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# PHILIPPINES AND HIV/AIDS

## TALKING POINTS

Although HIV-prevalence rates in the Philippines have remained below 1 percent in most population groups, the risk of an exploding epidemic is ever present.

- An estimated 43,000 adults and children will be infected by the year 2000.
- Over 23,000 adults between 15 and 49 years of age were estimated to be living with HIV at the end of 1997, representing an adult prevalence rate of 0.06 percent.
- More than 1,600 AIDS cases have occurred among adults and children since the beginning of the epidemic.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that 1,300 AIDS-related deaths have occurred since the beginning of the epidemic and 630 AIDS-related deaths occurred during 1997 alone. Life expectancy is 66 years for males and 69 years for females.

**Women and HIV/AIDS:** The number of women with HIV in the Philippines is growing. An estimated 7,000 women aged 15-49 years were living with HIV at the end of 1997. The highest rates of HIV in the Philippines have been found in female sex workers in the regions of Quezon, Pasay, Angeles, Iloilo, Davao, and General Santos. Female HIV infections are concentrated among 19-29 year olds.

**Children, Youth and HIV/AIDS:** The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others. An estimated 1,000 children under the age of 15 years were living with HIV at the end of 1997. Since the beginning of the epidemic, an estimated 480 children have become orphans due to AIDS.

**National Response:** AIDS has become a major problem in the countries of Southeast Asia. The majority of Filipinos with HIV infection have not yet developed AIDS. It is expected that up to 10,000 patients with AIDS will seek treatment from the health system within the next 5-10 years. An expanded multisectoral response involving all levels of government, the private sector and civil society is urgently needed, in addition to continued aggressive public outreach campaigns and education interventions targeting key high-risk populations.

**Donors:** USAID is the largest contributor to the Philippine National AIDS/STD Prevention and Control Program with proposed HIV/AIDS funding of \$4.4 million for fiscal year 2000. HIV/AIDS activities in the Philippines focus on institutionalizing public and private sector mechanisms for monitoring HIV prevalence and encouraging behaviors among target groups that reduce individual risk for contracting or transmitting sexually transmitted infections (STIs) and HIV.

# PHILIPPINES AND HIV/AIDS

## COUNTRY PROFILE

The Republic of the Philippines is bound on the west and north by the South China Sea, on the south by the Celebes Sea and on the east by the Pacific Ocean. The country consists of over 7,100 islands, with three main groupings—Luzon, the Visayas and Mindanao. With one of the highest population growth rates in East Asia of 2.3 percent, the population of almost 75 million is expected to double in 31 years.

The Philippine economy suffered significantly from spillover effects of the Asian financial crisis that began in mid-1997. The gross national product (GNP) dropped to zero, GNP per capita fell to almost 3 percent, imports declined precipitously, the nominal exchange rate fell by approximately 40 percent, and unemployment reached double-digit figures. Prior to the crisis, the Philippines had a significantly large proportion of its population living below or at the poverty line. Thus, the crisis has the potential to significantly increase poverty levels.

The country's burgeoning population is putting pressure on the natural resource base and contributing to the global problem of greenhouse gases. In addition to decreasing coastal and forest biodiversity, the Philippines' unchecked population growth is an important obstacle to achieving an environmentally sustainable economy and overall development gains.

Women constitute 31 percent of the adult labor force. Literacy rates are very high: 94 percent for women and 95 percent for men. Approximately 65 percent of girls attend secondary school. Although a vast majority of women have access to prenatal care, only half the deliveries are attended by skilled medical professionals. Overall health indicators have shown improvement over the last decade. However, many indicators remain at unacceptable levels: the total fertility rate is 3.7 and modern contraceptive use is only 28 percent (one of the lowest in the region); infant mortality and maternal mortality remain high at 35 and 209 deaths per 1,000 births, respectively; and, 86 percent of the population have access to safe water, 77 percent to adequate sanitation, and 71 percent to health services. Life expectancy is 66 years for males and 69 years for females.

## HIV/AIDS in the Philippines

The first case of AIDS in the Philippines was reported in 1984. Sexual transmission (including heterosexual, homosexual and bisexual contacts) accounts for 96 percent of the reported cases where the transmission mode was known, followed by perinatal transmission, blood products, and injecting drug use. An estimated 43,000 adults and children will be infected by the year 2000.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) has made the following estimations for the end of 1997:

- Over 23,000 adults between 15 and 49 years are estimated to be living with HIV, representing an adult prevalence rate of 0.06 percent.

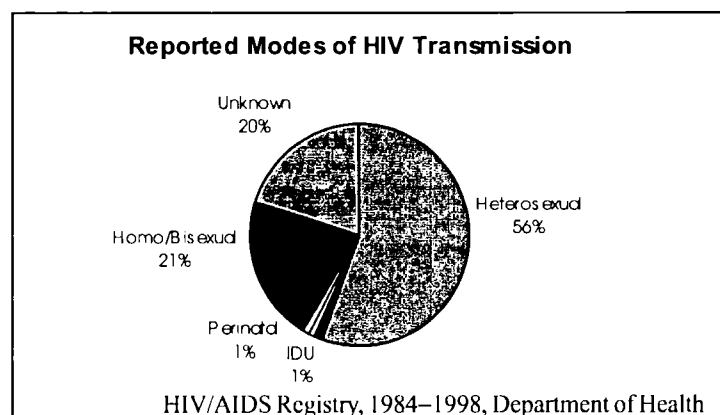
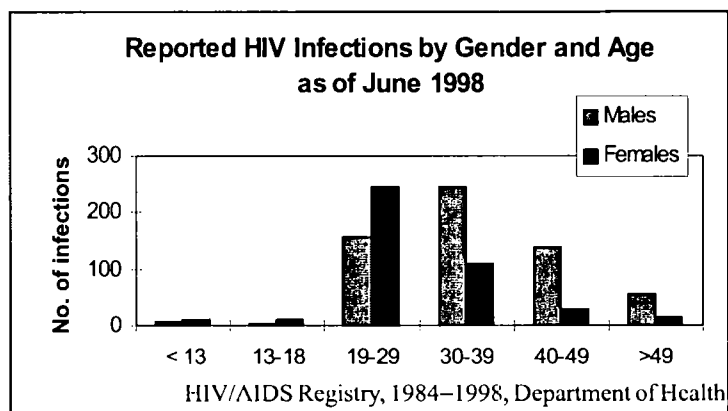
- More than 1,600 AIDS cases and 1,300 AIDS-related deaths have occurred among adults and children since the beginning of the epidemic.
- During 1997 alone, 630 AIDS-related deaths occurred in adults and children.

It is estimated that only 5 percent of HIV infections and 40 percent of AIDS cases are reported to or diagnosed by health authorities. There are now 10 serological surveillance sites established throughout the country, undertaking 12 monthly HIV surveys of high-risk population groups, including male and female sex workers, men who have sex with men (MSM), male patients with sexually transmitted infections (STIs), and injecting drug users (IDUs). There is also one special survey site for the Armed Forces.

Limited special studies among military recruits and prenatal women carried out from 1995 to 1997 revealed no HIV infection at that time. Overall HIV-prevalence rates among sex workers have remained below an estimated 3 percent in all sites. The male to female ratio is 1.42:1. Male infections are concentrated in the 30-39 year age group, while female infections are concentrated among 19-29 year olds. HIV infection has been noted in all regions of the country, although it appears to be concentrated around large urban sites.

A behavioral surveillance system was put into place in 1995 with the same 10 sites used for serological surveillance and including the same target populations. Behavioral data from 1997 show increasing knowledge of AIDS and prevention practices, although high levels of risk behavior continue.

| <b>Risk Groups with Estimated HIV Prevalence <math>\geq</math> 1%</b>                         |
|-----------------------------------------------------------------------------------------------|
| <b>Registered Female Sex Workers</b><br>Quezon, Pasay, Angeles, Iloilo, Davao, General Santos |
| <b>Unregistered Female Sex Workers</b><br>Angeles                                             |
| <b>Men with STIs</b><br>Angeles, Cebu                                                         |
| <b>Male Sex Workers</b><br>Quezon                                                             |
| <b>Injecting Drug Users</b><br>Cebu                                                           |
| Source: Department of Health, 1997 Annual Report of the HIV/AIDS Sentinel Surveillance System |



Possible factors contributing to low prevalence of HIV infection in the Philippines include:

- Female sex workers have relatively few sexual partners,
- Filipino males have a relatively low exposure rate to female sex workers,
- There is a low incidence of ulcerative STIs,
- MSMs engage in more oral sex than anal intercourse,
- Injecting drug use is not as common as in other East Asian countries, and
- First sexual experience may occur at marriage, as a preference over premarital sex.

### **Women and HIV/AIDS**

The number of women with HIV in the Philippines is growing. Socioeconomic disparities between women and men increase women's vulnerability to HIV infection, in addition to women's greater biological susceptibility to infection. Women generally have less negotiating power and control over sexual relations, further compounding their vulnerability.

- An estimated 7,000 women aged 15-49 years were living with HIV at the end of 1997.
- The highest rates of HIV in the Philippines have been found in female sex workers.

Although limited sentinel surveillance has shown no HIV infection among pregnant women, surveys in antenatal, family planning and gynecological clinics show that 6 of every 100 pregnant women may be infected with gonorrhea or genital chlamydia. As studies indicate that individuals with an STI, particularly women, are at greater risk of HIV infection due to the presence of another STI, these pregnant women are increasingly at risk.

### **Children, Youth and HIV/AIDS**

The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV, and most will develop AIDS and die within two years.

- Thirty-eight percent of the population is under 15 years of age.
- An estimated 1,000 children under the age of 15 were living with HIV at the end of 1997.
- An estimated 480 children have become orphans due to AIDS since the beginning of the epidemic.

Adolescents are particularly vulnerable to HIV infection due to high-risk behaviors, such as early onset of sexual activities, multiple sex-partnering, low perception of personal risk, low condom use, and drug and alcohol use. Cultural norms inhibiting discussions related to sex and reproductive health, in addition to stigmatization by health care workers and a lack of reproductive health services designed for young people, compound adolescents' vulnerability to HIV infection.

## **SOCIOECONOMIC EFFECTS OF HIV/AIDS**

About 90 percent of reported AIDS cases are among 20-49 year olds. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise<sup>3/4</sup>even in low-wage, labor-intensive industries<sup>3/4</sup>as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector similarly feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to less labor-intensive crops. In many cases, this implies switching from export crops to food crops, thus affecting the production of cash and food crops.

There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when forced to care for sick family members. AIDS also adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level, there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children, and in the absence of grandparents, young children often become heads of households.

## **INTERVENTIONS**

### **National Response**

The government of the Philippines (GOP) established the National AIDS Prevention and Control Program (NAPCP) in 1987. The first Medium-Term Plan covered the years 1988-94, followed by a second Medium-Term Plan through 1999.

The main strategies of the NAPCP include:

- Continued monitoring of STI and HIV infection among identified sentinel groups and the general population;
- Institutionalization of HIV screening for all blood administered through the government's health care system;
- Promotion of health education to encourage safe behavior among vulnerable groups and the general population;
- Promotion of condom use among populations practicing high-risk sexual behaviors;
- Development of specific guidelines for the screening of all blood products used in the private sector, including private hospitals;
- Enforcement of appropriate sterilization practices for skin piercing instruments, including syringes and needles; and,
- Reduction of the impact of HIV/AIDS/STI on individuals, groups and society through education, counseling and social support.

In 1995, the National HIV/AIDS Strategy was developed by the Philippine National AIDS Council (PNAC), the multisectoral national policy and advisory body for all HIV/AIDS prevention and control activities in the country. The strategy, which was expanded and reprinted in 1998, articulates principles to which the national response should adhere and contains a series of nine policy statements based on international covenants relating to the protection of human rights and responding to the AIDS epidemic. Development of the strategy involved extensive consultations throughout the country.

*The AIDS Prevention and Control Act (also known as RA8504) was signed into law in February 1998. It creates a legal and policy environment in the Philippines that will be of considerable value in both preventing new infections and protecting the human rights and civil liberties of people living with HIV/AIDS. Passage of the Act was a major achievement for the government and the many partners in the Philippines responding to the epidemic and demonstrates a practical commitment to HIV/AIDS prevention and care that will be of wide interest internationally.*

The AIDS Prevention and Control Act places great emphasis on the role of prevention in the response to the epidemic. The prevention response strives to strengthen family values within a framework of tolerance and acceptance of individuality and to increase the availability and accessibility of condoms. A communication strategy developed by the Department of Health in 1992 details target audiences and methodologies to be used in prevention efforts. Target audiences include influential individuals (policymakers, politicians, health professionals, religious leaders, media practitioners, and entertainers), gatekeepers (teachers, media practitioners, health care workers, religious leaders, and civic organizations), and individuals at risk (overseas contract workers, sex workers, MSM and IDUs).

The government response also includes research activities, STI prevention and control through improved STI management and availability of quality services, condom social marketing, blood safety programs, care and support, and HIV/AIDS education and information. Education and information is provided in schools, the workplace and communities and targets Filipinos going abroad, tourists and transients, IDUs, children and youth, prison populations, the military, and the police.

## **Donors**

Multilateral and bilateral donors are actively engaged in the Philippines.

**USAID** is the largest contributor to the Philippine National AIDS Prevention and Control Program (NAPCP). USAID proposed HIV/AIDS funding for HIV/AIDS and other selected infectious diseases is \$4.4 million for fiscal year 2000. HIV/AIDS activities in the Philippines focus on institutionalizing public and private sector mechanisms for monitoring HIV prevalence and encouraging behaviors among target groups that reduce the individual risk for contracting or transmitting STIs and HIV. A key objective of the USAID program is to maintain the HIV-seroprevalence rates below 3 percent among registered female sex workers.

USAID is assisting the GOP's Department of Health, nongovernmental organizations (NGOs) and other government organizations to implement a national sentinel surveillance system to monitor the transmission of the disease and risk behaviors among high-risk population groups, develop and implement effective communication and behavior change programs about AIDS prevention before AIDS reaches major epidemic

proportions, and establish model sites for STI care and management. The program provides technical assistance, supplies, and materials for the effective delivery of information, education and communication (IEC) services to STI/HIV/AIDS high-risk groups through a network of NGOs, government organizations and private commercial sector groups. With USAID support, the GOP and NGOs will develop, implement and evaluate a set of STI interventions among groups with high prevalence of STIs in selected sentinel sites. USAID also supports analysis, dissemination of results, and implementation of advocacy efforts on policy and environmental and structural constraints to promoting STI/HIV prevention.

USAID's AIDS Surveillance and Education Project (ASEP) is a multiyear project (1993-2000) that channels support to the national AIDS program for surveillance and prevention education activities. The Program for Appropriate Technology in Health (PATH) was selected to manage the education and behavior change components of ASEP. Implemented through local NGO partners, ASEP/Behavior Change provides support for interpersonal outreach, mass media exposure, condom access, and harm reduction activities. Client groups include female and male sex workers, male clients of sex workers, MSM, IDUs, and sexually exploited children.

The aim of ASEP/Education is to institutionalize public and private sector mechanisms, to reduce STI/HIV risk behaviors, and to systematically build the capacities of local NGOs. Training activities have focused on project and financial management, behavioral research, media materials development, community outreach and peer education among sex workers and MSM, harm reduction for IDUs, STI prevention and syndromic management, condom distribution, and project reporting, monitoring, and evaluation.

*Since the national health department has recently been decentralized, ASEP has actively promoted NGO collaboration with city health departments. The combination of institutional strengthening and coalition building between public and private sector agencies has resulted in higher quality interventions and increased coordination.*

Family Health International's (FHI) Implementing AIDS Prevention and Care Activities (IMPACT) project is addressing gaps in ASEP, especially in understanding the STI problem and how to refine the prevention response to accelerate the efforts made to date. Activities include validating the syndromic approach to STI case management, establishing a national STI surveillance system and monitoring of antimicrobial resistance pattern of *Neisseria gonorrhoeae*, and conducting a population-based survey of male sexual behavior and health care seeking behavior.

Also under USAID funding, the International HIV/AIDS Alliance is working to link organizations to enhance their skills in behavioral change communication and transfer knowledge and best practices to other NGOs. The Alliance works through the Philippine HIV/AIDS NGO Support Program (PHANSuP) in the Philippines with projects designed to increase the role of PHANSuP in policy and advocacy, revitalize and expand the capacity of the PNAC, and involve youth and other community members in activities to help them reduce their vulnerability to HIV.

**The European Union (EU)** supports NGO projects to strengthen community-based responses to AIDS, improved STI patient management, workplace interventions, and strengthening planning and regionalization of the PNAC.

**The government of Japan** provides complementary assistance to USAID's ASEP project, including provision of test kits, and laboratory, computer, communication and IEC equipment. Japan is also supporting the establishment of a central STI/AIDS laboratory, strengthening of social hygiene clinics, IEC activities and training for government and nongovernment staff.

**The Netherlands** contributes STI drugs, contraceptives and condoms to urban and rural poor communities.

**The Australian Agency for International Development (AusAID)** supports NGO projects to strengthen community-based responses to AIDS and to improve STI management in model clinics in commercial sex areas in a few selected urban areas. AusAID also supports the Women's Health Training Project and the Urban Health and Nutrition Project of the World Bank.

**France** is supporting a comparative study of new AIDS treatments between developed countries and the Philippines, where HIV has not yet mutated.

**UNAIDS** established a Theme Group on HIV/AIDS to coordinate the response of UN agencies to the epidemic and provide assistance to the GOP in the strategic development and evaluation of activities. The Theme Group is comprised of members from the United Nations Development Programme (UNDP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the International Labour Organization (ILO), the World Health Organization (WHO), and the World Bank.

UNAIDS activities include:

- Advocacy,
- Resource mobilization,
- Identification and promotion of best practices,
- Mainstreaming of HIV/AIDS efforts into existing programs,
- Expansion of the national response to STI,
- Development of STI management models, validation of syndromic management algorithms, and pilot integration into family planning programs, and
- Needs assessment workshops.

**UNICEF** supports projects for youth and street children, integration of HIV/AIDS into youth health policy, and integration of HIV/AIDS into Barangay health care and Hilot manuals.

**UNDP** activities focus on awareness raising on the development implications of HIV, development of a framework for the protection of rights of persons living with AIDS (PLWAs), and capacity development for government, nongovernmental and PLWA organizations.

**UNESCO** provides technical advice to school curricula development.

**UNFPA** supports IEC, training and service delivery; reproductive health projects, including advocacy; integration

of STI/AIDS into family planning projects; and, technical assistance to local government units.

**The World Bank** supports two projects which include HIV/AIDS activities: the Women's Health and Safe Motherhood project and the Urban Health and Nutrition Project.

**WHO** provides support to the national HIV surveillance system and to the development of model community health/STI clinics.

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

A number of PVOs/NGOs implement activities funded by multilateral and bilateral donors. NGOs also receive funding from a variety of sources and carry out most of the HIV/AIDS prevention and care activities in the Philippines.

NGOs and community-based organizations (CBOs) have played a key role in responding to the HIV/AIDS epidemic, providing a range of services, including education and social support. The responses of NGOs/CBOs have been restricted in scale due to limited resources. Activities include interpersonal communications with target audiences, advocacy with government officials, counseling and support to PLWAs, information centers and provision of lecturers to academic institutions, training activities, and resource mobilization.

The HIV/AIDS Network Philippines, a coalition of NGOs working in HIV/AIDS prevention, was formed in 1992 to coordinate activities of NGOs and share resources and information.

## **CHALLENGES**

The Philippines faces considerable challenges in its fight against AIDS.

- There is a lack of commitment from local government units to AIDS prevention and care.
- Mobilization of national and local resources is needed to ensure the institutionalization of HIV-surveillance activities.
- Education of the general public (through national and local government officials) that STI/AIDS is not just a problem of female sex workers is needed.
- There is significant opposition to the promotion of condoms by some religious groups.
- A large migrant worker population exists—there are estimates of 6 million Filipinos working overseas in about 140 countries (mostly in the Middle East, Hong Kong, Taiwan, Japan, Singapore, and Malaysia).
- A large commercial sex industry exists throughout the country that is illegal but mostly tolerated by local authorities.
- There are high levels of casual and commercial sex among young people so that education should be a priority.
- Condom use is low.
- There are significant gaps in research, particularly relating to the sexual behavior of Filipinos.
- There is a high prevalence of STI, including hepatitis B and significant resistance of STI to antibiotics.
- STI drugs are not affordable and accessible to at-risk populations.

## **FUTURE ACTIONS NEEDED**

AIDS has become a major problem in the countries of Southeast Asia. The Philippines has been relatively spared until now, despite an active sex industry and a sizable population of injecting drug users. The country can still prevent the extensive spread of HIV and STIs in the general population if individuals engaging in high-risk behaviors can be persuaded to change their practices.

The majority of Filipinos with HIV infection have not yet developed AIDS. It is expected that up to 10,000 patients with AIDS will seek treatment from the health system within the next 5-10 years. In addition, the burden of caring for the orphans of persons who have died of AIDS will place significant stress on the extended family support system over the coming years. Community support systems, including strategies for the sustainable provision of care to PLWAs, need to be strengthened.

Advocacy activities are urgently needed to convince local officials of the importance of STI/HIV/AIDS prevention and care programs and to increase government commitment to prevention activities. An expanded multisectoral response involving all levels of government, the private sector and civil society is needed, in addition to continued aggressive public outreach campaigns and education interventions targeting key high-risk populations.

## **IMPORTANT LINKS AND CONTACTS**

1. National AIDS Prevention and Control Program, Dr. Marlene Borromeo, Program Manager; Tel/Fax: (63) 771-6693, E-mail: [aidsunit@pworld.net.ph](mailto:aidsunit@pworld.net.ph).
2. UNAIDS, Dr. Victor Mari Ortega, National Country Programme Adviser, c/o UNDP, NEDA sa Makati Building, 106 Amorsolo Street, Makati City 1229, Manila; Tel: (63) 289-20611, Fax: (63) 281-64061, E-mail: [mari.ortega@undp.org](mailto:mari.ortega@undp.org).
3. HIV/AIDS Network Philippines, Mr. Jeramie Diaz, Chairperson; 1066 Remedios cnr. Singalong St., Malate, Manila; Tel: (63) 524-0924, Fax: (63) 522-3431, E-mail: [nenetgem@pacific.net.com](mailto:nenetgem@pacific.net.com).

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# SRI LANKA AND HIV/AIDS

## TALKING POINTS

Sri Lanka is considered a low HIV/AIDS prevalence rate country with a seroprevalence rate of 37 per 100,000 (September 1998).

- The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that there has been a cumulative 1,900 cases of AIDS with 1,700 deaths, 400 of them in 1997.
- The United Nations Development Programme (UNDP) estimates that, by the year 2005, Sri Lanka could have as many as 80,000 cumulative cases of HIV infection with an HIV prevalence rate of 0.54 percent among the population aged between 15 and 64 years.

**Women and HIV/AIDS:** A campaign of awareness of HIV/AIDS and methods of its transmission and prevention focused on the female population could make a difference in how pervasive the spread of HIV/AIDS becomes in Sri Lanka. Women are literate, have access to free health services, and many are income generating.

**Children, Youth and HIV/AIDS:** The estimated cumulative number of orphans having lost their mother or both parents to AIDS is estimated by UNAIDS at 450, 390 of whom were alive at the end of 1997. The onset of the HIV/AIDS epidemic comes at a time when youth in Sri Lanka are encountering multiple risks and uncertainties. An increase in the age of marriage, access to international media, and opportunities for male-female interactions are challenging cultural traditions against premarital sex and discussions of sexuality.

**Socioeconomic Effects of HIV/AIDS:** Socioeconomic factors that may contribute to the impact of HIV/AIDS include the number of Sri Lankans working abroad, the predominant age group of infection (86 percent of HIV/AIDS cases in age range 20–49 years), and the economics of an aging population.

**National Response:** With high literacy and a well-established infrastructure of health services, Sri Lanka is in a strong position to prevent the spread of the pandemic with information, prevention, and control measures if steps are taken now to implement such a program. To date, however, low prevalence, in combination with competing high priorities (civil war), has resulted in a lack of government commitment.

**Donors:** The World Bank has an ongoing Health Services Project focusing on malnutrition, malaria, and sexually transmitted diseases (STD)/HIV/AIDS and reproductive health (US \$18.8 million, 1997–2002). The project has been implemented through the Ministry of Health, with nongovernmental organizations (NGOs) playing especially significant roles in the implementation of the STD/HIV/AIDS, nutrition and noncommunicable disease components.

# **SRI LANKA AND HIV/AIDS**

## **COUNTRY PROFILE**

A densely populated island country of 19 million people, nation-building in Sri Lanka has been strained by hostilities between the majority Sinhalese and the minority Tamils. A civil war waged by Tamil separatists in the country's northern and eastern regions since 1983 has exacted a heavy toll on human lives and the economy.

Sri Lanka has achieved notable success in human development despite its civil strife and low per capita income of \$690 (1997), according to the World Bank. With government commitment and good policies in education and health, many of Sri Lanka's social indicators compare favorably to those of more advanced economies. Life expectancy at birth is 72 years, compared to a regional average of 61 years. There is near universal literacy and primary school enrollment rates. Immunization for tuberculosis, diphtheria, pertussis, tetanus, polio, and measles ranged between 86 and 91 percent. Infant mortality is 17 per 1,000 live births; the death rate of children under 5 years of age is 19 per 1,000 (1996 figures). The population growth rate of about 1.2 percent annually is nearing the replacement level of fertility.

Primary health issues include the increased incidence of malaria, the appearance of HIV/AIDS, and persistent malnutrition in children (38 percent of children under 5 years are malnourished and 25 percent of infants have low birth weight). The incidence of malnutrition is highest in the North and East, the conflict zone, and the southern region.

Sri Lanka is largely an agrarian society with 88 percent of the people living outside urban areas. In the mid-1990's, many aspects of health services were decentralized to the provincial health departments. About 93 percent of Sri Lankans have access to basic health care. A health care delivery unit can be found, on average, within 1.4 kilometers (km) (one mile) of any home and a free Western-style health care institution within 5 km (3 miles). Although free health care services are provided, over half the population use the private sector, which includes traditional and Western-style health care. In 1997, the government spent approximately 5 percent of the gross national product on health. According to the World Bank, the private sector is already a major contributor to the health care system, but it will have to play an even larger partnership role in the delivery of health care services in the future.

According to a 1998 study by Sri Lanka's Institute of Policy Studies, the country is becoming one of Asia's most rapidly aging countries and the only such country in the South Asian subregion. By 2025, 20 percent of the population will be over age 60, compared with the current 8 percent. This population shift, known as the "epidemiological transition," will require adapting reapportioning health and social services to treat chronic and degenerative diseases of aging adults.

## **HIV/AIDS in Sri Lanka**

Sri Lanka is considered a low HIV/AIDS prevalent rate country with a seroprevalence rate of 37 per 100,000 (September 1998). With high literacy and a well-established infrastructure of health services, the country is in

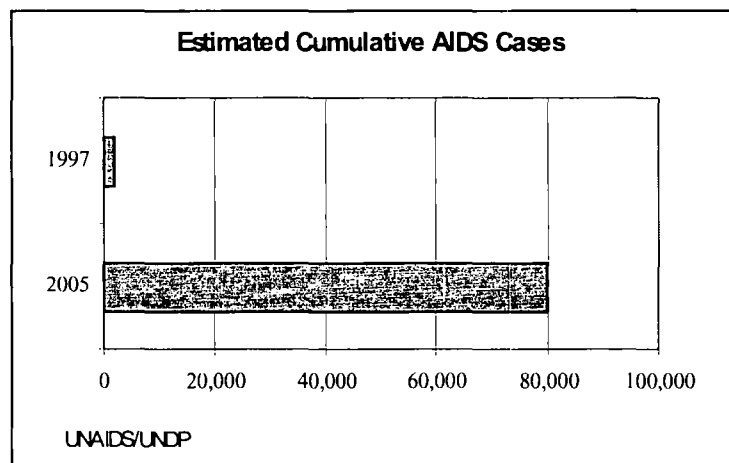
a strong position to prevent the spread of the pandemic with information, prevention, and control measures if steps are taken now to implement such a program.

The first case of HIV in Sri Lanka was detected in 1987.

- The number of HIV-positive cases has risen officially to 259 (November 1998).
- The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates 6,900 adults and children are living with HIV/AIDS (1997), 29 percent of whom are women (ages 15–49) and 3 percent children under 15 years of age.
- The age group most affected is between 20–49 years (86 percent).
- UNAIDS estimates that there has been a cumulative 1,900 cases of AIDS with 1,700 deaths, 400 of them in 1997.

The United Nations Development Programme (UNDP) estimates that, by the year 2005, Sri Lanka could have as many as 80,000 cumulative cases of HIV infection with an HIV prevalence rate of 0.54 percent among the population aged between 15 and 64.

Heterosexual relationships are the most common route of infection (84 percent). In addition to some 12,000 commercial sex workers (CSWs) on the island, tens of thousands of women and men live away from their families as migrant workers abroad and in the Free Trade Zones where casual sex rates are high. All donor blood is screened. The practice of collecting blood from professional donors has been virtually stopped. According to UNAIDS, in ad hoc screening of prisoners, drug users and military personnel, performed in 1998, no HIV-positive cases were detected.



HIV/AIDS is considered extremely contagious and many believe that even touching a patient would be a sure death sentence. Persons living with HIV/AIDS (PLWAs) and their families face not only the humiliation of social ostracism but limited health care. Even doctors and nurses in Colombo are known to refuse to attend to HIV/AIDS patients. People with AIDS are referred to the National Infectious Diseases Hospital in Mulleriyawa where, according to UNAIDS, medical and nursing facilities are reported to be poor.

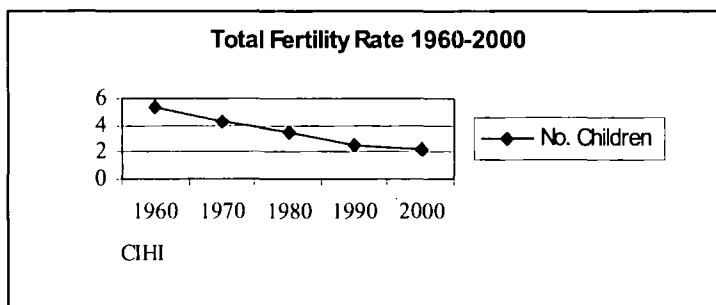
### Women and HIV/AIDS

A campaign of awareness of HIV/AIDS and methods of its transmission and prevention focused on the female population could make a difference in how pervasive the spread of HIV/AIDS becomes in Sri Lanka. Women in Sri Lanka have a relatively high social status compared to other countries in the region. They are literate and many are income generating, have at least basic education, access to free health services, and, at least among Sinhalese, have rights to own land and represent themselves in a court of law.

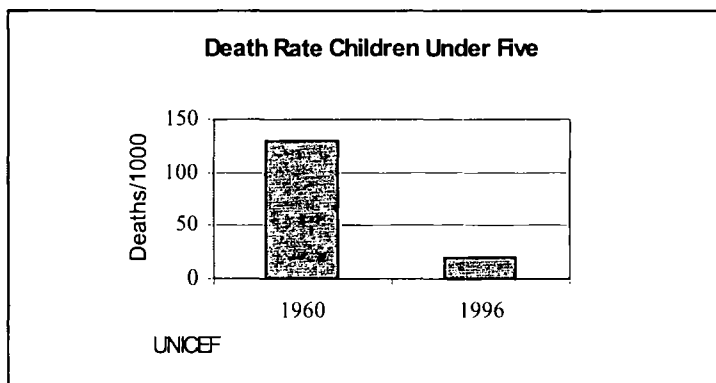
- The maternal mortality ratio in 1996 of 30 per 100,000 live births is well below that of countries with similar levels of per capita income.
- Ninety-four percent of births were attended by trained health personnel—at least one physician, nurse, midwife, or trained traditional birth attendant.

Although there is a high rate of contraceptive use and a low total fertility rate, thought to be due to availability of information and health services, in the view of a Sri Lanka representative of the United Nations Population Fund (UNFPA), the family planning success story has hidden reproductive health problems.

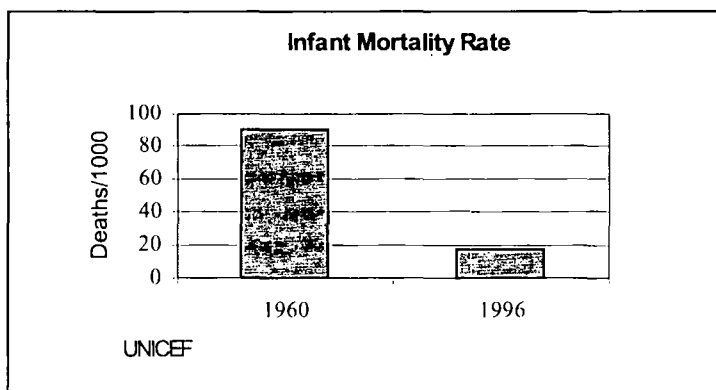
- 1997 infertility levels were between 10 and 12 percent.
- Anemia levels in pregnant women ranged from 59 to 74 percent.
- Health authorities estimated that between 500 to 600 illegal abortions are carried out daily in Sri Lanka, half of them for married couples, according to an official of the Family Planning Association.



According to a 1995 World Bank gender profile of Sri Lanka, there is a relatively high female labor force participation rate, doubling from the 1960's to 1990. The share of earned income in 1995 was 36 percent female and 64 percent male, very close to the 1995 U.S. ratio of 40 percent to 60 percent. An indicator of the economic importance of women is their dominance in the three sectors highest in foreign exchange earnings: the garment industry, remittances from the migrant workers in the Middle East, and the plantation sector, especially tea.



Poor women and women of ethnic minorities, particularly those in the estate sector, show higher maternal and infant mortality rates, and higher illiteracy and malnutrition rates, in contrast to other areas in the country.



### Children and HIV/AIDS

Thirty-five percent of the population is under age 15 years of age.

- The estimated cumulative number of orphans who have lost their mother or both parents to AIDS is estimated by UNAIDS at 450, 390 of whom were alive at the end of 1997.
- The number of deaths of children under five, due to all causes, has fallen 85 percent in the last 30 years, from 130 per 1,000 live births in 1960 to 19 per 1,000 in 1996.
- In the same time period, infant mortality has dropped from 90 per 1,000 births in 1960 to 17 per 1,000.

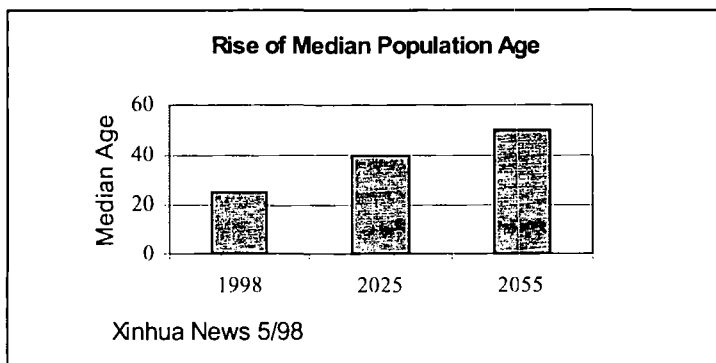
The sex trade in Sri Lanka includes children, known as beach boys. Nongovernmental organizations (NGOs) working in the area of child prostitution and pornography estimate that 5 percent of the 350,000–400,000 tourists arrive for the purpose of sex tourism.

### Youth and HIV/AIDS

The onset of the HIV/AIDS epidemic comes at a time when youth in Sri Lanka are encountering multiple risks and uncertainties. An increase in the age of marriage, access to international media, and opportunities for male-female interactions are challenging cultural traditions against premarital sex and discussions of sexuality. The high rate of school dropouts is putting more youth out of reach of information, education, and communication (IEC) campaigns via schools. There is an 80 percent failure rate for the ordinary level school exams taken at age 16.

An intervention study on sexual risks faced by young people, conducted for the International Center for Research on Women (ICRW) 1994–96, found that the most common sources of information perceived as useful in learning about sex were friends and school, television, and newspapers. In general, the role played by parents is minimal. In the survey sample, almost everyone had heard of AIDS, and while knowledge of transmission was satisfactory, nearly 43 percent believed that “condoms are only for birth control.”

According to the study, female virginity is an important issue in traditional Sri Lankan culture, although both males and females appeared concerned more about protecting the reputation and social status of a woman’s virginity, if not the biological aspects. Due to lack of awareness of risks of behaviors, a number of nonpenetrating, but nevertheless unsafe, sexual practices are common. The research findings highlight the different worlds of young males and females in access to information and advice and ability to communicate about sexuality and safe behavior. The restriction in “ways of knowing” for women in combination with the difference between males and females in the level of sexual behavior is reflected in gender differences in knowledge about sexuality, sexual risk, and risk reduction, and in perception of future sexual risk. Community youth—females in particular—are less knowledgeable about HIV/AIDS and risky sexual behavior compared with university males and females. Nineteen percent of the population is between 15 and 24 years of age.

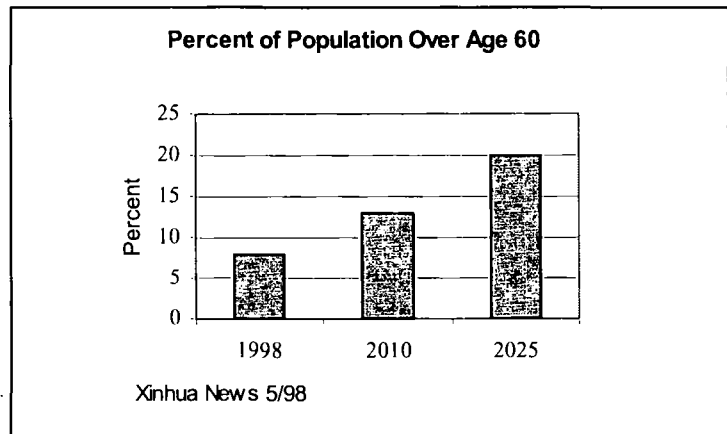


## SOCIOECONOMIC EFFECTS OF HIV/AIDS

Socioeconomic factors that may eventually contribute to the impact of HIV/AIDS include the number of Sri Lankans working abroad, the predominant age group of infection, and the economics of an aging population.

In 1996, over 160,000 people were employed abroad. Most of the females who have tested positive for HIV in Sri Lanka have been returnees of foreign employment. According to UNAIDS, 86 percent of HIV/AIDS cases have been in the most productive years—those aged 20 to 49 years.

Sri Lanka's successful family planning programs and efficient health services, coupled with economic factors, have made a significant impact on the country's demographic picture. Sri Lanka's population is aging faster than any other Asian country, according to a 1998 UNDP report. The report estimates that over the next two decades, the workforce will shrink, while the number of the elderly will double.



Currently, the average Sri Lankan is 25 years old, but by 2025, when the population is projected to stabilize at 21 million, the median age will be 40. By 2025, the population over age 60 will be 20 percent compared to the present 8 percent.

The Institute of Policy Studies reports that this rapid aging will have major socioeconomic and political consequences, not for the aged alone, but for the child, youth, and working age populations, too. An HIV/AIDS epidemic, predominantly affecting the breadwinners, will enhance these consequences.

## INTERVENTIONS

### National Response

The National AIDS Committee (NAC), established in 1992, is chaired by the Director General of Health Services, Ministry of Health and Indigenous Medicine (MOH). The NAC is multisectoral with representatives from the private sector, the police, the Department of National Planning, the Ministry of Education, the Ministry of Information, the National Youth Service Council, the Commissioner of Labor, the Federation of Chambers of Commerce, and various members of the National STD/AIDS Control Program (NSACP). In attendance at meetings are representatives from the World Health Organization (WHO), UNDP, UNFPA, the United Nations Children's Fund (UNICEF), USAID, the Director of the Respiratory Diseases Control Program, and the Director of the National Blood Transfusion Service.

The NAC coordinates most activities carried out by the government related to HIV/AIDS. It decides on policy related to HIV/AIDS prevention control and care. Presently, there are subcommittees on NGOs, legal and ethical issues, laboratory and surveillance, care and counseling, and information, education, and commu-

nication. The National AIDS Control Program (NACP), within the MOH, functions as the executive secretariat of the NAC. Overall responsibility rests with a full-time program coordinator.

A National AIDS Plan was endorsed by the MOH in 1994, with a particular focus on sexually transmitted diseases (STDs). The National STD/AIDS Control Program, headed by a full-time director, is the main implementing body for HIV/AIDS activities which are carried out with the assistance of the provincial directors of health services, the National Blood Transfusion Service, and NGOs. The capacity for implementation is hindered by inadequacies in facilities and staff (e.g., medical officers, lab technicians, clerks). HIV/AIDS activities are building on the infrastructure of the campaign against STDs, which was primarily a clinical program rather than a public health program prior to 1985.

There are seven sentinel sites where surveillance is conducted annually to monitor trends in HIV infection. Anonymous testing is done on female sex workers and users of STD clinics, patients newly diagnosed with tuberculosis, voluntary blood donors, and those attending antenatal clinics. HIV/AIDS-related research is being conducted on law and ethics, economic impact, and epidemiology. Institutions include the Center for Policy Research and Analysis (CEPRA), the Human Rights Center, the Economics Department, and the medical faculty of the University of Colombo; the departments of microbiology of various medical faculties; and, the Medical Research Institute.

Guidelines have been established and approved by NSACP on issues related to partner notification, confidentiality and contact tracing. Prevention strategies include IEC through the mass media, increased promotion of condom use, voluntary counseling and testing services established in family planning centers, involvement of family planning associations in teacher training on AIDS, and HIV/AIDS information integrated into the curriculum of all government schools. However, the political will to make radical changes, such as open condom promotion and regularization of commercial sex work, has not been visible.

More than 72 percent of all condoms in 1993 were made available through the social marketing program of Family Planning Association of Sri Lanka (FPASL) (7.3 million) and over 24 percent through government outlets and field workers (2.5 million). Condoms distributed through family planning clinics most frequently reach reproductive age women, not other at-risk populations.

A Presidential Task Force on Health Reform will provide guidance on changes needed in coping with the evolving demographic shifts. With adolescents comprising a significant proportion of the population, the government in 1996 appointed an intersectoral Steering Committee on Adolescent Reproductive Health to address important issues.

## **Donors**

USAID's goal in Sri Lanka since 1997 has been economic growth with complementary activities in human rights. The fiscal year (FY) 1998 funding request was US \$3 million, and US \$1.5 million for FY 1999. USAID continues to provide humanitarian assistance through the War Victims Fund and the Displaced Children and Orphans Fund under the Bureau for Global Programs, Field Support and Research.

Other multilateral and bilateral donors are also actively engaged in Sri Lanka.

**The World Bank** has an ongoing Health Services Project focusing on malnutrition, malaria, and STD/HIV/AIDS and reproductive health (US \$18.8 million, 1997–2002). The project has been implemented through the Ministry of Health, with NGOs playing especially significant roles in the implementation of the STD/HIV/AIDS, nutrition and noncommunicable disease components.

**The Netherlands, Multilateral Development Cooperation Department** supported the Family Life Education Project, through UNFPA, from 1993 to 1997, with NLG904,000. The project provided education and information to teachers, students, and parents to prevent the spread of HIV/AIDS.

**The Norwegian Organization for Relief and Development (NORAD)** supported the HIV/AIDS education programs of Worldview International Foundation with \$1,249,000 in 1997.

UNAIDS has a coordinating theme group based in Sri Lanka. The group, chaired by UNFPA, includes representatives from UNDP, UNFPA, UNICEF, WHO and the World Bank. UNAIDS has supported activities including production of advocacy materials, support for HIV/AIDS education and awareness programs, counseling programs, workplace seminars, provision of HIV test kits for surveillance, condom purchase and distribution, and the development of IEC materials on STDs.

*Nest workers persuaded hospital authorities to allow a dying AIDS patient to return home, which is not the normal practice. He had tears of gratitude in his eyes when he got home and died half an hour later. Since a Muslim must be buried within 24 hours, Nest stepped in to speed up the normally lengthy paper process, and even paid for funeral expenses, as the relatives were reluctant to touch the body.*

—Sally Hulgalle, Nest

**WHO** has worked with the Ministry of Health by strengthening program management on a project to promote safer sexual behavior and practice, to prevent HIV transmission through blood and skin piercing instruments, to reduce individual and social impact of HIV/AIDS infection, and to improve surveillance.

**The UNDP** has supported a national consensus workshop to develop a work plan for 1998–99 and IEC and surveillance activities.

**UNICEF** supports school health clubs and IEC programs targeting Free Trade Zone workers and Armed Services.

**UNFPA** has funded Family Life Education programs in schools and condom promotion.

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

There are about 85 NGOs working among persons living with HIV/AIDS (PLWAs) in Sri Lanka.

**Nest** provides counseling and care for PLWAs and is probably the only group that looks after the families of PLWAs, even after the person dies.

**The Community Front for the Prevention of AIDS (CFPA)** is an advocacy group organizing seminars and counseling services in Colombo and in southern beach resort towns which draw thousands of tourists every year. CFPA trains beach boys and female sex workers with leadership qualities to be counselors, peer educators, who in turn talk to others, making them aware of AIDS, other sexually transmitted illnesses, and the need to use condoms.

**The Don Bosco Center**, run by the Salesians, also target the beach boys with counseling and vocational training to help them find employment in a suitable trade.

**Alliance Lanka**, a member of Alliance International, has worked in capacity building of over 70 NGOs and community-based organizations (CBOs).

**Worldview International Foundation** provided HIV/AIDS education for 3,000 three-wheel drivers and an HIV/AIDS education program of seminars using teledrama for inmates in Colombo prisons.

## CHALLENGES

Although HIV/AIDS has a very low profile at this point, many consider its spread inevitable. With a well-established health delivery system and near universal literacy and school enrollment, Sri Lanka is in a position to keep the disease in check. In preparation for an effective prevention and control program, a number of factors need to be taken into consideration.

- Political will and top-level commitment are essential in addressing an epidemic. Low prevalence, in combination with competing high priorities (civil war), have resulted in a lack of government commitment.
- The NSACP would benefit from increased staff, appropriate office space, and logistical support. Donor funds available are not being fully used.
- Able and experienced NGOs are already part of the national response. With over 85 NGOs getting involved in HIV/AIDS-related activities, sustainability of projects will be a challenge without financing, coordination of efforts, and capacity building.
- Activities will be most effective if the government and NGOs work together in a collaborative approach.
- The private sector will have to become actively involved in the campaign against HIV/AIDS.
- Misinformation, myths, and discrimination against same-sex partners and PLWHs would best be addressed in all IEC efforts, starting with national leadership.
- Only a small percent of the sexually active population report using condoms.
- An approach targeting youth would include sex education and counseling in schools and for out-of-school youth, establishing a peer counselor program, and utilizing the infrastructure of the workplace, youth organizations, recreational centers, and religious institutions to create effective outreach and youth involvement.
- To protect children, the sex tourism industry will have to be targeted.
- Religious groups are integral to successful high-risk behavior change efforts. Currently there is strong opposition to condom promotion from Buddhist and Christian clergy.
- Advertising of condoms in the mass media is restricted.

## **IMPORTANT LINKS AND CONTACTS**

1. National AIDS Committee, Director General of Health Services, Ministry of Health and Indigenous Medicine.
2. National STD/AIDS Control Program (NSACP).
3. UNAIDS National Program Advisor, Dr. Hemamal Jayawardena, c/o UNFPA, 202 Bauddhaloka Mawatha, Colombo; Tel: (94) 1-58-08-40, Fax: (94) 1-58-06-98.

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# VIETNAM AND HIV/AIDS

## TALKING POINTS

Vietnam lies in the Mekong region of Southeast Asia where the incidence of HIV/AIDS is growing rapidly as economic development and transportation links increase mobility within and between countries. Vietnam has a low 0.22 percent HIV-prevalence rate, with 65 percent among injecting drug users (IDUs). A cumulative 11,681 HIV-positive cases had been recorded by January 1999, but there were an estimated 64,000–78,000 infections projected to double by the year 2000. Because Vietnam invested early in primary health care, 90 percent of the population has access to health care, and there is an existing infrastructure in which to build an HIV/AIDS prevention and care program.

**Women and HIV/AIDS:** At the end of 1997, 19 percent of HIV/AIDS cases in Vietnam were among women aged 15–49 years. A high abortion rate is one indication of unprotected sex. Economic hardship and increasing poverty are driving more women into sex work with single, female heads of households (32 percent) the most vulnerable.

**Children and HIV/AIDS:** An estimated 1,900 children (under 15 years old) have lost their mother or both parents to AIDS since the beginning of the epidemic. Thirty-five percent of the population is under 15 years of age.

**Youth and HIV/AIDS:** According to the “Consensus Report on STI, HIV, and AIDS Epidemiology 1998,” proportions of female and younger age groups are increasing among reported HIV infections. Coercion, trafficking, and economic need are factors leading young, unemployed women in the cities into prostitution. Twenty percent of abortions in Vietnam are among women under 20 years of age.

**National Response:** Vietnam has a National Strategic Plan for the Prevention and Control of HIV/AIDS in place (1994–2000). There is an active National AIDS Committee (NAC), comprised of 16 ministries and 5 national organizations. The National AIDS Bureau and its 20 full-time staff act as the NAC’s Secretariat. A sentinel surveillance system is in place with 20 sites. Vietnam spends approximately 5 percent of its gross domestic product on health and, in 1998, allocated US \$4.8 million to HIV/AIDS activities.

**Donors:** The Joint United Nations Programme on HIV/AIDS (UNAIDS) and its cosponsors, along with numerous bilateral donors, support HIV/AIDS activities with financing and technical assistance. The UNAIDS HIV/AIDS group is a networking body, including donors, government agencies, international nongovernmental organizations (INGOs), and national groups. Donors implement activities through government agencies, INGOs, provincial AIDS committees (PACs), nongovernmental organizations (NGOs), and private voluntary organizations (PVOs).

# VIETNAM AND HIV/AIDS

## COUNTRY PROFILE

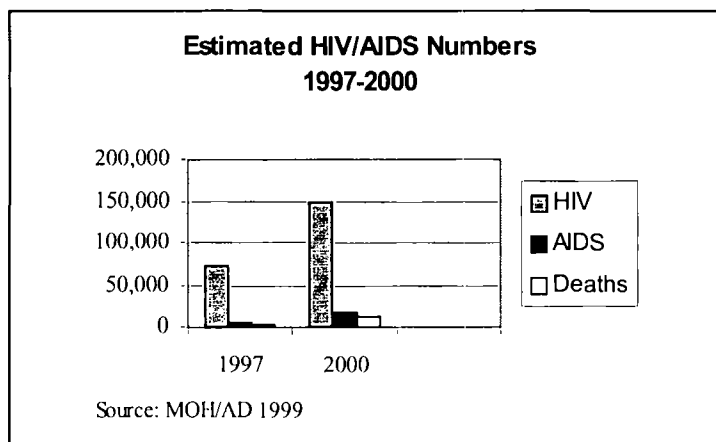
Vietnam lies in the Mekong region along with Cambodia, Lao People's Democratic Republic (PDR), Thailand, Myanmar, and the Yunnan Province of China. Vietnam has a population of 79.5 million, 50 percent of whom are between 15–49 years of age. The country has a rural society with 80 percent of the people living outside urban areas. Life expectancy is 66 years of age, which is relatively high for a post-war, low-income situation. The adult literacy rate is high for the region at 92 percent and there is a high level of education enrollment with only slightly lower figures for females than males. The 1997 gross national product is \$310, one third of the East Asia and Pacific region average. Fifty-one percent of the population live below the national poverty line.

Due to early investment in primary health care, Vietnam has relatively high levels of health status for a low-income country. All urban dwellers and 80 percent of the rural population have access to health services. Trained health personnel attend 95 percent of births. Infant mortality (33/1,000 live births) and under-5 mortality (44/1,000) fare better than other low-income countries (66 and 94, respectively). According to the World Bank, malnutrition remains a problem at 45 percent in children under 5 years of age. The population growth rate of 1.8 percent (compared with 3.2 percent at the beginning of the 1990's) gives a realistic hope that the replacement level fertility will be reached by 2005. The immunization rate for tuberculosis, diphtheria, pertussis, tetanus, polio, and measles is in the high 90th percentile. Vietnam spends approximately 5 percent of its gross domestic product on health care.

## HIV/AIDS in Vietnam

The first case of HIV infection was reported in December 1990 and the first cases of AIDS were defined in 1993. Vietnam is still at the early phase of a heterosexual HIV epidemic with very low HIV prevalence (0.22 percent) among the general public.

- By January 1999, 11,681 HIV-positive cases had been reported in all of Vietnam's 61 provinces, with a total of 2,231 AIDS cases, including 1,180 deceased.
- According to Ministry of Health (MOH) estimates, however, by the end of 1997 there were, more realistically, 64,000–78,000 HIV infections, with 3,000–5,000 having developed into AIDS and 2,000–4,000 deaths due to AIDS.
- By the year 2000, the cumulative number of HIV infections is projected to double, reaching 135,000–160,000, with 14,000–



21,000 cases of AIDS and 10,000–15,000 deaths due to AIDS.

- Injecting drug users (IDUs) make up 65 percent of HIV infections and 46 percent of AIDS cases.
- Eighty-five percent of reported HIV-positive cases are among males.
- The majority of HIV infections occur in young adults: 38 percent are 20–29 years old, 30 percent are 30–39, and 20 percent are 40–49.

### Risk Group Profile

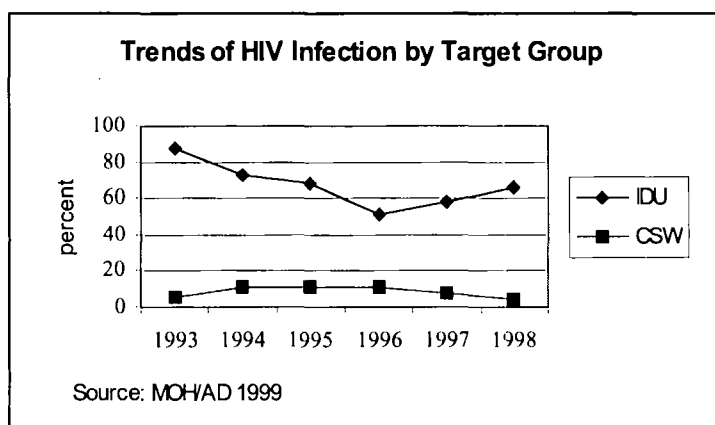
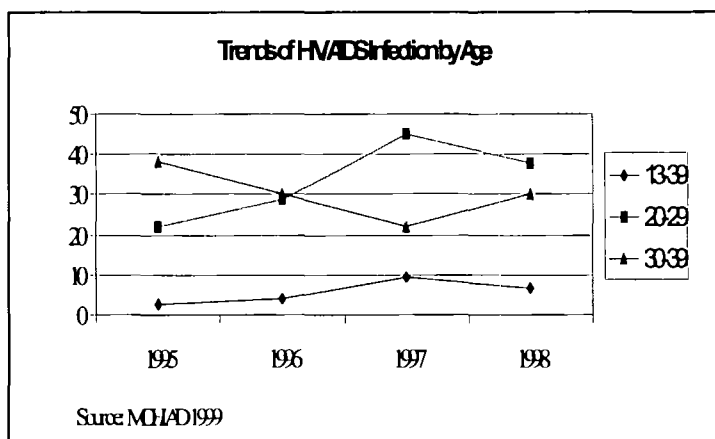
HIV infection is predominantly and rapidly being transmitted among IDUs—65 percent of HIV-infected persons. There has been low HIV prevalence, 4.5 percent, among commercial sex workers (CSWs) and patients with sexually transmitted infections (STIs) at 3 percent.

- STIs are seen as highly stigmatized social illnesses.
- An estimated one million new cases of STIs occur every year in the general population, with a predominance of chlamydial infections.
- Between 1996 and 1997, there was a 50 percent increase in reported STI cases.

The incidence of HIV/AIDS is growing rapidly in the Mekong as economic development and transportation links increase mobility within and between countries and once isolated rural people. Prevalent in these border areas are bars and low-fee commercial sex, with male clients in the transport and construction industries rapidly spreading HIV throughout the country.

### Knowledge and Behavior

A 1995 study of knowledge of HIV-preventive practices found that 78 percent of individuals between 15–49 years of age knew at least two acceptable methods of protection. Condom use, at 30 percent, revealed the difference between knowledge and behavior. Reportedly, condom use has increased since this study to 50–60 percent.



Many people believe that HIV/AIDS is a disease of foreigners only. CSWs believe that they are not at risk for HIV/AIDS because they can visually inspect genitalia to determine if someone has a disease. CSWs are reluctant to seek services or talk openly about STIs because their work is illegal.

### **Women and HIV/AIDS**

At the end of 1997, 19 percent of HIV/AIDS cases in Vietnam were among women aged 15–49. The median HIV prevalence in women at antenatal clinics is nil.

Intrauterine devices (IUDs) and legal abortion have been the most common practices for family planning in Vietnam, which has a very high abortion rate, thought to be 83 per 1,000 women. Officials attribute the high abortion rate to a shortage of affordable condoms, the social stigma attached to them, and a growing permissiveness towards sex before marriage. Unprotected sex increases the risk of HIV infection.

Women constitute 52 percent of the population of Vietnam, and in 1995, represented 42 percent of the earned income, compared with 37 percent in Thailand and 40 percent in the United States. Economic hardship and increasing poverty are driving more women into sex work. Recently divorced and widowed women (single, female heads of households) are the most vulnerable. Thirty-two percent of households are headed by females.

### **Children and HIV/AIDS**

With the recent economic downturn throughout Southeast Asia, many youth have dropped out of school, with the highest decline in young girls. The more young people who enter adulthood lacking employable skills, the more likely they are to drift into risk behaviors, such as drug use and sex work. Children bear the brunt of economic hardship and demise of the family structure when HIV/AIDS enters the family.

- An estimated 1,900 children (under 15 years old) have lost their mother or both parents to AIDS since the beginning of the epidemic.
- Thirty-five percent of the population are under age 15.

### **Youth and HIV/AIDS**

In a 1995 National AIDS Program study of knowledge of HIV-related preventive practices, 78 percent of males and 73 percent of females in the age group 15–29 years knew at least two methods of protection from HIV infection. However, only 13 percent of males and 9 percent of females reported condom use during their most recent sexual relations.

- The proportions of female and younger age groups among reported HIV infections are increasing and, among reported HIV infections, females are younger than males.
- Coercion, trafficking, and economic need are prevailing factors leading young, unemployed women in the cities into prostitution.
- An estimated 20 percent of the abortions in Vietnam each year are performed on women under age 20—an indication of increased sex among teenagers as well as unprotected sex.

## INTERVENTIONS

### National Response

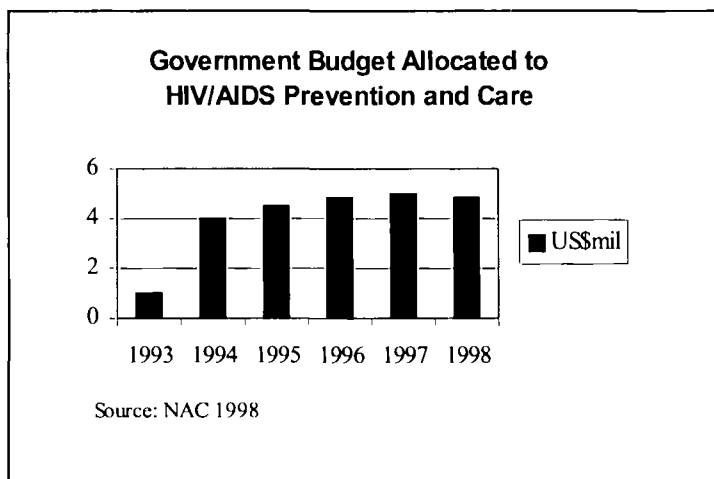
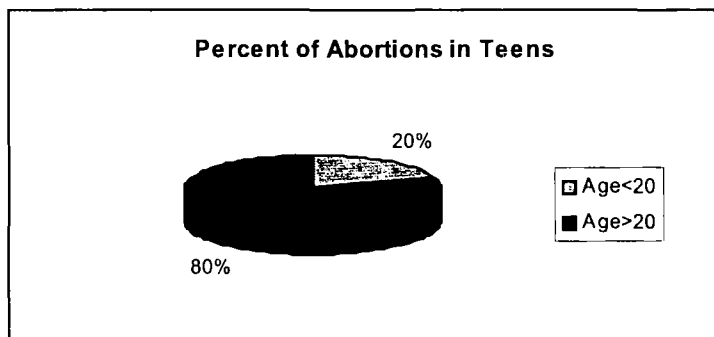
A National Strategic Plan for Prevention and Control of HIV/AIDS in Vietnam (1994–2000) was developed by the MOH. Priority interventions included:

- Promotion of safer sexual behaviors, including the use of condoms;
- Provision of condoms;
- Promotion of STI health-seeking behavior;
- Ensuring safe and efficient STI care services;
- Implementation of an education program for IDUs;
- Ensuring safe blood transfusion; and,
- Preparation of comprehensive care for HIV-infected persons and their families.

The National AIDS Committee (NAC) was established in 1990 with responsibility for the formulation of policy, planning, and allocation of financial resources and management in the prevention and control of HIV infection. Since 1994, the NAC has been chaired by the deputy prime minister. The National AIDS Bureau (NAB), with 20 full-time staff, is the Secretariat for the NAC. Members of the NAC include 16 ministries and organizations, including the Ho Chi Minh Communist Youth Union, the Vietnam Women's Union, the Vietnam Trade Union, the Vietnam Fatherland Front, and the Red Cross Society. The NAC participates in the Association of Southeast Asian nations (ASEAN) Regional program on HIV/AIDS.

There are 61 Provincial AIDS Committees (PACs) and centers for preventive medicine and health service centers in all 61 provinces. A number of medical and social research institutions play an integral role in the government's prevention and care programming.

The HIV/AIDS sentinel surveillance system with 20 sites was established in 1994. Target groups include IDUs, CSWs, STI patients, tuberculosis patients, pregnant women, and military recruits. Cross-sectional



surveys are repeated every 6 months for CSWs, IDUs and STI clinic attendees, and every 12 months for other groups.

Information, education and communication (IEC) efforts through mass media have targeted those with high-risk behaviors. Until recently, the practice of categorizing people, such as CSWs and IDUs, as participating in illegal behaviors and portraying the activities as “social evils,” encouraged discrimination and inhibited prevention and care measures among these groups. HIV/AIDS education programs are included in school curricula in grades 5, 9, 11 and at university. Annually, 35–40 percent of the total HIV/AIDS budget is allocated to IEC. Peer education is used widely throughout the country.

The government recognizes the need for counseling and support services for HIV/AIDS patients. Persons living with HIV/AIDS (PLWHAs) are rejected due to the stigma, and others have been forced to leave their jobs and/or homes due to discrimination. Provincial authorities are working with the NAB and MOH to establish services at medical prevention centers, large STI clinics, blood collection facilities, drug rehabilitation centers, and through community-based networks. Severe or complicated cases are sent to hospitals for care and treatment. Due to the limited budget, there is a lack of training in handling HIV/AIDS cases at all levels and lack of skills, experience, equipment, and drugs for clinical management of severe cases.

Quarterly coordinating meetings of all governmental and nongovernmental organizations (NGOs) are held both in Hanoi and Ho Chi Minh City.

### **Donors**

The government budget for the NAC is limited and many programs are dependent on external financing. Multilateral and bilateral donors are actively engaged in HIV/AIDS activities in Vietnam. Activities are implemented through international nongovernmental organizations (INGOs), provincial AIDS committees (PACs), local-NGOs, private voluntary organizations (PVOs), ministries, and United Nations agencies. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) HIV/AIDS group, each bilateral organization contributed in the following ways.

**USAID** has no mission in Vietnam, but HIV/AIDS activities are currently taking place under the Implementing AIDS Prevention and Control Activities (IMPACT) project, funded by the Asia/Near East (ANE) Bureau. Regional initiatives in counseling and crossborder activities are also taking place.

**The German Development Agency (GTZ)** promotes and supports safe behavior regarding HIV/STI transmission and promotes STI prevention measures, diagnostic procedures and appropriate therapy (US \$1,350,000, December 1995–June 2000). GTZ partners in these activities with the National AIDS Committee and the provincial AIDS committees.

**The European Community (EC)** financed the production of a 30-part television soap opera on HIV/AIDS prevention through CARE, funded the development of HIV/AIDS brochures and curricula for students, supported Save the Children/United Kingdom in capacity building of organizations working in HIV/AIDS (EC, SCF/UK, OXFAM/HK US \$689,000 since 1994), and promoted outreach activities to CSWs and IDUs (US \$30,000, 1994–99).

**The government of the Netherlands** has funded the United Nations Children's Fund (UNICEF), NGOs, ministries, and PACs for HIV/AIDS activities in the Mekong Region; HIV/AIDS and tuberculosis; and, administration capacity building. It is funding a 1997–2000 youth health development and HIV/AIDS prevention project with US \$888,000 through the Ministry of Education and Training (MOET) and the Vietnam Red Cross.

**The Canadian Fund** has financed NGOs and PACs in producing a behavior change video; HIV/AIDS counseling and support training for health center workers; IEC for former CSWs through theater groups; HIV/AIDS education activities for youth and restaurant workers; and, attendance by policymakers at international AIDS conferences.

**The Australian Agency for International Development (AusAID)** has funded community workshops with the American Red Cross for youth (18–25 years old) on sexual health, HIV/AIDS and other STI prevention run by youth trainers in districts and communes (US \$800,000, 1995–2001); promoted HIV/AIDS awareness in the business community; developed peer counselors among at-risk targets; supported assertiveness training for women; and, funded HIV/AIDS IEC activities through film, video, street theater, and print.

UNAIDS has a coordinating theme group based in Vietnam known as the UNAIDS Action Group. The group, currently chaired by UNICEF, includes representatives from the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), UNICEF, all partners in the NAC, the World Bank, the United Nations International Drug Control Programme (UNDCP), bilateral donors, and NGOs. UNAIDS' role includes advocacy, coordination, resource mobilization, joint planning and programming, monitoring, and evaluation.

| Agency                                   | Amount in U.S. Dollars | Period     |
|------------------------------------------|------------------------|------------|
| UNFPA                                    | 2,000,000              | 9/98–2/01  |
| UNDP                                     | 1,000,000              | 1/96–12/97 |
| UNDCP                                    | 635,086                | 1/98–12/00 |
| UNICEF                                   | 850,000                | 6/96–12/99 |
| UNAIDS                                   | 200,000                | 1/96–12/97 |
| <b>Total</b>                             | <b>4,685,086</b>       |            |
| <i>United Nations Support, 1996–2000</i> |                        |            |

UNAIDS HIV/AIDS activities have included capacity building in coordination, planning and management; IEC through mass media; incorporation of HIV/AIDS into reproductive health activities; training provincial/district workers in blood safety; condom social marketing and condom supply; community care of PLWHAs; and, harm reduction programs. UNAIDS hosts an annual retreat to plan its country strategy with the National AIDS Committee and various members of the international community.

#### **Private Voluntary Organizations (PVOs), Nongovernmental Organizations (NGOs), and International Nongovernmental Organizations (NGOs)**

An NGO consortium of nearly 100 members is the focal point for sharing information among NGOs. The NGO Resource Center publishes a directory detailing the activities of over 200 organizations working in

Vietnam. An HIV/AIDS working group of NGOs meets regularly each month. NGOs receive funding from a variety of sources.

A number of INGOs and PVOs implement activities funded by multilateral and bilateral donors. There is a monthly working group meeting of international NGOs in Hanoi. DKT International, an INGO, and NCPFP, a government family group, have been funded up to US \$ 1 million per year (1996–2000) for the social marketing of condoms with more than 30 million distributed in 1996 alone. Other major INGOs and PVOs working in Vietnam include CARE International, the Population Council, Save the Children Fund/United Kingdom, and Family Health International.

## **CHALLENGES**

Major constraints to HIV/AIDS care and prevention in Vietnam include the following:

- Although the NAB does not adhere to the “social evils” approach, some government agencies have not yet accepted a public health approach to HIV prevention, and, consequently, it is difficult to promote effective HIV/AIDS prevention when those most vulnerable (CSWs and IDUs) are stigmatized.
- Because the epidemic is still largely invisible, people need continuously reinforced prevention messages.
- There is a shortage of affordable condoms and a stigma is still attached to their use.
- The socioeconomics of poverty and development create an environment in which the sex trade and drug abuse proliferate.

The following additions may complement and support the government’s programming in its response to HIV/AIDS in Vietnam:

- Developing human resources at all levels of the AIDS prevention and care network;
- Improving capacity and skills in counseling, support and care for PLWHAs and their families at the community level;
- Building private and business sector relationships in HIV/AIDS prevention;
- Providing economically viable training and credit opportunities for widowed, divorced and other single female heads of households;
- Improving the prevention and care for STIs; and,
- Strengthening the harm reduction programs targeting IDUs and CSWs.

## **FUTURE ACTIONS NEEDED**

Vietnam is still on the edge of the HIV/AIDS epidemic. The government of Vietnam has made considerable progress in laying the groundwork for dealing with the epidemic. As the challenge grows, so will the need for additional financing for HIV/AIDS prevention and care activities. NAC priorities for 1999–2000 include:

- Increasing NAC capacity to assess, coordinate, supervise and manage national HIV/AIDS activities;

- Improving counseling, support and care skills and services for PLWHAs (includes setting up national and regional AIDS hotlines);
- Improving harm reduction programs targeting IDUs and CSWs;
- Developing partnerships with the private sector; and
- Strengthening campaigns for condom promotion, distribution, and use.

## **IMPORTANT LINKS AND CONTACTS**

1. National AIDS Committee (NAC), Prof. Do Nguyen Phuong, Permanent Vice-Chairman of NAC, Ministry of Health, Hanoi.
2. Vice Chair of the NAC and Director of the National AIDS Bureau (NAB), Prof. Chung, Ph.D.
3. Ministry of Health: AIDS Division, Prof. Nguyen Van Thuong 138 Gian Vo Street, Hanoi; Tel: (84) 4-846-0133, E-mail: moh aids@netnam.org.vn.
4. UNAIDS Country Program Advisor, Dr. Laurent Zessler, c/o UNDP, 25-29 Phan Boi Chau, Hanoi; Tel: (84) 4-846-0739, E-mail: kraus@netnam.org.vn.

# THAILAND AND HIV/AIDS

## TALKING POINTS

Since the first case of AIDS was detected in Thailand in September 1984, HIV has extended beyond the high-risk groups (sex workers and their clients, and injecting drug users) into the general population. The Joint United Nations Programme on AIDS (UNAIDS) has reported the following estimations for the end of 1997:

- There are 770,000 adults ages 15–49 years living with HIV/AIDS, representing 2.23 percent of the adult population.
- Since the beginning of the epidemic, 260,000 cases of AIDS have occurred among adults and children.
- By the year 2000, the cumulative number of HIV infections is projected to be 1.3 million.
- 230,000 AIDS-related deaths have occurred among adults and children since the beginning of the epidemic and 60,000 AIDS-related deaths occurred in 1997 alone.

**Women and HIV/AIDS:** At the end of 1997, an estimated 290,000 women (ages 15–49 years) were living with HIV/AIDS. HIV prevalence among sex workers was estimated at 25.8 percent outside major urban areas and 13 percent in major urban areas. In northern provinces in 1996, prevalence among sex workers was found to be as high as 60 percent.

**Children, Youth and HIV/AIDS:** The HIV/AIDS epidemic has a disproportionate impact on children. The current child mortality rate from AIDS is 13 percent higher than it would have been in its absence. An estimated 14,000 children under the age of 15 years were living with HIV/AIDS at the end of 1997, and 48,000 children have become orphans due to AIDS since the beginning of the epidemic.

**National Response:** The national response to the epidemic has moved from denial to development of one of the most comprehensive AIDS programs in the world. However, to continue prevention activities and achieve greater success with programming, Thailand will have to mobilize both technical and financial resources from internal and external sources and initiate an integrated, more decentralized approach with wider and more active participation of the civil society.

**Donors:** Since the closure of its Mission in Thailand in 1997, USAID has worked through Thai institutions and experts to train regional staff in HIV/AIDS prevention. In addition, through funding from USAID's Asia/Near East Bureau, Family Health International (FHI) is building the capacity of Thai agencies to serve regional programming needs. Additional funding of \$6.2 million has been proposed for fiscal year 2000 for a program that pilots and promotes best practices in preventing HIV transmission and providing care to AIDS victims and their families.

# THAILAND AND HIV/AIDS

## COUNTRY PROFILE

Situated in the heart of Southeast Asia, the Kingdom of Thailand hosts a population of almost 62 million, which accounts for approximately 1 percent of the world's population. With a current annual population growth rate of only 1 percent, a total fertility rate of 2, and life expectancy of 70 years for males and 75 years for females, Thailand's population indicators remain positive. Although Thailand has experienced great economic growth leading to rapid urbanization, considerable rural poverty remains.

The East Asian financial crisis, which began in 1997, plunged the Thai economy into a severe recession which threatened to erode the gains of high growth rates over the past decade. The initial manifestation of the crisis was in the currency markets, followed by a rapid contraction of overall economic activity, mainly through sharp declines in consumer spending and long-term investment. Soon thereafter, Thailand experienced declining levels of employment, wages and tax revenues. Fortunately, the government was able to sustain its level of investment in health, and although growth of the public health budget was interrupted, budget cuts were limited.

Thailand has achieved remarkable progress in terms of health over the last 30 years. Access to care has been ensured through an extensive network of public facilities, health indicators have improved dramatically, and coverage of health insurance has increased rapidly. In addition, greater attention has been given to the needs of women, safe motherhood, prevention of HIV transmission from mother-to-child, and alleviation of violence against women.

Thailand's success in family planning and reproductive health programs can be demonstrated by a number of key health indicators:

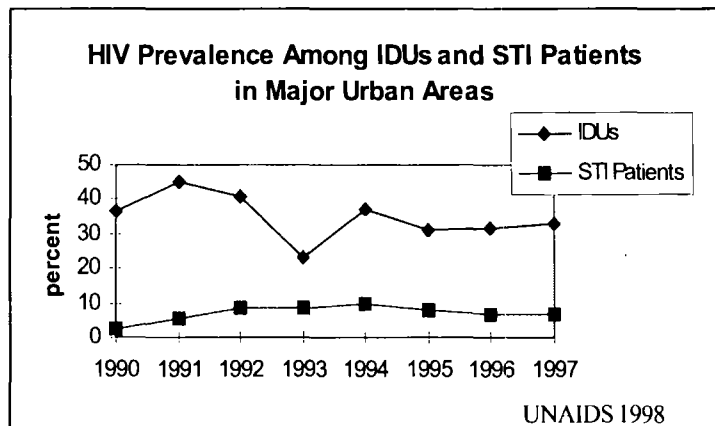
- Infant mortality has fallen to 25, and maternal mortality is 200 deaths per 1,000 live births;
- Of all new births, 95 percent are attended by trained health personnel; and,
- Eighty-nine percent of the population have access to safe water, 96 percent to adequate sanitation, and 90 percent to health services.

Thailand's principal development challenges stem from unbalanced economic growth, rapid urbanization, and large-scale internal and crossborder migration. The once eradicated or well-contained diseases, such as filariasis, malaria, and tuberculosis have been increasingly reported in the past few years. Other health problems among young adults and adolescents, such as HIV/AIDS, drug abuse, mental health conditions, poor nutritional status and unwanted pregnancy, are on the rise.

## HIV/AIDS in Thailand

The first case of AIDS in Thailand was detected in September 1984. Early cases were found among male homosexuals; thereafter, the disease spread rapidly among injecting drug users (IDUs) in 1987 and 1988, and then to sex workers and their clients. With more than two thirds of the world's supply of illicit opium originating in the region, Thailand is home to approximately 100,000 IDUs, and intravenous drug use is increasing.

HIV in Thailand has since extended beyond the high-risk groups and into the general population. Heterosexual transmission now accounts for the vast majority of HIV infections (over 80 percent), and the male to female infection ratio is 4.8:1. Geographically, HIV has been detected in all regions of Thailand; however, the greatest concentration of infections appears in the Upper Northern region.



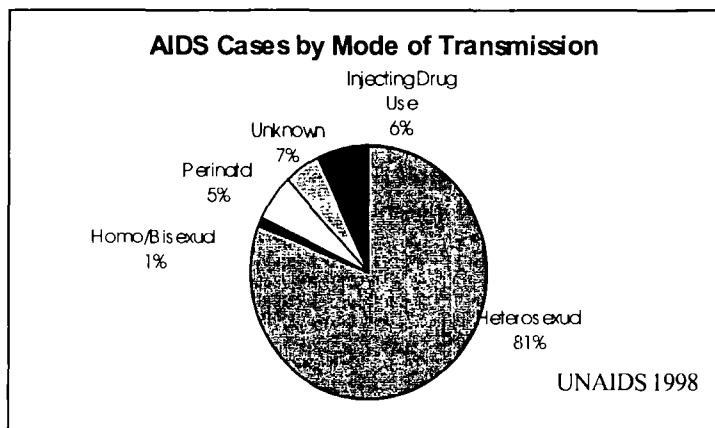
The Joint United Nations Programme on HIV/AIDS (UNAIDS) has reported the following estimations for the end of 1997:

- There are 770,000 adults ages 15–49 years living with HIV/AIDS, representing 2.23 percent of the adult population.
- Since the beginning of the epidemic, 260,000 cases of AIDS and 230,000 AIDS-related deaths have occurred among adults and children.
- In 1997 alone, 60,000 AIDS-related deaths occurred.
- In 1997, HIV prevalence among IDUs outside major urban areas was estimated at 41 percent and 33 percent in major urban areas.
- By the year 2000, the cumulative number of HIV infections is projected to be 1.3 million.

*HIV prevalence is declining in the northern region of Thailand, once the region most affected by HIV in East Asia. The MOPH also reported a fall in the demand for sex worker services in 1998, compared with 1997 (4 clients per day down to 1.5 clients per day).*

HIV-prevalence trends have shown a stabilization or decline in recent years, indicating positive results of the aggressive national response to the epidemic. The Division of Epidemiology of the Ministry of Public Health (MOPH) reported the following trends in April 1997:

- HIV infection in male conscripts dropped from 4 percent in 1993 to 1.9 percent in 1996.
- Among pregnant women, the HIV rate reached 2.4 percent in 1995 and dropped to 1.8 percent by mid-1996.
- HIV prevalence among males attending government sexually transmitted infection (STI) clinics reached 8 percent in 1993 and stabilized between 8 and 9 percent through 1997.
- Among sex workers, HIV prevalence seems to be stable, with a small variation between 28 and 33 percent.



The decrease in HIV prevalence is attributed to an increase in condom use among sex workers and their clients, a decline in the frequency of sex worker visits, and a decline in STI prevalence. Aggressive information and education campaigns, a national 100 Percent Condom Program for sex establishments, and countrywide condom distribution contributed to these changes. Although HIV/AIDS campaigns have led to widespread knowledge and adoption of safer sexual practices, many misconceptions about the disease remain, especially in rural areas.

*In Thai society, the expectation that a child will support his/her parents is much greater on daughters than on sons. A daughter's duty is to earn a living for the family in order to repay her debt of gratitude to the parents, while a son's is to spend time as a monk. Thus, the economic burden of the family is placed on the daughter. There is no reported incidence of the selling of sons by their parents, whereas selling daughters is quite common in some areas.*

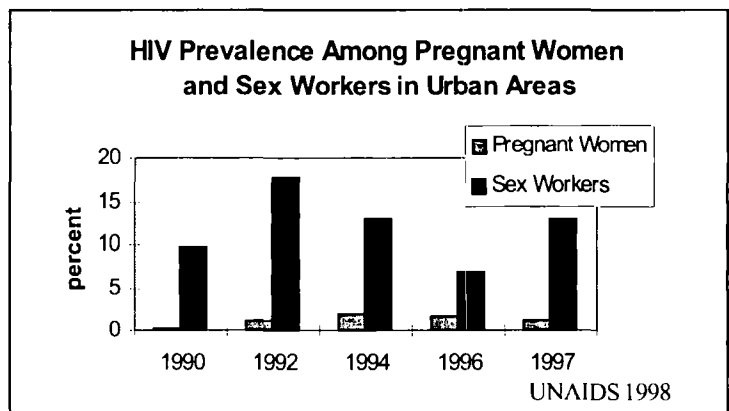
### Women and HIV/AIDS

Women are more vulnerable to HIV infection than men because of the asymptomatic nature of STIs among women and other biological factors. Compared with that of males, the female reproductive tract is more susceptible to infection with HIV and other STIs, particularly in young girls. Economic and social dependence of women on men also places them at greater risk. While promiscuity is acceptable for men, women are expected to be ignorant of sexual matters (including safe sex) and generally have less negotiating power in sexual relationships.

- At the end of 1997, an estimated 290,000 women (ages 15–49 years) were living with HIV/AIDS.
- In 1997, HIV prevalence among sex workers was estimated at 25.8 percent outside major urban areas and 13 percent in major urban areas. In northern provinces in 1996, prevalence among sex workers was found to be as high as 60 percent.
- Among pregnant women, HIV-prevalence rates are estimated to be between 1.7 and 3 percent.

Sex work has been an accepted part of Thai culture for centuries. Many young unemployed women in cities turn to sex work—through coercion, trafficking or economic need. A recent study in Thailand found 50 percent of the sex workers surveyed entered the sex industry due to their parents' financial need. Compounding the problem, young girls are seen as “safer” in terms of risk of HIV infection and are therefore targeted by sex establishments. Sex work often provides significantly higher wages than formal employment sectors, especially for young girls with little or no education.

The first cases of perinatal transmission of HIV were reported in 1991. Mother-to-child transmission now accounts for 5 percent of



all cases. It is believed that most HIV cases among non-sex-worker females are due to transmission from husbands who engage in high-risk behaviors (predominantly unprotected sex with sex workers). This places women in a particularly precarious situation as they are unable to control the actions of their husbands.

### Children, Youth and HIV/AIDS

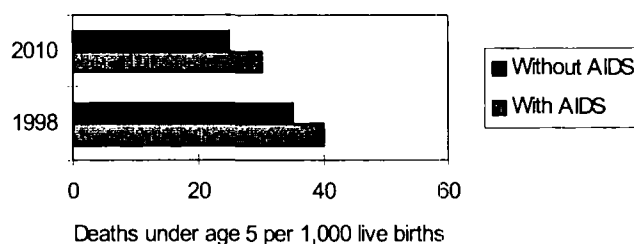
The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others. AIDS is currently resulting in a child mortality rate 13 percent higher than it would have been in the absence of AIDS. (Child mortality refers to the number of deaths in children after the age of one year.) By the year 2010, AIDS mortality is projected to increase the child mortality rate another 18 percent.

- An estimated 14,000 children under the age of 15 years were living with HIV/AIDS at the end of 1997.
- An estimated 48,000 children under 15 have become orphans due to AIDS since the beginning of epidemic.

More than 89 percent of HIV infections in Thailand are among individuals 15–49 years old. The migration of youth to cities in search of work has increased premarital sex, but not the use of condoms. As the economic crisis developed, many schools experienced declining enrollments and higher dropout rates. This reduces the opportunities to reach children and youth with HIV/AIDS education, in addition to leading some youth into risk behaviors, such as drug use and sex work. Estimates of the number of children involved in sex work in Thailand range from 13,000 to more than 100,000. These factors, coupled with adolescent marriages, early onset of sexual activities and low perception of personal risk, place adolescents, particularly young women, at increased risk of HIV and other STIs.

*The United Nations Children's Fund (UNICEF) provided the Thailand Public Health Ministry a supply of AZT to help reduce mother-to-child HIV transmission in 1998. The AZT was used in seven northeastern provinces. There are an estimated 15,000 to 20,000 pregnant women diagnosed with HIV in Thailand each year, with about 4,000 to 6,000 infants born with the virus annually.*

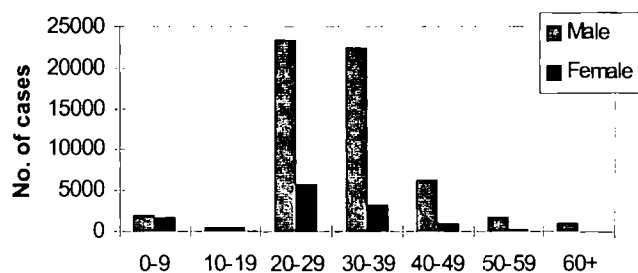
**Child Mortality Rate With and Without AIDS  
1998 and 2010**



HIV/AIDS in the Developing World, USAID and Bucen, May 99

*The HIV/AIDS epidemic also affects educational systems, as children are forced to leave school to care for ailing parents. When orphaned, children usually abandon school to search for a means to support themselves. Often, children are forced into sex work as a means to survive or support their remaining siblings or other family members.*

**AIDS Cases by Age and Gender**



UNAIDS 1998

## **SOCIOECONOMIC EFFECTS OF HIV/AIDS**

About 90 percent of reported AIDS cases are among 20–49 year olds. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector likewise feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to crops which are less labor intensive. In many cases, this implies switching from export crops to food crops, thus affecting the production of cash and food crops.

There are also many private costs associated with AIDS, including expenditures for medical care, medications and funeral expenses. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when forced to care for sick family members. AIDS also adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level, there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children, and in the absence of grandparents, young children often become heads of households.

## **INTERVENTIONS**

### **National Response**

The government of Thailand (GOT) established the National AIDS Prevention and Control Program (NAPCP) in 1987. With technical and financial support from the World Health Organization (WHO), a short-term plan, was developed, followed by a medium-term plan, covering the years 1989 to 1991. In 1992, the first five-year National AIDS Prevention Plan was adopted. Thailand is now implementing the second five-year phase of that plan, covering the years 1997 to 2001, with the overall objectives of reducing and controlling the spread of HIV/AIDS and reducing the social, economic and health impact of AIDS at all levels—individual, family, community, and national.

The National Economic and Social Development Board (NESDB) is the national planning authority. In 1991, NESDB was assigned the task of formulating the National AIDS Plans within the framework of the National Economic and Social Development Plan. This was to ensure smooth cooperation among government agencies, nongovernmental organizations (NGOs) and the private sector in formulating a comprehensive action plan involving multisectoral collaboration. This also reflected a shift in viewing HIV/AIDS as a communicable disease to a social problem. The National Plans have thus shifted from a sectoral approach to a holistic approach.

The national response to the epidemic has moved from denial to development of one of the most comprehensive AIDS programs in the world, which includes the following elements:

- Testing of all units of donated blood,
- Use of the mass media for HIV/AIDS education,
- Promotion of condom use,
- Reduction in the incidence of sexually transmitted diseases (STDs),
- Improvement of AIDS-related human rights,
- Piloting of models of home- and community-based care, and
- Research.

*According to the MOPH, condom availability and well-publicized messages to prevent HIV transmission have resulted in a decrease in STI cases of 80 percent between 1989 and 1997.*

Components of the NAPCP have been assigned to different ministries: public relations/mass media are assigned to the Office of the Prime Minister; AIDS programs for special target groups to the Ministry of Interior; medical counseling services to the Ministry of Public Health; human rights and social acceptance to the Ministry of Labor and Social Welfare; and, research and evaluation to the Ministry of University Affairs.

Targeted mass media campaigns began in earnest in 1989 when Mechai Viravaidya convinced the Thai Army to air television and radio spots through its national broadcast network. This ensured that the vast majority of the Thai population was made aware that HIV was spreading among Thais, that it was fatal, and that it could be prevented by behavior change. Then, in 1991, the Ministry of Public Health launched a national AIDS communication campaign to boost information on AIDS nationwide and educate the public on preventing the spread of HIV. Mass media efforts were carried out with the support of Thai marketing agencies, and persons living with HIV/AIDS (PLWHAs) were invited to speak to the public about AIDS. AIDS education was integrated into primary and secondary school curricula in 1992, in addition to teacher training programs. Workplace programs have also been adopted and expanded to the national level with government support.

The 100 Percent Condom Program was put into place in sex establishments in 1991; by 1992, all provinces reported the existence of such programs. The program was implemented with financial and technical support from USAID and in collaboration with provincial governors, police and public health officials. According to the NESDB, by 1994, the frequency of condom use had increased to 60 percent in sex establishments, from approximately 30 percent in 1990. Free or low-cost condoms are available at family planning clinics, drug treatment centers, STI/AIDS clinics, entertainment places, and through community volunteers. Private outlets also supply condoms at affordable prices. Promotion of the female condom has been undertaken, particularly targeting sex workers.

Counseling services are provided through anonymous clinics belonging to both the government and private sector. Since 1990, a national plan for counseling has been in place; however, the quality of counseling services is not yet standardized throughout the country. A wide range of multidisciplinary research from biomolecular, clinical and epidemiological research to behavioral and social science research, has been extensively conducted by government and nongovernmental institutes and individuals.

## Donors

Multilateral and bilateral donors are actively engaged in Thailand.

**USAID:** Until 1997, USAID had supported large, comprehensive HIV-prevention programs for vulnerable

populations in Bangkok and many other parts of Thailand. With the closure of the USAID Mission in that year, assistance to Thailand shifted to working through Thai institutions and experts as trainers for staff from other countries in the region. With funding from USAID's Asia/Near East Bureau, Family Health International (FHI) has been building the capacity of Thai agencies to serve regional programming needs in the areas of surveillance, behavior change communication, STD case management training, voluntary counseling and testing, AIDS policy, and structural interventions, such as the 100 percent condom program.

USAID funds The Population Council's HORIZONS project, which is conducting research in a number of areas, including secondary analysis of reproductive tract infection data, programming for HIV prevention in schools, evaluation and accreditation of workplace AIDS programs, and case management of opportunistic infections, in addition to conducting regional workshops on the integration of HIV/AIDS into family planning and reproductive health programs.

Under USAID funding, the International HIV/AIDS Alliance is working to link organizations to enhance their skills in behavioral change communication, and transfer best knowledge and practices to other NGOs.

**European Union (EU)** support has been directed towards control of STDs and HIV prevention and education for youth through peer education and high school curriculum development. EU funding for AIDS activities was almost \$7 million for 1997.

**The Thai–German Cooperation on AIDS** provided more than \$1 million to conduct operations research on the promotion of HIV/AIDS prevention and care among adolescents, youth and sex workers; to build the capacities of key institutions and agents in promoting HIV/AIDS prevention and care; and, for overall program evaluation, documentation and information dissemination.

**The Australian Agency for International Development (AusAID)** activities include human resource development, health education and information services; establishment of a drop-in center, newsletter and counseling services; and, the development of safe sex and behavior change strategies. AusAID funding is over \$4.7 million for 1994–2000.

**UNAIDS** established a Theme Group on HIV/AIDS to coordinate the response of United Nations agencies to the epidemic and provide assistance to the GOT in the strategic development and evaluation of activities. The Theme Group is comprised of members from the United Nations Development Programme (UNDP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations Development Fund for Women (UNIFEM), the United Nations International Drug Control Programme (UNDCP), the Food and Agriculture Organization of the United Nations (FAO), the World Health Organization (WHO), and the World Bank. UNAIDS provided \$256,000 in funding during 1996–97.

UNAIDS activities include:

- Resource mobilization;
- Evaluation of the management of the NAPCP;

- Maintaining an inventory on HIV/AIDS activities by member agencies of the Theme Group, donors and NGOs;
- Conducting donor meetings;
- Strengthening of PLWHA groups;
- Developing interagency collaboration;
- Developing a local technical consultancy roster; and,
- Reporting on best practices.

**UNICEF** activities include strengthening of communities to deal with AIDS and build the capacity of PLWHAs and families to provide care and economic support, provision of AIDS education and counseling via peer education and training, HIV/AIDS prevention and care among hilltribe populations, establishment of a resource center on AIDS and Health Care and of a network of peer educators for out-of-school children, holistic support for AIDS orphans, and training of PLWHAs to be peer counselors. UNICEF provided over \$3.7 million for AIDS activities from 1992–99.

**UNDP** supports training of health and development personnel and housewives on home-based care and HIV prevention; training of community leaders, monks and teachers to give support and counseling to PLWHAs and their families; training of teachers, pharmacists and drugstore personnel; education activities in the workplace; and, study tours. UNDP funding for 1994–98 was over \$1.3 million.

**UNESCO** supports a project on the Prevention of HIV/AIDS and Drug Abuse through Quality Improvement of Curriculum and Teaching/Learning Materials in Asia. The project aim is to introduce new curriculum approaches and materials in selected Asian countries, including Thailand. UNESCO provided \$100,000 for AIDS activities from 1996–97.

**UNFPA** supports a variety of education and training activities targeting students, teachers and women, in addition to materials development and dissemination. Funding for 1994–97 was over \$1.7 million.

**The World Bank** conducts regional activities to document and disseminate responses to the epidemic, including crossborder responses; monitors the mobilization, allocation and use of resources for HIV/AIDS; promotes awareness of existing HIV/AIDS information resources; and, supports the development of programs, team management and operations. The World Bank provided \$314,125 from 1994–96.

**UNDCP** has integrated HIV/AIDS prevention as a component in drug prevention activities, including the development of school curriculum for formal and nonformal education; outreach for out-of-school youth and children; awareness campaigns targeting hilltribe and urban populations; and, community-based prevention activities. UNDCP funding was \$101,000 for 1996–97.

**WHO** supports studies and models of care for PLWHAs; workplace interventions; youth education; an AIDS reference library; program planning, implementation, management, and, evaluation; development of strategies and guidelines; seminars; monitoring of blood testing; and, research. WHO AIDS funding was over \$1.7 million for 1994–96.

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

A number of PVOs/NGOs implement activities funded by multilateral and bilateral donors. NGOs also receive funding from a variety of sources and carry out most of the HIV/AIDS prevention and care activities in Thailand.

Over 200 local NGOs are participating in the fight against AIDS in Thailand. The Thai NGOs Coalition on AIDS was formed in 1989 with the objective of coordinating NGO activities and information sharing. The Network of Hilltribe Organizations on AIDS and Drugs was formed in 1997 to coordinate prevention and care work among minorities in the upland region and those which have migrated to urban settings. NGOs have taken the lead in working among stigmatized social groups, developing participatory forms of AIDS education and client-centered counseling and support services, in addition to campaigning for social acceptance of PLWHAs and their rights to nondiscrimination.

Community efforts to lessen the impact of AIDS are carried out by community-based organizations (CBOs) that have been mobilized to secure local support. There are also over 150 PLWHA groups formed nationwide to provide peer support and advocacy for PLWHA rights, as well as community education for AIDS prevention and a community campaign for Living with AIDS.

## **CHALLENGES**

Thailand faces considerable challenges in its fight against AIDS.

- There is a large migrant worker population.
- There is a high level of casual and commercial sex among young people.
- Injecting drug use and rates of infection among IDUs are increasing and there is opposition to the establishment of needle exchange programs as a strategy for reduced transmission.
- There is opposition by some educators and parents to sex education at primary and secondary schools.
- Discrimination against PLWHAs and their children remains high, resulting in violations of their rights.
- Reduced funding from the United Nations and bilateral/multilateral donors presents a great challenge in the face of an epidemic.
- Gender disparities and segregated sex roles continue to present obstacles in AIDS prevention.
- A large commercial sex industry exists which links sex work and tourism.
- The number of orphans and abandoned children related to AIDS is increasing.
- There are insufficient government social services, particularly in the areas of health care and educational scholarships.

## **FUTURE ACTIONS NEEDED**

Thailand will have to mobilize both technical and financial resources, from internal and external sources, in order to continue prevention activities. Although infection rates have seemingly stabilized or dropped among some populations, Thailand remains at risk of an explosive epidemic if prevention and control efforts are not

sustained. To achieve greater success with programs, an integrated, more decentralized approach with wider and more active participation of the civil society is needed.

Continuation of a compassion and solidarity campaign via different modes of media is needed to decrease stigmatization and discrimination of PLWHAs. In addition, support to strengthen community efforts to deal with the impact of AIDS needs to be increased. Although a National Policy and Plan of Action for the Prevention and Eradication of the Commercial Sexual Exploitation of Children was adopted in 1996, additional efforts need to be undertaken to eradicate the problem of child prostitution.

## **IMPORTANT LINKS AND CONTACTS**

1. National AIDS Prevention and Control Program, Dr. Chaiyos Kunanusont, Director, Tiwanond Rd. Nonthaburi 11000; Tel: 662-590-3200, Fax: 662-591-8413, E-mail: [chaiyos@health.moph.go.th](mailto:chaiyos@health.moph.go.th).
2. UNAIDS, Mr. Steve Kraus, Intercountry Team Leader, 3/F Block B, United Nations Building, Rajadamnern Ave., Bangkok 10200; Tel: 662-288-1272, Fax: 662-288-1092.
3. Thai NGOs Coalition on AIDS, Mrs. Dares Choosri, Office Director, 238/325 Sriwara Mansion 2, 15<sup>th</sup> Floor, Soi Nathong 3, Dindaeng Bangkok 10320; Tel: 662-41-2688, Fax: 662-641-2690, E-mail: [tnca@ksc.th.com](mailto:tnca@ksc.th.com).
4. Network of Hilltribe Organizations on AIDS and Drugs, Mr. Prasaeng Nakiri, Coordinator, 284 Phaholyothin Rd. Tambon Robwieng, Meaung District, Chiang Rai 57000; Tel/Fax: 66-53-713-408, Mobile Tel: 66-01-960-5890.

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# NEPAL AND HIV/AIDS

## TALKING POINTS

HIV—prevalence rates in Nepal remain low compared with other countries. However, Nepal runs a considerable risk of an increased epidemic due to an active sex trade, high rates of girl trafficking to India for sex work, apparently increasing numbers of injecting drug users (IDUs), and heavy labor migration.

- Thirty thousand adults and children are estimated to be living with HIV.
- By the year 2000, the cumulative number of AIDS cases is projected to reach 5,000 and more than 100,000 people may be infected with HIV.
- In 1997, HIV prevalence among sexually transmitted infection (STI) patients outside major urban areas was 1.42 percent.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that 2,100 cases of AIDS and 1,700 AIDS—related deaths have occurred since the beginning of the epidemic. According to the National Center for AIDS and STD Control (NCASC), as of July 31, 1999, 265 cases of AIDS have been reported, 137 of which have resulted in death.

**Women and HIV/AIDS:** At the end of 1997, 10,000 women (ages 15–49) were living with HIV/AIDS. High levels of illiteracy, limited access to resources and greater biological susceptibility to infection put women at increased risk of HIV. High rates of girl trafficking to India for forced sex work are a critical problem in Nepal.

**Children, Youth and HIV/AIDS:** The HIV epidemic has a disproportionate impact on children. UNAIDS estimates 580 children under the age of 15 were living with HIV/AIDS at the end of 1997, and 750 children had become orphans due to AIDS since the beginning of the epidemic.

**National Response:** In spite of growing awareness of the HIV/AIDS epidemic by His Majesty's Government (HMG) of Nepal, the presence of many competing priorities, political instability and lack of funds have resulted in a NCASC which lacks the resources to fulfill its role satisfactorily. In the absence of effective public health interventions focused on high-risk behavior groups HIV prevalence may increase to 1 to 2 percent of the 15–49 year-old population in the next 10 years, making AIDS the leading cause of death for this age group.

**Donors:** USAID is a major donor to HIV/AIDS prevention in Nepal, contributing \$2.4 million in fiscal year 1998. USAID's HIV/AIDS strategy in Nepal seeks to increase awareness and use of HIV and STI prevention and control services and methods through effective communications and counseling. USAID is also the chief donor supporting the private sector to deliver interventions to combat HIV/AIDS and other STIs.

# NEPAL AND HIV/AIDS

## COUNTRY PROFILE

Nepal ranks as one of the poorest countries in the world, with over half its population living in absolute poverty. While improvements have been made in infrastructure development and provision of government services, a higher rate of economic growth is needed to make tangible progress in reducing poverty. Nepal's principal development challenges include a limited natural resource base, rapid population growth, environmental degradation, low levels of social development, and widespread poverty.

Nepal's social indicators remain well below the average for the South Asia region. Life expectancy at birth is 57 years (compared with 63 years in India and Pakistan and 73 years in Sri Lanka), and infant mortality is 91 per 1,000 live births, the highest in the region. The total population of 22.6 million is growing at an annual rate of 2.3 percent, and although modern contraceptive use has risen from 2.9 percent to 28.8 percent over the past 20 years, the total fertility rate remains at 4.6 births per woman.

The pressure of population growth on scarce and fragile land means that the benefits of better education or irrigation are often outweighed by more fragmented land and reduced availability of forest products upon which most of the rural population depends for all or part of its livelihood. Of the 90 percent of Nepal's population living in rural areas, less than half have access to safe water, and less than 6 percent have access to sanitation.

Health indicators in Nepal are among the worst in the world, yet public expenditure in health represents only \$2 per capita annually. The health sector suffers from over-centralized planning, budgeting and implementation; lack of essential drugs in many health posts; widespread absenteeism in the more remote areas; lack of program ownership by local communities; and, little involvement of nongovernmental organizations (NGOs) and the private sector in the planning, delivery, and financing of social services.

## HIV/AIDS in Nepal

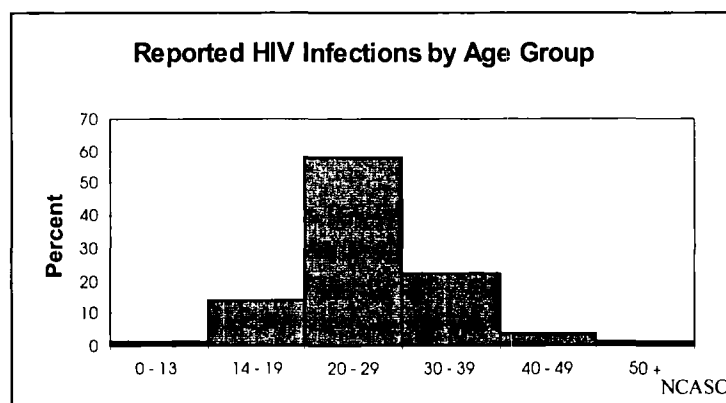
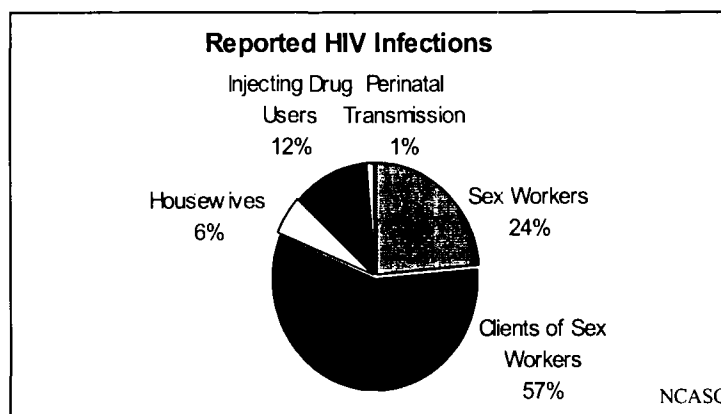
The first cases of AIDS were reported in Nepal in 1988. Surveillance data is scarce in Nepal; however, limited data indicate that HIV prevalence is currently below 0.5 percent of the general population. As of September 1999, 265 cases of AIDS and over 1,000 HIV infections have been reported to the Ministry of Health (MOH). Given the existing medical and public health infrastructure in Nepal and the lack of continuity in national HIV/AIDS surveillance systems, it is difficult to estimate the completeness or accuracy of these data. It is very likely that the actual number of cases is many times higher. The MOH estimates there are currently 30,000 HIV infections in Nepal.

- The Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that an estimated 26,000 adults and children were living with HIV at the end of 1997, and an estimated 2,100 cases of AIDS and 1,700 AIDS-related deaths have occurred since the beginning of the epidemic.
- In 1997, HIV prevalence among patients with sexually transmitted infections (STIs) outside major

urban areas was estimated at 1.42 percent.

- The National Center for AIDS and STD Control (NCASC) projects that the cumulative total number of AIDS cases will be close to 5,000 by the year 2000.

Limited seroprevalence studies conducted in various regions during the 1990's have shown a slow but gradually increasing prevalence among STI patients. Estimates have ranged from 4 percent in the western district of Mahendranagar to 12.8 percent in studies of injecting drug users (IDUs), commercial sex workers (CSWs) and STI patients in one clinic in the Kathmandu valley. HIV prevalence among IDUs has increased markedly from 2.2 percent in 1995–96 to almost 50 percent in 1997–98. Slow increases have also been reported among blood donors—in Kathmandu, prevalence ranged from 0.28 to 0.48 percent in 1997–98 and 0.39 percent in areas outside Kathmandu. No HIV–prevalence studies have been conducted among antenatal clinic women.



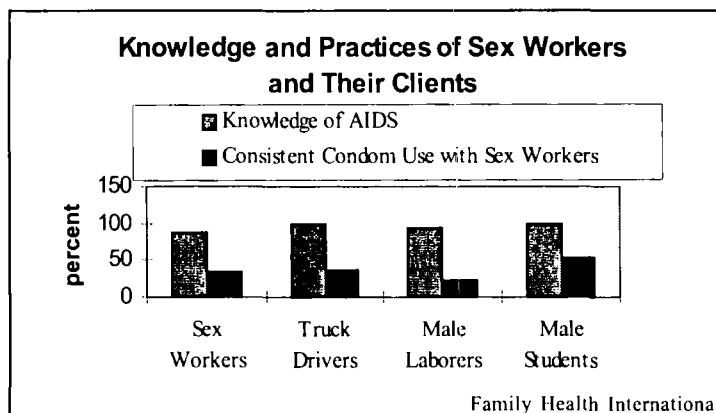
Although available data indicate relatively low HIV–prevalence rates compared with other countries, Nepal runs a considerable risk of an increased epidemic due to an active sex trade, high rates of girl trafficking to India for sex work, increasing numbers of IDUs, and seasonal and long-term labor migration (mainly to India). Kathmandu has the highest incidence of HIV infection. As of 1997, 48 out of 75 districts had reported HIV cases. The primary mode of transmission in Nepal is heterosexual contact; however, infection among IDUs has been increasing rapidly over the last few years. In 1998, of the approximate 20,000 IDUs, 48 percent were estimated by NCASC to be infected with HIV. It is also estimated that one third of HIV infections are among IDUs.

## Women and HIV/AIDS

As in many other countries, women's low social and economic status in Nepal, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Poor economic conditions, which make it difficult for women to access health and social services, compound this vulnerability. Eighty-six percent of Nepal's women are illiterate.

- At the end of 1997, an estimated 10,000 women (ages 15–49) were living with HIV/AIDS.

- According to the 1996 Family Health Survey, only 30 percent of females 24 to 49 could cite at least two acceptable ways of protection from HIV infection, and only 6.2 percent of women ages 15 to 49 had ever used a condom.
- In 1993, HIV prevalence among sex workers was estimated at 1.3 percent outside major urban areas and 0.9 percent in major urban areas.



According to the 1997 State of World Population report from the United Nations Population Fund (UNFPA), an estimated 100,000–200,000 Nepalese women have been sent or sold to brothels in India, and the complicity of police and local authorities in some of this trafficking has been reported. Women are recruited from villages or urban areas of Nepal where they have come to work in the carpet and garment industries. Some women are sold by their families, whereas others are deceived by false marriages and promises of economic opportunities. Once a sex worker is found to be HIV positive, she is sent back to Nepal where she is often rejected by her family and may be forced to remain in the sex industry as a means of survival.

### Children, Youth and HIV/AIDS

The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others. In Nepal, where more than 40 percent of the population is under age 15, approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV. Overall poor health conditions in Nepal also make children more susceptible to opportunistic infections.

- An estimated 580 children under the age of 15 were living with HIV/AIDS at the end of 1997.
- An estimated 750 children under 15 have become orphans due to AIDS since the beginning of the epidemic.
- Almost half of the children under 5 years of age suffer from malnutrition.
- Approximately 60 percent of rural children are not fully vaccinated.

High-risk behaviors among youth, such as low perception of personal risk, early onset of sexual activity and alcohol and drug use and, possibly, multiple sex partners, increase their risk of HIV infection. According to the 1996 Family Health Survey, over 50 percent of teenage women ages 15 to 19 have had at least one pregnancy. In addition, sexual exploitation and trafficking of children for sex work continues to be a problem in Nepal.

### SOCIOECONOMIC EFFECTS OF HIV/AIDS

The epidemic in Nepal has not yet reached the stage where widespread socioeconomic effects are noticed. As of July 31, 1999, about 84 percent of reported HIV cases are among 20 to 49 year olds. Since this age group

constitutes the most economically productive segment of the population, an important economic burden can be created. Productivity falls and business costs rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector likewise feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases, this implies switching from export crops to food crops, thus affecting the production of cash and food crops.

There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when forced to care for sick family members. AIDS also adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level, there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children and in the absence of grandparents, young children often become heads of households.

## **INTERVENTIONS**

### **National Response**

In response to the HIV/AIDS epidemic, His Majesty's Government (HMG) of Nepal established the National AIDS Control Program (NACP) in 1987, with financial and technical support from the World Health Organization (WHO). The project focused on preventing sexual, blood and perinatal transmission of HIV and reducing the impact of HIV/AIDS on individuals and families. The National AIDS Program (established in 1990 to coordinate the activities of the NACP) was succeeded in 1993 by the NCASC. Activities of NCASC include screening of blood samples; conducting surveillance; generation of information, education and communication (IEC) materials for the general public and high-risk groups; distribution and promotion of condoms; treatment of STIs; counseling persons at risk and those who test positive for HIV; and, training of health workers in the clinical management of HIV/AIDS patients.

In 1995, a National Policy on HIV/AIDS/STD was adopted by the MOH, establishing a multisectoral approach with high priority for STI prevention and control. Under the framework of this National Policy, the following points were addressed:

- Establishment of a multisectoral approach to HIV/AIDS/STI prevention at both the government and nongovernmental levels,
- Decentralization of AIDS prevention and control activities to the regional, district and village levels,
- Confidentiality in blood testing,
- Nondiscrimination of persons living with HIV/AIDS,
- Promotion of safer sexual behaviors,
- Blood screening,

- Counseling, and
- Program coordination, evaluation and policy issues.

The multisectoral response coordinating 12 government ministries sought to extend HIV/AIDS awareness and behavioral change among many at-risk populations, such as the defense forces, police, prison populations, and drug addicts. Focal points on HIV/AIDS were trained in various ministries. The Ministry of Education integrated HIV/AIDS education into secondary school curricula, and other ministries, including the Ministries of Defense and Labor, developed work plans including HIV/AIDS activities.

*In Nepal, a vigorous campaign to inform truck drivers and sex workers of the risk of unprotected sex, plus the provision of condoms at convenient points along truck routes, reduced the risk behavior of sex workers and of the transport workers who made up the bulk of their clientele. In areas where the prevention campaign was initiated, condom use by sex workers with their last client nearly doubled to 61 percent between 1994 and 1996.*

In 1997, a National HIV/AIDS Strategy covering the years 1997–2001 was adopted and is currently under implementation. At the decentralized level, HIV/AIDS is fully integrated in other health programs, and HIV–awareness information is integrated in safe motherhood and reproductive health programs. Active District AIDS Committees exist in a considerable number of districts, and the tuberculosis program has been broadened to integrate HIV counseling and care for persons testing positive. STI syndromic case management has been strengthened through the provision of training and treatment support. In addition, sentinel surveillance sites have been set up in five regions of Nepal to monitor the epidemic.

In 1995, the NCASC developed a National IEC Strategy which would use a combination of approaches such as mass media; peer education; street drama; condom promotion and social marketing; advocacy meetings; knowledge, attitudes, behaviors and practices (KABP) studies; training; and, materials development. The following target groups were identified as priority target groups for interventions under the strategy:

- Groups with high-risk behaviors,
- Sexually active men,
- Women of childbearing age,
- In-school youth (primary, secondary and college students), and
- Policy and decision-makers.

### **Donor Response and Nongovernmental Organization (NGO) Activities**

Multilateral and bilateral donors are actively engaged in Nepal.

USAID's HIV/AIDS funding for fiscal year 1998 was \$2.4 million. USAID's HIV/AIDS strategy in Nepal seeks to increase awareness and use of HIV and STI prevention and control services through effective communications and counseling. In 1998, the program expanded into new districts along truck routes and border areas. Crossborder collaboration serves as a regional model, resulting in improved, effective joint prevention and control activities. USAID is the chief donor supporting the private sector to deliver interventions to combat HIV/AIDS and other STIs.

USAID supports Family Health International (FHI) to carry out interventions designed to reduce the sexual

transmission of HIV in Nepal. Activities target sex workers and their clients as a priority group; women and men with multiple partners, wives with transient husbands, and adolescents as secondary groups; and focus on the following five areas:

- Improved utilization of quality STI services;
- Increased risk reduction behavior among target populations;
- Improved community-based information, advocacy and care systems that effectively respond to the needs of HIV-infected persons;
- Improved HMG of Nepal capacity in policy development and surveillance; and,
- Increased private sector participation in HIV/AIDS prevention efforts.

*Under USAID support, FHI conducted a behavioral surveillance survey in 1998 to measure and monitor HIV risk behavioral trends among female sex workers, male transport workers, laborers, and students along the major highway routes of midwestern Nepal. The study found that significant behavioral changes in terms of increased condom use have occurred among all groups. However, as consistent condom use remains low despite high knowledge of AIDS, future IEC interventions are needed.*

The Population Council's HORIZONS project, also funded under USAID, is conducting operations research on the trafficking of girls and women for sex work and on the care and support of affected persons.

USAID regional activities, which include Nepal, promote best practices in preventing HIV transmission and providing care to AIDS victims and their families. Activities include condom social marketing, crossborder prevention activities, capacity building for local authorities and NGOs to undertake surveillance and reporting on HIV/AIDS in high-risk areas, behavior change surveys, improved management of STIs, and support for improved national policy frameworks.

**The European Union (EU)** provides support to the University of Heidelberg and NCASC to carry out STI-related activities. EU funding to Nepal for 1995–1999 was \$1,525,000.

**The German Development Agency (GTZ)** is supporting a participatory needs assessment of PLWAs and home-based care. GTZ funding for 1996–1997 was \$100,000.

**The Swiss Development Corporation** supports an HIV/AIDS awareness program within a District Health Primary Health Care project and provided CHF 13 million (Swiss francs) for activities in Nepal.

**UNAIDS** has a coordinating Theme Group based in Kathmandu, comprised of members from United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), UNFPA, United Nations Educational, Scientific and Cultural Organization (UNESCO), WHO, United Nations International Drug Control Programme (UNDCP), and the International Labour Organization (ILO).

UNAIDS also provides direct support to NCASC for policy development, advocacy, resource mobilization, behavioral research, youth programs, and IEC, and support to HMG of Nepal for capacity development, networking activities and NGO support. UNAIDS support to Nepal for 1996–1998 was \$486,000.

**UNDP** supports HIV/AIDS prevention activities in rural communities and social, economic and educational

interventions. UNDP contributed \$582,000 for Nepal's HIV/AIDS activities from 1993–1996.

**UNICEF** supports HIV/AIDS policy advocacy, prevention activities, care and support of PLWAs, capacity development for HMG of Nepal for program development, awareness seminars on girl trafficking, protection and care projects for women and children affected by HIV/AIDS, rehabilitation of HIV–positive women and children, and development of a young child program. From 1992 to 1996, UNICEF provided \$1,378,000 for HIV/AIDS activities in Nepal.

**UNESCO** organizes workshops on HIV/AIDS education, prevention and self-protection for women. UNESCO funding to Nepal for 1995–1996 was \$7,000.

**UNFPA** activities include the integration of HIV/AIDS messages in reproductive health IEC materials, condom distribution at health posts, integration of HIV/AIDS in population support programs, and IEC materials provision to NGOs. UNFPA is providing \$35 million for activities in Nepal for 1997–2001.

**WHO** is working to identify target groups, undertake serological surveys to detect HIV carriers, strengthen laboratory facilities, improve disease outbreak investigation and containment activities, identify best practices through behavioral research, build the capacity of HMG, and reduce infection rates through prevention, IEC development, testing and counseling. WHO provided \$913,500 in HIV/AIDS funding from 1990 to 1996, and \$70,000 from 1996 to 1997.

**The World Bank** currently has no direct program on HIV/AIDS; however, support to health care infrastructure, medical equipment and training programs facilitates HIV/AIDS prevention programs.

Numerous private voluntary organizations (PVOs) implement activities funded by multilateral and bilateral donors. Social sector NGOs also play an important role in the national response and receive funding from a variety of sources. During the past seven years, Nepal has witnessed an emergence of a thriving NGO sector. There are currently more than 100 NGOs working in the area of HIV/AIDS.

A consortium of NGOs is working to coordinate and share IEC materials, experiences and lessons learned under the guidance of Save the Children Fund. A coalition of approximately 40 NGOs, initially established to tackle the problem of girl trafficking to India, has also undertaken the issue of HIV/AIDS.

## **CHALLENGES**

Nepal faces considerable challenges in its fight against HIV/AIDS:

- In spite of growing awareness of the HIV/AIDS epidemic by HMG of Nepal, the presence of many competing priorities, political instability and lack of funds, has resulted in a NCASC which lacks the resources to fulfill its role satisfactorily.
- Illiteracy, poverty, imbalance in gender relations, as well as the difficult geographical terrain, make prevention education, treatment of STIs and condom promotion difficult.
- Application of a multisectoral approach in practice remains a challenge.
- Political instability results in a lack of continuity and sustainability.

- Lack of qualified or available human resources for implementation of activities and treatment of PLWAs is a serious constraint.
- The rapid increase in IDUs creates a potentially explosive situation.
- Nepal alone cannot deal with the problems of girl trafficking and seasonal migration. Coordination with India is an urgent necessity.
- Surveillance, supervision and monitoring systems need strengthening.
- There is very limited involvement of the private sector in prevention activities.

## **FUTURE ACTIONS NEEDED**

While the current HIV-infection rate is less than 0.5 percent, in the absence of effective public health interventions focused on high-risk behavior groups (CSWs, their clients, and IDUs), prevalence may increase to 1–2 percent of the 15- to 49-year-old population in the next 10 years. This would represent a cumulative total of 100,000–200,000 infections with 10,000–15,000 annual AIDS cases and deaths, making AIDS the leading cause of death among this age group.

Systematic HIV sentinel surveillance is needed among high-risk groups, in addition to annual prevalence studies among antenatal clinic women in large urban regions and behavioral surveillance studies. Interventions to raise consistent condom use in high-risk sexual settings (targeting CSWs and their clients) should be prioritized with the goal of reaching 80 to 90 percent consistent condom use. Interventions designed to stop the spread of HIV among IDUs are also needed, such as needle exchange programs and promotion of the use of bleach in the sterilization of needles.

The relationship and communications between the government and the NGO community, as well as among NGOs themselves, need to be strengthened. There is little community participation in the fight against HIV/AIDS and limited appreciation and understanding of the gravity and potential seriousness of the impact of HIV/AIDS on society. Community participation, at all levels, is essential for effective HIV/AIDS care, prevention and support activities. In addition, improved understanding among HMG of Nepal and the public will prove conducive to enhancing the quality of the response.

## **IMPORTANT LINKS AND CONTACTS**

1. NCASC, Dr. Tara Nand Jha, Director, MOH Department of Health Services, Teku, Kathmandu; Tel: 9771-261-653, Fax: 9771-261-406, Email: [tnjha@mos.com.np](mailto:tnjha@mos.com.np).
2. UNAIDS, Mr. Stewart McNab, Chairperson, United Nations Theme Group on HIV/AIDS and UNICEF Representative, United Nations House, Pulchowk, Kathmandu; Tel: 9771-521-342, Fax: 9771-527-280, Email: [smcnab@unicef.org.np](mailto:smcnab@unicef.org.np).
3. FHI, Mr. Tony Bondurant, Country Director, P.O. Box 8803, Kathmandu; Tel: 9771-535-565, Fax: 9771-524-754, Email: [tony@fhi.org.np](mailto:tony@fhi.org.np).

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# INDIA AND HIV/AIDS

## TALKING POINTS

Cited as one of the global focal points for HIV/AIDS, India has the largest number of HIV-infected persons in the world.

- India now has an estimated 3 to 5 million people infected with HIV.
- Between 0.5 to 0.8 percent of the adult population are already infected.
- Surveillance data reflect the epidemic is growing outside the high-risk groups to include members of the general population and that the epidemic is moving from urban to rural districts.

Although the total number of AIDS cases reported to the National AIDS Control Organization (NACO) is greatly underestimated, the annual number has been steadily increasing since the first case was reported in 1986. A total of 2,020 cases was reported in 1997, compared with only 953 a year earlier, with a cumulative total of 5,204 by March 1998. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that 430,000 cases of AIDS and 350,000 AIDS-related deaths have occurred in adults and children since the beginning of the epidemic.

**Women and HIV/AIDS:** One in four cases of HIV is among women. At the end of 1997, an estimated 1 million women (15 to 49 years old) were living with HIV/AIDS. Although prevalence rates among pregnant women vary throughout the country, ranging from 0 to 2.4 percent infected, sentinel surveillance studies carried out in 1998 found HIV-seropositivity rates greater than 1 percent in 5 of the 32 states/territories surveyed.

**Children, Youth and HIV/AIDS:** According to UNAIDS, approximately 48,000 children under the age of 15 were living with HIV/AIDS at the end of 1997, and 120,000 children have become orphans due to AIDS since the beginning of the epidemic. India's infant mortality rate is projected to increase almost 2 percent between now and the year 2015 due to AIDS.

**National Response:** With a well-managed prevention program at the state and municipal level, HIV infection could remain below 2 percent of the adult population. Without a successful intervention, India could be faced with the same kind of devastation that many countries in the African continent are experiencing.

**USAID** is a major donor to HIV/AIDS prevention, with a commitment of more than \$50 million for HIV/AIDS prevention in India. USAID's AIDS Prevention and Control activity in Tamil Nadu supports nongovernmental organizations (NGOs) to design and implement community-based prevention programs targeting high-risk populations, including sex workers and their clients and sexually transmitted infection (STI) patients. USAID is expanding its activities to Maharashtra, where in addition to intervention programs, the \$41.5 million seven-year project will support activities related to care and support of HIV-infected individuals.

# INDIA AND HIV/AIDS

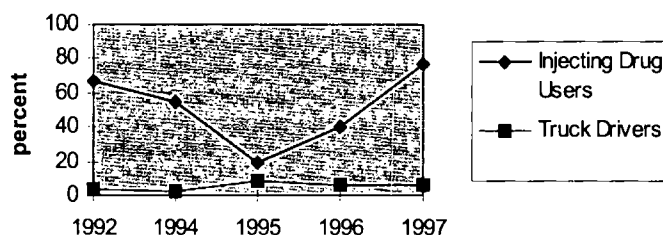
## COUNTRY PROFILE

India is the second most populous country in the world, accounting for 16 percent of the world's population. More than 300 million of its citizens live in poverty—the largest concentration of poor in the world. Despite food production gains, half of India's children are malnourished. With nearly a billion people, India is vital to successfully addressing the global issues of climate change, population growth and emerging diseases. India is the sixth largest and second fastest growing producer of greenhouse gases, and three of India's largest cities rank among the 10 worst polluted cities in the world. Environmental pollution in India costs the country billions of dollars each year.

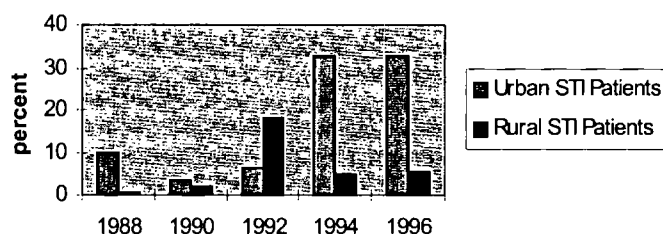
While the number of Indian scientists and engineers is among the highest in the world, India as a whole faces unacceptably high levels of illiteracy and low learning achievement. According to official government statistics, in 1991 over 60 percent of all women over 7 years old were illiterate. Sixty-two percent of boys were enrolled in primary school in 1994/1995, compared to only 47 percent of girls.

Although declining, largely preventable diseases such as leprosy, tuberculosis, cataract blindness, and malaria continue to account for a large percentage of reported illness. Pollution in cities causes premature deaths, chronic respiratory disease and the emergence of communicable diseases due to crowding and lack of access to clean water and sanitation. As of 1997, the government of India (GOI) reported maternal and infant

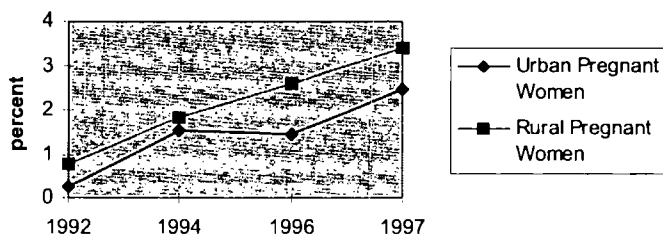
**HIV Prevalence Among IDUs and Truck Drivers Outside Major Urban Areas in India**



**HIV Prevalence Among Urban and Rural STI Patients in India**



**HIV Prevalence Among Urban and Rural Pregnant Women in India**



mortality rates of 570 and 71 deaths per 1,000 births, respectively. Life expectancy at birth is 58 years for males and 59 years for females (as of 1991).

## HIV/AIDS in India

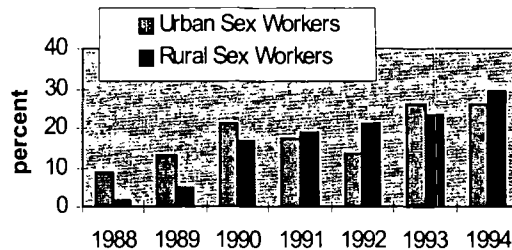
Cited as one of the global focal points for HIV/AIDS, India now has an estimated 3 to 5 million people who are HIV positive, more than any other country in the world. Although HIV prevalence remains low in comparison to many other countries worldwide (estimated at under 1 percent of the adult population), it is well over 10 times higher than in neighboring China.

The 1997–1998 annual report of the National AIDS Control Organization (NACO) reported the following:

- Approximately 4 million adults ages 15 to 49 are living with HIV/AIDS, representing 0.5 percent of the adult population.
- In five states, more than 1 percent of the population are already infected with HIV.
- Since the beginning of the epidemic (through March 1998), 5,204 AIDS cases have been reported in adults and children.
- The total number of reported cases increased from 924 in 1996 to 2,020 in 1997.

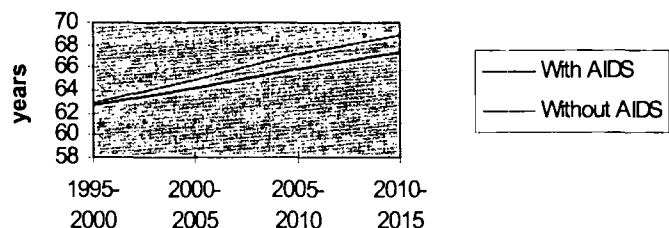
Until recently, it was commonly assumed that HIV infection in India was concentrated in urban areas among high-risk groups, such as commercial sex workers and their clients, including truck drivers, and injecting drug users (IDUs) liv-

**HIV Prevalence Among Urban and Rural Sex Workers in India**

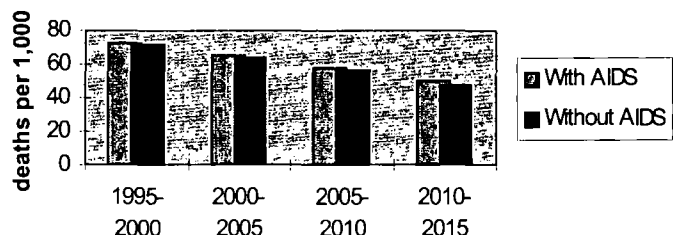


*HIV has spread to women whose only risk behavior is having sex with their own husbands. In a study of nearly 400 women attending STI clinics in Pune, 93 percent were married and 91 percent reported never having sex with anyone but their husband. All of these women were infected with a STI, and an alarming 13.6 percent of them tested positive for HIV.*

**Projected Life Expectancy, With and Without AIDS**



**Projected Infant Mortality Rate, With and Without AIDS**



ing in a few states. However, the March 1998 round of sentinel surveillance in antenatal clinics shows that in at least five states, more than 1 percent of pregnant women are now infected, reflecting a shift into the general population. Published reports have also indicated a rapid escalation of the epidemic in some areas among selected groups.

- Among clinic patients with sexually transmitted infections (STIs) in Pune, Maharashtra, yearly incidence of HIV was 10.2 percent.
- Among truck drivers in the southern state of Tamil Nadu, HIV prevalence quadrupled from 1.5 percent in 1995 to 6.2 percent just one year later.
- In the northeastern state of Manipur, where the epidemic took off quickly among male IDUs, some drug clinics registered HIV rates as high as 70 percent in 1998.
- In sentinel surveillance studies carried out in March 1998, more than 5 percent of STI clinic attendees in 8 states were HIV infected, with rates greater than 10 percent in 3 of the 8 states.

India's rural areas, home to about 70 percent of the country's population, were thought to be relatively spared by the epidemic, until recent studies which show HIV has become as common in some rural villages as in cities. A recent survey of randomly selected households in Tamil Nadu found that 2.1 percent of the adult population living in the countryside had HIV, as compared with 0.7 percent of the urban population. Considering that nearly 10 percent of the people surveyed had gonorrhea, syphilis or another STI, HIV clearly has fertile ground for further spread.

## Women and HIV/AIDS

Worldwide, women are becoming infected at faster rates than men and the total number of HIV-infected women is approaching that of men. Young women are particularly vulnerable; it is estimated that 70 percent of women infected with HIV are between 15 and 24 years of age.

*It is estimated that social marketing as a distribution channel accounts for approximately 85 percent of the total number of condoms provided throughout India, with 9 major companies and at least 4 nonprofit organizations involved in distribution through a network of over 300,000 outlets.*

- According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates, at the end of 1997, 1 million women in India (ages 15–49) were living with HIV/AIDS.
- In five states, more than 1 percent of pregnant women surveyed were HIV infected.
- Yearly incidence of HIV among commercial sex workers (CSWs) attending STI clinics in Pune was 26.1 percent.
- In one study in Mumbai, HIV-infection rates among CSWs increased from 1 percent in 1986 to 72 percent in 1997.

Women have less decision-making power in sexual relationships; this coupled with lower levels of education, greater biological susceptibility to infection, and limited access to resources, make women particularly vulnerable to HIV infection.

## **Children, Youth and HIV/AIDS**

The HIV epidemic has a profound impact in children, causing high morbidity and mortality rates among infected children and orphaning many others. Unless checked, the HIV epidemic has the potential to reverse the progress that has been made in lowering India's infant mortality rate, as has been demonstrated in other countries.

- According to UNAIDS, an estimated 48,000 children under the age of 15 were living with HIV/AIDS at the end of 1997, and an estimated 120,000 children have become orphans due to AIDS since the beginning of the epidemic.

## **SOCIOECONOMIC EFFECTS OF HIV/AIDS**

About 90 percent of reported AIDS cases are among 20 to 45 year olds. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector likewise feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to less labor-intensive crops. In many cases, this implies switching from export crops to food crops, thus affecting the production of cash and food crops.

There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when forced to care for sick family members. AIDS also adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level, there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children, and in the absence of grandparents, young children often become heads of households.

## **INTERVENTIONS**

### **National Response**

In 1992, the GOI developed the National HIV/AIDS Control Program (NACP) to be implemented by NACO of the Ministry of Health and Family Welfare (MOHFW). NACO has provided national leadership and facilitated the development of State AIDS Societies in all states across India. Knowledge about HIV/AIDS, especially in urban areas, has increased significantly. NACO has recently developed the next phase of the NACP with additional assistance from the World Bank. The objectives of this phase will be to:

- Reduce the spread of HIV infection in high-risk populations,

- Reduce the spread of infection in low-risk populations,
- Strengthen the impact and sustainability of national, state and local programs,
- Build capacity for provision of low-cost, community-based care, and
- Promote intersectoral links.

In this last phase, NACP will emphasize and enhance the technical leadership role of NACO, while devolving service delivery responsibility to state-, district- and municipal-level organizations.

## Donor Response

Multilateral and bilateral donors are actively engaged in India.

**USAID** began support for India's HIV/AIDS program in 1990. With a commitment of more than 50 million dollars, USAID is one of the largest donors in India. Operational in 1995, USAID's AIDS Prevention and Control (APAC) activity in Tamil Nadu was the first state-

specific intervention program in India. This multiyear, \$10 million project supports NGOs and technical institutions to design and implement community-based prevention programs to reduce sexual transmission of HIV. Working closely with NACP and the Tamil Nadu State AIDS Society, the program includes targeted interventions for behavior change, expanding access to and utilization of high-quality condoms, expanding access to and utilization of quality STI treatment, and behavioral and operations research to improve program planning and shape intervention strategies. APAC was the precursor of other donor-funded, state-specific HIV-prevention programs.

*In the last two years, 104 NGOs have been funded by USAID to work with high-risk groups on HIV/AIDS prevention. Among these are 11 NGOs that work at strategic locations on interstate highways and provide behavior change education to approximately 1.5 million truck drivers who travel through these locations each month. A training module was designed for training physicians in the diagnosis and management of STIs. Five institutions in Tamil Nadu have also been supported to train 1,400 physicians over the next three years in providing high quality care for STIs.*

In 1999, USAID expanded its activities to Maharashtra where, in addition to intervention programs, the \$41.5 million seven-year project, called AVERT, will support activities related to care and support of HIV-infected individuals. Modeled after APAC, the three major components of AVERT include:

- Improving the availability and quality of information, products and services to reduce transmission and mitigate the impact of HIV/AIDS and related infectious diseases;
- Strengthening the capacity of state and municipal organizations; and,
- Increasing the availability and use of data for advocacy and decision-making.

In 1999, USAID also initiated a series of projects to support activities for children affected by HIV/AIDS in Delhi, Tamil Nadu and Maharashtra. In addition, USAID supports NACP by providing financial and technical assistance to national programs and supporting the evaluation of programs, such as the Family Health Awareness Week, an annual activity to create awareness about STIs and the need for diagnosis and treatment.

USAID also supports the Program for Advancement of Commercial Technology/Child and Reproductive Health (PACT/CRH) which provides financial support and technical assistance to commercial and private

sector organizations to expand the marketing and distribution of condoms. To improve the quality of condom production in India, PACT/CRH assists the Drug Controller of India to strengthen the government's quality control and monitoring capacity and to work with manufacturers to improve condom packaging. PACT/CRH also supports the private and commercial sectors to create new diagnostic products and improve the quality and marketing of existing products.

USAID also supports the Population Council's activities to assess the economic impact of HIV/AIDS, increase decentralization of HIV/AIDS cases, improve affordable and appropriate care and support services for persons living with AIDS (PLWAs) in South India, and reduce stigma and discrimination against PLWAs in clinical settings.

USAID regional activities, which include India, promote best practices in preventing HIV transmission and providing care to AIDS victims and their families. Activities include condom social marketing, crossborder prevention activities, capacity building for local authorities and NGOs to undertake surveillance and reporting on HIV/AIDS in high-risk areas, behavior change surveys, improved management of STIs, and support for improved national policy frameworks.

**The Australian Agency for International Development, AusAID**, supports a project for the counseling and care of PLWAs and prevention activities focusing on women and children's health and capacity building. AusAID funding to India for HIV/AIDS activities for 1997–2000 is Aus\$43,000. AusAID is currently developing proposals for state-based programs in Mizoram, Meghalaya, Manipur, and Delhi.

**The European Union (EU)** supports NGO activities in HIV/AIDS prevention and care, and funds the Lawyers Collective to implement a project on human rights, ethics and law.

**Japan** supports blood safety and surveillance components of state government programs, in addition to providing funds to UNAIDS in support of interstate and international study tours.

**The Netherlands** supports several NGO awareness programs and capacity building in care and support.

**The British Department for International Development (DfID)** supports three major programs on HIV/AIDS: Interventions for Sexual Health, West Bengal Sexual Health Project, and a countrywide Health Highway project targeting truck drivers and their partners. DfID's total project budget for 1995–2000 is 8 million pounds sterling.

**The Swedish International Development Agency (SIDA)** provides direct support to NGOs in Nagaland and Manipur for IDU projects, support to home-based care in the North East, support to the Bombay Municipal Corporation for a project targeting sex workers, and assistance to state governments for the integration of adolescent sexual health and HIV/AIDS programs in the health sector. SIDA provided 500,000SK to India for activities in 1997.

**UNAIDS** established a Theme Group and Technical Working Group on HIV/AIDS to coordinate the response of United Nations agencies to the epidemic and provide assistance to the GOI in the strategic develop-

ment of activities. The Theme Group is comprised of members from the United Nations Development Programme (UNDP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), United Nations Development Fund for Women (UNIFEM), United Nations Information Centre (UNIC), the United Nations International Drug Control Programme (UNDCP), the International Labour Organization (ILO), the World Health Organization (WHO), and the World Bank.

UNAIDS activities include:

- Establishment of a national HIV/AIDS information exchange mechanism and resource centers;
- Technical assistance to NACO in the development of a national advocacy program;
- Technical assistance to GOI in the design and planning of the next phase of NACP;
- Technical assistance in the design and establishment of technical resource groups;
- Collation and documentation of existing literature, reports, and studies on HIV/AIDS;
- Facilitation of a school-based HIV/AIDS education program and a project aimed at reducing drug use and HIV/AIDS/STI among street children; and,
- Promotion of wider media coverage through workshops for journalists and dissemination of information packages to the media, and collaboration with entertainment media to promote HIV/AIDS information targeting youth.

UNICEF supports operations research on pediatric HIV/AIDS and vertical transmission, training of health workers on prevention and care for PLWAs, HIV/AIDS education for school-based and out-of-school youth, projects to reduce risk behavior related to drug use among street children, and regional workshops on the Rights of the Child.

UNFPA activities include District Reproductive Health projects, awareness-raising among out-of-school adolescent girls, training of health workers, strengthening of laboratories to provide testing and counseling, condom quality assurance, research in syndromic management of STIs, and support to social marketing programs.

*India has an opportunity to learn from the successes and mistakes of other countries. Thailand acted early with interventions targeted at groups at highest risk and was able to stabilize adult HIV/AIDS prevalence at about 2 percent. Zimbabwe did not act early and prevalence rates are now over 17 percent. India must act now with an expanded response.*

UNESCO is involved in school-based education programs, advocacy, peer education, and empowerment of women.

WHO is working to strengthen STI prevention and control through training, operations research and technical assistance to NACO; improve the provision of condoms through quality assurance protocols and studies on the female condom; ensure safe blood supply; improve the clinical management of HIV/AIDS; improve HIV/AIDS surveillance; increase support to PLWAs; and increase the capacity of NGOs to implement prevention activities.

**The World Bank** provided \$100 million to NACO to support the development of the national response to the epidemic. The World Bank has also recently pledged \$191 million to the GOI to support building India's capacity to respond to the epidemic and prevention efforts, specifically IEC, condom promotion, STI treatment and peer counseling targeting sex workers, migrant workers, IDUs, truck drivers, and other high-risk groups.

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

A number of PVOs/NGOs implement activities funded by multilateral and bilateral donors. NGOs also receive funding from a variety of sources and carry out most of the HIV/AIDS prevention and care activities in India.

The International HIV/AIDS Alliance is working in India to build and link existing capacity and expertise in HIV-related programming and NGO support. Activities include strengthening the technical skills of Centers of Excellence which provide technical support services to other NGOs in care and support; developing, evaluating, documenting, and disseminating model approaches to HIV/AIDS service delivery (including services for IDUs and men who have sex with men); and, promoting involvement of PLWAs in prevention activities.

## **CHALLENGES**

India faces considerable challenges in its fight against HIV/AIDS:

- GOI policy and implementation commitment at the national, state, district, and municipal levels is necessary. Commitment, advocacy, and resource allocation by all states are urgently needed.
- GOI must take innovative, community-based approaches to preventing new infections, starting with those groups at highest risk, within a broad-based strategy that helps build India's capacity to respond to long-term challenges.
- States unaware of the HIV threat or with poor capacities should be strengthened.
- Low-cost community-based care without stigmatization is urgently needed for those already suffering from AIDS.
- Intervention programs must respond to special needs of the target populations, including low literacy and social marginalization.
- Dialogue needs to focus on curtailing the epidemic with strategic choices and strengthening the public system.

## **FUTURE ACTIONS NEEDED**

HIV/AIDS reduces life expectancy, increases the demand for medical care, worsens other illness (like tuberculosis), and exacerbates poverty and inequality. Estimates indicate there are more HIV-infected people in India than any other country in the world. With a well-managed prevention program put into place now, HIV infection could stay below 2 percent of the adult population. Without a successful intervention, India could be faced with the same devastation that many countries in Africa face today.

The growth of the epidemic is determined largely by sexual transmission to and from groups at highest risk (sex workers and their clients, and IDUs). However, in no country has the infection remained within these groups; it will eventually affect all of India.

## **IMPORTANT LINKS AND CONTACTS**

1. NACO, Mr. J.V.R. Prasada Rao, Project Director; Tel/Fax: (91) 3011-7706, E-mail: [nacodel@del2.vsnl.net.in](mailto:nacodel@del2.vsnl.net.in).
2. UNAIDS, Mr. Alexander Gordon, Senior Country Program Adviser, UNICEF House, 55 Lodi Estate, New Delhi 110 003; Tel. (91) 11-464-9892, Fax: (91) 11-464-9895, E-mail: [gordon.alexander@undp.org](mailto:gordon.alexander@undp.org).

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# CAMBODIA AND HIV/AIDS

## TALKING POINTS

Cambodia's HIV/AIDS epidemic is the fastest growing in Asia. HIV prevalence is currently estimated at over 3.7 percent of the adult population (15–49 years of age).

- The first HIV infection was detected in 1991.
- By the end of 1998, an estimated 180,000 adults were infected with HIV.
- Initially concentrated in high-risk segments of the population, the epidemic has now reached the general population.
- Even with highly effective interventions, it has been estimated that AIDS will cost the Cambodian economy \$2 billion by 2006.

The National AIDS Program (NAP) estimates that 17,000 adults and 5,000 children will have died from AIDS by the end of 1999. An estimated 5,000 adults and 1,300 children died of AIDS in 1998 alone.

**Women and HIV/AIDS:** The HIV epidemic in Cambodia is centrally linked to gender roles, inequity, and the low social and economic status of women. Over 54,000 adult women (ages 15–49 years) were estimated to be living with HIV at the end of 1998. In 1998, HIV prevalence was 42.6 percent among direct sex workers, 19.1 percent among indirect sex workers, and 2.4 percent among married women.

**Children, Youth and HIV/AIDS:** The HIV epidemic has a substantial impact on children, causing high morbidity and mortality among infected children and orphaning many others. The number of AIDS-related orphans in Cambodia is expected to increase dramatically in the coming years. The Joint United Nations Programme on AIDS (UNAIDS) estimates 10,000 children under age 15 were living with HIV at the end of 1997 and an estimated 7,300 children have become orphans due to AIDS since the beginning of the epidemic.

**National Response:** HIV infection is now well established in Cambodia. Across the country, surveillance data suggest alarmingly high prevalence rates and the majority of Cambodians with HIV infection are not yet aware of their infection. An expanded multisectoral response involving all levels of government, the private sector and civil society is needed, in addition to continued aggressive public outreach campaigns and education interventions targeting key high-risk populations.

**Donors:** Proposed USAID funding for HIV/AIDS activities for fiscal year 2000 is \$2 million. USAID is focusing its prevention and control efforts on high-risk populations, in particular, the individuals (mostly men) who form bridges between the high-risk groups and the general population.

# CAMBODIA AND HIV/AIDS

## COUNTRY PROFILE

The kingdom of Cambodia is situated on the Indochina peninsula and shares borders with Thailand, Lao People's Democratic Republic and Vietnam. Cambodia's population of 11.8 million is primarily Buddhist (95 percent) and of the Khmer ethnic group (96 percent). Approximately 1 million people live in Phnom Penh, the capital city; however, 84 percent of the total population live in rural areas. With a rate of natural increase of 2.5, the population is expected to double in less than 28 years. The country's population is young, with 43 percent under 15 years of age.

Cambodia is steadily making the transition to a market economy as it recovers from decades of war and internal strife. The achievements of Cambodia's reform efforts have been impressive, given the state of Cambodia after a quarter century of devastation that left its human capital decimated through genocide and the exodus of educated citizens, and its economic and social infrastructure dismantled.

Cambodia remains, however, one of the poorest countries in the world, with widespread poverty (almost 40 percent of the population live below the poverty line) and a high incidence of malnutrition and infant mortality. Much of the population lacks access to health and educational facilities, safe water, electricity, sanitation and serviceable roads, and land mines continue to limit the use of arable land. Years of war and neglect have ravaged the country's physical infrastructure. The educated group of teachers, managers, doctors, nurses, and other skilled professionals, which was almost entirely wiped out by the Khmer Rouge, is only now being rebuilt. The result is a population ages 18-36 years, which lacks the basic skills necessary for more than subsistence living and a structure which is unable to support economic growth and the establishment of democratic processes—a situation which contributes to keeping the population in a state of poverty.

The health status of the population of Cambodia is one of the lowest in Asia. Leading causes of mortality are malaria, acute respiratory infections and tuberculosis. Cambodia has one of the lowest rates of utilization of health services in the world—an average Cambodian has only 0.35 medical contacts with organized health

| Key Population, Health and Socioeconomic Indicators |                                      |                                  |
|-----------------------------------------------------|--------------------------------------|----------------------------------|
| 1999 Population                                     | 11.4 million                         | 1998 Census                      |
| Rate of Natural Increase                            | 2.5                                  | 1998 Census                      |
| Life Expectancy                                     | Males: 50 years<br>Females: 58 years | National Institute of Statistics |
| Total Fertility Rate                                | 4.1                                  | 1998 National Health Survey      |
| Infant Mortality Rate                               | 89/1,000 live births                 | 1998 National Health Survey      |
| Maternal Mortality Rate                             | 500/100,000 live births              | 1995 Situation Assessment        |
| Adult Literacy (1995)                               | Males: 48%<br>Females: 22%           | Population Reference Bureau      |

services per year. Only 10 percent of deliveries take place in hospitals or health centers. Rehabilitation and improvement of health services remain key priorities of the Ministry of Health (MOH); however, improvements are constrained by a low national health budget. Infant, child and maternal mortality rates are among the highest in Asia and Cambodia's HIV/AIDS epidemic is the fastest growing.

## HIV/AIDS in Cambodia

HIV was first detected in Cambodia in 1991 in a male blood donor. There is evidence of an explosive increase of infections since 1992, and the first cases of AIDS were diagnosed in late 1993 and early 1994. The HIV epidemic has now spread into every province and every population group in the country.

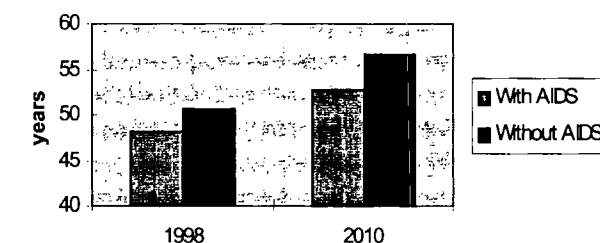
HIV prevalence is currently estimated at over 3.7 percent of the adult population (ages 15-49). A Consensus Workshop on HIV/AIDS in Cambodia was held in March 1999, resulting in the following estimations:

- By the end of 1999, a total of 241,000 HIV infections will have occurred in adults, with 219,000 persons living with the virus.
- By the end of 1999, 22,000 AIDS cases will have occurred in adults, with 18,000 resulting in death.
- By the end of 2005, an estimated 120,000 adults will have died of AIDS.
- The male to female ratio is approximately 2:1.

Heterosexual activities are the major mode of transmission. There is little information regarding homosexual/bisexual transmission available, although preliminary studies concerning men who have sex with men (MSM) are currently underway. The highest rates of HIV have been found among female sex workers. Significant perinatal transmission has also been reported; however, higher levels of infection are suspected. Geographically, the highest rates have been found in the southeast and central provinces and along the Thai border. HIV infection has been noted in all regions of the country, although it appears to be concentrated in urban areas.

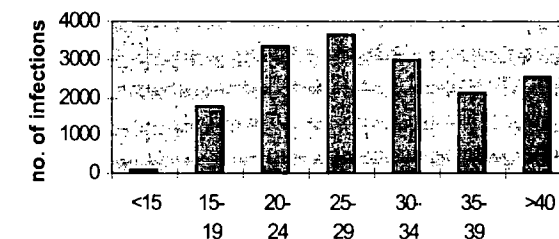
- HIV prevalence among police in 1998 ranged from 0.7 percent to 25.8 percent, and was 2 percent or higher in 15 of the 18 provinces surveyed.
- Among male blood donors in 1998, HIV prevalence was 4.1 percent, and 2.5 percent among female donors.

**Life Expectancy With and Without AIDS in Cambodia, 1998 - 2010**



Source: USAID/UCEN May 1999

**Reported HIV Infections by Age Group Among Sentinel Groups in 1998**



Source: NCHADS/MOH 1998

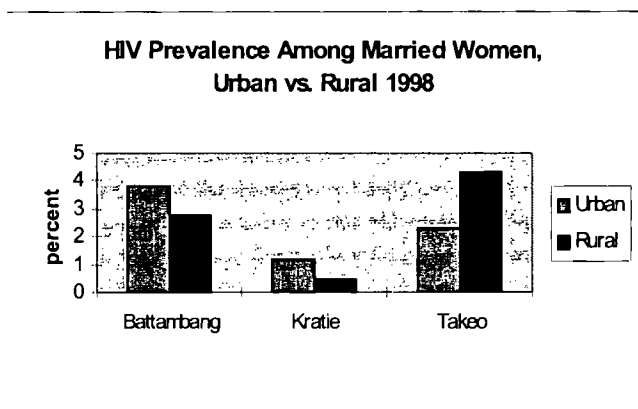
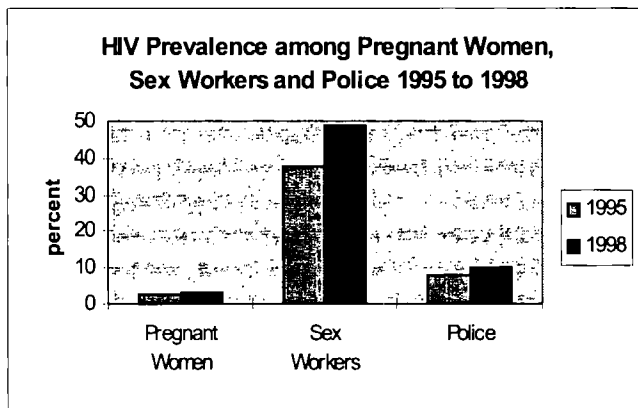
High levels of sexually transmitted infection (STI) have also been reported. A 1996 study revealed that 44 percent of sex workers surveyed had at least one STI other than HIV and over 50 percent of those with an STI had no clinical signs. The same study found 17 percent of men examined had the presence of at least one STI.

Behavioral surveillance data indicate that risk behaviors are widespread among sex workers, their clients and youth. Surveys conducted in 1998 indicate that overall condom use among men with sex workers was between 53 and 63 percent, compared with only 5 to 24 percent with regular or non-sex worker partners. Condom use among sex workers appears to be rising and the use of commercial sex appears to be decreasing; however, high-risk behaviors continue to be unacceptably high.

### Women and HIV/AIDS

Women account for approximately 52 percent of the population and 26 percent of households are headed by women (1 in 4 households in rural areas and 1 in 3 in Phnom Penh). The HIV/AIDS epidemic in Cambodia is centrally linked to gender roles, inequity and the low social and economic status of women. Women's vulnerability to HIV is further compounded by their greater biological susceptibility to HIV infection and lower literacy rates than men. Women are discouraged through cultural norms and peer pressure from being knowledgeable about sexual matters and have less negotiating power in sexual relationships.

- Over 54,000 adult women (15-49 years old) were estimated to be living with HIV at the end of 1998.
- HIV prevalence among female sex workers in 1998 ranged from 6.7 percent to 64.1 percent.
- HIV prevalence among married women in 1998 ranged from 0.2 percent to 6 percent, but was 2 percent or higher in 12 of the 19 provinces surveyed.
- In 1997, 3.2 percent of pregnant women were HIV positive.



Commercial sex has been a culturally and socially accepted tradition for centuries. In 1990, there were approximately 1,500 sex workers operating in Phnom Penh. By the late 1990's, the number of sex workers in Phnom Penh and Battambang had increased to approximately 40,000. It is estimated that over 40 percent of these sex workers are now infected with HIV.

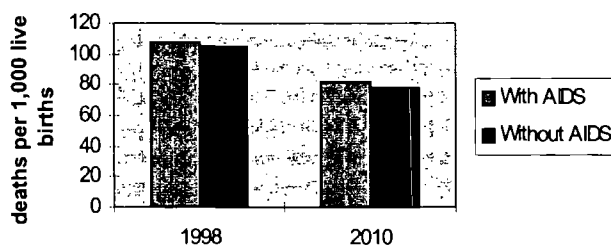
## Children, Youth and HIV/AIDS

The HIV epidemic has a substantial impact on children, causing high morbidity and mortality rates among infected children and orphaning many others. The number of orphans in Cambodia is expected to increase dramatically due to AIDS in the coming years. Infant mortality rates are currently estimated at 3 percent higher than they would have been in the absence of AIDS and child mortality rates are 6 percent higher due to AIDS.

- The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that 10,000 children under 15 years of age were living with HIV at the end of 1997.
- An estimated 7,300 children have become orphans due to AIDS since the beginning of the epidemic.

Youth are more vulnerable to HIV/AIDS/STI due to greater exposure to sexual exploitation, limited knowledge of reproductive health issues, and high-risk behaviors, such as early onset of sexual activities, multiple sex-partnering, low perception of personal risk, low condom use, and drug and alcohol use. Cultural norms inhibiting discussions related to sex and reproductive health, in addition to stigmatization by health care workers and a lack of reproductive health services designed for young people, compound adolescents' vulnerability to HIV infection. Research suggests that sex among unmarried youth is becoming more common, especially in urban areas. Illiterate, out-of-school youth are especially vulnerable to HIV/AIDS, in particular homeless youth and orphans.

Infant Mortality Rate With and Without AIDS  
in Cambodia, 1998-2010



*According to a survey of urban youth ages 11 to 20, while nearly all knew that AIDS was present in Cambodia, 80 percent believed it would not be possible for them to contract HIV, and only one in four thought it would be possible to contract an STI.*

## SOCIOECONOMIC EFFECTS OF HIV/AIDS

In 1997, an estimate of the economic impact of AIDS in Cambodia found that even with highly effective interventions, AIDS would cost the Cambodian economy \$2 billion by 2006. A prime determinant of this cost is the fact that about 90 percent of reported AIDS cases are among 20-49 year olds. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector similarly feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to less labor-intensive crops. In many cases, this implies switching from export crops to food crops, thus affecting the production of cash and food crops.

There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when forced to care for sick family members. AIDS also adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level, there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children, and in the absence of grandparents, young children often become heads of households.

## **INTERVENTIONS**

### **National Response**

Following the establishment of the National AIDS Program (NAP) in 1991, a Comprehensive National Plan for AIDS Prevention and Control for 1993-98 was developed with the overall goals of reducing HIV transmission and reducing the morbidity and mortality associated with HIV infection. The National Plan includes the following objectives:

- Coordinate policy,
- Collect accurate surveillance data on HIV infection in selected populations,
- Diagnose HIV and STIs accurately in populations at risk,
- Reduce the incidence of sexual transmission of HIV and STIs,
- Provide educational information to coincide with surveillance,
- Prevent transmission through blood products,
- Prevent the spread of HIV among injecting drug users (IDUs),
- Prevent the spread of HIV by skin-piercing instruments,
- Reduce the transmission of HIV from mother to child,
- Minimize the personal suffering and social stigma associated with AIDS and provide psychosocial support to those affected by HIV/AIDS,
- Provide the best available medical care for persons with AIDS, and
- Monitor and evaluate activities of the National Plan.

The National Center for HIV/AIDS, Dermatology and STD (NCHADS) was established by the MOH in 1998 to oversee the response of the MOH, as well as to provide technical support to other government agencies and national partners. In January 1999, the National AIDS Authority (NAA), reporting directly to the Council of Ministers, was established to strengthen the multisectoral response to the epidemic and heighten high-level awareness of the problem. In the new structure, NCHADS serves as a technical bureau. The National Strategic Plan for 1998-2000 emphasizes the implementation of interventions that have the highest impact on the spread of the virus, address vulnerable populations, and promote community participation and involvement of persons living with AIDS (PLWA). The strategic plan also provides guidance to the provincial planning process and places great emphasis on the role of prevention and increasing the availability, affordability and accessibility of condoms.

Strengthening the HIV/AIDS response at the provincial level is a priority of both the government and the United Nations. The NAP/NAA identified that, previously, too much involvement at the provincial level was inhibiting implementation of prevention activities; however, there was limited capacity at the provincial level to undertake AIDS prevention and care. Provincial AIDS committees (PACs), provincial AIDS secretariats (PASs) and provincial AIDS offices (PAOs) were established and are seen as crucial bodies in implementing the National Strategic Plan on a provincial level. NAA oversees the results of the PACs and pilot projects aimed at strengthening PACs and PASs have been supported through UNAIDS and other United Nations agencies.

The government response also includes research activities, STI prevention and control through improved STI management and availability of quality services, condom social marketing, blood safety programs, care and support for PLWAs, and HIV/AIDS education and information.

The corporate sector has been slow to respond to the epidemic, with involvement to date amounting to limited sponsorship of events or activities and few workplace activities.

## **Donors**

Multilateral and bilateral donors have been actively engaged in Cambodia; however, political events of July 1997 resulted in a suspension or drastic reduction in bilateral assistance. Prior to the 1997 aid suspension, USAID was the second largest bilateral donor after Japan. With the formation of a new government, some donors have signaled their intention to resume development cooperation with Cambodia. The HIV/AIDS response in Cambodia is highly dependent on foreign donors. However, due to political events, an estimated 80 percent of donor money is given directly to nongovernmental organizations (NGOs), rather than to the government, for implementation of activities.

USAID's proposed funding for HIV/AIDS activities for fiscal year 2000 is \$2 million. USAID is focusing its prevention and control efforts on high-risk populations, and in particular, the individuals (mostly men) who form bridges between the high-risk groups and the general population. Three key target results for current activities are: policymakers are better informed about the HIV/AIDS epidemic in Cambodia, high-risk behaviors are reduced in target areas, and STI and reproductive health service delivery programs for high-risk populations are piloted and replicated in target areas.

Under USAID funding, the Implementing AIDS Prevention and Care Activities (IMPACT) project of Family Health International (FHI) is operating with partners, including the Institute for Tropical Medicine (ITM), Management Sciences for Health (MSH), Population Services International (PSI), the Program for Appropriate Technology in Health (PATH), and the University of North Carolina (UNC). The project focuses on reducing HIV and STI transmission, primarily among sex workers and their clients in Phnom Penh, Kompong Cham, and Kandal and will extend to Kompong Chhnang, Kompong Thom and Kompong Speu in the second phase of project implementation. Activities include promoting condom use in brothels, increasing participation of religious leaders in prevention and care, strengthening NGO networks, behavior change intervention programs for high-risk men and women, development of behavior change communication (BCC) materials, and development of STI prevention and care facilities for sex workers and their clients.

With USAID funding, PSI has played an important role in a nationwide condom distribution program in Cambodia since 1993. Through its social marketing program, over 40.6 million condoms have been sold with increasing sales every year (10.5 million in 1997 and 11.5 million in 1998). Currently, condoms are reported to be available in over 90 percent of commercial sex establishments. PSI has also implemented a highly effective and appropriate information, communication and education (IEC) program to raise awareness among the general population of the dangers of HIV/AIDS/STI and of means of prevention.

Recently, under USAID child survival supplemental funds, FHI/IMPACT and the International HIV/AIDS Alliance have initiated new activities to address the needs of children affected by HIV/AIDS, including orphans. FHI/IMPACT will focus on providing education and information about HIV/AIDS/STI prevention and care to sexually active street children and educate their families on how to prevent HIV transmission. The International HIV/AIDS Alliance (through its local partner KHANA) will undertake a country situation assessment to identify specific needs of vulnerable children, strengthen NGO capacity, and mobilize communities to provide care and support to vulnerable children, including orphans.

The Population Council's HIV Operations Research (HORIZONS) project is conducting research in a number of areas, including the impact on prevention behaviors of providing home care to PLWAs and a community mobilization approach to decreasing HIV transmission in sex work.

**European Union (EU)** activities include support to strengthen the technical capacities of NCHADS, especially in the field of STI control; strengthening STI services for sex workers; and, strengthening STI services for women of the general population. EU funding for the period 1997-2000 is 1,990,000 ECUs.

**The Australian Agency for International Development (AusAID)** supports the Mekong Subregional HIV/AIDS Initiative, which involves six countries, including Cambodia. Key activities include STI management and prevention, condom use, behavior change, and care in crossborder areas. AusAID funding for regional activities in Cambodia was Aus\$100,000 for 1998-99 and Aus\$200,000 for 1999-2000. In addition, AusAID supports a youth peer education project implemented by the Australian Red Cross. Funding for this project totaled Aus\$1,012,000 for 1995-98.

**UNAIDS** established a Theme Group on HIV/AIDS to coordinate the response of United Nations agencies to the epidemic and provide assistance to the government of Cambodia in the strategic development and evaluation of activities. The Theme Group is comprised of members from the United Nations Development Program (UNDP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations High Commissioner for Refugees (UNHCR), the United Nations International Drug Control Program (UNDCP), the Food and Agriculture Organization of the United Nations (FAO), the World Health Organization (WHO), and the World Bank.

UNAIDS activities include:

- Advocacy,
- Resource mobilization,
- Identification and promotion of best practices, and

- Support to the NCHADS, NAA, PACs, and selected government ministries for the expansion of the national response to the epidemic.

UNAIDS provided \$652,000 during the years 1997-99 for HIV/AIDS activities.

**UNICEF** activities include information dissemination for awareness raising and the promotion of appropriate behavior and life skills, and support for the decentralization of prevention activities through the consolidation and expansion of PACs. UNICEF provided \$770,000 for AIDS activities in 1997-98.

**UNDP** provides technical assistance to PACs and supports the development of a national policy concerning the promotion of condom use in sex establishments. Other UNDP activities include policy development and strategic planning with select ministries; support to the Subregional Project on HIV which is conducting a mapping exercise to identify target mobile populations between Thailand, Vietnam and Cambodia; and, support to the Greater Involvement of People Living with AIDS (GIPA) project. UNDP funding for 1997-98 was \$1.1 million.

**UNESCO** activities include the development of educational materials, training of trainers and teachers, awareness campaigns through cultural performances, research, and seminars. UNESCO funding for 1997-98 was \$77,500.

**UNFPA** HIV/AIDS activities are fully integrated into the reproductive health programs supported by UNFPA. Support includes procurement of condoms, training on HIV/AIDS and STI management for public health service providers, HIV screening and counseling services, support to NGOs for training and advocacy, materials production and IEC activities. Funding for UNFPA HIV/AIDS activities for 1997-98 was approximately \$557,000. (HIV/AIDS funding is approximately 10 percent of the total reproductive health project budget.)

**The World Bank** has budgeted \$6.5 million to support the NAP from 1996 to 2000. The project has budgeted \$1.6 million for the period June 1998 to December 1999. Activities include IEC, blood safety services, risk behavior reduction, STI service strengthening, support to the HIV sentinel surveillance and behavioral surveillance systems, and provision of small grants to NGOs for community-based interventions.

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

A number of PVOs/NGOs implement activities funded by multilateral and bilateral donors. NGOs also receive funding from a variety of sources and carry out most of the HIV/AIDS prevention and care activities in Cambodia.

Under USAID funding, the International HIV/AIDS Alliance is working to link organizations to enhance their skills in behavioral change communication and transfer best practices and knowledge to other NGOs. In Cambodia, the Alliance has supported the establishment of the Khmer HIV/AIDS NGO Alliance (KHANA), which functions as a linking organization for Cambodian NGOs, facilitating financial and technical resources to expand and strengthen their activities. To date, 26 Cambodian NGOs have been supported.

USAID currently supports the Border Area HIV/AIDS Project (BAHAP) implemented by CARE International. The goal of BAHAP is to conduct crossborder HIV/AIDS/STI research, prevention and care in the provinces of Svay Rieng and Koh Kong along Cambodian borders to Vietnam and Thailand.

NGOs and community-based organizations (CBOs) have been involved since the early years of the epidemic and play a key role, providing a range of services, including education and social support. The NGOs/CBOs response has been restricted due to limited resources. However, NGOs, which have greater capacity and access to populations, have been able to implement a number of activities for the government.

Over 70 organizations working in the field of health formed an organization called MEDICAM, which has developed a database of NGO activities, including the geographic location of activities and type of support being provided. In addition, a number of organizations meet monthly in the HIV/AIDS Coordinating Committee (HACC), which was established to coordinate the efforts of NGOs and NAA, promote cooperation and information exchange, foster linkages, and work for the benefit of the public in awareness campaigns. The work of the HACC is led by a steering committee and includes working groups on training and counseling, care and support, and mass media.

## CHALLENGES

Cambodia faces considerable challenges in its fight against AIDS:

- Developing the capacity and capabilities of the NAA and PACs to ensure timely responses and implementation of the National Strategic Plan;
- Increasing the nonhealth sector's understanding of the impact of the AIDS epidemic, and ensuring an expanded multisectoral response;
- Ensuring that commitment is maintained by members of all committees through consistent attendance and appropriate action;
- Translating national policy into provincial responses for provincial government units and ensuring that implementation of activities is transferred from the national to the provincial level;
- Educating and enlisting the corporate sector to respond to the epidemic and increase understanding of the importance of prevention activities;
- Developing prevention programs to reach illiterate populations (particularly rural women);
- Increasing the involvement of religious and political leaders and provincial governors in the fight against AIDS;
- Improving STI surveillance, minimizing the increase in drug resistance to STI, and increasing the availability and use of quality STI services, particularly among adolescents and single women;
- Increasing the use of condoms by Cambodians;
- Overcoming the stigmatization of HIV/AIDS and providing a future for children and youth orphaned by AIDS;
- Expanding extremely limited counseling services and training and recruitment of knowledgeable staff and volunteers at all levels;
- Educating a large military which has significant HIV--infection levels and varying degrees of awareness; and,

- Coping with a large commercial sex industry throughout the country which is illegal but mostly tolerated and sometimes exploited by local authorities.

## **FUTURE ACTIONS NEEDED**

It is clear that HIV has now spread to the general population in Cambodia. It is essential to break the chain of transmission from sex workers and their clients and subsequently to wives and girlfriends as well as to protect the blood supply, assure adequate sterilization of needles and syringes and other invasive instruments between uses, and inform the public of the multiple potential sources of HIV infection in Cambodia.

The majority of Cambodians with HIV infection are not yet aware of their infection. It is expected that up to 200,000 patients with AIDS will seek treatment through the health system within the next 5-10 years. Efforts must be made to ensure that the health care system is prepared to deal with the needs of persons with AIDS and to ensure that services are integrated. The burden of caring for PLWAs and their orphans will place significant stress on communities over the coming years. Community support systems, including strategies for the sustainable provision of care to PLWAs, must be strengthened.

Advocacy activities are urgently needed to convince local officials of the importance of HIV/AIDS/STI prevention and care programs and to increase government commitment to prevention activities. An expanded multisectoral response involving all levels of government, the private sector and civil society is needed, in addition to continued aggressive public outreach campaigns and education interventions targeting key high-risk populations. Additional policy development should be undertaken in support of the national response.

## **IMPORTANT LINKS AND CONTACTS**

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6. UNAIDS, Mr. Geoff Manthey, Country Programme Adviser, National Center for Health Promotion,

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