+ people will ultimately die from tuberculosis (TB). Although HIV prevalence rates are highest in Africa, Asia will have more HIV infected people than any other region in the world by 2010[1]

- The HIV/AIDS epidemic is emerging mostly in South and Southeast Asia. The Philippines and Indonesia have low rates of infection but the epidemic is spreading rapidly in Cambodia and in several states in India. HIV transmission is occurring predominantly through heterosexual contacts (especially in southern India, Cambodia, and Thailand) and intravenous drug use (Burma, Vietnam, and Manipur and Mizoram States in India). HIV/AIDS rates in the Middle East, while highly under-reported, are still relatively low.

Tuberculosis:

- In 1998, TB caused 907,000 deaths (61% of global total) in Asia and the Near East (excluding China). The incidence of disease was highest in South and Southeast Asia with significantly fewer cases in the Middle East. Presently, fewer than half of the people in Asia and the Near East have access to DOTS (Directly-Observe Treatment, Short-course).

- The TB problem in Asia will likely worsen because: (1) several of countries have also experienced a limited spread of HIV/AIDS from high-risk groups to the general population; and (2) improper treatment with anti-TB drugs and poor compliance has led to multi-drug resistant (MDR) TB.

II. Challenges/Issues

- To date, HIV/AIDS prevention programs have focused on high-risk populations.

- We will continue prevention activities in high prevalence countries and sub-regions (e.g. states in southern India). However, it is imperative that we focus *now* on low prevalence countries (e.g. Lao P.D.R., Vietnam, Bangladesh, and Nepal) that have geographic proximity to high prevalence countries, population mobility and risk behaviors for epidemic explosion (e.g., brothel based sex work, high STI rates, increasing use of intravenous drugs). We have real opportunities to curtail the epidemic in these countries.

- The biggest threats to HIV/AIDS and TB control are complacency and the lack of political will to address the diseases.

- Successful programs exist to prevent HIV/AIDS transmission and to treat TB cases. However, capacity to implement these programs is severely limited because of deficiencies in training, management, monitoring and evaluation, and procurement of commodities such as condoms, drugs, reagents, and equipment.

III. Current USAID Response

- USAID supports HIV/AIDS and TB programs in India, Nepal, Bangladesh, Cambodia, Philippines and Indonesia. All HIV/AIDS programs focus on prevention among vulnerable populations like sex workers, their clients, and STI clinic patients. In 1999, India, Nepal and Cambodia initiated activities for children affected by AIDS. TB programs focus on improving surveillance, case detection, and treatment. (See table below for budget allocations.)

- The USAID/Asia and Near East Bureau (ANE) manages a regional HIV/AIDS and Infectious Disease program in both presence and non-presence countries (such as Lao P.D.R., Vietnam, and Thailand). The regional program focuses on:
  - reaching mobile populations;
  - promoting community-based HIV/AIDS and TB care and support;
  - strengthening capacity for policy development, surveillance, prevention (including condom social marketing), and care.

- India was the only ANE country included in the Presidential LIFE Initiative (Leadership in Fighting an Epidemic), receiving an additional $3 million dollars in FY 00. LIFE funds are being used to:
  - expand prevention activities
  - train health care providers in appropriate care of those infected with HIV
  - develop a Business Coalition on AIDS to engage the private sector in HIV prevention.

USAID Funding	HIV/AIDS		TB	
	FY00	Per cent of total Agency funding	FY00	Per cent of total Agency funding
Agency Total	$200,000,000	100%	$20,000,000	100%
ANE Bureau Total	$25,500,000	13%	$2,660,000	13%
ANE Regional Program	$4,000,000	0.02%	$360,000	0.02%

IV. Future USAID Priorities in ANE Region

Priorities include expansion of existing HIV/AIDS and TB programs that focus on:
- Strengthening regional/national/local capacity (including surveillance, prevention, care and support);
- Promoting policy dialogue (including human rights);
- Expanding prevention activities (education, behavior change, commodity security, etc.);
- Assisting children and families affected by HIV/AIDS and TB.

The priority countries for expanded HIV/AIDS and TB activities are shown in the table below.

Geographic Focus	HIV/AIDS	TB
Bangladesh	Medium	High
Cambodia	High	High
India	High	High
Indonesia	Low	High
Nepal	Medium	Medium
Philippines	Low	High

The ANE Bureau also plans to expand regional programs addressing mobile populations.

[1] *The Global Infectious Disease Threat and Its Implications for the United States. National Intelligence Estimate. National Intelligence Council, January 2000.*

V. Funding Requirements for Asia and Near East

HIV/AIDS

COUNTRY	FY 2000	FY 2001 Funding Scenarios		
		LOW	MEDIUM	HIGH
Bangladesh	$ 3,000,000	$ 4,000,000	$ 4,000,000	$ 5,000,000
India	$ 8.500,000	$ 12,000,000	$ 12,000,000	$ 13,000,000
Nepal	$ 2,000,000	$ 2,500,000	$ 3,000,000	$ 4,000,000
Cambodia	$ 2,050,000	$ 3,500,000	$ 4,000,000	$ 5.000,000
Indonesia	$ 4,500,000	$ 4,000,000	$ 5,000,000	$ 5,000,000
Philippines	$ 1,500,000	$ 1,500,000	$ 2,000,000	$ 3,000,000
Regional Programs	$ 4,000,000	$ 7,500,000	$ 10,000,000	$ 15,000,000
TOTAL	$ 25,550,000	$ 35,000,000	$ 40,000,000	$ 50,000,000

TUBERCULOSIS

COUNTRY	FY 2000	FY 2001 Funding Scenarios		
		LOW	MEDIUM	HIGH
Bangladesh	$ 0	$ 500,000	$ 1,000,000	$ 1,500,000
India	$ 1,200,000	$ 2,500,000	$ 3,500,000	$ 4,000,000
Nepal	$ 0	$ 500,000	$ 1,000,000	$ 1,500,000
Cambodia	$ 0	$ 500,000	$ 1,000,000	$ 2,000,000
Indonesia	$ 500,000	$ 1,500,000	$ 2,000,000	$ 2,500,000
Philippines	$ 600,000	$ 1,500,000	$ 2,000,000	$ 2,500,000
Regional Programs	$ 360,000	$ 1,000,000	$ 1,500,000	$ 2,000,000
TOTAL	$ 2,660,000	$ 8,000,000	$ 12,000,000	$ 16,000,000

BANGLADESH AND HIV/AIDS

TALKING POINTS

The HIV/AIDS pandemic is still nascent in Bangladesh, but without significant behavior change activities and HIV/AIDS information dissemination, HIV could spread quickly among high-risk groups, including sex workers, their clients, migrants and injectable drug users. By all accounts, the overall prevalence of HIV remains low (0.03 percent or less).

- Little reliable statistical data on HIV/AIDS exists in Bangladesh; however, in 1997, the Joint United Nations Programme on AIDS (UNAIDS)/World Health Organization (WHO) estimated that there were 21,000 people living with HIV.
- Commercial sex workers and their clients, sexually transmitted infection (STI) patients, truckers, and intravenous drug users show indications of significant risk behavior, according to several studies.

Women and HIV/AIDS: Very little is known about the number of women living with HIV. With a high rate of STIs and low condom use, women in high-risk groups are particularly vulnerable to HIV.

National Response: There have been a number of statements of concern about HIV by Bangladeshi leaders and a gradually growing awareness of HIV/AIDS by the general population. This is due, in part, to small-scale public education efforts and some excellent innovative work by nongovernmental organizations (NGOs), with government support. Although the government has a good intersectoral mechanism in place for HIV/AIDS prevention and control, the new structure does not appear to favor the delivery of a strong and coherent multisectoral response. Rapid action is needed in behavior change communication and implementing effective prevention measures nationwide. The government needs to take a more active stance.

Donors: USAID/Dhaka, one of the largest donors in the HIV/AIDS sector, supports the control of HIV/AIDS through a social marketing program; peer education and condom promotion activities targeted at high-risk populations; information, education and communication efforts geared toward the general public and high-risk groups; STI treatment centers throughout the country; and, surveillance and operational research. USAID's 1998 HIV/AIDS funding was $1.35 million in Bangladesh. This funding level is expected to significantly increase in the coming years. Through the USAID-funded Implementing AIDS Prevention and Care Activities (IMPACT) Project, Family Health International has helped the government of Bangladesh refine its national strategy in light of low HIV-prevalence rates. IMPACT will also be conducting an assessment and pilot project in the Phulburi corridor that connects Bangladesh, India, and Nepal. Following an IMPACT assessment, the British Department for International Development is funding an intervention in the Chittagong port area. The International HIV/AIDS Alliance has been working with an NGO, HIV/AIDS/STI Activities in Bangladesh, since 1995 to mobilize local NGOs for intensive capacity building, provision of community care and support, and technical and communication skill-building.

BANGLADESH AND HIV/AIDS

COUNTRY PROFILE

At present, Bangladesh has a population of approximately 125 million people. With 830 people per square kilometer, it is one of the world's most densely populated countries. Poverty and rapid population growth continue to strain the country's resources. Per capita income is $220. Almost half of the population (45 percent) live in poverty, malnutrition is high, and infant mortality is above the average for low-income countries. Bangladesh remains highly vulnerable to natural disasters, such as cyclones and floods. While HIV/AIDS is still in a nascent stage in Bangladesh, the country harbors many risk factors conducive to the rapid spread of HIV. Given this environment, a definitive and energetic government and nongovernmental organization (NGO) strategy and response are needed to help diminish the pandemic's potential impact.

HIV/AIDS in Bangladesh

While overall HIV prevalence is low in Bangladesh, (0.03 percent or less), several high-risk factors put the country in jeopardy for the rapid spread of HIV/AIDS:

- Low use of condoms among high-risk groups (e.g., students, truck drivers, migrants, sex workers and their clients, dock workers);
- Significant prevalence of sexually transmitted infections (STIs) among commercial sex workers (CSWs) in Dhaka, (60 percent with syphilis, 18 percent with gonorrhea, and 20 percent with chlamydiae, according to a 1996 report);
- An unsafe blood supply and low awareness of the dangers of HIV and STIs among the general population; and,
- Contact through shared borders with India and Myanmar (countries with higher HIV prevalence) via sea and land routes.

In Bangladesh, very little reliable data exist on the number of HIV/AIDS cases among the general population. According to the Ministry of Health and Family Welfare (MOH), 12 persons have tested positive for HIV/AIDS (6 of whom have already died and the remaining 6 were suffering from tuberculosis and in critical condition). In a 1998 AIDS newsletter, the MOH reported that 105 people had tested positive for HIV/AIDS. This official figure, however, underestimates the real scope of the problem in Bangladesh. According to the Joint United Nations Programme on AIDS (UNAIDS)/World Health Organization (WHO), at the end of 1997, approximately 21,000 people were HIV infected, of which an estimated 31 percent were between 16 and 30 years of age. This estimate, however, does not correspond with recent sentinel results. For example, HIV prevalence in the various high-risk populations was found to be relatively low when compared with neighboring countries: brothel-based sex workers (0.6 percent), STI patients (0.2 percent), and injecting drug users (2.5 percent).

The *Bangladesh Demographic and Health Survey, 1996–1997,* found that the vast majority of Bangladeshi adults had never heard of AIDS. However, urban women were four times more likely to have heard of AIDS than their rural counterparts (58 versus 14 percent), while women with some secondary school education were

10 times more likely to know of AIDS than uneducated women (59 versus 6 percent). Similar patterns existed for men. While urban respondents were considerably better informed about the disease than their rural counterparts, little in general was known about AIDS in Bangladesh. Most knew that a healthy-looking person can have AIDS and that AIDS is a fatal disease (68 percent of women and 81 percent of men).

Women and HIV/AIDS

At present, little is known regarding the number of women infected with HIV in Bangladesh. However, with the risk factors listed above, women are more vulnerable to AIDS for a number of reasons:

- Biologically, HIV transmission from a man to a woman is two to four times more likely than from a woman to a man.
- For cultural reasons, women are relatively powerless to insist on condoms; as a result, many women suffer from STIs, which are cofactors for HIV transmission.
- Women often receive blood transfusions in childbirth or because of anemia; the country's unsafe blood supply puts women at additional risk for contracting HIV/AIDS.
- Women are more at risk from coercive sex and forced prostitution.
- Many faithful women are at risk of infection from their partners, especially those men who are among the 2 million working abroad, mainly in Southeast Asia and the Gulf nations.

INTERVENTIONS

National Response

The government of Bangladesh provides significant funding for the national family planning and health program, with a $420 million fiscal year (FY)1996–97 budget. In late 1996, the Directorate of Health Services, with the Ministry of Health and Family Welfare's support, issued a National Policy on HIV/AIDS. A multidisciplinary task force drafted the document, which included a broad policy statement and guiding principles, with specific guidelines on a range of HIV/AIDS issues including testing, care, blood safety, prevention among youth, women, and in the workplace; mobility and CSWs; and, STIs. The National AIDS Committee (NAC) was reconstituted with the Health Minister as Chair. A technical committee was set up to provide policy guidance and a coordination committee to coordinate and monitor implementation. The NAC includes representatives from the key ministries and NGOs, and a few parliamentarians. Within the Primary Health Care unit, a program manager heads the National AIDS and STI Program.

In May 1997, the Ministry of Health and Family Welfare's AIDS Prevention and Control Programme (BAPCP) issued a National Strategic Plan (1997–2002). The plan resulted from a consultation process among a number of government agencies, NGOs, and international partners that culminated in a national consensus workshop. The Plan provides a framework; defines priorities, strategies, and priority interventions; and, underlines a multisectoral approach.

In November 1997, the government issued a Plan of Action to address HIV/AIDS issues within the Health and Population Sector Programme framework. Prevention and care related to HIV are included within an

Essential Services Package that incorporates basic reproductive health and child services, some communicable diseases, care, and behavior change communications.

With both a strategy and a structure in place, the government has a good intersectoral mechanism for HIV/AIDS prevention and control, with focal points in all concerned ministries. However, the Director-General of the Directorate of Health Services division responsible for implementing this work faces several problems. Few of the 41 staff positions are filled, and the Directorate is too low in the hierarchy to command resources and lacks expertise in a number of technical areas. At present, leadership is still needed for this important health issue. The new structures do not appear to favor the delivery of a strong and coherent multisectoral response. There have been numerous statements of concern about HIV by Bangladeshi leaders, a gradually growing awareness of the population, in part from small-scale public education efforts, and some excellent innovative work by NGOs with government support.

Donor Response

USAID/Dhaka, one of the largest donors in the HIV/AIDS sector, supports the control of HIV/AIDS through a social marketing program; peer education and condom promotion efforts targeted at high-risk populations; information, education and communication efforts geared toward the general public and high-risk groups; STI treatment centers throughout the country, and surveillance and operational research. USAID's 1998 HIV/AIDS funding was $1.35 million in Bangladesh. This funding level is expected to significantly increase in the coming years. In addition, the USAID–funded Implementing Prevention and Care Activities (IMPACT) Project is assisting the government of Bangladesh to refine its national strategy in light of low HIV–prevalence rates. IMPACT will also be conducting an assessment and pilot project in the Phulburi corridor that connects Bangladesh, India, and Nepal. Following an IMPACT assessment, the British Department for International Development (DfID) is funding an intervention in the Chittagong port area. Since 1995, the International HIV/AIDS Alliance has been working with the HIV/AIDS/STI Activities in Bangladesh NGO to mobilize local NGOs for intensive capacity building, provision of community care and support, and technical and communication skill building.

Other multilateral and bilateral donors are also actively engaged in Bangladesh.

The World Bank's strategy to accelerate growth and reduce poverty in Bangladesh includes promoting human development through a "long-term vision in education, health, nutrition, and population." The World Bank and its consortium of nine bilateral and five multilateral donors support the delivery of essential health and family planning services, primarily through the government sector, with targeted interventions in such areas as nutrition, communicable disease control, and strengthening government training. However, little funding has been provided in the HIV/AIDS sector to date. Within a year, the World Bank plans to develop a $40 million HIV/AIDS component to complement its ongoing activities.

The British Department for International Development (DfID) recently funded CARE RASTTA–BANDOR; this program will work with transport workers and associated CSWs in target areas to increase their participation in a high-quality control program. The HIV/AIDS CARE Project aims to prevent the spread of AIDS and develop an awareness program (1994–99; £1.9 million); the United Kingdom Overseas Development Administration sponsors this project.

Until recently, the **United Nations Development Programme (UNDP)** was the only United Nations organization with a significant investment in HIV/AIDS prevention through its support of the Bangladesh AIDS Prevention and Control project. With UNAIDS and the push for a common UN system approach to country issues, the UN system has a good opportunity to develop a more cohesive, proactive program. UNDP is contributing to an education campaign run by the Islamic Medical Mission in Dhaka to train imams (Islamic clerics) to impart awareness about HIV transmission. This training is part of a larger program to give imams basic medical training so that they can act as "barefoot doctors" in rural areas.

Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)

There is a very strong and active NGO sector with many working in HIV/AIDS. The sector includes both HIV–specific and mainstream NGOs as well as coalitions that have developed either nationally or through international patronage. The NGOs have an immense capacity for effective involvement in AIDS–related prevention activities across a range of venues.

USAID–Funded Organizations

Family Planning Logistics Management Project (John Snow Inc.) provides technical support to the government of Bangladesh to ensure that condoms are regularly and efficiently distributed throughout the nation to ensure condom availability.

Urban Family Health Partnership provides clinic services for STI treatment, HIV/AIDS counseling, peer education support, and general awareness through their clinic-based infrastructure throughout Bangladesh.

The Social Marketing Company (SMC) distributes over 10 million condoms per month throughout Bangladesh. In addition, SMC implements peer education programs in high-risk areas to promote safe sex/ condom use behaviors. The company also shows HIV/AIDS films that deal with different aspects of the problem through mobile outreach vans.

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) has conducted many research projects in an effort to address a full range of issues associated with the HIV/AIDS problem in Bangladesh. These projects include STI Syndrome Approach in an Urban Government of Bangladesh Clinic, STI Syndromic Approach in a Rural Clinic, Antenatal Screening for Syphilis, Validity Assessment of Syndromic Management, and Training Assessment of Syndromic Management. In collaboration with the IMPACT Project, SMC is also conducting research to test the feasibility of pre-packaged STI syndromic treatment packages and of female condoms in high-risk populations.

Non–USAID–Funded Nongovernmental Organizations (NGOs)

The Asian Red Cross and **Red Crescent AIDS Task Force (ART)** was established in 1994 by professionals and young people from 10 national Red Cross and Red Crescent Societies in Asia to promote HIV/AIDS activities at the grassroots level. Between 1994 and 1996, ART trained 1,000 young people as peer educators using a life-skills approach and culturally sensitive training manuals on sexual and reproductive health and HIV/ AIDS. As part of a media campaign, the Red Cross and Red Crescent Societies of East and Southeast Asia

recently held a poster competition to create awareness about HIV/AIDS discrimination among target groups in the region.

The Bangladesh Rural Advancement Committee (BRAC) developed a reproductive health Rural Service Delivery Program in 1995 for poor youth, 70 percent of whom are girls. The program includes monthly reproductive health sessions that are integrated into the regular school curriculum and covers STIs, family planning, and contraception. An assessment found that youth wanted the curriculum to provide more emphasis on reproductive health, sex education, and strengthening peer education.

CARE/Bangladesh: Stopping HIV/AIDS through Knowledge and Training Initiatives, the SHAKTI project (i.e., "strength"), aims to provide knowledge and skills so that individuals can make decisions and take appropriate actions to prevent HIV/AIDS transmission. CARE is working in the Dhaka and Tangail districts with 10 local NGOs to develop and implement HIV/AIDS staff education programs. The project also works directly with high-risk populations (2,400 commercial sex workers and intravenous drug users) to promote peer education on preventive behavior. These individuals become peer educators and are teaching HIV/AIDS prevention to 100,000 high-risk individuals. CARE is sharing the project results with the government and other NGOs to promote project replication in other areas and have a wider impact. The Tangail clinic provides syndromic management of STIs and basic curative services for sex workers and their children. SHAKTI is now planning to open a health education and promotion unit. DfID supports SHAKTI.

Recently, CARE/Bangladesh mapped the clients of street-based CSWs in Dhaka under the SATHI project, with funding from the Netherlands Embassy. The CSWs' organization, "Durjoy Nari Samity," disseminated the findings through a community theater presentation. According to CARE, it was a great success and attracted many donors and other NGOs.

Christian Commission for Development in Bangladesh (CCDB) has been actively involved in NGO HIV/AIDS activities since 1993 and was an initiator of the STI/AIDS Network of Bangladesh. CCDB's HIV/AIDS and Mobility Program is building a network of organizations and institutes to work with migrants. The program focuses on reducing Bangladeshi migrant workers' vulnerability prior to or after their return from overseas work. The Free University of Amsterdam provides overall technical guidance to the Bangladesh program.

The Marie Stopes Clinic Society (MSCS) in Bangladesh operates a reproductive health network in seven towns: Brahmanbaria, Chittagong, Comilla, Dhaka, Feni, Khulna, and Sylhet. With European Union and DfID support, MSCS is developing a sustainable reproductive health program in Bangladesh. Eight clinics, mobile units, and satellite health posts provide vital health care and family planning to women, men, and children in some of the country's neediest communities. Its factory-based health clinics provide essential advice and services to thousands of young women whose long working hours prevent them from accessing clinic-based services. Outreach work spreads safe sex messages throughout the commercial sex industry and provides services for CSWs. The organization also operates men's health clinics.

The Salvation Army–Bangladesh Rural Health Project in Jessore operates in 15 villages and focuses on primary health care delivery. Its objectives include developing and providing an integrated approach to AIDS

management. With the government, the project participated in World AIDS Day. Project staff were trained in HIV/AIDS awareness, universal precautions, and communication and motivation, among other areas.

CHALLENGES

While highlighting behavior change communication as a priority area, the government's challenge is to ensure solid oversight and coordination in implementing its strategy.

Major opportunities exist for meaningful integration and mainstreaming efforts of ongoing programs in different sectors, such as reproductive health, life skills education and services for youth, and innovative programs that reach out to groups with high-risk behavior.

FUTURE ACTIONS NEEDED

By taking immediate and decisive actions, the government, donor and NGO communities could quickly implement effective measures on a national basis. A sense of urgency is needed to move the HIV/AIDS prevention and education agenda forward. Specifically:

- Staff the Directorate of Health Services division that is responsible for HIV/AIDS strategy implementation with the best personnel available, and elevate its status in the MOH hierarchy.
- The blood safety program—three years in refinement—in conjunction with an approved behavior change communication package to provide information through media sources on causes, transmission modes, and prevention efforts regarding HIV/AIDS, needs to be speedily implemented.
- Rapid dissemination of the surveillance data and a vigorous education effort for both high-risk groups and the general public will facilitate public understanding of the problem.
- The government should continue to encourage NGOs to take on difficult and sensitive tasks and release funds for this purpose.
- Intervention programs need targeted outreach to men, women, and youth.
- Additional involvement of religious leaders in the education effort is needed.

IMPORTANT LINKS AND CONTACTS

1. UNAIDS, Chief Gita Seti C/O UNDP, House No. 60, Road No. 11 A, Dhanmondi Residential Area; Tel: 880-2-881600-7.

2. UNDP, Resident Representative, Mr. David Lockwood, House No. 60, Road No. 11A, Box 224, Dhaka, Bangladesh; Tel: 880-2-813-320, Fax: 880-2-813-196, E-mail: fo.bdg@undp.org.

3. CARE, Country Director, Mr. Steve Wallace; Tel: 814195-98, Fax: 814183.

4. Marie Stopes Clinic Society, 1st floor, 759 Satmasjid Road, Dhanmondi, Dhaka 129, Bangladesh; Tel: 00-880-2-912-1208/9022, E-mail: mscs@citechco.net.

5. The World Bank, 3a Paribagh, Dhaka, Tel: 880-2-861057-68, 9669301-8, Fax: 880-2-863220; E-mail: info@worldbank-bangladesh.org.

6. Asian Development Bank, Resident Representative, Mr. Phipit Suphaphiphat, Hotel Sheraton Annex Building, 3rd Floor, Shahbagh, Dhaka; Tel: 9334017-22.

7. USAID, Matthew Friedman, Population and Health Team, American Embassy, Baridhara, Dhaka; Tel: 884700-22, Ext. 551.

8. WHO Representative, Dr. Witjaksono Hardjotanojo, GPO, Box 250, Dhaka, Bangladesh; Tel: 880-2-86-46-53/86-46-54, Fax: 880-2-86-32-47.

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EGYPT AND HIV/AIDS

TALKING POINTS

The HIV/AIDS pandemic appears to be at a very early stage in Egypt. Limited available data indicate that HIV cases have been reported in certain vulnerable groups, such as commercial sex workers (CSWs), the largely hidden bisexual and homosexual communities, and injecting drug users (IDUs). The influence of the Islamic moral code, which forbids adultery, sex before marriage, and homosexual practices, may be an important factor in discouraging high-risk sexual behavior and limiting the spread of HIV/AIDS.

- By the end of 1997, the number of adults and children estimated to be living with HIV/AIDS was 8,100.
- The adult prevalence rate is estimated to be 0.03 percent.
- Twenty-five AIDS cases were reported in 1997, according to the World Health Organization (WHO). Due to gaps in diagnosis, underreporting, and reporting delays, officially reported AIDS cases represent only a portion of all cases.
- There are no estimates on the number of deaths due to AIDS or AIDS orphans.

Women, Youth and HIV/AIDS: Young women are particularly at risk because of their greater biological vulnerability, limited knowledge of HIV–prevention methods, and limited use of condoms. Women also find it difficult to discuss the topic with their sexual partners or enforce spousal fidelity.

Socioeconomic Effects of HIV/AIDS: Egypt has yet to feel the brunt of the HIV/AIDS pandemic. However, several critical factors, including low condom use for disease prevention, high rates of reproductive tract infections among women, a general lack of knowledge about HIV transmission and prevention, and the more than 2 million Egyptian men working abroad may bring HIV into the general population.

National Response: The Ministry of Health and Population (MOHP) has a small but vigorous HIV/AIDS control program. Its HIV/AIDS hotline, developed with a Ford Foundation grant, is considered to be one of the most innovative HIV/AIDS prevention activities in the region.

Donor and NGO Activity: USAID/Cairo's nongovernmental organization (NGO) Service Center will provide technical assistance, training, and small grants to Egyptian NGOs (1999, $4 million). The USAID-funded International HIV/AIDS Alliance will be working with NGOs and the MOHP's Women's Clubs on HIV/AIDS prevention. USAID has proposed $6.3 million in funding for fiscal year 2000 for the Asia/Near East Regional HIV/AIDS project. USAID also works closely with the Joint United Nations Programme on HIV/AIDS (UNAIDS) in the region. The United Nations Children's Fund (UNICEF) is also working with NGOs on HIV/AIDS prevention activities.

EGYPT AND HIV/AIDS

COUNTRY PROFILE

Egypt is the most populous country in the Arab world and second most populous in Africa. A country of about 59.3 million people, Egypt is located in Northern Africa, bordering the Mediterranean Sea, between Libya and the Gaza Strip. Islam plays a major role, as 9 out of 10 Egyptians are Muslim.

In 1979, following the Camp David Accords and in recognition of Egypt's moderating role in the Middle East, Egypt became the recipient of one of the largest U.S. economic assistance programs in the world. Since 1979, the U.S. Congress has provided an average of $815 million annually to support Egypt's development, for a total of $21 billion. In 1999, USAID is providing $775 million.

In the past 15 years, Egypt has stabilized its economy and initiated numerous social and economic reforms. Since 1985, the government and donors have heavily promoted family planning programs which has led to significant declines in the total fertility rate, from 4.1 in 1990 to 3.3 in 1997. Infant mortality also declined from 77 (1990) to 53 (1997) deaths per 1,000 live births. Between 1990 and 1998, the Egyptian economy also improved rapidly; inflation fell from 15 to 3.5 percent, the budget deficit declined from 17 percent of the gross domestic product (GDP) to less than 1 percent, and GDP grew from 3.6 percent to about 5 percent. Literacy rates remain low. Only 51 percent of Egyptian adults are literate; the literacy rate for women is much lower (39 percent) than that for men (64 percent).

While Egypt has made significant progress on several fronts, the country needs to complete its transition to a fully open and competitive economy that is able to generate half a million jobs annually to absorb new entrants into the job market. This requires continued legal and regulatory reform to encourage private sector investment. Substantial investments are needed in health, family planning, education, and other basic services to assist the vast numbers who are not currently being reached.

The Egyptian health system, while improving, still shows significant regional and rural disparities. The poorest areas lag behind in infant, under 5-year, and maternal mortality rates. There is an urgent need to target resources to narrow these gaps and improve the health of the poorest Egyptians.

HIV/AIDS in Egypt

The HIV/AIDS pandemic is in a very early stage in Egypt. According to the limited data available, HIV/AIDS has been reported only among certain vulnerable groups, such as commercial sex workers (CSWs), bisexual and homosexual men, and injecting drug users (IDUs). A proactive information and education campaign on HIV transmission and prevention could help stem the pandemic before it reaches the general population.

- As of the end of 1997, 8,100 adults and children were estimated to be living with HIV/AIDS.
- The adult prevalence rate is estimated to be 0.03 percent.
- There were 25 AIDS cases reported in 1997, according to the World Health Organization (WHO).

Due to gaps in diagnosis, underreporting, and reporting delays, officially reported AIDS cases represent only a portion of all cases. There are no estimates on the number of deaths due to AIDS or AIDS orphans.

Because sexually transmitted infections (STIs) are known to be an important factor in HIV transmission, Egypt's potentially high levels of STIs, strong stigma against STIs, and limited capacity to diagnose and treat STIs adequately are serious problems.

Women, Youth and HIV/AIDS

Young women are particularly at risk because of their greater biological vulnerability, limited knowledge of HIV–prevention methods, limited use of condoms, and difficulty in discussing the topic with their sexual partners. Married women also have difficulty enforcing spousal fidelity. A 1995 Demographic and Health Survey found that only 7.7 percent of all ever-married women had ever used a condom. Traditional Islamic attitudes can limit contraceptive use. Among married men and women, a husband may only agree to contraception after his wife has borne sons.

SOCIOECONOMIC EFFECTS OF HIV/AIDS

Egypt has yet to feel the brunt of the HIV/AIDS pandemic. However, if HIV/AIDS spreads into the general population, it will strongly affect the country's economy.

INTERVENTIONS

National Response

The Ministry of Health and Population (MOHP) has a small but vigorous HIV/AIDS control program. Its HIV/AIDS hotline, developed with a Ford Foundation grant, is considered to be one of the most innovative HIV/AIDS prevention activities in the region.

Donors, Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)

USAID first assessed the HIV/AIDS situation in Egypt in 1996, under the AIDS Control and Prevention (AIDSCAP) project, and then implemented a prevention program. Currently, through the USAID–funded Implementing AIDS Prevention and Care Activities (IMPACT) project, Family Health International (FHI), a U.S. private voluntary organization, is completing an STI prevalence study with the MOHP and developing a plan with USAID/Cairo to complement the comprehensive Swiss blood bank project. In the area of blood-borne disease control, IMPACT is conducting a situational analysis of health and nonhealth personnel behaviors. USAID/Cairo is also considering conducting a sociobehavioral and HIV–prevalence study. This study would identify high-risk groups within the population and then conduct HIV point prevalence surveys of these groups. Potential risk groups include STI patients, homosexual and heterosexual CSWs, (IDUs), tuberculosis patients, tourism workers, truck and van drivers, port workers, and merchant sailors.

USAID has proposed $6.3 million in fiscal year 2000 funding for the Asia/Near East Regional HIV/AIDS

project. USAID also works closely with the Joint United Nations Programme on HIV/AIDS (UNAIDS) in the region.

The International HIV/AIDS Alliance will be working on HIV/AIDS prevention with NGOs and the MOHP's Women's Clubs. USAID/Cairo's NGO Service Center will provide technical assistance, training, and small grants to Egyptian NGOs (1999, $4 million).

The United Nations Children's Fund (UNICEF) is working with NGOs on a variety of HIV/AIDS prevention and treatment activities. These include studies, counseling and care of HIV–positive individuals, NGO workshops, clinical management of HIV, educational workshops for young people, and support for the MOHP hotline. The organization is also following up on a USAID–funded knowledge, attitudes and practices study of college students that found sexual activity levels that were low in comparison with other countries, but surprisingly high to Egyptians.

UNAIDS has a regional representative who is resident in Alexandria, Egypt.

The **Ford Foundation** administered a program of activities on AIDS and sexuality (1996–97, $120,000) and gave a grant to the Western Consortium for Public Health to provide training in AIDS counseling to several MOHP staff (1994–96, $20,000). The Ministry of Foreign Affairs, on behalf of the MOHP, received a Ford Foundation grant to train counselors to expand the AIDS hotline (1994–96, $150,000). Caritas, Germany, received a grant to support a school-based health education program on AIDS focusing on youth. (1996, $27,000).

The British Department for International Development (DfID) identified HIV/AIDS as a worldwide concern and will support programs that improve access to quality basic services and community-based campaigns to promote safer sex to help empower women and girls.

The German Development Agency (GTZ) supported an AIDS Programme in Egypt (1997, DM 84,000).

CHALLENGES

High-risk behaviors and limited STI treatment and prevention programs are significant challenges in Egypt.

- Lack of condom use, the commercial sex industry, and other high-risk sexual behavior in the population will continue to foster high STI rates.
- Population shifts from rural to urban areas to search for jobs and increased economic opportunities can contribute to HIV vulnerability. Also, increased travel in and out of Egypt can open the door to STIs.
- Improvements are needed in the STI control program infrastructure, health education, and condom knowledge and availability.

FUTURE ACTIONS NEEDED

Donors, PVOs and NGOs have identified the following as priority action areas:

- Improved STI/HIV/AIDS prevention and control programs, including effective surveillance systems;
- Increased knowledge and understanding of HIV/AIDS/STI case management and transmission among clients and providers;
- Tailored HIV/AIDS/STI information, education and communication behavior change materials that are disseminated, then monitored and evaluated to ensure that they reach high-risk groups, such as CSWs, STI patients, homosexuals, and youth;
- An improved data collection system, beginning with a prevalence study and a better surveillance system;
- Improved drug supplies for STI treatment;
- Improved condom promotion and social marketing efforts; and,
- Improved blood bank safety and management, including an increased supply of rapid diagnostic tests, better training and supervision, better equipped laboratories, quality assurance programs, and an increased number of voluntary blood donors and ongoing testing of paid blood donors. These items may be addressed through a bridging activity (1999–2000), until the Swiss government starts its 10–year project in the year 2000 to centralize blood banks and reduce the number of small, peripheral blood banks.

Little is known about the population's health care seeking behaviors, such as self-medication, rate of STIs, and sexual behaviors. More research is needed.

IMPORTANT LINKS AND CONTACTS

1. USAID/Egypt, Development Information Center (Research) 6th Floor, Cairo Center, 106, Kasr El Aini Street, Cairo, Egypt; Tel: (2-02)-357-3225, Fax: (2-02)-356-2932/357-2233.

2. GTZ Office Cairo, Mr. Christian Pollak, 4d, El Gezira Street, 3rd Floor, 11211 Zamalek-Cairo, Egypt; Tel: 202-3-409-750, 3-420-714, Fax: 202-3-412-445, E-mail: gtzpvb@starnet.com.eg.

3. UNICEF Cairo, 7, Lazoughly Street, Garden City, Cairo, Egypt; Tel: 20-2-3942.270, 3557.898, 5943.314, 5943.316 – 19, Fax: 5942.270, E-mail: unicef@idsc.gov.eg .

4. Dr. Jihane Tawilah, InterCountry Programme Adviser, c/o WHO Regional Office for the Eastern Mediterranean, P.O. Box 1517, Alexandria, 21511, Egypt; Tel: 20-3-482-0223/0224, Fax: 20-3-483-9816, E-mail: tawilahj@who.sci.eg.

5. IMPACT: Implementing AIDS Prevention and Care Project, Family Health International, 2101 Wilson Blvd., Suite 700, Arlington, VA 22201 USA; Tel: 703-516-9779, Fax: 703-516-9781, Internet: www.fhi.org.

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INDONESIA AND HIV/AIDS

TALKING POINTS

With 212 million people, Indonesia is the fourth largest country in the world. A regionwide economic slump in 1998, along with domestic political and social turmoil, has created widespread unemployment, impoverished millions, and caused extensive human suffering. Eighty million people now live below the poverty line and cannot meet basic needs.

The first AIDS case in Indonesia was a foreigner in 1987; one fourth of HIV/AIDS infections have been among foreigners. The HIV/AIDS pandemic has yet to invade Indonesia, which has an estimated seroprevalence rate of only 0.05. However, the current unstable environment provides more opportunities for the rapid spread of HIV infection: high rates of male migration, more widespread prostitution, high rates of sexually transmitted infections (STIs), and an absence of sex education for youth.

Women and HIV/AIDS: The HIV–positive rate for women attending antenatal clinics in 1996 was zero. However, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that the number of women aged 15–49 years living with HIV/AIDS is 13,000, or 25 percent of adults living with HIV/AIDs. STIs are reportedly rising with increased prostitution and reduced condom use.

Children and HIV/AIDS: Thirty-three percent of the population are under age 15, less than 2 percent of whom are living with HIV/AIDS. According to a 1996 AIDS Control and Prevention (AIDSCAP) study, up to 20,000 children were living on the streets of Jakarta, engaging in high-risk behaviors in exchange for food and shelter.

Youth and HIV/AIDS: The HIV/AIDS Prevention Program study (1996–97) found that 41 percent of males and females (aged 15–24) were aware of HIV infection, and 51 percent of females in the same age group were aware of AIDS. Television was the most frequently cited source of information.

National Response: A structure for dealing with the HIV/AIDS epidemic is in place from the central to community levels. However, investing in preventive action when the epidemic seems to be a distant possibility competes for priority status with current more tangible health issues. The decline in the national health budget from 0.7 percent in 1996 due to economic and political crises in the last two years has exacerbated this competition of priorities.

Donors have provided the mainstay of funds and technical assistance in efforts to date in establishing a campaign against HIV/AIDS/STIs. The epidemic cannot be contained from the outside. USAID has provided major bilateral funding to HIV/AIDS prevention and care efforts, having committed 29,481,000 between 1995 and 1999.

INDONESIA AND HIV/AIDS

COUNTRY PROFILE

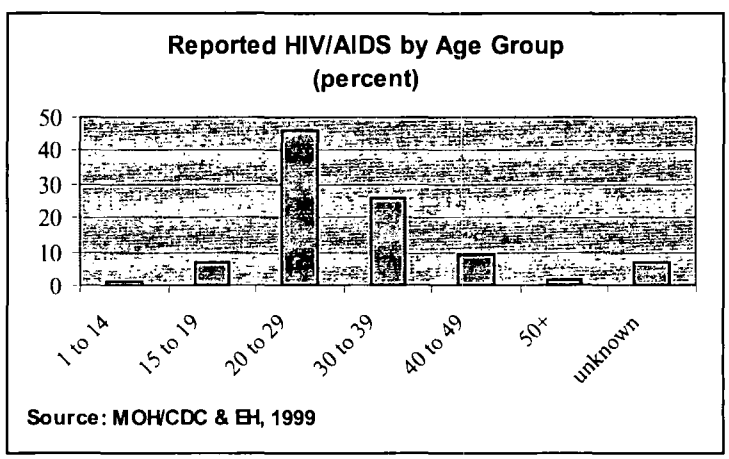
With a population of 212 million people, Indonesia is the fourth largest country in the world and has the largest Muslim population. The country's enormous natural and human resource base and geographic position in the midst of strategic sea-lanes have made it a major emerging market. As a central member of the Association of Southeast Asian Nations (ASEAN), Indonesia plays an important role in regional stability.

The sudden regional economic slump in 1998 along with political and social turmoil have created widespread unemployment (20 percent), impoverished millions and caused extensive human suffering. Inflation in 1998 approached 70 percent, the rupiah dropped to one third its previous year level, and per capita income dropped from $1,200 to $400. An estimated 80 million people now live below the poverty line and cannot meet basic needs, including nutritious diet, transportation to health facilities, and payment of fees for health care, medicine, and contraceptives. At the same time that people lost their purchasing power, the government of Indonesia's (GOI) budget for the health sector decreased by as much as 15-20 percent; in 1996, only 0.7 percent of the gross domestic product was allocated to health.

On average, 15,000 workers in the formal sector have been losing their jobs every day. Malnutrition, anemia, and the number of women turning to commercial sex work are increasing. This situation follows better times when 93 percent of the population had access to health care and over 90 percent of children were vaccinated against diphtheria, pertussis, tetanus, polio, and measles. The 1996 maternal mortality rate was 390/100,000 live births, a decline from the 1990 figure of 650/100,000, while the infant mortality rate is 49/1,000 live births. Life expectancy is 63 years. Ninety percent of males and 78 percent of females are literate.

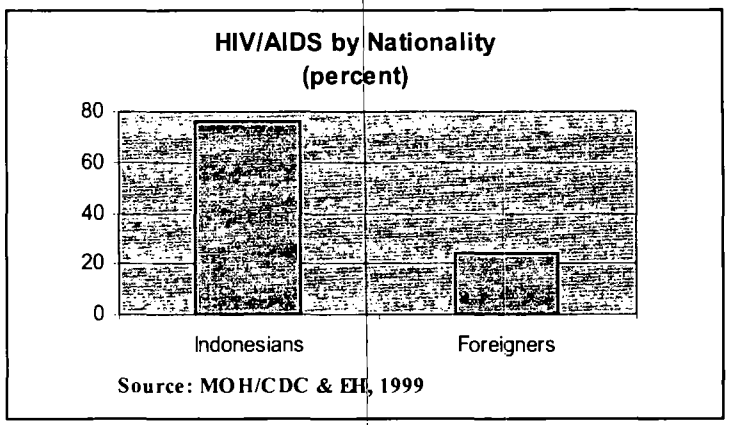
HIV/AIDS in Indonesia

The first AIDS case was identified in 1987 when a foreign tourist died in Bali, but shortly thereafter cases were identified in the local population. The estimated seroprevalence rate is a low 0.05.



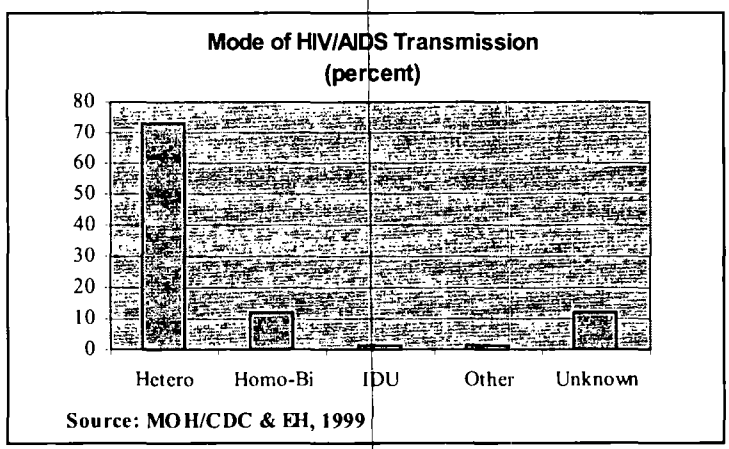
- The recorded number of HIV/AIDS cases is 918, through July 1999.
- The majority of identified HIV-positive persons (79 percent) was in the 20-39 year age range, the reproductive and most economically productive years.
- Sixty-three percent of cases were among males.

- Seventy-six percent of HIV/AIDS infections were among Indonesians and 24 percent among foreigners.
- Eighty-four percent of reported cases of HIV transmission are heterosexual.



The recorded cases are considered to be a very small portion of the actual number of cases, which is estimated by the World Health Organization (WHO) Southeast Asia Region as closer to 51,000 HIV infections as of November 1998.

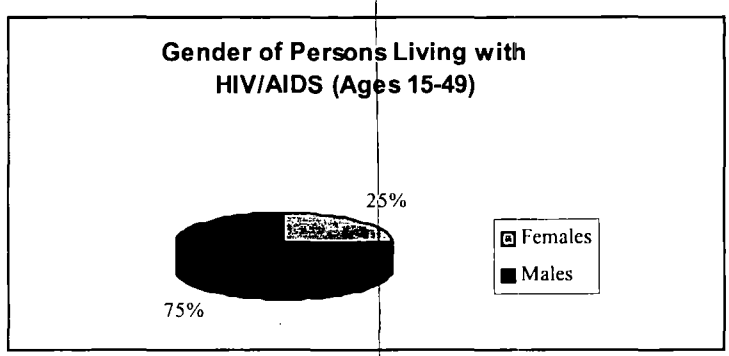
- The Minister of People's Welfare recently forecast 400,000 HIV infections in the year 2000.
- The estimated number of deaths due to AIDS among adults and children at the end of 1997 was 3,900, with 1,600 dying in 1997.



HIV/AIDS has not reached the epidemic stage in Indonesia as in other countries in the region. A 1996-97 behavioral study by the HIV/AIDS Prevention Project (HAPP) suggests that the reasons for the low prevalence rate to date are:

- a high age at first intercourse (20-24 years),
- a low prevalence of concurrent partnerships among women, and
- a relatively low number (compared with Thailand) of clients per commercial sex worker (CSW).

However, with the economic, political, and social upheaval of the last two years, the current environment provides more opportunities for the rapid spread of HIV infection: high rates of male migration, more widespread prostitution, high rates of sexually transmitted infections (STIs), and an absence of sex education for youth. Particularly at risk of becoming infected with HIV are CSWs, truck drivers, migrant workers, women and youth, and people who live in port areas.



The HAPP study found that more than 90 percent of adults were aware of AIDS, but HIV awareness was lower: 72 percent for men and 50 percent for women.

Women and HIV/AIDS

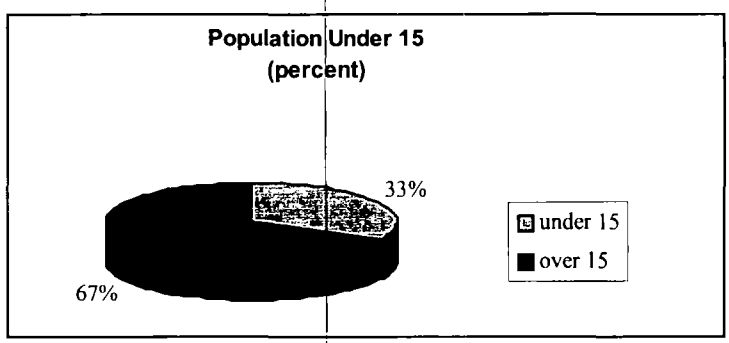
UNAIDS estimates that of adults aged 15-49 years living with HIV/AIDS, women constitute 25 percent. The HIV prevalence in women attending antenatal clinics in 1996 was zero. Seventy-eight percent of pregnant women received prenatal care in 1999, but trained health personnel attended only 43 percent of births.

Fewer poor women are using trained providers for prenatal care and delivery of their babies, resulting in increased complications and risk of mortality. A decline in the use of contraceptives is leading to increased pregnancies, higher birthrates and increased reliance on abortion. STIs are reportedly rising with increased prostitution and reduced condom use.

Children and HIV/AIDS

The estimated number of children under 15 years of age living with HIV/AIDS is less than 2 percent. The cumulative number of orphans, those who have lost their mother or both parents to AIDS, is estimated by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO at 1,000, with 940 still living. Thirty-three percent of the population is under age 15.

Eight NGOs trained street educators to reach street youth with inte-grated messages on HIV/AIDS, self-care, and life skills. AIDSCAP/HAPP 1997



Declining use of basic child health services is leading to increased child morbidity and mortality. Unable to afford school fees, parents have enrolled fewer children in 1998 than 1997.

According to a 1996 AIDS Control and Prevention (AIDSCAP) study, 4,000-20,000 children live on the streets of Jakarta, doing whatever is necessary to survive. Surveys indicate that 25 percent are younger than 11 years old, 15 percent are homeless, 40 percent live in slum rooms with other children, and approximately 90 percent are boys.

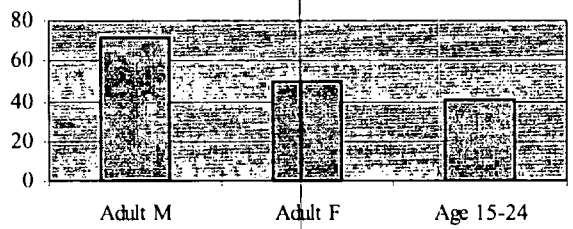
Youth and HIV/AIDS

The HAPP behavioral study found that awareness of AIDS was 51 percent among females 15-24 years old, and awareness of HIV was 41 percent among males and females in the same age group. Television was the

most frequently cited source of information. There is a general lack of information on reproduction and responsible sexual behavior for young people.

Only 65 percent of males and 53 percent of females continue to secondary school. The highest decline in student enrollment appears to be among young girls (e.g., enrollments for girls in junior secondary schools in Jakarta dropped nearly 20 percent in 1998-99).

Population Aware of HIV (percent)



Source: HAPP Survey, 1997

INTERVENTIONS

National Response

The GOI established the National AIDS Control Commission (NACC) in 1987 and surveillance activities began the same year. DepKes (the Ministry of Health) began activities in a number of provinces believed to be at greatest risk for HIV infection. In May 1994, Presidential Decree No. 36 established an interministerial AIDS Prevention and Control Commission (KPA) under the direction of the Coordinating Minister for People's Welfare. A technical working group (POKJA) comprised of key Indonesian leaders was also established to advise the Minister for Health and to provide support to the KPA. Other ministries have established their AIDS POKJA to take responsibility for HIV/AIDS policy and programming in their sectors.

The official strategy of the NACC addresses the challenge of HIV/AIDS, not just as a health problem, but rather one with major political, economic, social, ethical, religious, and legal consequences that eventually will affect all aspects of national life. Some of the basic principles of the strategy are that

- The government has the responsibility to lead and guide the efforts to control HIV/AIDS while community members are the primary actors,
- Approaches to control HIV/AIDS should reflect Indonesian religious-cultural values,
- HIV/AIDS prevention will focus on education and public information, and
- Policy, programs, services, and activities should promote and preserve the dignity and self-respect of those affected either directly or indirectly by HIV/AIDS.

A multisectoral National AIDS Strategy (NAS) was completed in 1994 and is operationalized in the National HIV/AIDS Program (NAP) for the five-year National Development Program 1996/97-1999/2000 (Pelita VI). The five-year program specifically identifies STI prevention and treatment as a priority area to be undertaken in the goal of HIV prevention.

Presidential Decree No. 36 requires all provinces to establish AIDS commissions (KPA/D) at provincial, district and local levels. These commissions are responsible for coordinating prevention activities and carrying out national policy at the provincial and local levels.

With many competing priorities, including the provision of basic nutrition and health care, Indonesia has not yet fully appreciated the need to mount prevention initiatives for a problem which is perceived as being relatively unimportant and in the distant future.

The deputy director of HAPP/Indonesia has served on the ASEAN Task Force on AIDS, keeping Indonesia abreast of regional HIV/AIDS programming and new initiatives.

Donor	Amount in U.S. Dollars	Period
USAID	29,481,000	1995-99
German Development Agency	15,000,000	1996-99
Aus AID	12,000,000	1995-99
Ford Foundation	717,000	1994-97

Worsening unemployment and reduced government services due to the current economic crisis put an additional strain on nongovernmental organizations (NGOs), which play an important role in HAPP. NGOs target groups such as religious, youth, and women, as well as sex workers and drug users not reached by government programs.

Donor coordination occurs through the GOI National Planning Board (BAPPENAS) via the Communicable Disease Control/Environmental Health Department (CDC/EH) of the Ministry of Health (MOH).

Donors

Multilateral and bilateral donors are actively engaged in HIV/AIDS activities in Indonesia.

USAID's fiscal years 1997-98 obligation to HIV/AIDS was a total of US $9,481,000. In fiscal years 1996-97, USAID and the GOI co-funded HAPP, a collaborative effort between the GOI, NGOs, and USAID (US $20 million, GOI $6.667 million). HAPP activities included increasing CSWs' use of condoms and the knowledge base of those at risk, provision of standard STI diagnosis and treatment in clinics, and STI/AIDS counseling, mass media campaigns, and condom social marketing. The USAID Asia/Near East Bureau (ANE) funded HIV/AIDS activities (US $3.2 million, July 1997-January 1999) in the region.

The German Development Agency's (GTZ) HIV Prevention Measures Program (US $15 million: 1996-99) includes condom social marketing, counseling, blood safety, and information, education, and communication (IEC) activities in the public sector through the Center for Health Education of the MOH.

The Australian Agency for International Development (AusAID) manages the HIV/AIDS/STI Prevention and Care Project (US $12 million: 1995-99) providing support for national government in policy and strategy development and project management, strengthening and support of NGOs, STI management, and condom quality assurance.

The Ford Foundation has supported a community-based center for persons living with HIV/AIDS (PLWHAs), training on AIDS/STIs for nursing students, AIDS education for traditional healers, and television and radio serials to create public awareness of HIV/AIDS (US $717,000: 1994-97).

UNAIDS works with the GOI to coordinate the activities of the United Nations agencies and other donors working in HIV/AIDS.

The United Nations Population Fund (UNFPA) has a US $1.4 million, five-year project with the National Family Planning Coordination Board (BKKBN) that is focused on a family-centered approach to HIV/AIDS awareness in four locations. Activities have included AIDS education for traditional healers, development of resource and training centers on AIDS for journalists, and support for community-based efforts in protecting the dignity of PLWAs.

The United Nations Development Programme (UNDP) has contributed significantly to the development of the Indonesia NAS.

The World Bank initiated a US $23 million loan with the GOI for HIV/AIDS communication campaigns, policy development, monitoring, evaluation, and surveillance focusing in two areas.

The European Union provides ongoing technical support, including a US $1.2 million 1996-98 program with the CDC/EH establishing national guidelines for a syndromic approach to STI treatment, strengthening STI management and control (including HIV/AIDS), and conducting behavior change research among CSWs.

Private Voluntary Organizations (PVOs), Nongovernmental Organizations (NGOs), and International NGOs (INGOs)

A number of INGOs and PVOs implement activities funded by multilateral and bilateral donors as well as GOI agencies. USAID HIV/AIDS activities are carried out through Family Health International's (FHI) Implementing AIDS Prevention and Care Activities (IMPACT) project. DKT International implements the condom social marketing project (US $7 million: 1996-2000). Approximately 15 NGOs in Indonesia play a key role in HIV prevention. Private Agencies Collaborating Together, Inc. (PACT) has assisted them with capacity building in delivering youth-oriented IEC programs. PACT produces a web site (www1.rad.net.id/aids) supporting individuals and organizations in Indonesia that are concerned with AIDS prevention, counseling and care for PLWAs. Their newsletter *WartaAIDS* shares information about PLWAs and those who care for them and the newsletter *HindarAIDS* addresses prevention and counseling.

CHALLENGES

Challenges to HIV/AIDS prevention and care in Indonesia include:

- Political and economic crises,
- Investing in preventive action when the HIV/AIDS epidemic seems a distant possibility competes for priority status while there are currently more tangible health issues,

- General public lack of knowledge of HIV and its transmission,
- Lack of information programs for youth on reproductive health and safe, responsible sexual behavior, and
- Formal and nonformal health care workers have little training in STI prevention and care or syndromic management or knowledge of HIV transmission.

The following improvements in programming are necessary to mount an effective response to HIV/AIDS in Indonesia:

- IEC campaigns for the general public on prevention of HIV infection are needed now, with special programs targeting CSWs, truckers and other mobile workers, women and youth.
- Anonymous surveillance systems are needed for HIV/AIDS/STIs.
- Research on knowledge, attitudes, and behaviors related to STI transmission and treatment seeking will produce more informed and effective IEC and behavior change programs.
- Enhanced and improved services in STI case management are needed.
- Behavior change interventions as well as IEC campaigns for prevention and appropriate care of STIs would complement improved STI services.

FUTURE ACTIONS NEEDED

The question is how to sustain political interest and support for HIV-prevention activities given the fact that HIV prevalence is still low in Indonesia. The government can begin by adjusting national strategies emphasizing STI control and reproductive health which are documented areas of public concern.

A 1998 study of the comprehensive concept of sexual and reproductive health concludes that Indonesia has achieved considerable success in addressing family planning and infant and child mortality, but limited success in addressing HIV/AIDS, and very little progress in addressing STIs, adolescent needs, and positive sexuality.

The time for follow through with the official National HIV/AIDS Strategy of comprehensive family health is now. External financial and technical assistance appears to be available from agencies and organizations with experience in the region but the epidemic cannot be contained from the outside.

IMPORTANT LINKS AND CONTACTS

1. Indonesian National AIDS Commission, Chair, Coordinating Minister for People's Welfare.

2. UNAIDS, CPA.

Prepared by TvT Associates, Inc.
under The Synergy Project
October 1999

LAO PEOPLE'S DEMOCRATIC REPUBLIC AND HIV/AIDS

TALKING POINTS

The HIV–seroprevalence rate for Lao People's Democratic Republic (Lao PDR) is a negligible 0.04 percent. However, the country is vulnerable to crossborder invasion of the pandemic because it is the key state in the economic integration of the Mekong region of Southeast Asia with infrastructure projects linking Thailand, Vietnam, and southern China—locations with high incidence of HIV/AIDS. Reaching the largely rural population (79 percent) with HIV/AIDS–prevention messages is challenging, with 49 percent ethnic minority communities, a limited health care system, and almost no access to television, radio, or print media.

Women and HIV/AIDS: In addition to a low literacy rate (44 percent), poverty, and a maternal mortality rate of 650/100,000, Lao women have little access to health information or services. Sexually transmitted illnesses are on the increase in women.

Children, Youth and HIV/AIDS: Children under 15 years of age make up 45 percent of the population. Economic and social changes are exposing more young people to high-risk behaviors as they seek work in urban areas and abroad. Lao youth have little information on reproductive health and sexual responsibility and scant access to health care and counseling.

The National Response: to the impending HIV/AIDS epidemic has been almost totally dependent on external financing and technical assistance. A National HIV/AIDS/STI Plan is in place with a National Committee for the Control of AIDS (NCCA) and a National AIDS Program (NAP). It will require enormous effort to develop the health care system, develop a sentinel surveillance system for HIV/AIDS and sexually transmitted infections (STIs), and reach the entire population with prevention messages where there is limited access to mass media. The Lao Red Cross and the Lao Women's Union are key domestic organizations working in HIV/AIDS prevention and behavior change communication.

Donors: USAID does not have a Mission in Lao PDR but through Family Health International's Implementing AIDS Prevention and Care Activities (IMPACT) Project is funding four activities (fiscal year 2000 US $500,000), including a national condom social marketing program, crossborder HIV prevention, capacity building for mass media on HIV and STIs, and a crossborder behavioral surveillance survey in northern Lao PDR. The Joint United Nations Programme on HIV/AIDS (UNAIDS) and its cosponsors, a handful of bilateral donors, and several international nongovernmental organizations (INGOs) have been financing and providing technical assistance for HIV/AIDS activities in Lao PDR. Most are also working in countries in the region where there is a high prevalence of HIV/AIDS and are experienced in prevention campaigns.

LAO PEOPLE'S DEMOCRATIC REPUBLIC AND HIV/AIDS

COUNTRY PROFILE

The Lao People's Democratic Republic (Lao PDR) is the key state in the economic integration of the Mekong region of Southeast Asia with infrastructure projects, including roads and bridges that will eventually link Thailand, Vietnam and southern China.

Lao PDR has a population of over 5 million, with approximately 79 percent living in rural areas. There are 45 diverse ethnic minority communities making up 49 percent of the population. Life expectancy is only 53 years. The fertility rate (5.6 children per woman) is high even by Southeast Asian standards, and there is a 2.6 percent population growth rate (1997). The infant mortality rate is high at 104/1,000 live births and 15 percent of children die before the age of 5 years. Forty percent of children under 5 years are malnourished. Immunization rates varied: for diphtheria, pertussis, and tetanus, it was 28 percent; for polio, 33 percent; and, for measles, 62 percent.

Lao PDR is a low-income country with a per capita gross national product (GNP) of $400. Forty-six percent of the population have annual incomes under $100. Real incomes have diminished further due to the Asian economic crisis and the devaluation of the kip. The adult (15 years and over) literacy rate is a low 57 percent.

The government of Lao PDR is already facing a severe shortage of trained and skilled health staff that affects the quality of health service delivery. Sixty-seven percent of the population had access to health care as of 1995. One percent of the GNP is spent on health; health-sector financing is predominately reliant on external support.

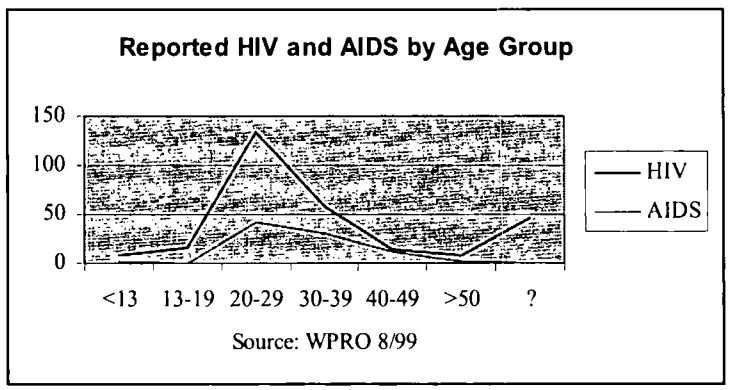
HIV/AIDS in Lao PDR

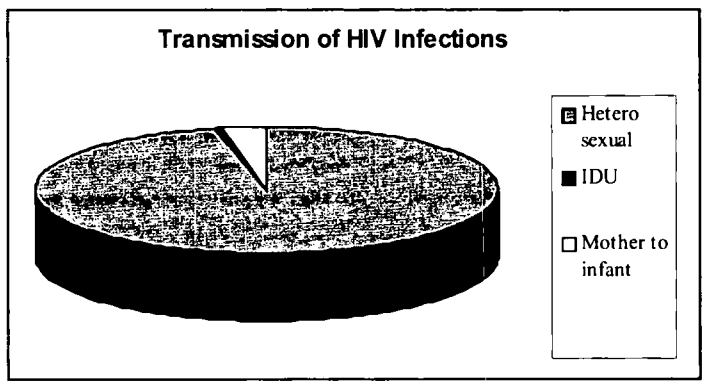
The first AIDS case was reported in Lao PDR in 1991. The country is in the fortunate position of pre-epidemic status; the adult HIV-seroprevalence rate is estimated to be a negligible 0.04 percent.

- Through 1998, according to government records, 288 HIV infections and 91 AIDS cases have been reported.
- Considering the reported numbers low due to limited testing, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) estimate that there are more likely to have been 1,100 persons living with HIV/AIDS (PLWHAs) by the end of 1997, with a total to date of 240 AIDS cases.
- Officially, 34 deaths have been attributed to AIDS.
- Sixty-seven percent of reported HIV infections and 80 percent of AIDS cases are in the 20-39 year old age group, the reproductive and highest economically productive years.
- Over 96 percent of reported HIV/AIDS infections were transmitted through heterosexual rela-

tions, approximately 3 percent were from mother to infant, and only 0.35 percent were through injecting drug users (IDUs).

- Unreleased data suggest that there was an outbreak of HIV in one province of central Lao PDR in mid-1999 or earlier. During a serosurvey of bar workers, 4.8 percent of 84 blood samples were HIV positive. Since few Lao bar-based sex workers travel out of the country, the data suggest that this heterosexual epidemic was sparked by (male) bar customers who travel across borders.

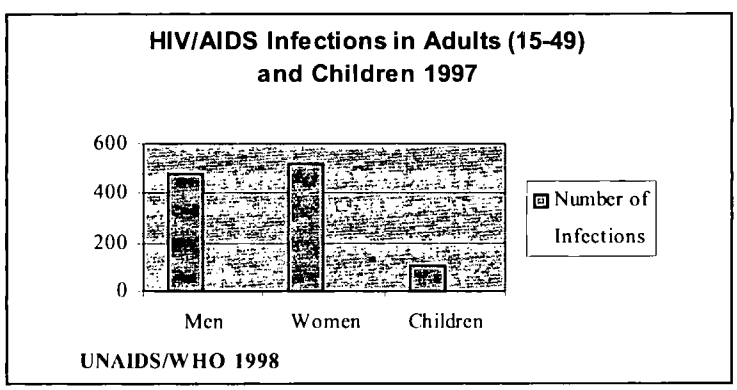




According to the National Committee for the Control of AIDS (NCCA), there have been significant increases in domestic and crossborder population movements, including repatriates and foreign labor. A transitional economy with major infrastructural development and rapid regional integration will undoubtedly have an impact on society and culture in Lao PDR, as it has in neighboring countries, with increased consumerism, drug use and prostitution. In the border areas of the Mekong, where the incidence of HIV/AIDS is high, bars and low-fee commercial sex are prevalent, heightening potential for the HIV/AIDS epidemic to cross the borders into Lao PDR.

Women and HIV/AIDS

In addition to low literacy (44 percent) and poverty, Lao women have little access to health information or services. The Lao maternal mortality rate in the reproductive age is 650/100,000. Anecdotal evidence points to increasing rates of sexually transmitted infections (STIs). The NCCA reports that, of 140 women consulting the Gynecology Department of Mahosof Teaching Hospital with complaints, 76 percent of those examined for chlamydia were positive.

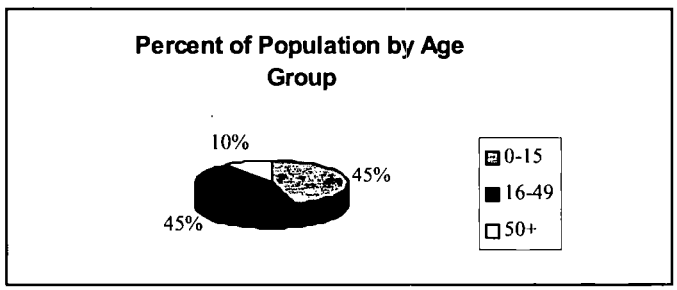


To date, 52 percent of the adult (ages 15-49 years) HIV infections have been among women. There are two programs targeting women who may lay the groundwork for HIV/AIDS information, education, and communication (IEC) dissemination.

The Lao Women's Union is working in collaboration with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) to improve conditions for women, particularly improving access to resources in regard to personal and family well-being. Targeted areas are birth spacing programs, knowledge and skills development, access to emergency food resources and essential medicines, and credit. The birth-spacing project, implemented by the Institute of Mother and Child Health, which reaches out to remote villages with mobile teams of health care personnel, has been successful in creating awareness of reproductive health/ family planning issues and motivating community people. In many areas, community people have voiced their desire to sustain services with their own support if outside funding is withdrawn.

Children and HIV/AIDS

The estimated number of children who have lost their mother or both parents to AIDS since the beginning of the epidemic is 150, with 140 still living at the end of 1997. Children under the age of 15 make up 45 percent of the population.



Youth and HIV/AIDS

Economic and social changes are exposing more young people to high-risk behaviors. Young adults from rural areas are seeking work in urban/semi-urban centers where there are significant levels of youth unemployment. Youth are also increasingly seeking work abroad, especially in Thailand, which has one of the highest prevalence of HIV in Southeast Asia.

The vice chairman of the State Planning Committee, in his 1999 address to the United Nations, acknowledged special concerns about adolescent reproductive health risks. He stated that youth had been left without much information and guidance on reproductive health and sexual responsibility and access to health care and counseling.

INTERVENTIONS

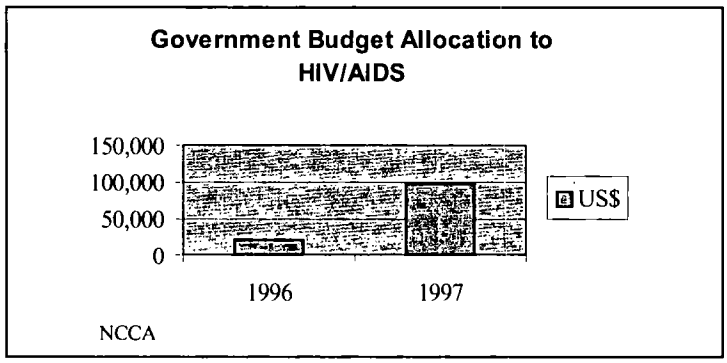
National Response

The Lao PDR National HIV/AIDS/STI Plan (1997-2001) was endorsed by a national advocacy workshop in November 1997. The plan is not prescriptive but outlines the role of each National AIDS Program (NAP) partner as a basis for these partners to develop their own strategies and work plans. The goal is to enhance the ability of the people to respond to the challenges of the HIV epidemic and the long-term objectives are to:

- prevent the further transmission of HIV,
- reduce the impact of HIV on people who are infected, and

- minimize the negative social and economic consequences of the HIV epidemic for families, communities, provinces, and the whole country.

The National Committee for the Control of AIDS (NCCA), established in 1988, is currently under reorganization. Member representatives are from the Ministries of Education, Information and Culture, Labor and Social Welfare, Defense, Interior, Finance, Health, and Foreign Affairs; Committee for Investment Cooperation; Lao Women's Union; Lao Youth Union; Lao Trade Union; Lao Red Cross; Lao National Front for Construction and Development; and, the National Tourism Authority.



The National AIDS Program (NAP), which manages programs in IEC, training, surveillance, and counseling, is managed under the NCCA Secretariat. The NAP has eight professional staff, one of whom is attached to the National STI program and two of whom are studying abroad. Only two members are full time. The NCCA and NAP depend on the National Institute for Hygiene and Epidemiology (NIHE) for financial management, administrative support, professional staff, and logistics services. The government budget for HIV/AIDS programs in 1996 was US $21,600, and in 1997, US $97,200.

The HIV/AIDS Trust, established in 1998, coordinates and mobilizes resources and facilitates management of the NAP. The Trust is managed by a management committee, chaired by the vice minister of health and composed of senior government and United Nations officials as well as a donor representative. A trust management unit based within the NCCA Secretariat administers the Trust. The Trust aims to raise US $4.5 million by the end of 2001, with US $1.1 million committed at the end of October 1998.

Multisectoral provincial committees for the control of AIDS (PCCAs) have been in operation since 1993. IEC activities are mainly conducted with urban and provincial capital populations through PCCAs supported by a few international nongovernmental organizations (INGOs). Television and radio have limited geographic coverage and there are no sustained mass media campaigns.

An anonymous unlinked HIV sentinel surveillance system has not yet been established. To date, sera are randomly tested for vulnerable groups, including hospital patients, bar workers, students, pregnant women, laborers, military personnel, villagers, volunteers, prisoners, and truck drivers.

The incidence and prevalence of STIs are not well defined in Lao PDR; STI prevalence surveys are urgently needed.

The blood transfusion service is coordinated nationally by the Lao Red Cross. National policies on condoms and testing and counseling are being developed. There is currently one location for voluntary counseling and

testing (VCT) in the country. Due to repeated police crackdowns and societal repression, sex workers keep a low profile, hampering behavior change communication (BCC), outreach, and condom distribution programs. Until recently, condoms were all imported from China, Vietnam and Thailand. In 1999, a nationwide condom social marketing program was launched by Population Services International (PSI)/Lao PDR making quality condoms affordable and available in and around high-risk sections of urban areas.

According to the NCCA, considerable HIV-related social/behavioral research has been conducted and is planned related to adolescents, bar workers, border areas, condom use, mobile populations, child prostitution, and young women and STIs.

The private sector's involvement is just beginning. (Nongovernmental organizations [NGOs] and community-based organizations [CBOs] do not exist in the Lao context.) The Lao Red Cross conducts HIV/AIDS education and prevention programs and, along with the Lao Women's Union, is the main provider of community-based education.

Donors

Most HIV/AIDS activities in Lao PDR are funded by external donors.

Donor	Amount in U.S. Dollars	Period
European Community	1,807,000	1997-99
Netherlands Government	771,053	1997-99
USAID	500,000	1999-00
France	221,239	1997-98
Embassy of Japan/JICA	151,049	1996-99
German Development Agency	125,700	1996-98
Total	**3,576,041**	

Bilateral Donor Contributions

Multilateral and bilateral donors are actively engaged in HIV/AIDS activities in Lao PDR. Activities are implemented through INGOs, private voluntary organizations (PVOs), and government agencies. According to NCCA/UNAIDS, each bilateral organization contributed in the following ways:

USAID does not have a Mission in Lao PDR but through Family Health International's Implementing AIDS Prevention and Care Activities (IMPACT) is funding four activities, including a national condom social marketing program through PSI, crossborder HIV prevention through CARE International, capacity building for mass media on HIV and STIs in collaboration with UNICEF, and a crossborder behavioral surveillance survey in northern Lao PDR.

The European Community (EC) has focused on STI activities, including the development of national STI case management guidelines, establishment of a national STI management unit within NCCA Secretariat/

NIHE, and strengthening of provincial services, laboratory services, health care worker training, and reporting systems.

The government of the Netherlands supported IEC activities; peer education; integration of HIV/AIDS into formal/nonformal education, community health, and out-of-school youth programs; and, building a counseling, care, and support network.

The German Development Agency (GTZ) supported NCCA/NIHE to establish sentinel sites and conduct a first round of sentinel surveillance in the country, strengthened the capacity of Lao National Television to develop mass media messages focusing on youth, and developed HIV/AIDS educational materials/curricula in junior secondary schools.

The Japan International Cooperation Agency (JICA) financed the renovation of the NCCA building and vehicles for the NCCA Secretariat and is funding a pilot care and support project.

The government of France (MOFA) funded activities under the UNAIDS agreement with NCCA.

UNAIDS has a coordinating theme group based in Lao PDR. The group, currently chaired by the United Nations Development Programme (UNDP) representative, includes representatives from UNICEF, UNFPA, WHO, the World Bank, and the United Nations International Drug Control Programme (UNDCP). Other members are from the INGO community, the bilateral community, the Lao Red Cross Society, and the Secretary of the NCCA. Support from UNAIDS cosponsors for HIV/AIDS activities includes:

Donor	Amount U.S. Dollars	Period of Activities
UNFPA	1,523,121	1997-00
UNICEF	800,000	1996-98
UNDP	449,260	1995-01
World Bank	200,000	1996-98
UNAIDS	150,000	1996-97
Total	**3,122,381**	

UNAIDS and Cosponsor Contributions 1996-2000
Source: NCCA

The HIV/AIDS activities of UNAIDS and its cosponsors have included roles in advocacy and policy development, strengthening the sentinel surveillance system, peer educator training, counseling and care training, development of IEC programs for vulnerable groups, capacity building in the NCCA and PCCAs in strategy

development, integration of HIV/AIDS into school curricula, condom supply, training of health care workers in syndromic STI management, and capacity building for the Lao Women's Union to effectively program HIV/AIDS work into its community development and gender work.

Private Voluntary Organizations (PVOs), Nongovernmental Organizations (NGOs), and International NGOs (INGOs)

A number of INGOs and PVOs implement activities funded by multilateral and bilateral donors. NGOs and CBOs do not exist in Lao PDR. The Lao Red Cross and the Lao Women's Union are active in HIV/AIDS activities. Of the 53 INGOs in Lao PDR, three currently have vertical HIV/AIDS programs with significant budgets: CARE International ($415,907 to 1996), the Australian Red Cross ($462,627 to 1996), and Norwegian Church Aid ($215,385 to 1996). PSI launched a condom social marketing program in 1999. Save the Children/Australia and Save the Children Fund/United Kingdom have integrated HIV/AIDS education for prevention activities into multisectoral projects.

CHALLENGES

Major constraints to HIV/AIDS control in Lao PDR include:

- The majority of the population (79 percent), with 45 ethnic minority groups, lives in rural areas with little or no access to television, radio or print media.
- There are no sustained mass media campaigns on television, radio, billboards, or in newspapers in the urban and peri-urban centers.
- Almost all HIV/AIDS prevention activities are dependent on external financing and technical assistance. The NCCA does not have control over allocation of its funding.
- The periodic police crackdowns on sex workers hamper open communication with outreach workers and a reluctance to stock condoms at work sites.
- Formal and nonformal health care workers have little training in STI prevention and care; syndromic management is not widely practiced.
- PLWHAs are not involved as community animators/educators.

The following improvements in programming are necessary to mount an effective response to HIV/AIDS in Lao PDR:

- Behavior change interventions would be timely to complement the expansion of IEC.
- Enhanced IEC messages would incorporate care and support and the risks of injecting drug use.
- Behavioral surveillance in risk populations is urgently needed to establish levels of risk behavior and set a benchmark by which to monitor changes and potential program impact.
- Workbased education programs both in the public and private sectors have yet to be developed and implemented.
- Enhanced and improved services in STI case management are needed along with IEC/behavior

change communication programs for prevention and appropriate care.

Anonymous surveillance systems are needed for HIV/AIDS/STIs.

FUTURE ACTIONS NEEDED

Being in the crossroads of the Mekong region, Lao PDR is in a geographically vulnerable position for the invasion of the HIV/AIDS pandemic. The government and the people have the opportunity to take action before the increased crossborder traffic from countries with higher rates of HIV infection, such as Vietnam, Thailand, and Cambodia, can get a foothold. A preventive program will only be effective if the government demonstrates commitment now. External financial and technical assistance appears to be available from agencies and organizations with experience in the region but the epidemic cannot be contained from the outside.

IMPORTANT LINKS AND CONTACTS

1. National Committee for the Control of AIDS, Secretary: Director of the National Institute for Hygiene and Epidemiology.

2. UNAIDS, Country Program Adviser.

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under The Synergy Project
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MONGOLIA AND HIV/AIDS

TALKING POINTS

HIV/AIDS is in a nascent stage in Mongolia.

- As of the end of 1997, less than 100 adults and children were estimated to be living with HIV/AIDS.
- The adult prevalence rate is estimated to be 0.01 percent.
- Two people have tested HIV positive and one person died of AIDS in early 1999, according to official government statistics. There are no estimates on the number of AIDS orphans.

However, there are several high-risk factors that make the country vulnerable to the pandemic, including an increase in syphilis among blood donors and pregnant women, high rates of STIs among sex workers and pregnant women, and lack of access to high-quality condoms.

Women and HIV/AIDS: With a significant STI problem in Mongolia, young women are particularly at risk because of their greater biological vulnerability and inability to negotiate condom use with sexual partners.

Children and HIV/AIDS: Health care workers regularly lecture young people in school about family planning and STIs, but medical facilities offer adolescents limited counseling and services.

Socioeconomic Effects of HIV/AIDS: In its current "pre-emptive strike" phase, Mongolia has yet to feel the brunt of the HIV/AIDS pandemic. However, its growing young population is feeling the effects of the decade's immense social changes, which have resulted in greater sexual freedom.

National Response: Mongolia began addressing HIV/AIDS in 1987, although the initial prevention programs were not always well planned. More recent efforts with the United Nations system are benefiting from improved design and targeting approaches.

Donors: USAID funds the Implementing AIDS Prevention and Care Activities (IMPACT) Project, which is developing several Asia regional HIV/AIDS initiatives that can benefit Mongolia. In addition, USAID has proposed $6.3 million in fiscal year 2000 funding for the Asia Near East Regional HIV/AIDS project. Although UNAIDs is not represented in Mongolia, other agencies within the United Nations system are collaborating with the government of Mongolia on HIV/AIDS programs and several provide funding to private voluntary organizations (PVOs) and nongovernmental organizations (NGOs).

MONGOLIA AND HIV/AIDS

COUNTRY PROFILE

Mongolia is a vast, sparsely populated country in northeast Asia, situated between Russia and China. Nearly half of its relatively small population, 2.5 million, live in rural areas. Within its 1.6 million kilometers (km), Mongolia is rich in natural resources, with 31 million heads of livestock, as well as copper, gold, coal, and other minerals. The country has a well-developed human resource base and boasts a 96 percent adult literacy rate. Mongolia made a peaceful transition to a stable democracy in 1990. After the 1989–90 economic collapse and several years of negative growth, the economy began to grow in 1994. The country's severe climate, widespread geographical area, and limited physical infrastructure make health services delivery a difficult task.

Slightly more than one third (36 percent) of the population live below the poverty line. The Mongolian health care system was based on the Soviet model of universal access health care. The Soviet Union heavily subsidized this program until Mongolian independence in 1990, when Russia's 60 percent share of the national health care budget was withdrawn abruptly, without any transitional bridging program. This caused a major budget crisis and severely affected the Mongolian health care system. Ongoing problems include a lack of medical supplies and training, crumbling facilities, poor management of health care facilities, and a decreasing number of health care services available to Mongolians.

HIV/AIDS in Mongolia

HIV/AIDS is in a nascent stage in Mongolia but the evidence points to an increase in high-risk factors.

- As of the end of 1997, less than 100 adults and children were estimated to be living with HIV/AIDS.
- The adult prevalence rate is estimated to be 0.01 percent.
- According to official government statistics, there have been two AIDS cases reported in Mongolia and one death from AIDS in early 1999.
- According to the Joint United Nations Programme on AIDS (UNAIDS), there are no estimates on the number of AIDS orphans.
- In 1994, HIV testing of nearly 7,000 blood donors found no evidence of HIV, but from 1992 to 1997, the prevalence of syphilis among blood donors increased from 0.19 percent to 2.75 percent.
- The prevalence of syphilis among pregnant women increased from 0.1 percent in 1993 to 0.5 percent in 1997.
- Sexually transmitted infection (STI) prevalence was 0.37 among pregnant women aged 15–24 whose blood was screened for syphilis.
- Slightly more than half (58 percent) of sex workers tested were found to have STIs.

Because STIs are known to be an important factor in HIV transmission, Mongolia's high levels of STIs and low capacity to diagnose and treat STIs adequately are serious problems. While Mongolia has a tradition of STI clinical care and treatment, these services are provided on an inadequate basis. According to the United Nations Population Fund (UNFPA), there are limited patient respect and diagnostic capacity, poor inpatient care, a lack of drugs, limited client ability to pay for drugs, and misconceptions about STIs, even among health workers.

- Frequently, inpatient STI treatment at hospitals and fee-based voluntary screening are the only available options.
- Of people presenting with STI or for STI care in health facilities, 27 percent received basic advice on condoms and partner notification.
- Condom use is low. Preliminary results from the 1998 Reproductive Health Survey indicate that current use of condoms by married women is only 4.6 percent.
- There is limited availability of quality condoms.
- Condoms are often unavailable at government health services; in 1996, they were available at a per capita rate of 1, according to the UNFPA.
- The significant STI problem includes antimicrobial resistant N. gonorrhea and an extremely high rate of trichomoniasis among women; resistance to penicillin is also quite high.
- The recent increase in STIs and high abortion rates (about 24 percent of reported pregnancies) indicates that there is a large unmet need for reproductive health services, including HIV/AIDS/ STI prevention and care.

A 1998 Association for Voluntary and Safe Contraception (AVSC)/Ministry of Health and Social Welfare/ UNFPA assessment found that Mongolians are fearful of STIs, which are considered a source of shame. Anecdotal information indicates that suicides or suicide attempts among adolescents are often related to STIs. Given the stigma attached to STIs and the lack of anonymity at STI clinics, there is a strong possibility that many STI cases are self-medicated or left untreated. Health administrators conducted an aggressive campaign of compulsory screening aimed primarily at schoolgirls, women and soldiers; this poorly targeted campaign lacked an understanding of STI transmission and at-risk behaviors.

Women and HIV/AIDS

There is a continuing trend toward earlier initiation of sexual activity, which positions a substantial number of young people, especially young women, at risk for STIs. Young women are particularly at risk because of their greater biological vulnerability to HIV and other STIs and their limited power to negotiate condom use with their sexual partners. Mongolia's growing young population is feeling the effects of the decade's powerful social changes, which have resulted in greater sexual freedom.

Traditional attitudes can also limit contraceptive use. Among married men and women, a husband may only agree to contraception after his wife has borne sons. Buying condoms can be a source of embarrassment in a village. The 1998 AVSC/Ministry of Health and Social Welfare/UNFPA assessment found that most women would like more contraceptive information and many men feel "left out of reproductive health services and are

more than ready to play their part." In addition, the dispersed rural population has limited access to health services. UNFPA has arranged for a donation of female condoms from UNAIDS and is supporting the introduction of female condoms through social marketing in September and October 1999.

Children and HIV/AIDS

Health care workers regularly lecture young people at school about family planning and STIs, yet medical facilities offer them limited counseling and services. Many doctors are reluctant to provide contraception to adolescents.

SOCIOECONOMIC EFFECTS OF HIV/AIDS

In its current "pre-emptive strike" phase, Mongolia has yet to feel the brunt of the HIV/AIDS pandemic. However, the government has been contributing considerable funds and other resources, from a very limited budget, into fighting HIV/AIDS when other pressing social issues, such as rising poverty levels and increased numbers of female-headed households, are also affecting the country. As a result, donors' continued support and nongovernmental organization (NGO)–run HIV/AIDS prevention programs will be needed for some time to keep the pandemic from gaining a strong foothold in Mongolia. With the weakened economy, there has been a reported increase in domestic violence and alcoholism, and a growing number of commercial sex workers. These factors heighten the risk of HIV/AIDS/STI transmission.

INTERVENTIONS

National Response

In 1987, the government of Mongolia addressed AIDS prevention and control in its first National Short-Term Plan (1987–89), which was developed with the World Health Organization (WHO) Global Programme on AIDS. The Plan helped establish the National AIDS Reference Center and HIV/AIDS Laboratory, and supported serological surveys, blood screening, and HIV/AIDS information and education for the general population.

The Medium-Term Plan I (1990–95) established a National AIDS Committee and a National AIDS Programme. After a 1992 program review and consensus workshop, the Medium-Term Program II (1994–97) shifted the program direction to preventing HIV through sexual transmission. HIV/AIDS/STI education and teacher training were added to the school curriculum, priority high-risk populations targeted for intensified interventions, and community-based activities initiated with NGOs. The government merged its STI and HIV/AIDS efforts into one program. Health workers were trained in STI/HIV/AIDS prevention and care.

In March 1994, the government of Mongolia passed a law on the prevention of AIDS that upholds the rights of people with AIDS, the government, medical institutions and personnel, NGOs, and other involved parties.

On June 24, 1997, the government of Mongolia and four United Nations organizations operating in-country—United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), UNFPA,

and WHO—signed a Memorandum of Understanding, "Response to HIV/AIDS/STI in Mongolia: 1997–2001." This document signaled their firm commitment to build a more effective national response to the HIV/AIDS/STI pandemic. The Memorandum's strategic objectives focus on developing national policies and programs, and information, education and communication (IEC) activities; ensuring and promoting the availability and use of high quality condoms; and, improving STI prevention and care. The government can draw on the United Nations system's expertise.

The 1992 National AIDS Programme is currently being revised and updated. The government has committed 77 million in local currency (Tugrug) for STIs, which is viewed as an extremely encouraging sign. Unfortunately, the National AIDS Committee, chaired by the Prime Minister, is fairly inactive. The United Nations organizations want to revitalize the National AIDS Foundation so that it will become the umbrella organization for all HIV/AIDS/STI activities. A draft outline is being prepared to be discussed with the government.

The lack of integration of HIV/AIDS/STI activities into the reproductive health program is a strong concern for many donors, including UNFPA and UNDP.

The government of Mongolia recently identified 12 health priority areas that included the control of communicable diseases with particular emphasis on tuberculosis, STIs, viral hepatitis B, and brucellosis.

Donor Response and Nongovernmental Organization (NGO) Activities

USAID has proposed $6.3 million in fiscal year 2000 funding for the Asia Near East Regional HIV/AIDS project. USAID also works closely with UNAIDS in the region, although UNAIDS does not have a presence in Mongolia. The USAID–funded Implementing AIDS Prevention and Care Activities (IMPACT) Project is developing several Asia regional HIV/AIDS initiatives that can benefit Mongolia.

WHO continues to provide assistance in STI/HIV policy development, training health workers in STI case management, and integrating STI/HIV preventive interventions into the Health Promotion and Safe Motherhood Program.

UNAIDS is not represented in Mongolia.

UNDP developed a two-year project (1997–99) to strengthen program management and partnership grants to national NGOs for community-based prevention and education activities for high-risk groups. UNDP also supported the establishment of the United Nations Program Office and is involved in a subregional HIV/AIDS project that involves Mongolia, China, Republic of Korea, and North Korea.

UNFPA supports and integrates STI/HIV/AIDS activities in its Reproductive Health Programme, which includes the Reproductive Health Needs Assessment and Survey, IEC activities, and the logistics and management system activities. This area is included in the reproductive health training provided to health workers and integrated into the new school curriculum on sexuality and reproductive health that UNFPA supports, in close collaboration with SOROS. Margaret Sanger Centre International is implementing a UNFPA–funded program on adolescent reproductive health that includes a school curriculum, training of teachers, training of doctors

who treat adolescents, and support to local NGOs for out-of-school youth. UNFPA is also providing condoms for the public health system for family planning and STI prevention, and supports condom social marketing.

UNFPA chairs the United Nations Theme Group on STD/HIV/AIDS, which includes the United Nations agencies and the Mongolian government. At monthly meetings, the group aims to build on its comparative advantages and work together as a unit. Beginning in September 1999, bilateral agencies and NGOs will be included in the meetings.

A March 1998 AVSC/Ministry of Health and Social Welfare/UNFPA mission assessed the quality and availability of reproductive health services and recommended that donors encourage and support social marketing activities in Mongolia on a priority basis. UNFPA is using the assessment findings to design and fund a program to improve reproductive health services; the government will work with AVSC to implement the program. UNFPA is also helping the government develop new protocols for STIs, and in 2000, will assist in an STI prevalence survey. UNFPA is providing drugs for STI treatment. UNFPA and Marie Stopes International, with some support from the Dutch government, are introducing social marketing of male condoms in the fall of 1999. However, limited resources are available for this initiative.

UNFPA is funding a health clinic run by Marie Stopes International Mongolia. The clinic offers Ulaanbaator's street youth, a particularly vulnerable group, free treatment and advice on family planning and safe sex. The first clinic provides a wide range of family planning methods and reproductive health care and is open in the evenings for its clients' convenience. UNFPA is also funding an education program for general and private practitioners through Marie Stopes International. This program aims to increase the quality and extent of family planning and reproductive health services available.

The **UNICEF** Safe Motherhood Program (1997) included education and services for out-of-school youth, including outreach to children in difficult circumstances, life skills education, and an HIV/AIDS education program. UNICEF played a major role in developing the National IEC Strategy. The organization is assisting in coordinating IEC activities, providing basic IEC skills in capacity-building workshops, and encouraging collaborative participation between the government, United Nations system, local and international NGOs, and the media.

The **British Department for International Development (DfID)** identified HIV/AIDS as a worldwide concern and will support programs that improve access to quality basic services and community-based campaigns to promote safer sex to help empower women and girls.

The **Asian Development Bank** is focusing on primary health care services and capacity building. The bank's program is supporting the comprehensive reform of health sector policies, including introducing private sector health services delivery.

The **Japan International Cooperation Agency (JICA)** identified support for the "provision of education and health care services, and the creation of social safety nets for the poor," as a potential sectoral priority in 1998 in Mongolia.

The **German Development Agency (GTZ)** and **Medecins Sans Frontières (MSF)** are also involved in this sector in Mongolia. MSF is supporting an HIV/AIDS/STI reference unit and a large media campaign on HIV/AIDS/STI prevention.

The **Mongolian Foundation for Open Society**, a SOROS–supported group, supports the government's medical and health program with a strong emphasis on training, procuring hospital equipment, and grants. Its Medical and Health Program is developing health education curricula for secondary schools that includes information on AIDS, alcohol, human sexuality, nutrition, and smoking.

CHALLENGES

High-risk behaviors and limited STI treatment and prevention programs are significant challenges in Mongolia.

- Inadequate diagnostic techniques in Ulaanbaator, combined with alcoholism, the lack of condom use, growth of the commercial sex industry, and other high-risk sexual behavior in the population will continue to foster high STI rates.

- Population shifts to urban areas—away from the traditional nomadic Mongolian lifestyle—to search for jobs and increased economic opportunities, can contribute to HIV vulnerability. Also, increased travel in and out of Mongolia, after decades of being closed off from the non-Soviet world, can open the door to STIs.

- Improvements are needed in the STI control program infrastructure, health education, and condom availability.

FUTURE ACTIONS NEEDED

Donors, private voluntary organizations (PVOs) and NGOs have identified the following as priority action areas:

- Improved STI/HIV/AIDS prevention and control programs, including effective surveillance systems;
- Better knowledge and understanding of HIV/AIDS/STI case management and transmission among clients and providers;
- Tailored HIV/AIDS/STI IEC behavior change materials that are disseminated, then monitored and evaluated to ensure that they reach high-risk groups. such as commercial sex workers, STI patients, homosexuals, and youth;
- Improved data collection system, beginning with a prevalence study and improved surveillance system;
- Improved drug supplies for STI treatment; and,
- Improved condom promotion and social marketing efforts.

Little is known about the population's health care seeking behaviors, such as self-medication and sexual behaviors, and additional research is needed.

IMPORTANT LINKS AND CONTACTS

1. SOROS–Mongolia, contact: Ms. L. Tugsjargal, Medical and Health Program Coordinator, Center for Scientific and Technological Information, Room #306, Baga Toiruu 49, Ulaanbaator 46, Mongolia; Tel: 976-1-313207, 976-1-328783, 976-1-321471, Fax: 976-1-32485, E-mail: tugso@soros.org.mn.

2. Medecins Sans Frontières (MSF), Ms. Tanja Andreeva; Tel: 976-1-362-766.

3. Mr. Gene V. George, Acting Mission Director, Ms. D. Sukhgerel, Program Specialist, Office of the USAID Representative, Ulaanbaator, Mongolia.

4. UNDP, Pie Meulenkamp, Programme Officer, 7 Erkhuu Str., P.O. Box 49/207, Ulaanbaator, Mongolia; Tel: 976-1-327585/586/587, Fax: 976-1-326221, 873-3824-20352, E-mail: fo.mng@undp.org, Internet: www.un-mongolia.mn.

5. UNFPA, Linda Demers, Representative, 3 Erkhuu Str., P.O. Box 49/645, Ulaanbaator, Mongolia; Tel: 976-1-35-35-01, Fax: 976-1-35-35-02, E-mail: unfpa.mn@undp.org, Internet: www.un-mongolia.mn/unfpa.

6. United Nations Theme Group on STD/HIV/AIDS, Linda Demers, Chairperson; Tel: 976-1-35-35-01, Fax: 976-1-35-35-02.

7. The World Bank—Mongolia Office, Richard Lynn Ground; Tel: 976-1-312-647.

8. WHO Representative, Dr. Susantha de Silva.

9. IMPACT: Implementing AIDS Prevention and Care Project, Family Health International, 2101 Wilson Blvd., Suite 700, Arlington, VA 22201 USA; Tel: 703-516-9779, Fax: 703-516-9781, Internet: www.fhi.org.

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MOROCCO AND HIV/AIDS

TALKING POINTS

HIV/AIDS appears to be at a nascent stage in Morocco. However, limited statistics present an incomplete picture of the situation. However, given increasing STI levels, a general lack of knowledge on STI/HIV/AIDS transmission and prevention as well as other sexual health issues, Morocco is vulnerable to increased HIV–prevalence rates.

- By the end of 1997, an estimated 5,000 adults and children were HIV positive.
- The adult prevalence rate is estimated to be 0.03 percent.
- From 1986 to mid–1999, there have been 606 reported cases of AIDS in Morocco, with women composing 31 percent of these cases and men 69 percent.
- In 1998, the number of reported cases of sexually transmitted infections (STIs), was 212,241, but many cases were not reported. In 1999, the Ministry of Public Health (MOH) estimated an annual occurrence of up to 600,000 new cases of STIs.

Women, Youth and HIV/AIDS: Young women are particularly at risk because of greater biological vulnerability to HIV and other STIs, limited knowledge and use of HIV prevention methods including condoms, and difficulty discussing the topic with their sexual partners. While adolescents appear to be aware of campaigns to control the spread of STIs/HIV/AIDS, without access to accurate sexual health information, they rely on rumors or popular beliefs.

Socioeconomic Effects of HIV/AIDS: Morocco has yet to feel the brunt of the HIV/AIDS pandemic, but without an intensive public awareness campaign, its growing young population will be increasingly at risk.

National Response: Morocco began addressing HIV/AIDS in 1986, when the Ministry of Public Health created the multisectoral National Committee Against AIDS. In response to numerous epidemiological and sociological studies, the Ministry established a national STI prevention program in 1995.

Donor and NGO Activities: The European Union and World Bank play leading roles in STI/HIV/AIDS prevention programs in Morocco. A growing number of local nongovernmental organizations (NGOs) are active in HIV/STI information, education and support programs. Since 1996, the USAID–funded International HIV/AIDS Alliance has been working with local NGOs and AMSED, an NGO–networking organization, to increase the number of NGOs delivering HIV–prevention services, improve technical skills, and strengthen its capacity to mobilize local and international resources.

MOROCCO AND HIV/AIDS

COUNTRY PROFILE

The Kingdom of Morocco is a stable, lower-middle income country of about 27 million people located in North Africa, where it borders Algeria and Mauritania. Its large and sophisticated agribusiness and phosphate production enterprises earn a substantial amount of foreign exchange, but one third of export earnings are used to service internal and external debts, constraining the government's capacity to manage the fiscal deficit. Voters recently elected their first opposition government. The new government is redefining policies on health care, human rights, education, and social development. The fragile new democracy must cope with vast urban and rural poverty that coexists alongside modern urban centers.

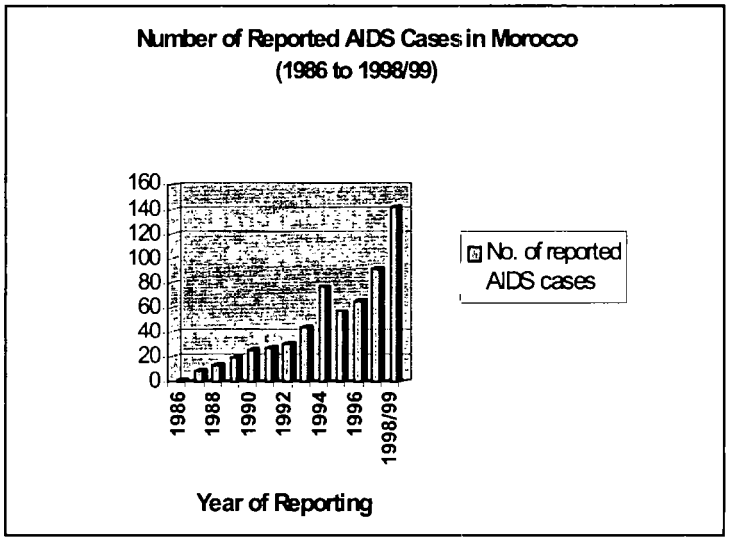
Almost half the population lives at or below the poverty line. The urban unemployment rate is approximately 20 percent and is 35 percent among new university graduates. More than half the population are illiterate, and in rural areas, female illiteracy is close to 90 percent. Infant mortality remains high (36/1,000), and the population is growing at 1.9 percent annually. About 35 percent of the population are under 15 years of age. Population growth and rural to urban migration are fueling high unemployment and lack of access to housing, land, credit, and other productive resources.

A 1996 World Bank report noted many problems within Morocco's basic health system, beginning with its overall poor quality, poorly trained and unmotivated health personnel, insufficient health financing, and low per capita health expenditure.

HIV/AIDS in Morocco

HIV/AIDS is in an early stage in Morocco, but with growing and often unreported numbers of cases of sexually transmitted infections (STIs), the sexually active population will face increasing risk, according to the Joint United Nations Programme on AIDS (UNAIDS) and World Health Organization (WHO).

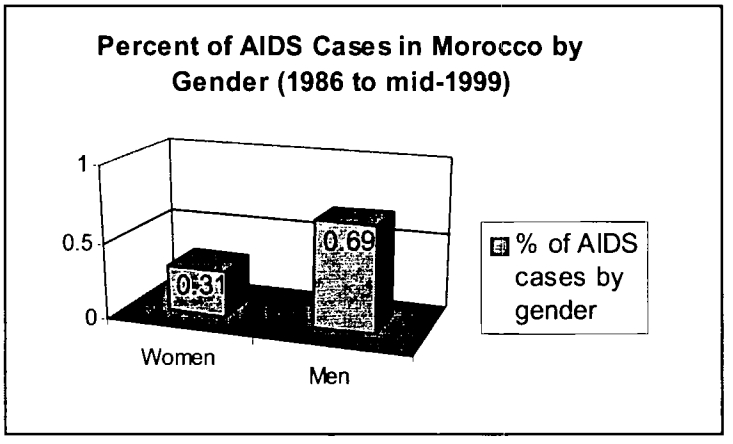
- As of the end of 1997, 5,000 adults and children were estimated to be HIV positive.
- The adult prevalence rate is estimated to be 0.03 percent.
- From 1986 to mid–1999, there have been 606 reported cases of AIDS in Morocco, with women composing 31 percent of these cases

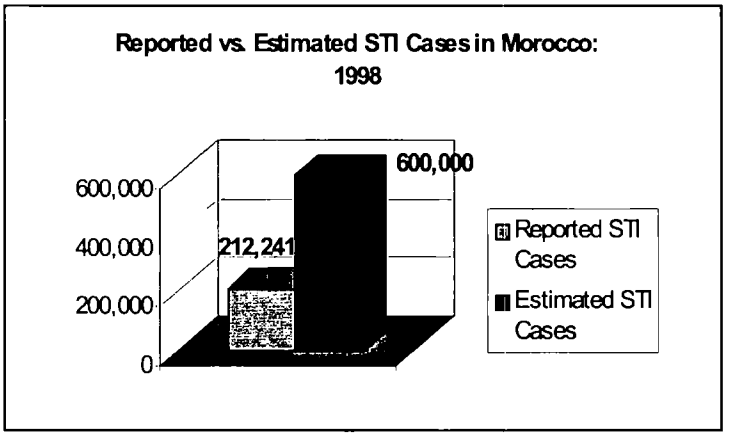


Ministry of Public Health, 1999

and men 69 percent, according to the Ministry of Public Health (MOH).

- There are no estimates on deaths due to AIDS or AIDS orphans.
- From 1990 to 1992, no evidence of HIV infection was found among antenatal clinic attendees in Agadir, Casablanca, Marrakech, Rabat, and Tangier, but in 1997, 0.014 percent of antenatal women tested as a part of nationwide sentinel surveillance were HIV positive.
- In 1998, there were 212,241 reported cases of STIs, but it is accepted that, due to underreporting, these data do not reflect the true situation. Physical, financial and cultural inaccessibility to public health clinics and self-medication contribute to STI underreporting.
- In 1999, the Ministry of Public Health estimated an annual occurrence of up to 600,000 new cases of STIs.





Ministry of Health, 1999

Morocco has a weak infrastructure of health services delivery in rural areas. Often lacking comfort or privacy, the rural clinics also provide poor treatment and lack accurate reproductive health and STI/HIV/AIDS information. Because STIs are known to be an important factor in HIV transmission, Morocco's growing levels of STIs and low capacity to diagnose and treat STIs adequately are serious problems, according to a 1998 International Planned Parenthood Federation (IPPF) report.

- Condom use is low. The 1995 Demographic and Health Survey found that only 9.5 percent of ever-married women had ever used a condom.

- The recent increase in STIs and strong demand for elective abortions (which are illegal except to save the mother's life) indicate an unmet need for quality reproductive health services, including HIV/AIDS/STI prevention and care, according to a 1998 Population Reference Bureau (PRB) report.

Moroccans are fearful of STIs, which are considered a source of shame and guilt. STIs represent such a strong social stigma that even medical doctors are very cautious when they explain an STI to a patient, referring to

STIs as "colds." In Moroccan culture, many illnesses are explained as "catching a cold." Given the stigma attached to STIs and the poor treatment at many health clinics, there is a strong possibility that many STI cases are self-medicated or left untreated. A 1998 PRB report stated that couples do not communicate easily about the subject and STIs are seen as evidence of spousal betrayal.

Young women are particularly at risk of HIV infection because of their greater biological vulnerability to HIV and other STIs, limited knowledge of HIV prevention methods, limited use of condoms, and difficulty in discussing the topic with their sexual partners. Women also have little power to negotiate condom use with their sexual partners.

Adolescents and unmarried adults appear to be aware of the campaigns to control the spread of STIs and AIDS and prevention methods. However, a 1998 IPPF survey found that youth had very limited knowledge of sexual and reproductive health issues. Only about 18 percent had correct information on AIDS, and about 38 percent of the interviewed sample listed condoms as a means of AIDS prevention. There has been a total lack of youth-oriented information and education on sexual health, particularly in rural areas. Adolescents express an urgent need for access to STI–prevention programs.

The 1998 IPPF survey also reported a large unmet need for contraception among married women. Poor information at health clinics was cited as a primary barrier to achieving good reproductive health practices and meeting contraceptive needs.

SOCIOECONOMIC EFFECTS OF HIV/AIDS

Morocco has yet to feel the full force of the HIV/AIDS pandemic on its economy. However, given its limited budget, the government has been contributing considerable funds and other resources into fighting HIV/AIDS when other pressing social issues, such as rising poverty levels and growing unemployment, are also affecting the country. As a result, donors' continued support and nongovernmental organization (NGO)–run HIV/AIDS–prevention programs will be needed for some time to keep the pandemic from gaining a strong foothold in Morocco.

INTERVENTIONS

National Response

Morocco began addressing HIV/AIDS in 1986, when the Ministry of Public Health created the multisectoral National Committee Against AIDS. In 1990, blood-donor screenings began to safeguard the blood supply. In 1993, surveillance sites were created for the epidemiological monitoring of HIV in target populations: STI counselors, tuberculosis patients, pregnant women, and blood donors. In response to numerous epidemiological and sociological studies, the Ministry established a national STI prevention program in 1995. The program aims to systematically detect and treat cases using WHO procedures. It conducts information and communication activities, especially among target populations, in a new vertical program and provides health personnel with clinical training.

Ministry of Public Health funds budgeted for reproductive health increased from 9 percent in 1991 to 13.4 percent in 1998. Donor loans and contributions for reproductive health have grown significantly since 1994, increasing at a 45 percent annual rate. Of these funds, 8 percent have been allocated to STI/HIV/AIDS prevention.

Donors

The European Union and World Bank now play lead roles in STI/HIV/AIDS prevention programs in Morocco. **USAID** plans to phase out assistance to the health and population sector by the end of 2004. USAID ended direct assistance to HIV/STI programs in 1997 and focuses current support on reproductive health programs. UNAIDS does not have a direct representative in Morocco although United Nations' agencies in-country meet regularly to address the UNAIDS program agenda.

USAID funded the development of pilot approaches to STI/HIV/AIDS. These resulting strategies and protocols were adopted as the national guidelines and are currently being expanded nationwide with other donor and government of Morocco (GOM) funding to provide quality and cost-effective treatment of STIs and to continue AIDS–prevention programs. In addition, USAID funds some condom procurement as a part of overall contraceptive procurement. With USAID planning to phase out assistance to the health and population sector in Morocco, the Agency will focus on decentralized management of primary health care and increased access to private sector family planning/maternal and child health services in the final strategy period, 2000–04.

WHO continues to provide assistance in AIDS control, public health training, communicable diseases, and epidemiology. It also provides support to STI/HIV policy development, training of health workers in STI case management, and integrating STI/HIV preventive interventions into the Health Promotion and Safe Motherhood Program.

UNAIDS: Although UNAIDS does not have a direct representative in Morocco, the United Nations' agencies meet regularly under the auspices of WHO to pursue UNAIDS program objectives.

The United Nations Population Fund (UNFPA) AIDS Prevention project worked to educate 200 students and 40 directors of women's associations on HIV/AIDS prevention. The project also produced and disseminated information on AIDS and AIDS prevention (1993–96, US $139,000).

The United Nations Children's Fund (UNICEF) and United Nations Development Programme (UNDP): UNICEF is active in the health sector in Morocco at both the national and provincial levels. UNDP is currently expanding the USAID HIV/STI program model, including providing training, in several provinces.

The World Bank has two active health sector loans that are primarily for infrastructure development. The World Bank is implementing the Morocco Social Priorities Program/Basic Health Project to increase access to essential curative and preventive health services in 13 target provinces. One project component addresses STIs. The February 1996 project update noted the high STI rate, stating that "sexually transmitted diseases (which increase the risk of HIV infection) affect more than 7 percent of the population, according to a recent

survey." World Bank loans are also being used by the GOM to finance the host country counterpart for nationwide contraceptive procurement.
The British Department for International Development (DfID) identified HIV/AIDS as a worldwide concern and will support programs that improve access to quality basic services and community-based campaigns to promote safer sex to help empower women and girls.

The **NGO** sector is involved in HIV/AIDS prevention, with some AIDS Service Organizations (ASOs) targeting potentially high-risk communities, such as sex workers and injecting drug users, and offering anonymous testing. The ASOs include the Association Lutte Contre le SIDA (ALCS), OPALS and Association Magrebien de Lutte Contre le SIDA (AMLCS). The USAID–funded International HIV/AIDS Alliance has been working since 1996 with NGOs and an NGO–linking organization, AMSED, to mobilize and strengthen NGOs working on HIV prevention. Between 1996 and 1998, the number of NGOs in Morocco with significant HIV/AIDS activities nearly tripled, growing from 12 to 32, due to the Alliance's work.

AMSED's USAID–supported PASA/SIDA program (Programme d'appui au secteur associatif/SIDA) is strengthening NGO technical skills in the areas of HIV prevention programming and building its organizational, managerial, and administrative capacity. PASA/SIDA, in turn, aims to strengthen the capacity of Moroccan organizations in the young NGO sector. It mobilizes groups working in development or AIDS for community assessments, then trains the group in participatory prevention activities that address gender, sexuality, sexual health, and AIDS/STI issues. These activities are combined with community mobilization and/or development activities. In 1998, PASA/SIDA provided technical support to partner NGOs in HIV/AIDS management and organizational development through technical assistance, workshops, and/or exchanges. PASA/SIDA provided support to 20 NGOs between 1995 and 1998. Its 1998 activities targeted persons living with HIV/AIDS (PLWHAs), the poor, women, and youth.

CHALLENGES

High-risk behaviors, the stigma attached to STIs and other sexual health issues, and limited or poor STI treatment and prevention programs are significant challenges in Morocco.

- Inadequate diagnostic techniques and the lack of condom use and other high-risk sexual behavior will continue to foster growing STI rates.
- Population shifts from rural to urban areas to search for jobs and increased economic opportunities can contribute to HIV vulnerability.
- Improvements are needed in the STI control program infrastructure, health education, and condom availability.

FUTURE ACTIONS NEEDED

The following priority action areas for HIV/AIDS prevention and control should be viewed in the context of improving overall reproductive health in Morocco, in both urban and rural areas:

- Improved STI/HIV/AIDS prevention and control programs, including effective surveillance systems;
- Better knowledge and understanding of HIV/AIDS/STI case management and transmission among clients and providers;
- Tailored HIV/AIDS/STI information, education and communication and behavior change materials that are disseminated, then monitored and evaluated to ensure that they reach high-risk groups such as commercial sex workers, STI patients, homosexuals, and youth;
- An improved data collection system beginning with a prevalence study and a better surveillance system;
- Improved drug supplies for STI treatment; and,
- Better condom promotion and social marketing efforts.

Little is known about the population's health care seeking behaviors; more research is needed.

IMPORTANT LINKS AND CONTACTS

1. USAID/Morocco, Michele Moloney-Kitts, Office Chief, Population/Health, 10, Ave. Mehdi Ben Barka, Souissi, Rabat, Morocco; Tel: (07) 63-20-01, Fax: (07) 63-20-12, Internet: mmoloneykitts@usaid.gov.

2. Ministry of Health, Dr. Ahmed Zidouh, Division of Epidemiology, Ministère de la Santé, Rabat, Morocco; Tel/Fax: (07) 77-18-31.

3. UNDP, Bouna Sémou Diouf, Casier ONU, Chellah, Rabat, Morocco; Tel: (07) 70-35-55, Fax: (07) 70-14-82.

4. UNFPA, Vincent Faveau, Representative, Casier ONU, Chellah, Rabat, Morocco; Tel: (07) 76-78-31,Fax: (07) 70-14-82.

5. World Bank: Linda Likar, Chief Economist, 7, Rue Laarbi Ben Abdullah, Souissi, Rabat, Morocco; Tel: (07) 63-60-50, Fax: (07) 63-60-51.

6. WHO: Raouf Benammar, Representative, Ministère de la Santé, Rabat, Morocco; Tel: (07) 76-67-44, Fax: (07) 76-68-05.

7. UNICEF: Oliver Theo Degreef, Representative, 28, Rue Oum Rabia, Agdal, Rabat, Morocco; Tel: (07) 77-22-12, Fax: (07) 77-24-37

8. IMPACT: Implementing AIDS Prevention and Care Project, Family Health International, 2101 Wilson Blvd., Suite 700, Arlington, VA 22201 USA; Tel: (703) 516-9779, Fax: (703) 516-9781; Internet: www.fhi.org