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- 10 Gordon RD, Stowasser M, Klemm SA, Tunney TJ. Primary aldosteronism and other forms of mineralocorticoid hypertension. In: Swales J, ed. *Textbook of hypertension*. Oxford: Blackwell Scientific, 1994: 865-92.
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Public health

Impact of Thailand's HIV-control programme as indicated by the decline of sexually transmitted diseases

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Summary

The Thai government began an HIV-control programme in 1989. The programme had the following parts: the government bought and distributed sufficient condoms to protect much of the commercial sex in the country; sanctions were brought against commercial sex establishments where condoms were not used consistently; and a media campaign bluntly advised men to use condoms with prostitutes.

Between 1989 and 1993 the use of condoms in commercial sex in Thailand increased from 14 to 94%, according to surveys of prostitutes, and the number of cases of the five major sexually transmitted diseases declined by 79% in men. We estimate that sex acts with prostitutes where there was a risk of HIV transmission declined from about 2.6% in June, 1989, to about 1.6% in June, 1993.

If condom use in commercial sex stays high, future cohorts of young men and women may experience lower HIV incidence rates than those of the recent past. However, although condom use is high, there are many more infected prostitutes than before and many infected men who will pass HIV to their wives.

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Introduction

From negligible prevalence in 1988, HIV spread through the Thai population in a very short time. By mid-1993, 4.0% of men drafted into the army and 1.4% of urban women presenting for antenatal care tested positive for HIV (table 1). As soon as the epidemic spread of HIV was detected, the government reacted with a programme to enforce condom use in commercial sex, which was the main source of heterosexual HIV infection (in 1989, almost all men coming to government sexually transmitted disease [STD] clinics said they had contracted their STD from a prostitute). In 1989 the government piloted a project in

Ratchaburi province to ensure that men could not obtain commercial sex without using a condom. The approach was copied in many other provinces. In August 1991, it became the official policy of the National AIDS Committee.^{1,2}

It was understood that if sex establishments adhered strictly to the condom policy, the authorities would not intensify sanctions against prostitution. But any evidence of the transmission of STDs to men in a sex establishment was taken to mean that condoms were not being used there, and resulted in sanctions by the police. Men soon learned that they could not obtain sex in a commercial sex establishment without condoms. Therefore, neither prostitutes nor brothel owners lost income, and neither group opposed the programme. The programme relied on the STD treatment system, which had been in place for over 25 years. Before the HIV epidemic, men presenting for treatment for an STD were asked where they contracted it. This procedure was adapted to identify establishments that were not co-operating with the government's policy on condoms. The second part of the programme was to provide free condoms for commercial sex. The government bought enough condoms to supply most of the commercial sex industry, and distributed them to prostitutes during their periodic STD examinations. The third part of the programme was mass advertising. Television and radio spots stressed that men should use condoms with prostitutes.

We describe several independent sources of data that, taken together, suggest strongly that the HIV-control programme has been a success.

Methods

Every 6 months since 1989, samples of blood have been taken from six groups in each Thai province: intravenous drug abusers, blood donors, pregnant women, male STD patients, and direct and indirect prostitutes (defined in the footnote to table 1).^{3,4} Every prostitute whose blood is tested is asked the following questions: "How many customers did you have the last night you worked?" and "Of these, how many used condoms?" In addition, since November, 1989, the army has screened new conscripts twice a year (table 1). Statistics on numbers of prostitutes have been collected by the Venereal Disease Division of the Ministry of Public Health (MOPH) since 1971.⁵ These statistics are based on continuously updated lists of sex establishments, compiled from reports from STD patients about where they contracted their infection, and supplemented by 1 surveys, annually since 1971 and 1 -

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Date	HIV prevalence (%)				Commercial sex acts where condoms were used (%) [†]
	Prostitution ^{††}	Prostitution ^{††}	Pregnant women ^{††}	Army conscripts ^{††}	
	Direct	Indirect			
1982-January 1989	..	..	..	..	14 (actual)
June, 1989	3.6	0.0	0.0	..	25
December, 1989	8.3	1.2	0.0	0.5	60
June, 1990	9.3	1.2	0.0	1.4	56
December, 1990	12.2	2.7	0.3	2.1	85
June, 1991	16.2	4.0	0.8	2.9	72
December, 1991	21.6	5.4	0.7	3.0	84
June, 1992	23.6	6.7	1.0	3.6	90
December, 1992	23.9	8.5	1.0	3.5	93
June, 1993	27.1	7.5	1.4	4.0	94
December, 1993	29.6	7.7	1.5	..	..

Pregnant women were those presenting for antenatal care in government hospitals in urban areas. Direct prostitutes are those who sell sex directly, as opposed to indirect prostitutes who may provide a service like massage or dancing, followed by sex at a separately negotiated price.

[†]From June, 1989, numbers are median values of the distributions of provincial means.

^{††}For June, 1989, data were based on the sentinel surveillance of 14 provinces; for December, 1989, 31 provinces; thereafter on all 73 provinces.

[‡]Data for army conscripts refer to May and November rather than June and December. Since the conscripts in May and November tend to come from different regions, the May rounds cannot be compared with the November rounds.

[§]Based on four local area studies from 1982 (14%), 1986 (7%), 1988 (14%), and January, 1989 (14%); and based on 12 provinces for June, 1989, 31 provinces in June, 1990, and 73 provinces thereafter.

Table 1: HIV prevalence and condom use among direct prostitutes

annually since 1983. There is no significant prostitution outside of commercial sex establishments. About 40% of prostitutes are direct prostitutes.

Government STD statistics come from the MOPH Division of Epidemiology, which collects data from the outpatient departments of government hospitals plus certain STD clinics, and the MOPH Venereal Disease Division, whose statistics incorporate data from additional STD clinics. The AIDS Division of the MOPH records numbers of condoms procured by the government and distributed to end-users. The Food and Drug Administration records numbers of condoms sold to retail outlets.

Results

From 1989 to 1993, condom use increased from 14 to 94% of commercial sex acts (table 1). Using estimates of the numbers of prostitutes (around 100 000), the number of clients they had per night (around 1.9), and the number of nights worked each month (around 25), we calculate that in 1992 there were about 57 million commercial sex acts in Thailand. During that year the government supplied 45 million condoms to sex establishments, and the private sector supplied 26.4 million to retail outlets (exclusive of condoms used for family planning). Thus, the government supplied enough condoms to protect 79% of commercial sex acts and the private sector sold enough condoms to protect 47%. Therefore, in theory, enough condoms were available to protect 126% of commercial sex acts. In 1993 both the government and the private sector reduced the numbers of condoms shipped, because it was evident that enough were available. The government supplied enough condoms to protect 60% of commercial sex acts, and the private sector 35%, a total of 95%.

Data in the figure came from the Venereal Disease Division and show the number of visits to STD clinics and the number of new cases of five classic STDs (syphilis, gonorrhoea, non-gonococcal urethritis, lymphogranuloma venereum, and chancroid) for 1967-1993.

In men, STDs increased continuously from the late 1960s to late 1970s. The dip in 1981-1982 was due to a departmental reorganisation that disrupted the reporting system. After that the number of cases and visits began to climb again until 1985. Beginning in 1986 until the condom

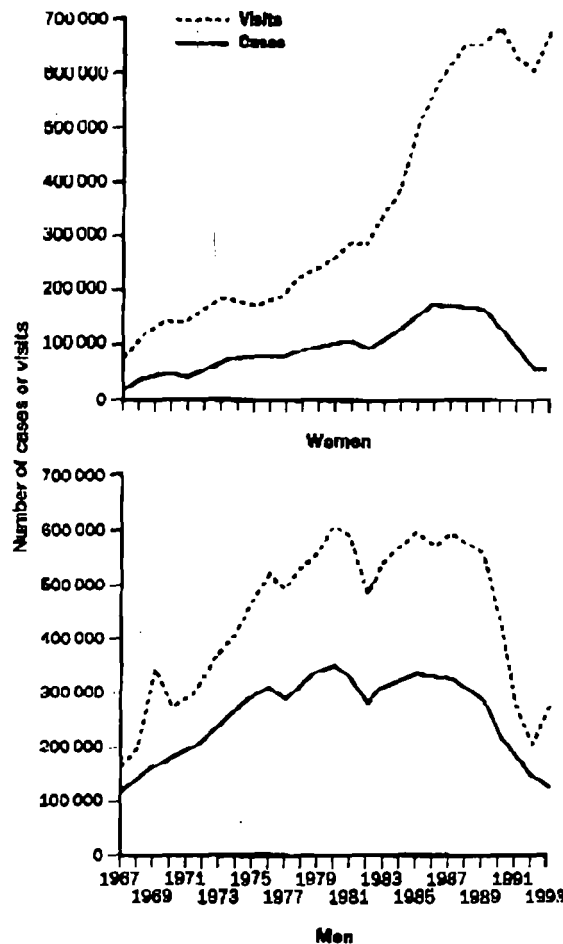


Figure: Number of STD clinic visits and cases of five major STDs

Data from annual report of the Venereal Disease Division of the MOPH. A case is the diagnosis of a new STD; a visit is either a case or an initial follow-up patient encounter where a new STD was not diagnosed.

programme in 1989, there was a modest decline, and from 1989, a steep drop. The reason for the decline in cases and visits in 1986, before the condom programme started in 1989, may have been because gonorrhoea and chancroid were declining slowly. These two STDs were susceptible to the quinolone antibiotics that were introduced in Thailand in 1986. Quinolones are not effective, however, against the other classic STDs, which declined hardly at all before 1989 (table 2). From 1989 the number of cases of gonorrhoea and chancroid declined much faster than before, and the other three STDs also began a rapid decline. Between 1989 and 1993 the number of male cases of the five classic STDs declined by 79%. A small part of this decline may have happened without the condom programme because of the use of quinolones. Between 1989 and 1993 gonorrhoea and chancroid declined by 85%, and the other STDs by 74%. These declines would have been even sharper if new STD clinics had not opened. 40 such clinics were opened in 1992, and 100 in 1993, which probably explains why visits increased in 1993, whereas new cases continued to decline.

Prostitutes accounted for most female STD clinic visits. The steady increase in visits and cases over the period shown in the figure was due to expanded coverage of the sex industry. Prostitutes were given free weekly tests, which included pelvic examinations, gram stains of cervical swabs,

Year	Syphilis	Gonorrhoea	Chancroid	Lympho- granuloma venereum	Herpes genitalis	Total
1987	11 855	108 289	38 754	17 353	69 986	237 237
1988	11 179	98 731	38 350	17 807	56 199	217 266
1989	11 487	84 676	29 675	16 020	57 191	199 048
1990	8330	50 344	16 133	8816	41 756	126 379
1991	8714	35 641	10 053	8935	31 995	89 238
1992	4233	22 052	4272	2339	21 137	54 203
1993	3845	14 750	1990	1027	17 423	38 835

Data are from annual reports of the Venereal Disease Division of the MOPH and refer to fiscal year. A case is the diagnosis of a new STD.

Table 2: Number of male STD cases at government clinics

gonorrhoea cultures, and serological tests for syphilis. Testing procedures have remained uniform in recent years. Although visits to government clinics by women remained high after the condom promotion programme, STDs fell substantially. The number of visits declined slightly (11%) in 1900-1992, but the number of new cases fell by 54%. As with men, the decline would have been even sharper without the opening of new STD facilities. In 1993, visits by women increased, but new cases continued to fall.

Unpublished data for 1992 for both sexes show that without the 40 new clinics that opened in 1992, the decline in cases would have been 85%, whereas the actual decline was only 69%.

Discussion

Our data have several limitations. First, prostitutes may have exaggerated condom use to please the interviewers. However, other independent surveys have confirmed the increase in condom use. Second, although we know how many condoms were shipped, we cannot document how many were actually used. All we can say is that the supply of condoms was more than sufficient to protect all commercial sex acts in the country. Finally, private clinics and pharmacies do not report STD cases. However, most anecdotal data suggest that the number of STD cases declined greatly in the private as well as in the public sector.

Despite these limitations, the data suggest that the condom programme has been successful in controlling bacterial STDs. In addition, since STDs are an important cofactor, HIV transmission is reduced when STD prevalence is reduced, even during unprotected sex. Without the high level of condom use reported here, HIV would undoubtedly have spread more quickly and widely. However, it is difficult to determine whether the incidence of HIV infection has decreased absolutely. Table 1 shows that from June, 1989, to December, 1993, the prevalence of HIV increased in all sentinel groups: to 29.5% of direct prostitutes (May, 1993), 7.7% of indirect prostitutes, 4.0% of army conscripts, and 1.5% of pregnant women.

Among clients of prostitutes such as army conscripts, 90% condom use should greatly decrease HIV incidence. However, incidence may remain high because the prevalence of infection among prostitutes is much higher now than previously. For example, in June, 1989, when prevalence in direct prostitutes was 3.5% and condom use 25%, 2.6% of sex acts were at-risk for HIV transmission. The highest risk of transmission from prostitutes to clients was probably in 1990 and 1991, when about 4% of sex acts were at risk. In June, 1993, with prevalence at 27% and condom use at 94%, at-risk sex acts were down to 1.6%. Thus, risk of HIV transmission to clients has probably been greatly reduced from what it was in 1990 and 1991.

Condom use may not be so protective for prostitutes, for three reasons. First, prostitutes are less likely to

condoms with boyfriends or regular clients, who may have a relatively high prevalence of HIV infection. Second, HIV-positive clients, mostly unaware of their status, are probably less likely to use condoms than HIV-negative clients. Third, given the sheer number of exposures, the cumulative prevalence among prostitutes may continue to increase unless condoms are used during every sex act (which is unlikely), or until equilibrium is reached between the rate of new infections and the rate that women leave prostitution. Among non-prostitute women, condom use in commercial sex will have a delayed effect on risk of HIV infection. Many unmarried men have recently become infected, and they are likely to infect their wives after they get married. An equilibrium may eventually be reached, but unless more women have their flances tested before marriage, it is likely that prevalence of infection among non-prostitute women will continue to increase slowly for several years as infected men marry uninfected women.

If this analysis is correct, and if the condom programme has actually succeeded in lowering the rate of HIV transmission in commercial sex, then the evidence of decreasing infection levels is likely to become apparent first among military conscripts. Assuming that future conscripts get infected at an average age of 18, then it should take about 3 years for a decrease in HIV incidence to become apparent in decreased HIV prevalence among 21-year-old conscripts. In that case, one might hope to see a decrease in HIV prevalence among conscripts by 1995. However, the continued increase in HIV prevalence among prostitutes might delay or even nullify such a decrease.

Whether or not the Thai condom programme reduced HIV transmission absolutely, it certainly prevented a far worse epidemic. The programme succeeded by recognising that the epidemic was generated by core group prostitution and by concentrating on that target. It did not try to change sexual behaviour or enforce the laws on prostitution (which is technically illegal), but only to ensure that condoms were used in commercial sex. Officials worked through the commercial sex system not against it. Not only did the government supply free condoms directly to prostitutes, it broadcast explicit television and radio messages telling men to use condoms in commercial sex. The success of the programme depended on the cooperation of numerous government agencies in addition to the MOPH including the police. The coordination of these agencies was made possible by strong commitment at the top level of government, in particular from the Prime Minister's office.

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Condom promotion, sexually transmitted diseases treatment, and declining incidence of HIV-1 infection in female Zairian sex workers

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Summary

The control of sexually transmitted diseases, including HIV-1, among sex workers and their clients in urban areas in developing countries, is considered a valuable and cost-effective intervention to contain the spread of HIV-1. The effect of a programme of STD treatment combined with condom promotion on HIV-1 incidence has so far not been measured.

During an intervention including condom promotion, as well as monthly sexually transmitted disease screening and treatment among 631 initially HIV-1 negative female sex workers in Kinshasa, Zaire, 70 became infected with HIV-1 (incidence of 8.0 per 100 women-years (wy)). A decline of HIV-1 incidence was observed over time, from 11.7/100 wy during the first 6 months, to 4.4/100 wy over the last 6 months, 3 years later ($p=0.003$). Simultaneously, regular use of condoms with clients went up from 11% to 52% and 68%, after 6 and 36 months of intervention, respectively. Risk factors for HIV-1 seroconversion after multivariate analysis included irregular condom use (RR 1.6 [95% CI 1.1-2.8]), gonorrhoea (RR 2.5 [1.1-6.4]), trichomoniasis (RR 1.7 [1.1-2.8]), and genital ulcer disease (RR 2.5 [1.1-6.4]), during the probable period of acquisition of HIV-1. In women who attended more than 90% of their clinic appointments, the HIV-1 incidence was 2.7/100 wy compared to 7.1, 20.3, and 44.1 per 100 wy among women who attended 76-90%, 50-75%, and less than 50% of the monthly appointments, respectively ($p<0.0001$). These trends remained after controlling for reported condom use and number of clients.

This study confirms earlier findings that STDs facilitate transmission of HIV-1 and shows that a clinic-based intervention consisting of STD care and condom promotion can result in a major decline of HIV-1 incidence among female sex workers.

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Introduction

HIV-1 infection has been spreading at a high rate among female sex workers in the developing world. Prevalence rates can be as high as 75% and incidence rates of 38% per year or even 10% per month have been reported in Africa and Asia.^{1,2} Although controlling sexually transmitted diseases (STDs) and HIV-1 among populations at high risk is believed to be crucial and cost-effective it is not clear what the most feasible and effective interventions are. We report here the results of an intensive clinic-based intervention including condom promotion as well as monthly STD screening and treatment among female sex workers in Zaire followed for up to 3 years.

Subjects and methods

The study population consisted of women from Kinshasa, Zaire who identified themselves as sex workers, and who had a high prevalence of STD, a prevalence of HIV-1 of 55% and low use of preventive behaviours.³ A special Women's Health Centre clinic was set up in an area easy to reach, and where many of the women live.

Consenting HIV-1-seronegative women were enrolled in a cohort study, which included monthly interviews and STD laboratory diagnosis, and screening for HIV-1 antibodies every 3 months. STD were treated free of charge. Women received monthly individual health education and free condoms. In addition, every 3 months group sessions for condom promotion were held. The characteristics of this cohort have been described previously.⁴ This intervention started in 1988 and was interrupted in September, 1991, because of civil unrest.

6-monthly HIV-1 incidence rates were computed assuming that seroconversion had occurred at mid-point between the first positive HIV-1 serological test and the last negative one. The numerator is the cumulative number of seroconversions occurring during that 6 months, and the denominator the total number of women-years (wy) at risk of follow up. 3-monthly incidence rates (per 100 women-months) of STDs were computed assuming that a new infection had occurred at mid-point between a positive result and the last visit.

Condom use and number of clients were assessed by monthly interviews covering the last working week. This information was then extrapolated for the whole previous month. Regular condom use (combining data on the number of clients and condom use) was defined as having an average of not more than one unprotected sexual intercourse with clients per week during a three-month period. To validate the data from an earlier case-control analysis,⁴ a Cox proportional hazard model was built on the incidence data of the full cohort. When appropriate, the values of the independent exposure variables were allowed to vary over time in this model to correspond to the exposure in the 2-6 month interval preceding each HIV-1 serological test. Regularity of attendance (the proportion of scheduled monthly appointments attended) was used to quantify exposure to the combined intervention (condom promotion and STD control). Tests for trends in incidence over ordinal categorical data were also done with the proportional hazard model using an independent variable in the model corresponding to the median value within each category.

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Results

The cohort consisted of 531 initially HIV-1-negative female sex workers followed up for 879.8 women-years (wy) (median duration per woman, 23 months). Condoms were used occasionally by 11% of women, but no women reported consistent condom use with all clients. After initiation of the intervention, the proportion of women who always used condoms with their clients went up to 52% after 3 months, to 62% after 12 months, and to 68% after 36 months. The proportion of women who reported 1 or less unprotected sex contacts (during the last week) went up from 0% at recruitment to 62%, 65%, and 84% at 12, 24, and 36 months respectively ($p < 0.001$, test for trend) and the mean number of clients per week without condom use declined from 2.2 at 6 months, to 2.0, 1.4, and 0.7 at 12, 24, and 36 months.

70 women seroconverted, an overall HIV-1 incidence of 8.0 per 100 wy. The figure shows the trends in 6-monthly HIV-1 incidence, which declined steadily from 11.7 per 100 wy during the first 6 months of follow-up to 4.4 per 100 wy over the last 6 months, 3 years later ($p = 0.003$, test for trend). With the exception of chlamydial infection ($p = 0.21$), the incidence of other STDs also declined significantly over the 3 years (all $p < 0.01$, test for trend).

In a Cox proportional hazard model, irregular condom use (RR 1.6 [CI 1.0-2.6]), gonorrhoea (RR 2.3 [1.4-3.7]), trichomoniasis (RR 1.7 [1.1-2.8]), and genital ulcer disease (RR 2.5 [1.1-6.4]) remained significantly associated with an increased risk for HIV-1 seroconversion with multivariate analysis.

To assess the impact of regular STD treatment combined with condom promotion on HIV-1 incidence, we calculated incidence rates among women with different exposures to the clinic. The HIV-1 incidence rate increased from 2.7 per 100 wy among very regular clinic visitors (>90% of the appointments attended), to 7.1, 20.3, and 44.2 per 100 wy among regular visitors (76-90% of appointments), medium regular visitors (50-75% of appointments), and irregular visitors (<50% of appointments) respectively (table). However, condom use was also associated with regularity of clinic visits. Women with 1 or fewer unprotected sex contacts per week were more likely to be regular visitors to the clinic (median proportion of visits 87%), as compared to women who had more than one unprotected sex contact per

Proportion of scheduled visits attended	Overall incidence per 100 women years	Incidence per 100 women years among:	
		regular condom users	irregular condom users
<50% (n=221)	44.2	34.4	92.3
50-75% (n=111)	20.3	16.2	114.6
76-90% (n=178)	7.1	7.0	10.1
>90% (n=220)	2.7	2.8	0
P	<0.001*	<0.001	0.017

*Test for trend on incidence values in different strata of declining number of clinic visits. % of visits is expressed as number of times women attended the clinic divided by the number of appointments (on monthly basis) that were given.

Table: HIV-1 incidence by regularity of attending the clinic and by level of reported condom use

week (median proportion of visits 75%, $p = 0.009$). The incidence rates in irregular condom users were consistently higher in every stratum than the non-regular users (table), but the declining trend of HIV-1 incidence with increasing regularity of clinic visits remained significant in both groups, indicating that exposure to the clinic had an independent impact on both the level of reported condom use and on the incidence of HIV-1 infection.

Discussion

This study shows that an intervention programme of condom promotion and regular STD treatment is feasible and had considerable impact on the number of new HIV-1 infections among female sex workers. If biological susceptibility to HIV-1 in the absence of other cofactors is comparable in most individuals and this population is reasonably homogenous in terms of behaviour, no significant spontaneous decline in HIV-1 incidence rates among HIV-1-negative women should be expected. In Rwanda, the incidence of HIV-1 among childbearing women was 4.1 per 100 wy of follow-up, and declined to 1.8 per 100 wy after testing, counselling, and condom promotion was initiated.⁵

Among female sex workers, increases in HIV-1 prevalence rates have been shown despite condom promotion.^{2,6} In our study, correlation between time trends of STD incidence and safe-sex practices, and HIV-1 incidence suggest that the declining trend of HIV-1 infection was at least partly the result of this intervention. Another possible explanation for this declining trend in HIV-1 incidence is the differential risk for HIV-1 acquisition among the members of a closed cohort, with those at highest risk seroconverting first. However women who seroconverted did not report a significantly higher mean number of partners.

Although condom use increased markedly among these women, condom use with all clients never exceeded more than 60% of the women per month. The main obstacle for reaching 100% condom use was male client's refusal (unpublished data). This illustrates the urgent need for additional chemical or physical barrier methods which are under the control of women.

The table shows that the more the women were exposed to intervention the more likely they were to remain HIV-1 negative. The most obvious explanation is that the regular clinic visitors were the most consistent condom users. Despite a relation between condom use and regular attendance at the clinic, HIV-1 incidence declined with increasing frequency of clinic attendance among both regular and irregular condom users. Regular detection and treatment of STDs leading to a shorter duration of this

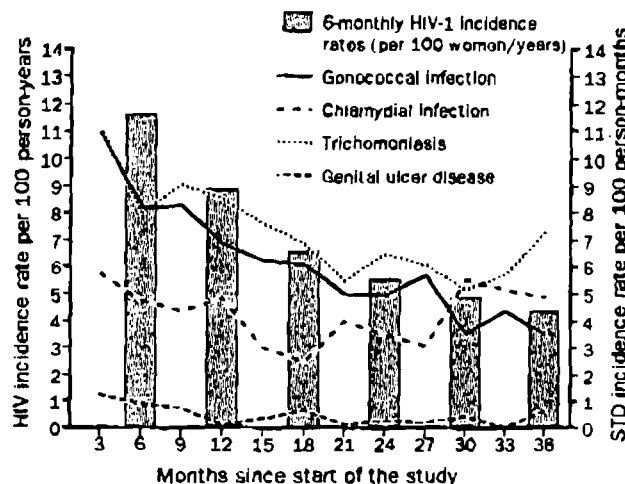


Figure: Time trends in incidence of HIV and other STD among HIV-1-negative women followed up for a maximum of 36 months

potential risk factor for HIV-1 transmission, probably also played a part.

The incidence rates of the major STDs also declined significantly, which may be a direct result of increasing condom use. The unexpected increase in chlamydial incidence may be explained by a change to a more sensitive diagnostic test during the study. Throughout the observation period, genital ulcer disease, gonorrhoea, trichomoniasis, and irregular condom use were independent risk factors for seroconversion. These data confirm results from an earlier nested case-control analysis of this data set, showing that STDs were independently associated with seroconversion.⁴

Our study confirms earlier findings that STDs facilitate HIV-1 transmission, and more importantly shows that a clinic-based intervention consisting of STD care and condom promotion, can result in decline in HIV-1 incidence among highly exposed women. Offering a non-judgemental and accessible service to vulnerable populations such as sex workers contributes considerably to prevention. The project provides a strong case for large-scale implementation of a combined service/prevention model for HIV-1 prevention among female sex workers in the developing world who are at greatest risk of HIV-1 infection.

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Viewpoint

International transfers of National Health Service reforms: problems and issues

Charles D Collins, Andrew T Green, David J Hunter

Summary

Recent market-style reforms in the UK National Health Service (NHS) have attracted the attention of health care professionals, managers, and policy-makers from many developing and central and eastern European countries. This article asks how NHS managers and health professionals should react to such international interest. Six key issues have to be considered when introducing market-style reforms into developing and eastern European countries. First, health sector reform should be formulated on the basis of sound research and evidence. We should also take particular care in understanding how efficiency contributes to health policy objectives and the extent to which private management practices are appropriate to the public sector. We should also question the value of international technology transfer and evaluate the experiences of health sector reform in other countries. Last we should look at the way in which health sector reform is formulated and implemented. Here we highlight important questions about the suitability of replicating the UK experience in other countries.

Lancet 1994; 344: 248-50

Introduction

The UK National Health Service (NHS) has attracted the attention of health care professionals, managers, and policy-makers from many countries. It was once a source of inspiration with its far-sighted goals of universal and comprehensive medical coverage and its contribution to social justice as part of an integrated welfare system. However, the NHS has lately been the subject of growing international attention for quite different reasons. Foreign observers have looked on with great interest, but with varying degrees of approval, as the NHS has undergone market-style reforms in its organisation and management.

Overseas observers will spot several familiar developments in the new-style NHS. A new worldwide vocabulary on health sector reform has emerged, incorporating an orthodoxy based on market principles.¹ Significantly, it is an orthodoxy advocated by the World Bank² and is shaping the changes in both developing and developed countries, notably the UK. Because the NHS has already introduced substantive changes across the whole service in a short space of time, it has become a focus of international attention.

Market orthodoxy is based on three inter-linked tenets:^{1,3} that functions of financing, resource allocation (or purchasing), and health care provision should be split; that market competition will lead to greater efficiency in the use of resources; and that there should be a shift away from social or collective responsibility for health towards greater

Wednesday, May 13, 1996

Spread of AIDS Alarms Chinese

Government Has Been Slow to Confront Problem

By Steven Mufson

Washington Post Foreign Service

BEIJING

Just two years ago, when a Beijing hospital's first AIDS patient died, the nurses panicked, fearing they had contracted the disease. They asked the municipal center for hygiene and epidemic control: Should they bury the respirator and other equipment the patient had touched?

A recent caller to an AIDS hotline in Beijing wanted to know if she could catch AIDS from a piece of second-hand clothing. Even after testing negative for the HIV virus, she was so stricken with anxiety that she called in sick to work and lay in bed for a month.

A Beijing man who said he was the victim of a homosexual rape in a public toilet contracted the AIDS virus and suggested to his wife that the whole family commit suicide.

These cases reflect the anxiety gripping China as the AIDS virus spreads to its last and largest frontier. So far, the number of reported cases is modest. Through last September, the government had reported that 2,594 persons had HIV (human immunodeficiency virus) infection, 80 of whom had developed AIDS and 50 of whom had died—a tiny fraction in a nation of 1.2 billion.

But AIDS experts here estimate the actual cases could number as high as 100,000 and say the total is growing fast. China diagnosed twice as many people with HIV in 1995 as it did in 1994. Zhang Konglai, chairman of the epidemiology department at Beijing Union Medical College and director of the China AIDS Network, said: "I always give a number 10 times the reported cases. There isn't enough testing. Ninety percent of the cases are still hiding somewhere."

Two-thirds of the reported cases occur in the southern province of Yunnan, where the use of heroin from nearby Burma, Laos and Thailand and the sharing of dirty needles has helped spread HIV. This month, China committed \$60 million to set up six border crossings along Yunnan's border and to try to establish a "disease-prevention belt" by 2000.

But it is too late to build fences. Although long dismissed as a foreigners' disease, AIDS and HIV have shown up in virtually every one of China's 30 provinces and the proportion of sexually transmitted cases is climbing steadily. Last December, spot checks at Beijing's elite universities turned up 10 cases of the AIDS virus. At least one high-level Communist Party official has AIDS; to keep it secret, his wife calls in to the Beijing municipal disease center to report on his condition.

Several conditions in China make the country fertile ground for the disease to take root.

One element is ignorance, born of the prudish Chinese Communist government's reluctance to talk about sex. Zhang, who interviewed prostitutes at four reeducation centers, said they knew virtually nothing about AIDS. The government

See AIDS, A24, Col. 1

THE PROBLEM WITH BLOOD

- **Lack of blood screening** at hospitals in China and unhygienic procedures.
- **Chronic shortage** of healthy blood donors because of widespread hepatitis.
- **Many poor people repeatedly sell blood** to augment their meager wages.

After Years of 'Playing Down' Problem, China Is Moving Now to Combat AIDS

AIDS, From A21

...not promoted condom use, even at universities, where one-third of the students say they have had premarital sex.

"We have encountered... the view that condom promotion might promote promiscuity and that we should work on moral standards instead," Zhang said.

Many experts say that the government explains the horrors of AIDS without telling people how infection spreads. "AIDS should be talked about at least as much as family planning and birth control," said He Xiong, a physician in the department of epidemiology at the Beijing Municipal Center for Hygiene and Epidemic Control.

Another problem is the lack of blood screening at hospitals and unhygienic procedures. Because of widespread hepatitis, Chinese hospitals face chronic shortages of blood donors. Many poor people repeatedly sell blood to augment their meager wages. Last year police broke up a gang that lured gullible peasants to cities with promises of work and then took a fee after coercing them into selling blood.

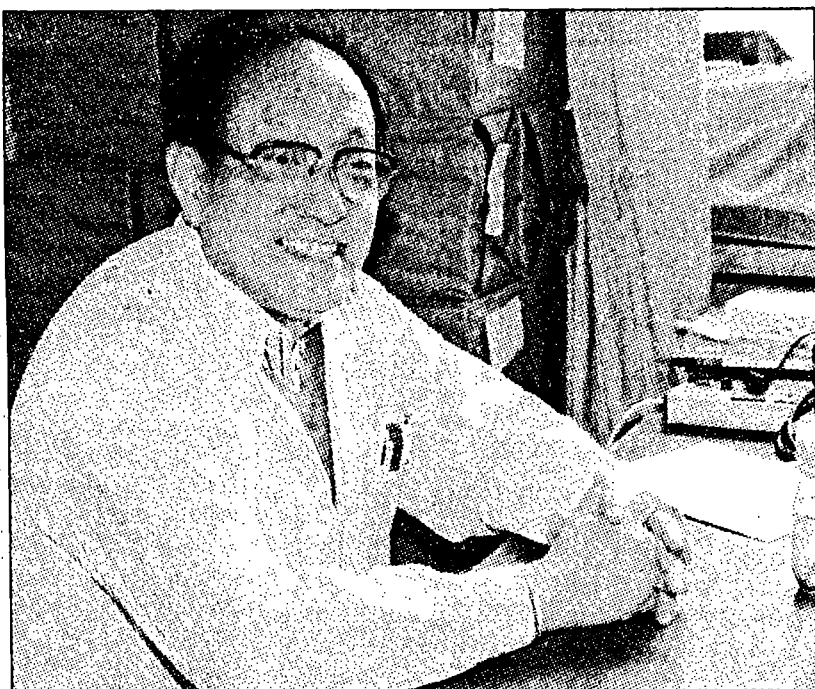
Recently a clinic outside Beijing that was collecting blood plasma accepted blood from an infected donor and then used the same instruments on scores of other donors and recipients, according to Newsweek magazine. Eventually as many as 400 people tested positive for HIV.

The emergence of AIDS in China is a public health problem, but to some Chinese it has also become an indicator of the corrupting influences of China's era of reform. To some, the "open-door policy" has let in an ill wind, and new mobility in Chinese society has led to a dissolution of social and sexual taboos and a breakdown in morals.

Yet AIDS is evidence that for all of China's frequent talk about its "special characteristics," Chinese people share human weaknesses and diseases. "Some professionals and decision makers would like to think that the Chinese are different: We have Confucianism, more family values, a different political system, blah, blah, blah," said Zhang, the epidemiologist. "But our data show we're changing."

Those changes include a migrant population of about 100 million, booming foreign trade and contacts and increasingly porous borders—all good vehicles for spreading disease. Prostitution, virtually eradicated in the early years of Communist rule, has blossomed again.

Hundreds of thousands of Chinese also study and travel abroad every year. A survey by Zhang indicated that 5 percent of Chinese traveling abroad on business said they took the opportunity to visit a prostitute, a figure Zhang said may be low because of people's reluctance to make



BY HILLARY SMITH FOR THE WASHINGTON POST

Zhang Konglai, a physician researching AIDS at the Beijing Union Medical College, says he multiplies reported cases by 10 to get an accurate picture.

that admission even with assurances of confidentiality.

The government finally appears ready to confront the problem of AIDS, in part because of the catastrophic example of nearby Thailand, where there are about 800,000 cases and where soon as much as 10 percent of the population will be infected, experts predict. China is beginning to talk more openly about AIDS; last Dec. 1, the government hosted a major conference on AIDS awareness day.

Yet even Chinese medical experts pay little attention to the situation of AIDS patients living relatively normal lives for long periods. Last year Robert Geyer of Arlington, Va., who has AIDS and worked for 15 years at the Committee on Scholarly Exchange with China at the National Academy of Sciences, gave a talk here to a conference of medical experts about living with AIDS. He was then detained in a hotel by police and deported even though he had disclosed the illness when he entered the country.

"Neither the Chinese nor American sponsors anticipated that at an international AIDS meeting there might be someone with AIDS," Geyer said. Even among the medical experts, he said, "a lot of comments were naive. They didn't have an understanding that [with treatment] AIDS could become a chronic disease like diabetes and that people can live with and cope with it."

Ordinary citizens are often susceptible to superstition and swindlers peddling false hope. Packets of moist hand wipes promise to prevent AIDS infection. A "Love Solution" promises a cure in "two minutes."

The China Daily recently printed an article describing a program by Chinese traditional medicine experts who have treated more than a thousand HIV-infected patients in Tanza-

nia and claim to have made progress. The report encapsulates all the elements of Chinese thinking on AIDS as a force of moral evil that can be overcome with traditional Chinese values.

"The traditional Chinese medicine theory considers various pathogenic factors as *xie*, evil forces, and the body's resistance as *zheng*, healthy energy," the article says. "When the *zheng* is greater than *xie*, that is, the life activity is exuberant and the body resistance is strong enough to protect the body from the attack of pathogens, the person is healthy; otherwise the person is ill."

"The evils are external causes," a Chinese traditional medicine expert said. "Therefore by improving one's resistance, the evils can be overwhelmed." He said the prescription included eight ingredients that "have been proven through several thousand years of practice."

Reality for Chinese who contract AIDS is much tougher than such articles would suggest. As in other nations during the early days of the disease, people here have lacked sympathy or understanding for AIDS patients. Work units are not required to pay for AIDS treatment and medical insurance does not cover it.

The first documented AIDS fatality in China came just three years ago. As the victim neared death, 28 months after being diagnosed, the family decided to take him to a hospital, but feared that calling an ambulance would tip off the neighborhood and that they would be ostracized. By the time they arrived by taxi, the man was dead.

He may soon have lots of company. Geyer warned, "Once even a small number of Chinese are infected, if they are unaware of measures to prevent transmission, the problem is going to get more and more serious, and in a population of 1.2 billion it's a pretty frightening prospect."

Reversal on Military HIV Issue Is Rare Victory for Gay Rights Activists

By John Mintz
Washington Post Staff Writer

The last 15 months of Republican dominance in Congress have been grim for gay rights lobbyists, who have scrambled to reverse attempts to gut AIDS funding and other attacks on their interests. But yesterday they savored a rare victory that they said showed the nation does not support punitive actions against people with HIV.

As part of Wednesday night's agreement between the White House and congressional leaders to compromise on a massive bill financing much of the federal government, the two sides killed a regulation enacted by Congress last year that would have discharged 1,049 military service members

with HIV, that virus that causes AIDS, and denied them medical benefits.

In the end, the leadership of both the Senate and House turned against the measure after it became clear the U.S. military's entire command structure opposed it, congressional staff members and gay activists said.

Rep. Robert K. Dornan (R-Calif.) had succeeded in attaching the ban to the 1996 defense authorization bill. President Clinton reluctantly signed the defense bill into law, but said the Dornan measure was unconstitutional and ordered government lawyers not to oppose legal challenges to it.

"Bob Dornan lost big today because his provision was clearly malicious and unnecessary," said Winnie Stachelberg, health

policy advocate for the Human Rights Campaign, a gay lobbying group that lately has

Service members with HIV have been banned from combat and overseas duties since the mid-1980s.

fought many attempted assaults on its interests in Congress. "This issue seems to be an obsession with him."

Dornan denounced GOP colleagues for "caving in" to homosexual rights lobbyists, saying it "dooms" the challenge of Sen. Robert J. Dole (R-Kan.) in the presidential race. And yesterday Dornan succeeded in pushing the same provision—and another to reestablish the ban on gays in the military—through his House National Security military personnel subcommittee.

Service members with HIV have been banned from combat and overseas duty since the mid-1980s, so many in Congress said the issue was not crying out for new action—especially since there had been no complaints about the work performance of those with HIV. Dornan's opponents pointed out it would cost taxpayers millions of

dollars to train people for replacing the experienced officers.

Defense Secretary William J. Perry and many admirals and generals—including Gen. John Shalikashvili, chairman of the Joint Chiefs of Staff—had denounced the 1996 measure as unfair. They were joined by the Veterans of Foreign Wars, the Air Force Association and the American Medical Association.

"This blunder will dog our party until it's repealed," former senator Barry Goldwater (R-Ariz.) wrote to Congress two weeks ago, in a letter said to have swayed some in his party. "Our [Republican] revolution . . . is not about throwing 1,049 patriotic Americans out of the armed forces because they happen to be HIV positive."

Tuesday, April 30, 1996 The Post

HIV in the Armed Forces

THERE'S A BONUS in the final omnibus appropriations bill Congress passed Thursday. Legislators took the opportunity to repeal a bad provision that had been tacked onto the Defense Department authorization bill barring HIV-positive individuals from the armed services. That measure was the brainchild of Rep. Bob Dornan, who claimed it was directed only against "drug dealers, people who visited whorehouses or homosexuals."

President Clinton strongly objected to this penalty but had to sign the authorization bill to keep the Defense Department afloat. When he did so, however, he also urged a quick repeal of this rider and promised a court test if necessary. That military leaders themselves strongly supported repeal was surely a factor in the turnaround.

There are about 1,000 HIV-positive men and women in the armed forces. Because the military routinely monitors the health of its members, blood tests usually turn up evidence of the infection fairly early, perhaps 10 years or more before AIDS appears. The Defense Department's

policy has been to allow individuals to remain in the service until they are unable to work. Once they are disabled, they receive medical discharges, disability benefits and continuing medical care for themselves and their families.

Mr. Dornan would have booted them out early, before they became disabled, which would have deprived them of disability benefits and family medical care, in addition to the dignity and well-being that go with meaningful employment in the service of their country.

Service personnel with all sorts of physical maladies other than HIV infection are allowed to work as long as they are able to do their jobs. Employees in the private sector are protected by law from the kind of discrimination Mr. Dornan would have forced the Defense Department to practice. Pentagon leaders had no problem with the regulations that had been in place since the beginning of the AIDS epidemic, and they neither sought nor supported the punitive change. Congressional reconsideration and repeal were right. Mr. Dornan's attempt to revive the issue by offering another bill ought to be defeated.

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ASIA NEAR EAST BUREAU EARMARK FOR HIV/AIDS

I. INTRODUCTION

A. Epidemiology of HIV/AIDS in ANE

The estimated number of people with AIDS rose by 60% during the past year, from 2.5 to 4 million. The World Health Organization estimates that there are now over 14 million cases of HIV infection worldwide, with approximately 9 million in Subsaharan Africa and 2 million in South and Southeast Asia. Developing countries account for 80% of the worldwide HIV incidence, and this is expected to rise to 95% by the year 2000.

The epidemic is spreading faster in Asia than in any other part of the world. Projections indicate that by 1997 more individuals will be infected by HIV per year in Southeast Asia than in Subsaharan Africa. Asia will surpass Africa in cumulative number of infections by the end of the decade.

Asia has a very large population, and many factors are present which foster HIV transmission, including high rates of sexually transmitted diseases and injecting drug use, low condom use rates and active commercial sex industries. Cross border movement by migrant laborers, traders, transport workers and tourists also play important roles in the spread of the virus in the region. Towns on the borders of Burma and Thailand have some of the highest infections rates in the world. Mobile populations between India and its neighbors contribute to HIV transmission in India, Nepal and Bangladesh. And in Cambodia a recent study found an HIV seroprevalence rate of 10% among 200 pregnant women living on the border with Thailand.

The epidemic is most mature and most severe in Thailand. Approximately 600,000 Thais are HIV positive and the epidemic is spreading across the shared borders with Myanmar, Southern China, Laos and Cambodia. HIV prevalence among commercial sex workers in the Thai provinces bordering Laos range from 20% to 54%, and returnees from Thailand account for all known HIV cases in Laos. The Thai Red Cross estimates that there are 300,000 to 400,000 HIV+ persons in Myanmar. The National AIDS Control Program of Vietnam, which shares borders with Cambodia, Laos and Southern China, projects an annual incidence of 350,000 by the year 2000 and recorded HIV prevalence among commercial sex workers there rose from 0% in 1992 to 34.8% in 1994.

It is estimated that there are 1,600,000 HIV+ people in India. Partly due to its sheer population size, India will have more HIV cases than any other nation in the latter part of the decade. It is estimated that there will be 5 million HIV+ people in India by the year 2000.

Little is known about the actual level of HIV infections in most countries in Asia due to inadequate surveillance and reporting systems. For example, by mid-1994 only 235 HIV infections had been confirmed in Indonesia, but estimates of HIV prevalence range from 25,000 to 40,000. With a doubling time of less than six months, Indonesia will have 500,000 infections within three years and up to 3 million by the year 2000.

Even less is known about the epidemic in the Middle East and Northern Africa. Fewer than 1,400 AIDS cases had been reported to the WHO by mid-1993, but it is likely the epidemic is more established in the Near East than official reports indicate. Sample studies conducted between 1989 and 1992 suggest that rapid spread of HIV/AIDS is fueled by the mobility of the population in the region, where many migrate to seek work and education, and by social instability, poverty, commercial sex and injecting drug use.

While little information regarding high risk sexual behavior in the Near East countries is available, reports of high levels of various STDs serve as markers of the risk levels for HIV infection. Recent DHS surveys show very low condom use among married couples in the region, indicating a vulnerability for the spouses of partners engaged in risk behaviors. Knowledge, Attitude and Practice studies in Egypt and Israel indicate that general knowledge of HIV and its modes of transmission is low. Thus, the limited information available shows the dangerous combination of risk behaviors and limited knowledge about prevention.

B. Socio-Economic Impact

HIV/AIDS is a development problem as well as a health problem in developing countries. In Asia it threatens to undermine the socio-economic gains made in several countries, thereby jeopardizing the considerable USAID investments made in this region. Furthermore, the impacts likely will ripple throughout the industrialized economies as well when markets for commercial exports expand less rapidly or even begin to shrink due to decreased purchasing power.

Existing health care systems in Asian countries will be inadequate as the millions of HIV infected people in this region develop AIDS. As in Africa, much of the burden of care will fall upon the household members of those who are sick. Added caregiving responsibilities will threaten family economic security, as women will be forced to drop out of the labor force and children pulled out of school.

Finally, the HIV/AIDS epidemic interferes with family health and demographic stability, which are preconditions for limiting population growth. Productive adults will be lost with a corresponding increase in households consisting of the elderly and the young.

C. Asia Near East Bureau Regional HIV/AIDS Program

As outlined in the Bureau's "HIV/AIDS Strategic Action Plan for Asia", *USAID/ANE is using regional HIV/AIDS funds to support the implementation of HIV prevention activities throughout the region. The Bureau's HIV/AIDS strategy expands the capacity of centrally-funded and mission bilateral HIV/AIDS prevention programs and projects, which largely focus on preventing the spread of the epidemic within specific countries. Through this strategy, the ANE and Global Bureaus and Missions have coordinated the use of Agency HIV/AIDS resources to implement an integrated and comprehensive HIV prevention program that addresses the regional dimensions of a global health problem.

The Bureau's HIV/AIDS Strategy has five primary objectives:

- to limit cross-border HIV transmission
- to address regional HIV/AIDS issues
- to limit the spread of the epidemic in the region by supporting the initiation of HIV prevention activities in all ANE countries.
- to support innovative pilot projects which may be replicated throughout the region.
- to support regional training, policy and research efforts.

The "Strategic Plan" was revised in 1994 in response to the evolving epidemic in Asia and the merger of the Asia and Near East programs. While the objectives remain the same, ANE is expanding the regional program in FY '95 to include the Near East as well as Asia. In addition to including country specific activities for Egypt, the '95 Earmark will support participants from the Near East in policy tours and other regional training activities.

ANE regional HIV/AIDS funds are obligated as a buy-in to Global Bureau projects. Through this mechanism, G/PHN/HIV-AIDS, Missions and Mission cooperating agencies are implementing regional training and intervention activities which support the objectives of the ANE Regional HIV/AIDS Strategy.

** United States Agency for International Development*



BY HILLARY SMITH FOR THE WASHINGTON POST

Liu Ying, a physician, fields calls for an AIDS hot line, giving advice to anxious Beijing residents about how to prevent or deal with the disease.



THE SPREAD OF AIDS IN ASIA

The first AIDS cases were reported in Asia in 1986/87. At the end of last year, the World Health Organization reported these HIV/AIDS figures in major Asian nations:

	Cumulative reported AIDS cases	Estimated number of adult HIV infections
India	2,095	1,750,000
Thailand	22,135	700,000
Cambodia	86	90,000
Indonesia	82	50,000
Pakistan	52	40,000
Vietnam	292	25,000
Philippines	220	18,000
Bangladesh	7	15,000
China	80	10,000
S. Korea	32	2,000



GLOBAL PROGRAMME ON AIDS

The Current Global Situation of the HIV/AIDS Pandemic

3 July 1995

As of 30 June 1995, 1 169 811 cumulative AIDS cases in adults and children have been reported to the World Health Organization Global Programme on AIDS since the onset of the pandemic. This represents a 19% increase from the 985 119 cases reported in the 1 July 1994 Report.

The accompanying tables provide, by country and WHO Region, the number of reported AIDS cases to date, by year of diagnosis.

Figure 1 presents the global distribution of reported and estimated AIDS cases as of mid 1995. Allowing for under-diagnosis, incomplete reporting and reporting delay, and based on the available data on HIV infections around the world, it is estimated that over 4.5 million AIDS cases in adults and children have occurred worldwide since the pandemic began.

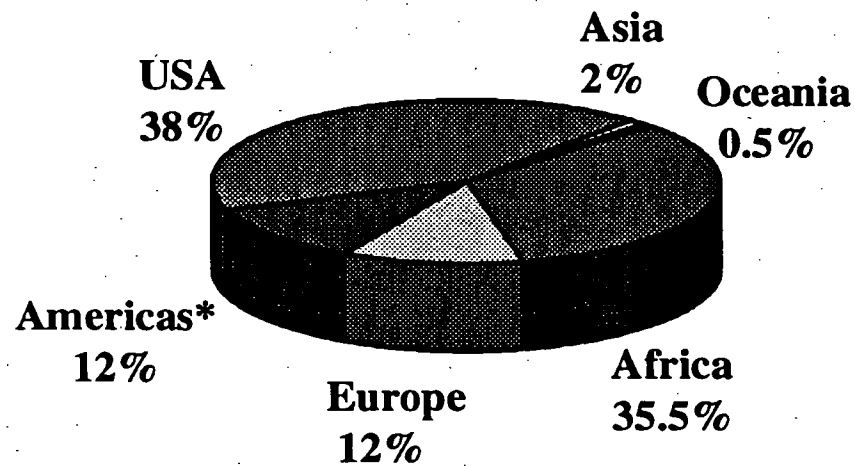
As of mid 1995, it is estimated that around 18.5 million adults, and more than 1.5 million children, have been infected with HIV since the beginning of the pandemic (late 1970s to early 1980s). Figure 2 presents the estimated regional distribution of total HIV infections in adults to date. The continued increase in HIV infections, particularly in southern and central Africa and South Asia, will accentuate the disproportionate impact of HIV/AIDS on the developing world.

Figure 3 shows the estimated regional distribution of HIV-infected adults (including AIDS cases) alive as of mid 1995.

Figure 1

**Total number of AIDS cases in adults and children from
late 1970s/early 1980s until mid-1995**

Reported: 1 169 811



Excluding USA

Estimated: 4 500 000 +

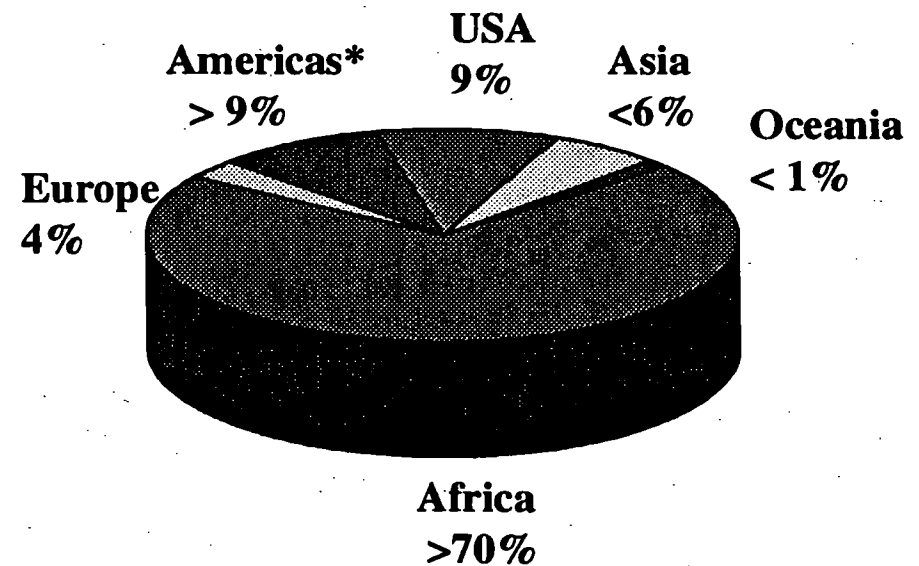
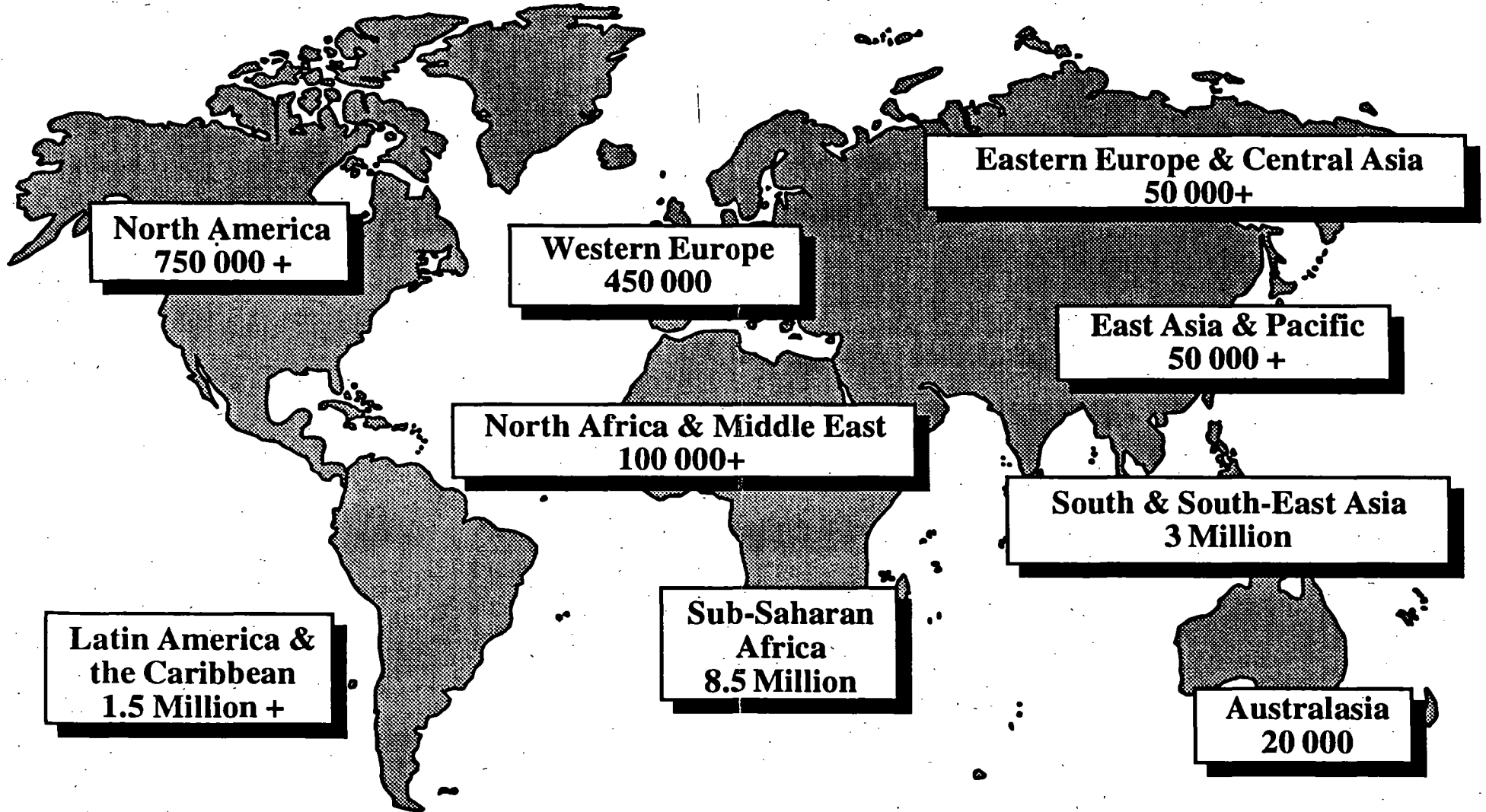


Figure 3
Estimated distribution of HIV-infected adults
alive as of mid-1995



Global Total : 4-5 Million

Regional Office for Africa (AFRO)

AIDS Cases Reported to WHO by Country/Area Based on Reports Received through 30 June 1995

Country	1979-92	1993 Rate	1994 Rate	1995	Total	Last Report	Comments
Algeria	98	40 0.1	79 0.3	0	217	31/12/94	
Angola	588	135 1.2	157 1.4	35	895	31/03/95	
Benin	485	277 5.3	114 2.1	0	858	14/12/94	
Burkina Faso	2886	838 8.5	0 0.0	0	3722	31/12/93	
Botswana	1078	870 61.0	968 65.8	194	3110	05/08/95	
Burundi	6763	117 2.0	144 2.4	0	7024	31/12/94	
Cameroon	2197	1761 14.4	1417 11.3	0	5375	31/12/94	
Central African Rep.	3730	0 0.0	0 0.0	0	3730	30/11/92	
Cape Verde	65	17 4.1	10 2.3	0	92	31/12/94	
Chad	587	1010 16.5	1268 20.2	592	3457	31/05/95	
Congo	5267	1206 55.7	1300 58.4	0	7773	22/04/95	
Comoros	3	0 0.0	2 0.3	0	5	31/08/94	
Equatorial Guinea	19	24 5.1	18 3.3	15	74	07/06/95	
Eritrea	389	300 ***.*	625 ***.*	245	1539	31/05/95	
Ethiopia	4884	5124 10.1	5558 10.7	2478	18042	12/05/95	
Gabon	393	128 9.9	204 15.3	158	881	29/05/95	
Gambia	236	38 4.1	53 5.5	13	340	31/03/95	
Ghana	10305	2371 14.4	2330 13.7	0	15006	31/12/94	
Guinea-Bissau	288	165 15.6	254 23.5	0	707	31/12/94	
Guinea	677	328 4.4	543 7.1	0	1548	04/01/95	
Cote d'Ivoire	14655	4015 28.3	6568 44.6	0	25238	31/05/95	
Kenya	37029	11580 40.7	7347 24.8	637	56573	25/04/95	
Lesotho	182	297 15.4	36 1.8	0	515	31/12/94	
Liberia	28	163 5.8	0 0.0	0	191	31/03/94	
Madagascar	5	6 0.0	7 0.1	0	18	31/03/95	
Mali	1313	672 6.6	609 5.8	0	2594	10/01/95	
Malawi	26955	4916 52.8	4732 49.2	1070	37673	05/08/95	
Mauritius	15	3 0.3	9 0.8	0	27	31/12/94	
Mauritania	40	10 0.5	9 0.4	0	59	30/09/94	
Mozambique	662	164 1.0	534 3.1	455	1815	31/05/95	
Namibia	3622	1479 71.8	0 0.0	0	5101	31/12/93	
Nigeria	705	256 0.2	630 0.5	0	1591	31/05/95	
Niger	809	453 5.8	429 5.3	0	1691	07/03/95	
Reunion	65	0 0.0	0 0.0	0	65	20/03/92	
Rwanda	9486	1220 15.2	0 0.0	0	10708	30/06/93	
Senegal	848	349 4.4	100 1.2	0	1297	22/11/94	
Seychelles	0	1 1.5	5 7.6	0	6	12/09/94	
Sierra Leone	88	23 0.5	22 0.5	22	155	31/05/95	
South Africa	1891	1567 4.2	391 1.0	0	3849	27/07/94	
Sao Tome & Principe	11	2 1.8	0 0.0	0	13	25/03/94	
Swaziland	250	163 18.6	0 0.0	0	413	15/02/94	
United Rep. Tanzania	42422	3327 10.9	219 0.7	0	45968	30/06/94	Provisional distribution of cases by year
Togo	2142	1330 35.1	1284 32.8	353	5109	08/06/95	
Uganda	38552	2641 12.9	4927 23.2	0	46120	31/12/94	
Zaire	22159	588 1.5	3384 8.3	0	26131	08/07/94	Provisional distribution of cases by year
Zambia	7124	22610 239.3	0 0.0	0	29734	20/10/93	Provisional distribution of cases by year
Zimbabwe	18731	9174 86.0	10647 96.7	0	38552	31/12/94	
Total for the Region	270667	81736	56929	6263	415595		

***.* in the rate column indicates no population data available

Regional Office for Eastern Mediterranean (EMRO)

**AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995**

Country	1979-92	1993	Rate	1994	Rate	1995	Total	Last	Comments
								Report	
Afghanistan	0	0	0.0	0	0.0	0	0	15/02/92	
Bahrain	11	4	0.7	5	0.9	0	20	15/04/95	
Cyprus	24	6	0.8	11	1.5	0	41	28/04/95	Consolidated report
Djibouti	309	144	32.4	196	42.7	63	712	30/05/95	
Egypt	62	29	0.1	22	0.0	0	113	23/01/95	
Iran (Islamic Rep.)	60	32	0.1	19	0.0	3	114	07/06/95	
Iraq	13	11	0.1	12	0.1	2	38	11/04/95	
Jordan	24	7	0.1	7	0.1	0	38	07/02/95	
Kuwait	8	2	0.1	5	0.2	0	15	22/01/95	
Lebanon	37	32	1.0	14	0.4	0	83	18/04/95	
Libyan Arab J.	10	2	0.0	3	0.1	0	15	10/04/95	
Morocco	128	44	0.2	77	0.3	16	265	03/05/95	
Oman	30	4	0.2	14	0.8	3	51	07/05/95	
Pakistan	26	12	0.0	8	0.0	0	46	08/01/95	
Qatar	90	10	2.5	12	2.8	0	112	22/03/95	
Saudi Arabia	50	12	0.1	38	0.2	6	106	30/05/95	
Somalia	13	0	0.0	0	0.0	0	13	01/01/91	
Sudan	692	191	0.7	201	0.7	45	1129	31/01/95	
Syrian Arab Republic	23	3	0.0	4	0.0	0	30	31/05/95	
Tunisia	130	36	0.4	43	0.5	0	209	24/02/95	
United Arab Emirates	8	0	0.0	0	0.0	0	8	12/02/93	
Yemen	4	4	0.0	3	0.0	2	13	23/04/95	
Total for the Region	1752	585		694		140	3171		

Above statistics do not include 8 cases reported for UNRWA

Rate = per 100,000 population

Regional Office for South-East Asia (SEARO)***AIDS Cases Reported to WHO by Country/Area
Based on Reports Received through 30 June 1995**

Country	1979-82	1993 Rate	1994 Rate	1995	Total	Last Report	Comments
Bangladesh	1	0 0.0	0 0.0	0	1	17/04/95	
Bhutan	0	0 0.0	0 0.0	0	0	17/04/95	
India	242	252 0.0	391 0.0	151	1038	17/04/95	
Indonesia	34	17 0.0	9 0.0	7	67	17/04/95	
Dem.P.Rep. of Korea	0	0 0.0	0 0.0	0	0	17/04/95	
Maldives	0	0 0.0	1 0.5	1	2	17/04/95	
Myanmar	47	142 0.3	196 0.5	90	475	17/04/95	
Nepal	12	12 0.1	8 0.0	3	35	17/04/95	
Sri Lanka	20	13 0.1	8 0.0	6	47	17/04/95	
Thailand	2141	8312 10.9	10303 17.5	339	19085	30/04/95	
Total for the Region	2487	8748	10916	597	20758		

* Mongolia is a member of the WHO Western Pacific Region as of 1.7.95

Rate = per 100,000 population

AIDS C s reported to WHO by Continent/year
Based on Reports Received through 30 June 1995

NEW CASES							CUMULATIVE CASES					
Year	Africa	America	Asia	Europe	Oceania	TOTALS	Africa	America	Asia	Europe	Oceania	TOTALS
1979	0	2	0	0	0	2	0	2	0	0	0	2
1980	0	185	1	17	0	203	0	187	1	17	0	205
1981	0	322	1	20	0	343	0	509	2	37	0	548
1982	2	1156	1	80	91	1330	2	1665	3	117	91	1878
1983	17	3352	8	295	6	3678	19	5017	11	412	97	5556
1984	207	6680	8	570	76	7541	226	11697	19	982	173	13087
1985	518	12682	27	1475	142	14844	744	24379	46	2457	315	27941
1986	4108	21322	85	2416	269	28200	4852	45701	131	4873	584	56141
1987	13401	34562	150	8508	419	58040	18253	80263	281	14381	1003	114181
1988	24605	45880	174	10774	590	82023	42858	126143	455	25155	1593	196204
1989	37941	49360	289	14307	679	102576	80799	175503	744	39462	2272	298780
1990	49301	69882	482	17251	758	137674	130100	245385	1226	56713	3030	438454
1991	77012	77641	833	18824	866	175176	207112	323026	2059	75537	3896	611630
1992	64899	97968	2052	20477	810	186206	272011	420994	4111	96014	4706	797836
1993	82182	96958	7376	21528	865	208909	354193	517952	11487	117542	5571	1006745
1994	57471	60991	11718	21377	871	152428	411664	578943	23205	138919	6442	1159173
1995	6387	1186	707	2356	2	10638	418051	580129	23912	141275	6444	1169811
TOTALS	418051	580129	23912	141275	6444	1169811	418051	580129	23912	141275	6444	1169811

Reporting Countries by continent

Reporting countries by WHO Region

	One or more cases	No of cases		One or more cases	No of cases
AFRICA	54	418051	AFRICA	47	415595
AMERICAS	45	580129	AMERICAS	45	580129
ASIA	42	23912	EASTERN MEDITERRANEAN	21	3171
EUROPE	37	141275	EUROPE	45	141768
OCEANIA	14	6444	SOUTH-EAST ASIA	8	20758
			WESTERN PACIFIC	26	8390
TOTAL	192	1169811	TOTAL	192	1169811

February 1996



Commercial Sex Workers on Front Lines of Bombay AIDS Battle

Five million people in India will have contracted HIV by the year 2000 and one million more will have AIDS, if current trends continue. Thirty million people could be infected with HIV a mere ten years later -- twice today's worldwide total.

No population is more central to the spread of AIDS in India than commercial sex workers and, in turn, their male clients who often unwittingly transmit the disease throughout the rest of society. Because a high percentage of all HIV transmissions occurs between sex workers and their clients, there exists an immediate and strategic opportunity to limit the spread of this disease throughout a country whose population is rapidly reaching one billion.

In response to this challenge and as part of its ongoing and larger effort to prevent AIDS in India, PSI/India operates an innovative project in Bombay's red light district. The Bombay Project targets the largest conglomeration of commercial sex workers in the world (70,000 girls and women) and educates both sex workers and their clients while motivating them to use condoms. Underwriting from the Ford Foundation since the Project's inception in 1991 has enabled its continued success.

Four integrated elements form the backbone of the project:

1. *Personal Contact with Sex Workers*

A cadre of female social workers interact daily with the girls and women in the red light district. They provide advice on AIDS prevention, deliver condoms, instruct sex workers and brothel owners on health risks, impart condom negotiating skills, and generally lend a compassionate ear. In the process, these "interpersonal communicators" gain the confidence of the sex workers, the first step to changing their attitudes and behavior.

2. *Reaching Male Clients*

The Bombay Project is well known for its dynamic "infotainment" activities, designed to educate and entertain in a way that overcomes the information fatigue that plagues other well-intentioned outreach efforts. Using a variety of creative outlets, the Project works with street

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U.S.A.

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magicians, taxi drivers, film stars, dancers, and bartenders to reach sex workers and, most importantly, their male clients while they are in the red light district and about to engage in sex. The men are increasingly critical to the Project's work because of their role in deciding whether sex is protected and, because once they're infected, they carry the HIV virus to other parts of India.

3. Social Marketing of Condoms

Condom social marketing is an integral part of the Bombay Project. Project staff distribute condoms in two ways: by supplying them at subsidized prices to shops and chemists in the red light district, and by selling them directly to commercial sex workers and their clients after the infotainment shows.

4. Medical Consultations and Rehabilitation Center

Located in the heart of the red light district, the Project office includes a medical examination room and well-baby clinic, and provides a variety of medical services, including treatment of STDs and tuberculosis, and referrals to hospitals. The Project's rehabilitation center provides employment opportunities for the sex workers outside of the brothels, skills training, help with opening bank accounts, and literacy classes. Dr. Shilpa Merchant, Project director and member of the National AIDS Committee of India, oversees all activities.

An impact study conducted three years after the launch of the Bombay Project indicated 80 percent awareness of HIV/AIDS, and that condoms -- previously associated only with family planning -- are now clearly associated with AIDS and STD prevention. "Key to the Project's success," notes Dr. Merchant, "is a holistic approach, combining entertaining AIDS messages with clinical care, condom accessibility, and one-on-one counseling. The response has been overwhelming."

The Bombay Project is a part of PSI/India which was founded in 1988 to assist the Government in the social marketing of products for family planning, maternal and child health, and AIDS prevention. PSI/India's projects include marketing *Nirodh* and *Masti* brand condoms, a low-dose oral contraceptive pill called *Pearl*, and *Neotral*, an oral rehydration salt. In 1995, PSI/India sold over 75 million condoms at prices readily affordable to low-income Indians. PSI/India's two other AIDS prevention initiatives include the "Nexus" project, which works with journalists to write stories on AIDS and related health issues, and Project "Disha," which includes a radio call-in show that reaches young people with sexuality and reproductive health issues.

For more information on Population Services International (PSI), contact: Kitty Thuermer, PSI, 1120 19th St. N.W., Washington, D.C. 20036. Tel: 202-785-0072; Fax: 202-785-0120; E-mail: GeneralInfo@PSIWASH.org.

For information on PSI/India, contact: Jhum-Jhum Shirali, PSI/India, E-18A, East of Kailash, New Delhi -- 110 065, India. Tel: 642-8375; Fax: 642-0208; E-mail: nv.del@psi.sprintrpg.sprint.com. Or contact Dr. Shilpa Merchant, at: Trust Building H.No. 149/151 Rajaram Mohan Rai Road, Bombay 400004, India. Tel: 387-0883; Fax: 387-1415.



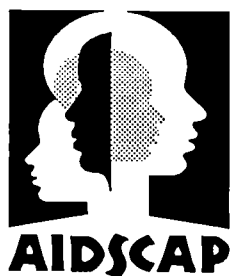
Status of General Response to HIV in Asia - Late 1994

- Greatest prevention challenge is still mobilization of response in the absence of visible AIDS cases
- Most admirable response from Thai government; National allocation to HIV increased from US\$182K in 1988 to US\$45 million in 1994
- Response from other countries lagging; Currently promoting lessons learned from Thai experience
- Possible ray of hope in Thailand: Signs that HIV rate is decreasing, STD declines noted



AIDSCAP Asia Regional Strategy

- Priority country programs in Thailand, India, Indonesia
- Associate country programs in Nepal, Laos, Philippines
- Major buy-in from Asia Bureau permits regional and border foci
 1. Border area, country assessments and research
 2. Epidemiologic estimates and training
 3. Journalist workshops
 4. Regional resource center



Priority Country Programs

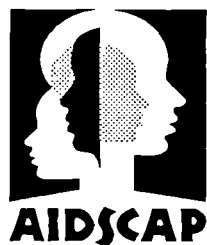
- Thailand
- India
- Indonesia

Other Country Programs

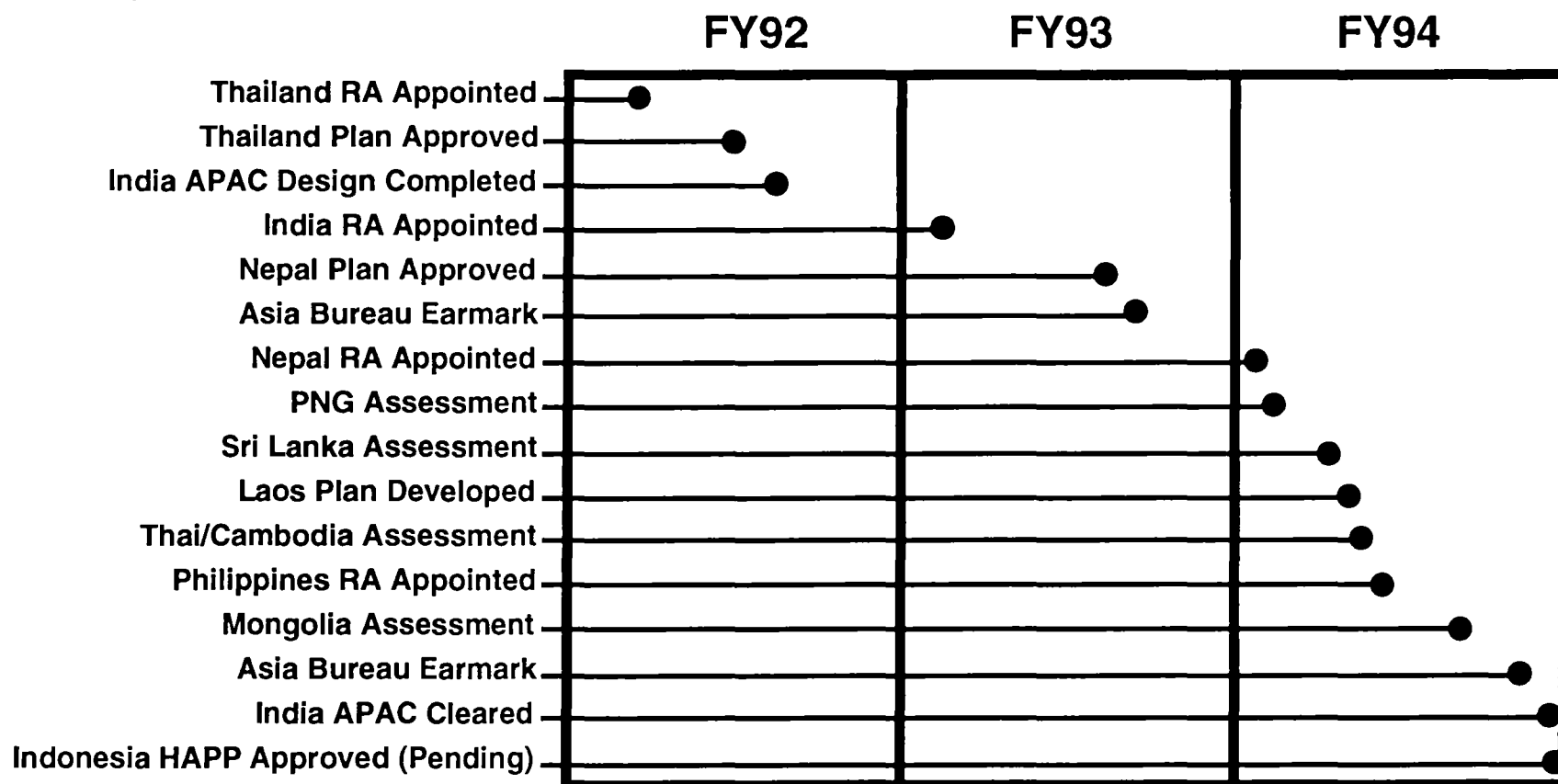
- Nepal •Sri Lanka
- Philippines •PNG
- Laos •Mongolia
- Areas of Affinity

Regional Program

- Training
- Conferences
- Epi/Policy



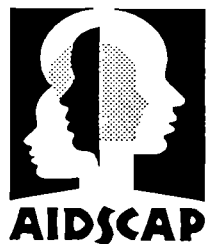
AIDSCAP Asia Region





Capacity Building Efforts in Asia

- **Thailand:** technical support for coalition of over 40 NGOs active in AIDS prevention
- **Indonesia:** four policy tours for government officials to high prevalence countries resulted in on-going multi-sectoral policy dialogue
- **India:** rapid response funds for generating HIV/AIDS database for NGOs with information about available resources, materials, and access to world-wide HIV information sources
- **Regional:** enhanced technical skills
 - 15 organizations in project evaluation/monitoring
 - 7 organizations in STD diagnosis, treatment, clinic management and lab methods
 - 11 organizations in design and implementation of behavior change communication programs
 - 6 organizations in budget development and accounting



Accomplishments to Date

Materials Distributed

110,699

Total Educated

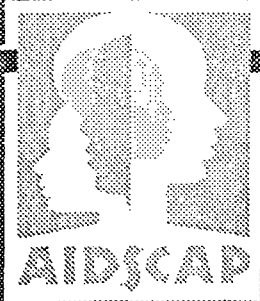
59,889

Total Trained

1,544

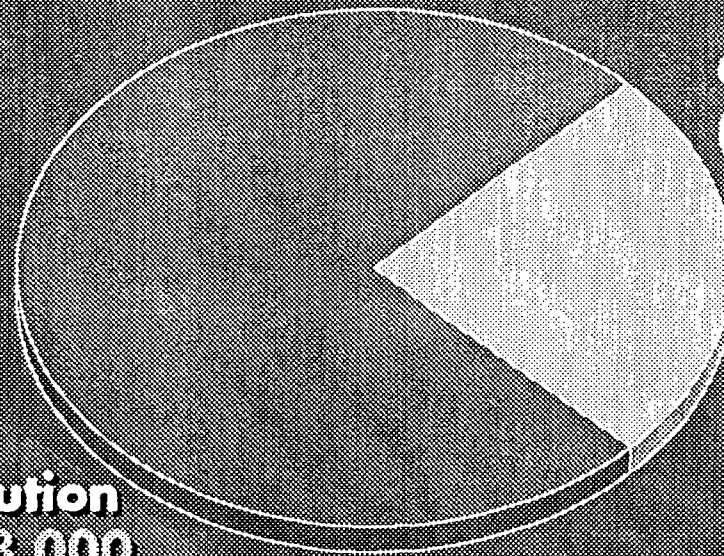
Condoms Distributed

738,441



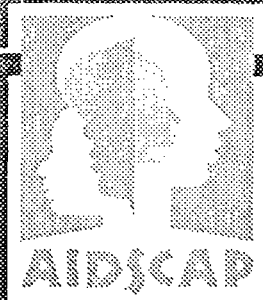
LAC Field Operations Division

Counterpart Contribution as % of
Total LAC Budgets



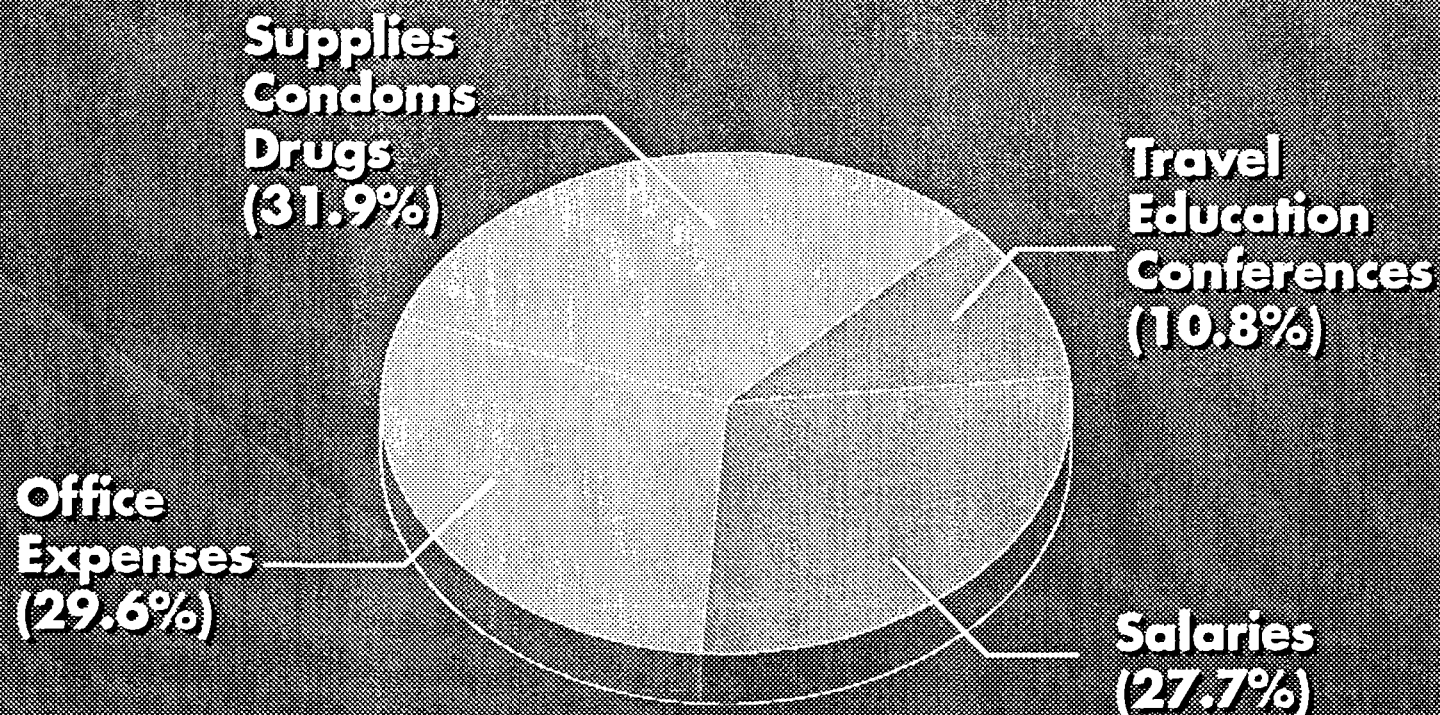
AIDSCAP Contribution
(75.4%): \$12,508,000

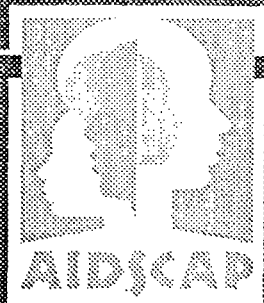
CP Contribution
(24.6%): \$4,090,000



LAC Field Operations Division

Counterpart Contribution Components—Brazil

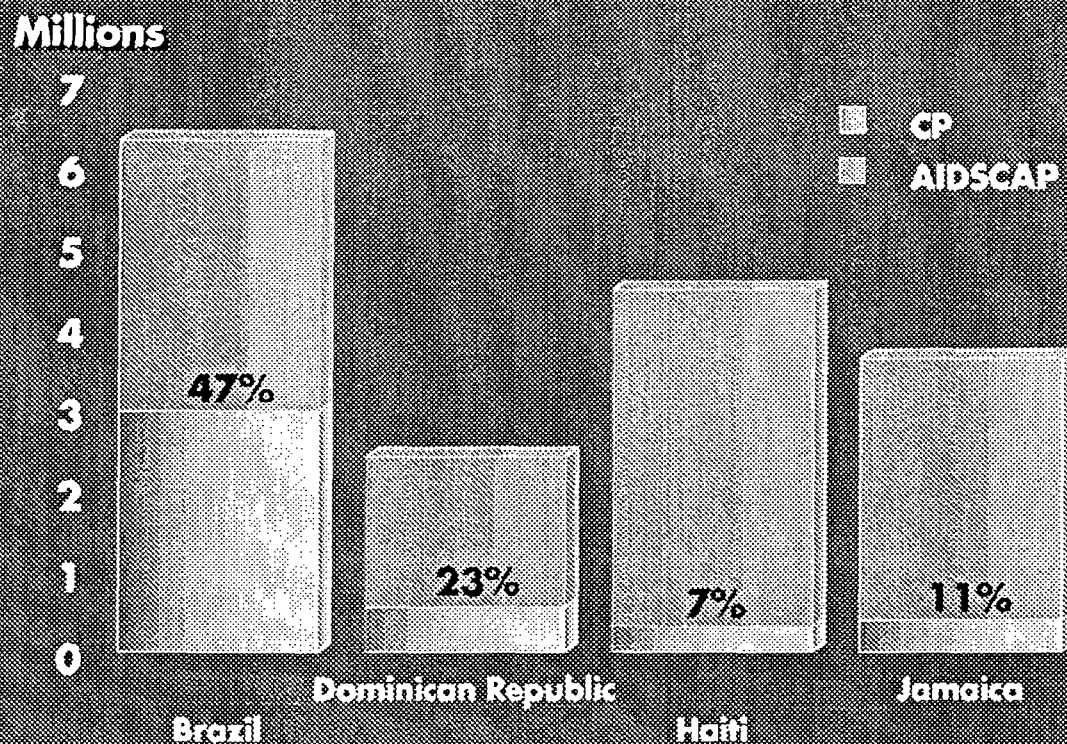




LAC Field Operations Division

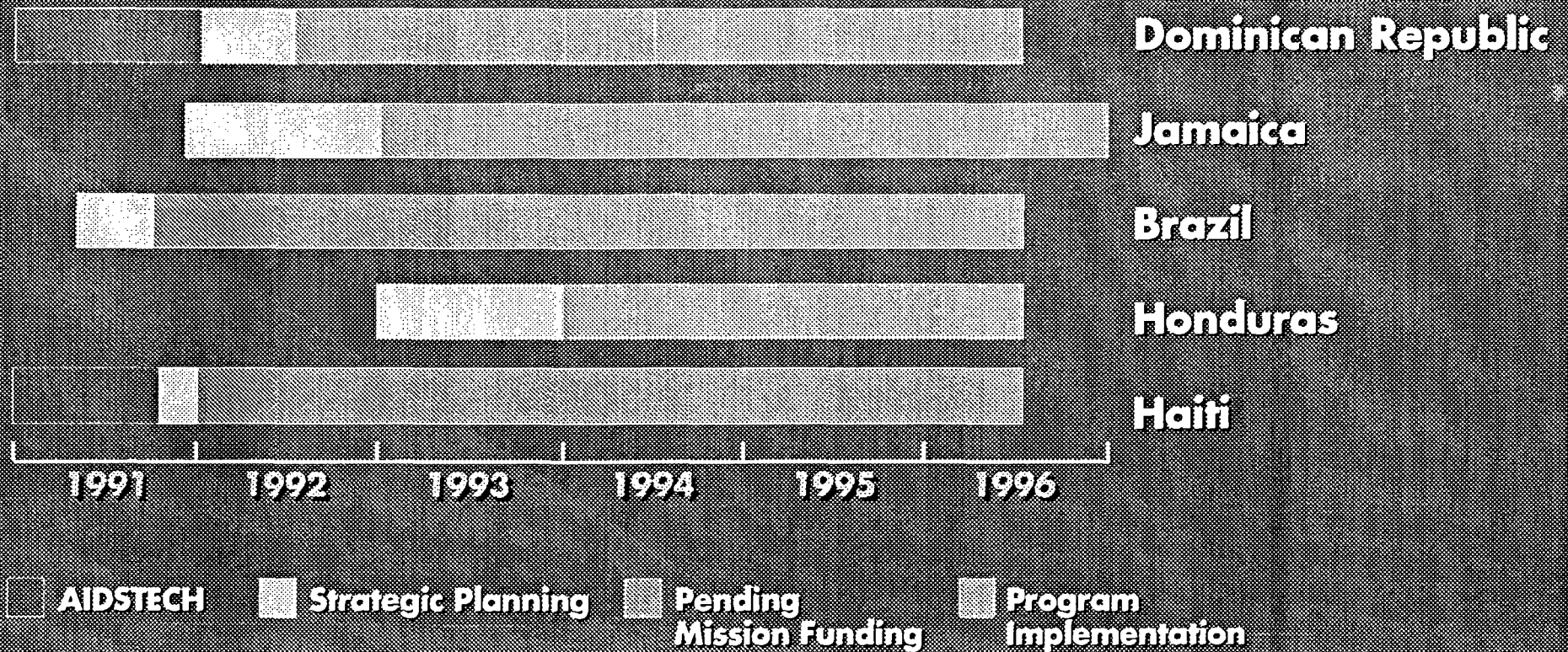
Counterpart Budget Contribution—LAC

Percent of Total Budget





AIDSCAP Program Design and Implementation





LAC Field Operations Division

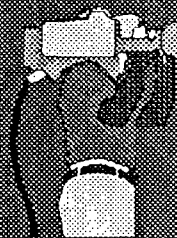
Cumulative Output Totals for Implementing Agencies,
as of November 1, 1994

Latin America & Caribbean

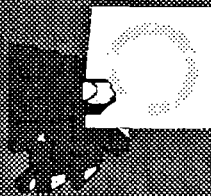


People Trained
15,218

People Educated
1,007,378



Media Events
53,819

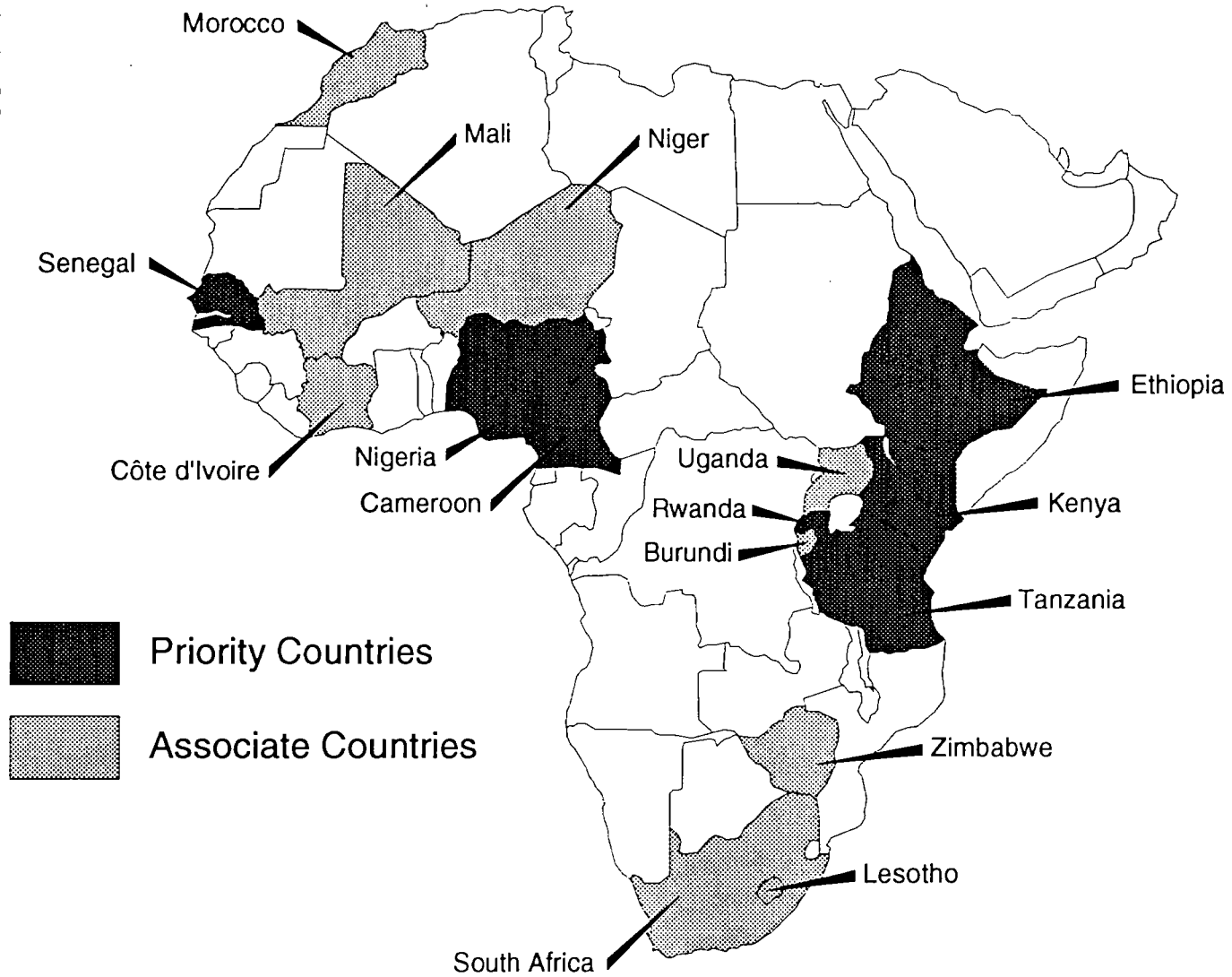


Condoms
Distributed
28,636,427



Materials
Distributed
1,268,559







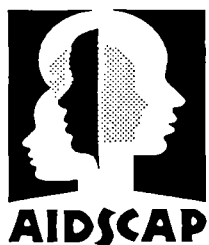
Epidemiological Highlights

- 66% of HIV infections in adults (15-49 years) in the world; 8.8% of adult population
- 73% of total AIDS cases reported in the world
- 74% of total AIDS deaths reported in the world
- Female to male ration of HIV infections is 1:0.87

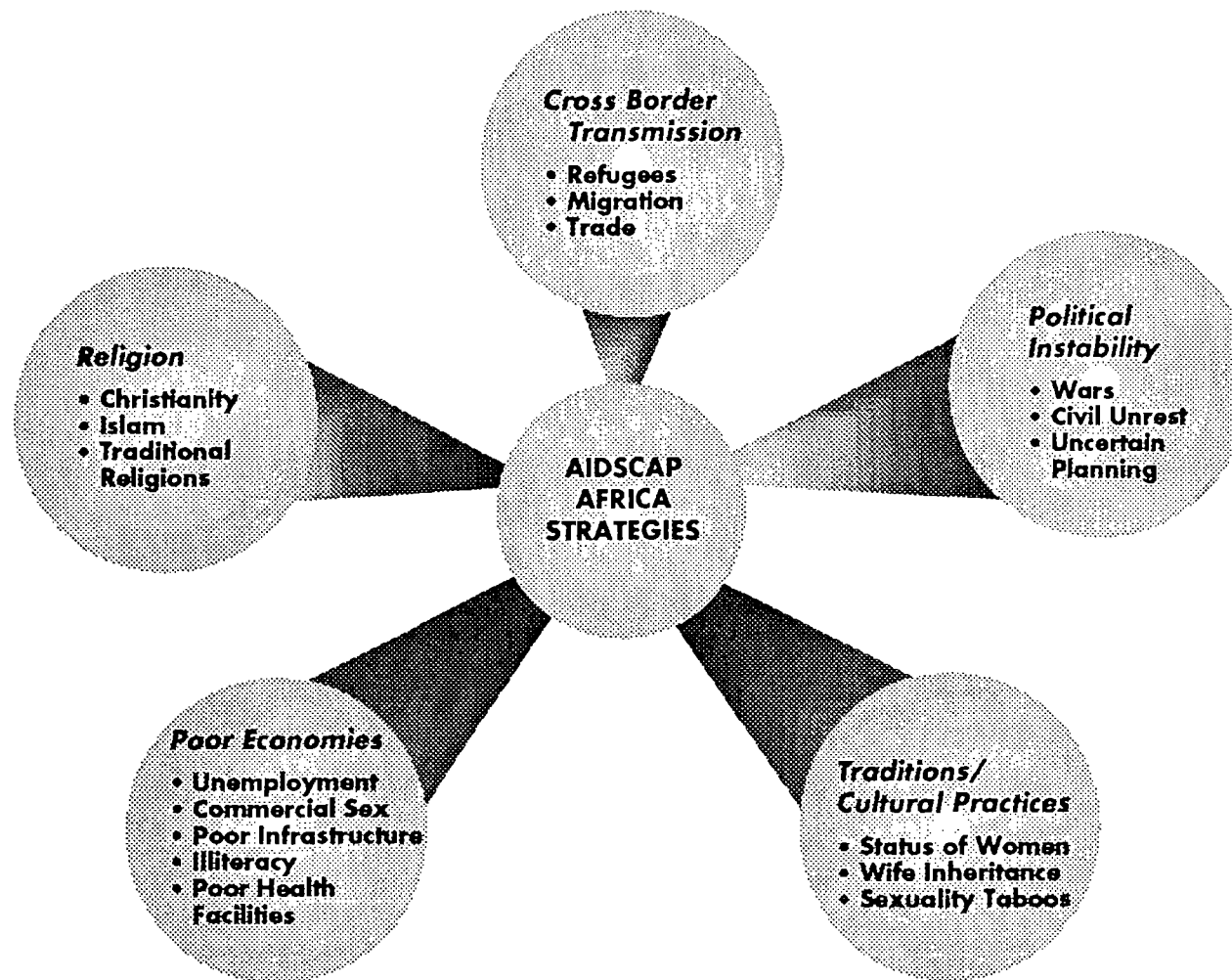


Status of the Epidemic in Africa

- Projections are coming true
- High and increasing number of infected people
- Disproportionate number of AIDS cases
- Large number of deaths of young economical viable people
- Burden on women



Realities in Africa





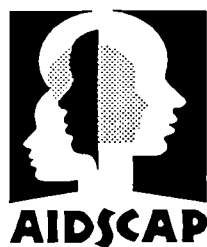
Challenges

- Realities of Africa
- Demand for condoms versus supply
- Controlling STDs without drugs
- Limited coverage of target group populations
- Sustainability
- Immediate vs long-term development

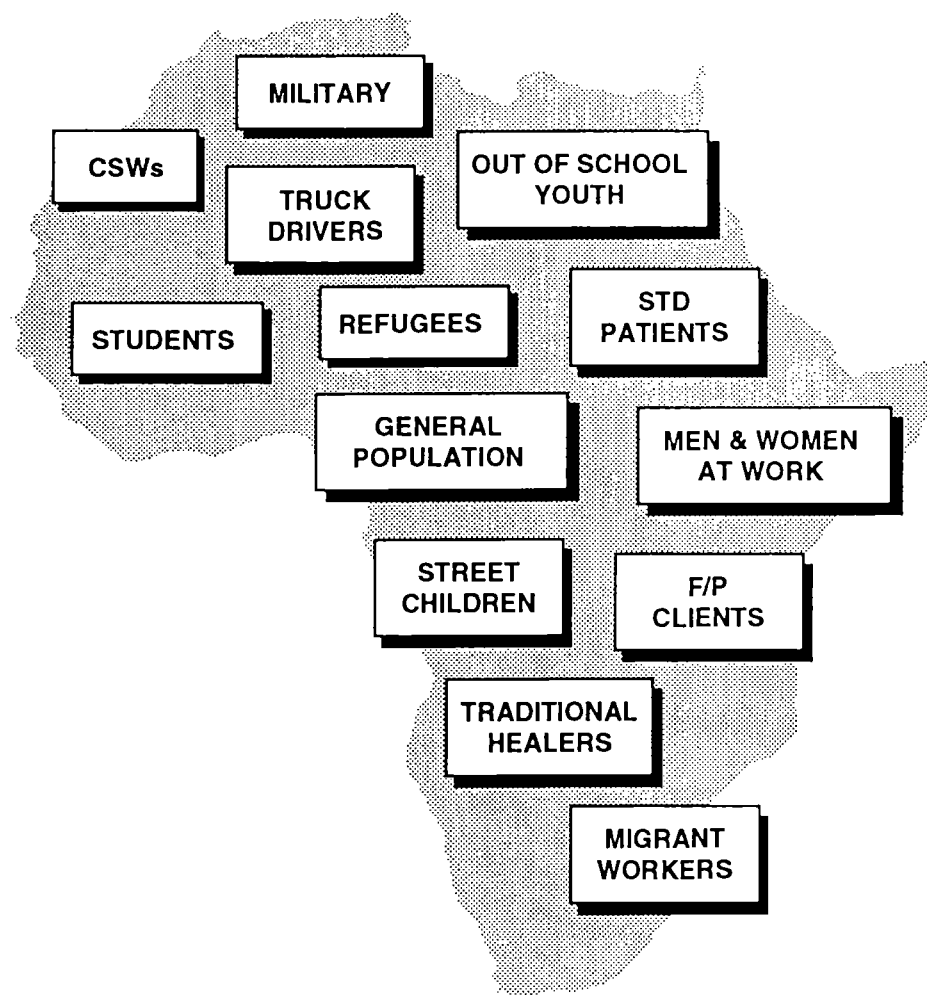


Capacity Building

- Mostly focused on NGOs
- Examples include training in:
 - Project management monitoring and evaluation
(59 organizations)
 - Design and implementation of BCC programs
(45 organizations)
 - Project design and proposal writing
(20 organizations)
 - Budget design and accounting
(26 organizations)
 - STD diagnosis, treatment, clinic management
(6 organizations)
 - Policy dialogue, modeling and socio economic assessment
(4 organizations)



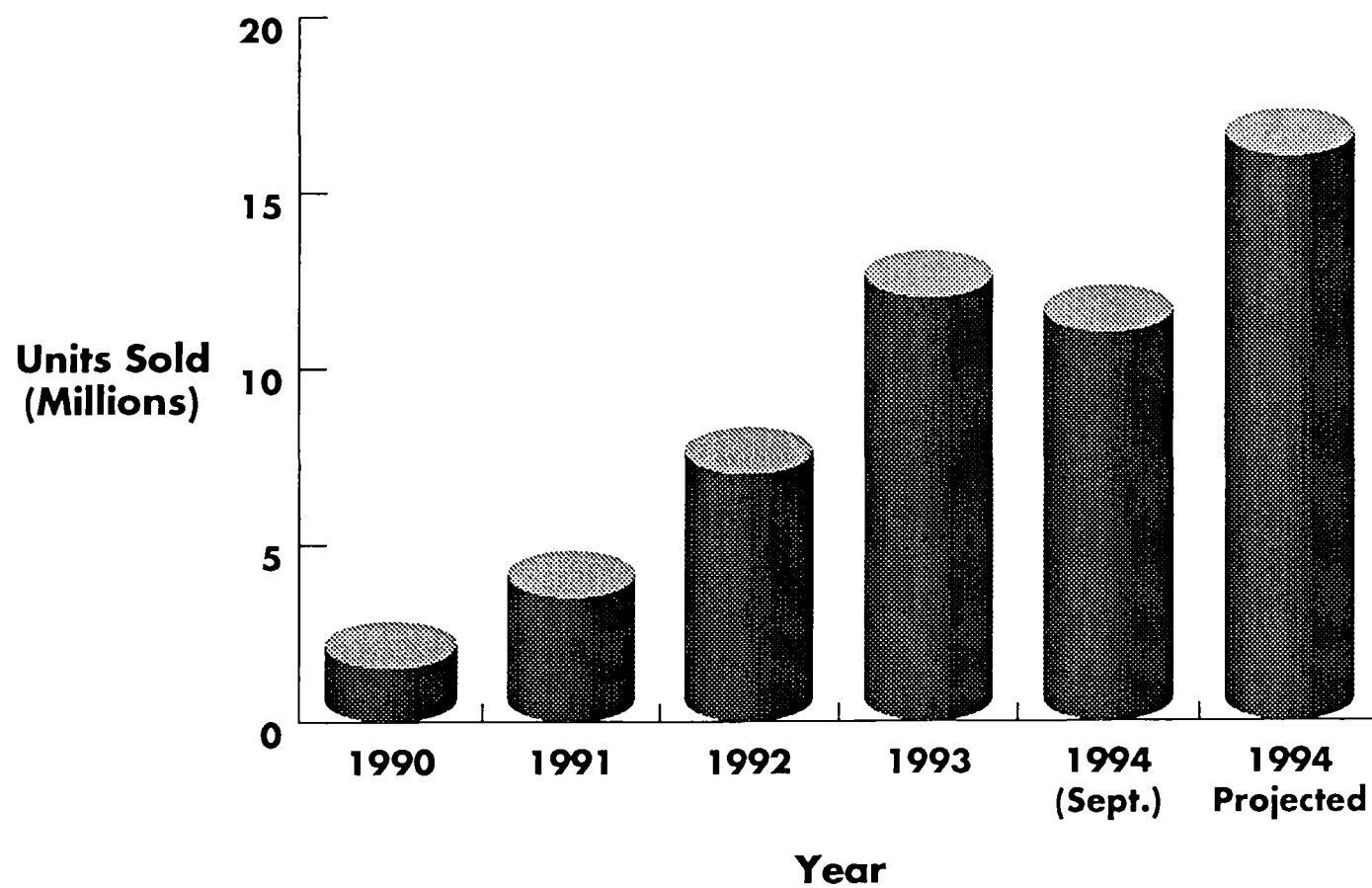
BCC Target Groups





Ethiopia Social Marketing

Condom Sales





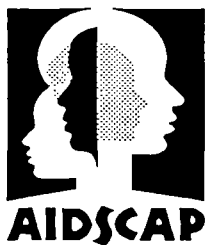
Care and Management of AIDS Patients

Africa realities

- Hospitals overburdened
- Need for community/home-based care
- Care as an entry point to prevention

Activities

- Up to \$50,000/priority country for organizations involved in community or home based care.



Accomplishments to Date

Materials Distributed

360,301

Media Events Held

2,078

Total Educated

474,852

Total Trained

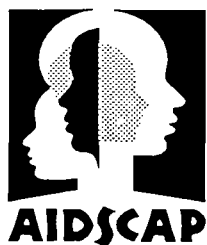
24,641

Condoms Sold

31,185,000

Condom Given Free

6,374,000



*AIDSCAP Asia Regional Strategy —
RATE: Regional AIDS Training and
Education*

14 RATE activities including:

- The Indonesia Policy Makers Study Program
- Epidemiology/Policy Workshop
- Reporting on HIV/AIDS in Asia: Facing the Facts
- Workshop on Communication Strategies and Techniques for Sexual Behavior Change

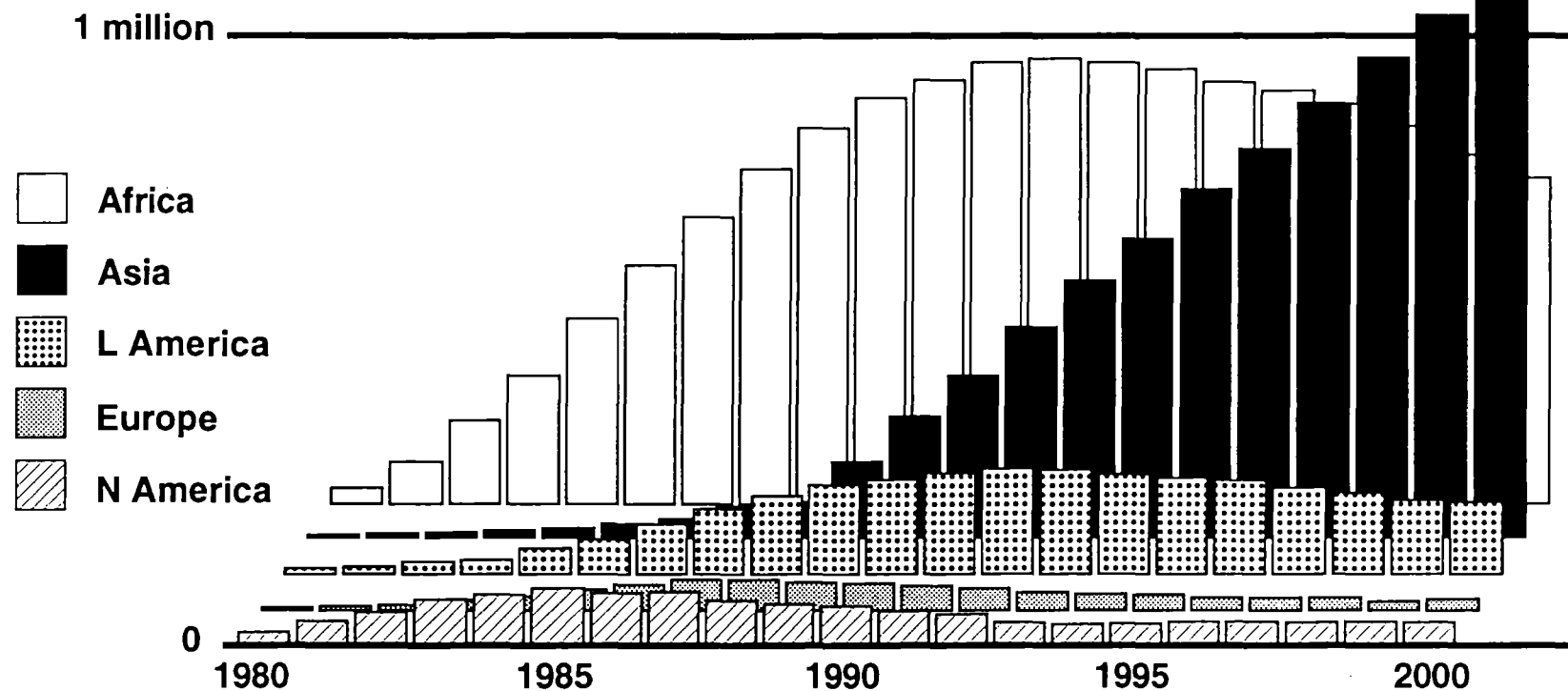


Capacity Building Efforts: Asia Region

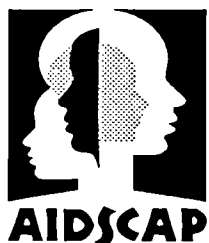
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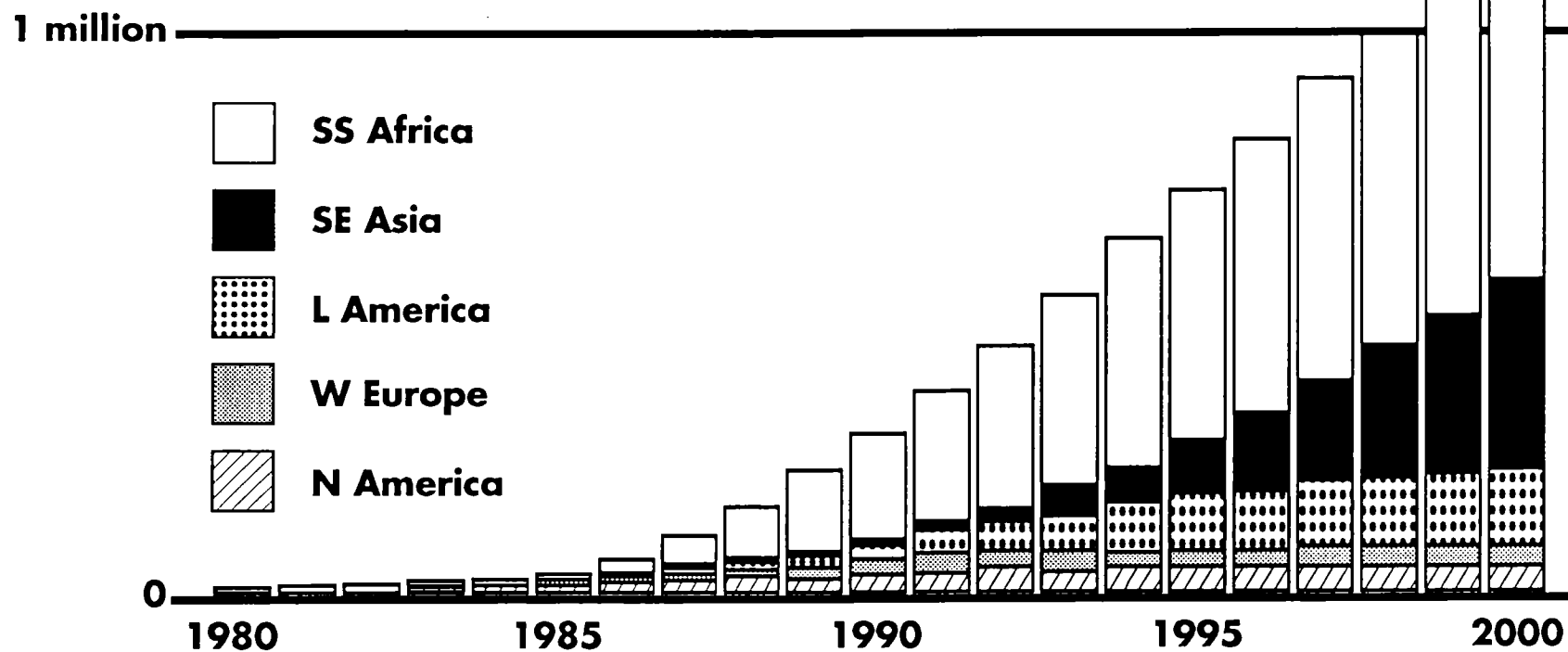
Estimated/Projected Annual Adult HIV Infections



Source: Dr. James Chin/AIDSCAP Asia Regional Office



Estimated/Projected Annual Adult AIDS Cases





Behavioral Research Grants Program in Asia: Social Mobility, Sexual Behavior, and HIV in Northern Thailand

David Celantano
Department of Health Policy and Management
The Johns Hopkins University

C. Vaddhanaphuti and S. Phonsopakul
Social Research Institute
Chiang Mai University

- **Design**

- Longitudinal cohort study
- Men in the Royal Thai Army (RTA)
- Brothel-based CSWs

- **Purpose**

- Investigate psychosocial determinants of high risk sexual behavior
- Evaluate controlled interventions to change behavior and reduce risk of HIV infection
- Develop strategies to combat HIV infection in northern Thailand



Behavioral Research Grants Program in Asia: Social Mobility, Sexual Behavior, and HIV in Northern Thailand

- **Status**

- 2 Interventions for RTA developed and fielded with structural/administrative and peer communication strategy
- Alternative occupational opportunities established for female CSWs
- Data collection and established interventions continue
- Data sets suggest declining risk in RTA population

- **Constraint**

- Brothel closings hindered data collection and delayed interventions



PVO Competitive Grants Program in Asia

- Thailand: World Vision Relief & Dev., Bangsue District, Bangkok
 - May 1993 to April, 1996
 - Targeting adolescents, young adults and mothers aged 15-30
 - BCC through community networks; access to STD services
- India: PLAN International, Belgaum District, Karnataka State
 - July 1994 to August 1996
 - Targeting sexually active adults aged 15-49 in four taluks
 - BCC; condoms; access to improved STD case management



*PVO Competitive Grants: Thailand
World Vision: Bangsue District AIDS Prevention
Project/Bangkok
May 1993 to April, 1996*

- Target groups: adolescents, young adults and mothers ages 15-30
- Outputs:
 - 1. BCC through community networks
 - 2. Improve STD services in health centers and pharmacies
- Accomplishments
 - Completed implementation plan
 - Completed baseline survey
 - Oriented 21 Bangsue District AIDS Committee members
 - Trained 100 community leaders in first quarter
 - Recruited and trained 36 women/42 men as peer educators
 - Provided refresher training for 30 peer educators (on-going)
 - Participated in World AIDS Day with two posters and AIDS awareness videos
 - Distributed 1,500 AIDS awareness materials
 - Published/disseminated two AIDS prevention newsletters
 - Hold regular planning meetings with community leaders



World Vision: Bangsue District AIDS Prevention Project/Bangkok

- Completed baseline survey in 13 communities of 43 in district
 - FGDs and in-depth interviews prior to study
 - 1000 people interviewed/cluster sampling
- Adolescents (all single, average age 16) N=400
- Young adults (most married, average age 24) N=400
- Mothers (all married, average age 25) N=200
 - Knows 2 ways to prevent transmission
44% (mothers) to 72% (adolescent males)
 - More than one sex partner during last 6 months
1% (mothers) to 31% (adolescent males)
 - Used condoms at last sexual contact
8% (mothers) to 56% (adolescent males)
 - Believe they are at risk of HIV infection
20% (adolescent females) to 34% (female young adults and mothers)



PVO Competitive Grants: India

PLAN International: AIDS /STDS Awareness, Prevention and Control program in Belgaum District, Karnataka State

July 1994 to August 1996

- Target population: sexually active adults aged 15-49 in four taluks in district
- Outputs
 - 1. BCC in four taluks
 - 2. Condom promotion and distribution
 - 3. Increase access to improved STD case management
- Accomplishments
 - Trained 98 women/277 men as outreach workers
 - Involved 4 village level institutions in community outreach
 - Trained 4 women and 16 men for street theater teams
 - Distributed 1,000 pamphlets and brochures
 - Established interaction with local authorities
 - Planned collaboration with India National Literacy Mission (NLM) to train their village-based volunteers and staff to incorporate AIDS education in established literacy program
 - Started baseline behavioral data collection



Nepal: Syndrome Management Guidelines

- Development
 - Working group of experts
 - 1993 National STD guidelines
- Constraints
 - No antibiotic sensitivity data
 - No risk assessment data
 - Political unrest



AIDSCAP Response to At-Risk Populations in Asia: STD Clients in the Clinical Setting

- Uniqueness of the region
 - Large private sector
 - Active professional organizations
 - Good access to STD drugs (issues of q.c.)
- Nepal
 - Syndrome management guidelines
 - Case management training
- Philippines
 - STD prevalence (ANC/CSW)
 - STD health seeking behavior (TIR)
 - Case management practices
- Thailand
 - BMA STD clinic and outreach network
 - Private STD services
 - STD/AIDS intervention model for drugstore personnel



Nepal: STD Case Management Training

- Develop and produce training materials
 - Participatory approach
 - Attention to communications skills for prevention education and condoms
- TOT, then regional workshops



Philippines: STD Prevalence

	<u>Reg. CSW CC</u>	<u>Unreg. CSW CC</u>	<u>CSW Manila</u>	<u>ANC Manila</u>
GC*	8%	42%	15%	0.5%
CT	15%	30%	21%	5%
TV	20%	41%	10%	0.5%
Syphilis	4%	9%	2%	1%

**42% of isolates were resistant to Ciprofloxacin
(MIC $\geq$ 0.125 mg/ml)*

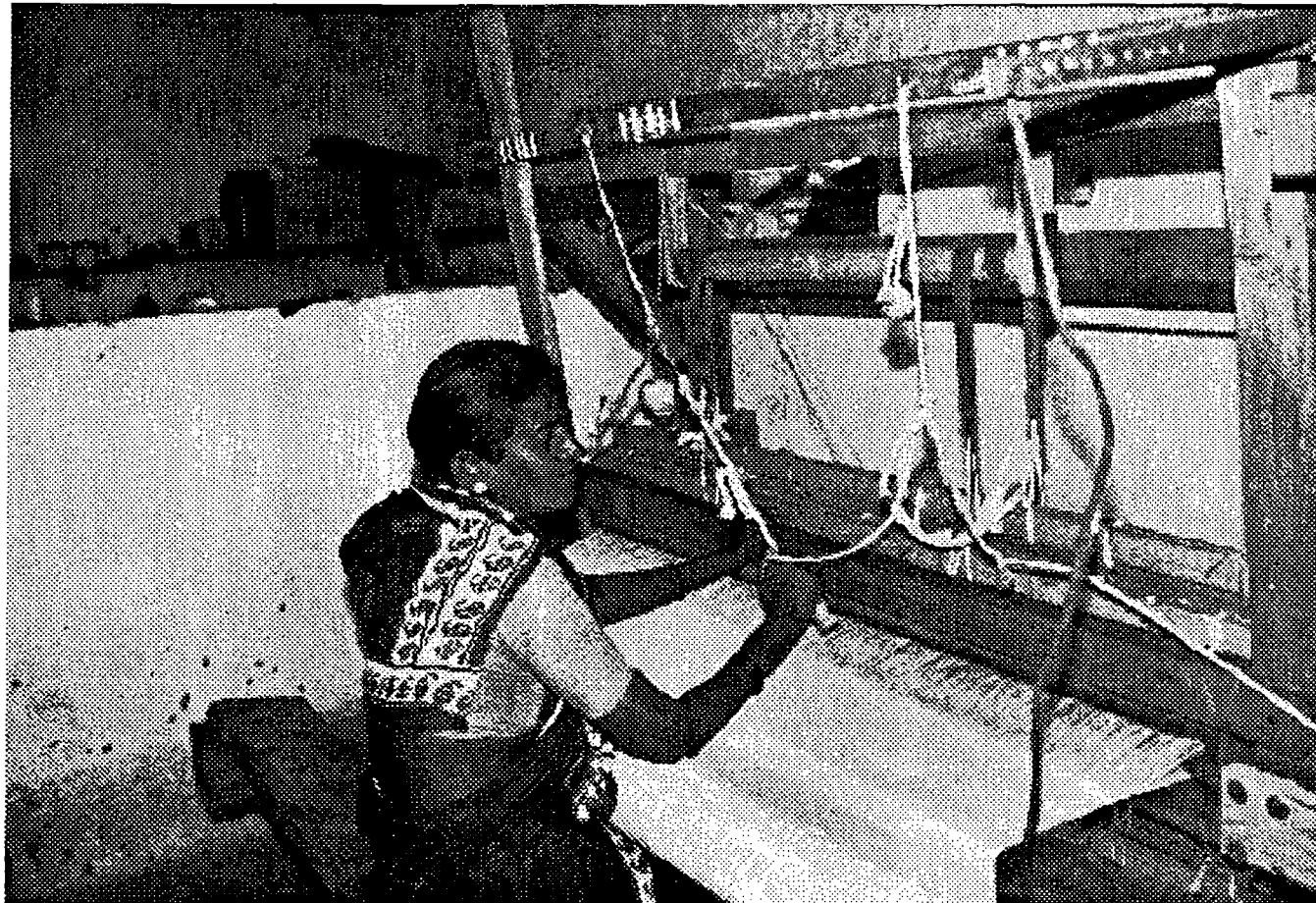


Epidemiology/Policy in Asia

- December 1993 workshop and follow-up
- Indonesian policy tours
- Analysis of policy process in Thailand
- Country epidemiology/policy workshops
- Journalist workshops



A Devadesi's Woman at Her Loom
PVO Grant
PLAN International USA, India





*PVO Competitive Grants Program in Asia:
Bangsue District AIDS Prevention Project/Bangkok,
Thailand (World Vision)*

Baseline survey in 13 communities of 43 in district
(N=1000)

- Knows 2 ways to prevent transmission
44% (mothers) to 72% (adolescent males)
- More than one sex partner during last 6 months
1% (mothers) to 31% (adolescent males)
- Used condom at last sexual contact
8% (mothers) to 56% (adolescent males)
- Believe they are at risk of HIV infection
20% (adolescent females) to 34% (female young
adults and mothers)



AIDSCAP Asia: Evaluation

Sentinel Populations Bangkok Behavioral Sentinel Surveillance

Office Workers	(male, female 15-29 years)
Service Laborers	(male, female 15-29 years)
Vocational Students	(male, female 15-29 years)
Ante natal Clinics	(female over 15 years)
STD Clinic Patients	(male over 15 years)
Lower Fee CSWs	(female over 15 years)
Higher Fee CSWs	(female over 15 years)



NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

1701 K STREET, N.W. SUITE 600, WASHINGTON, DC 20006, (202) 833-5900, FAX: (202) 833-0075

9 December 1996

FAX TRANSMISSION

*LHRS
Let's talk
PP*

TO: Pasty Fleming, Director
Office of National AIDS Policy

FR: Cynthia E. Mariel, AIDS Program Director
National Council for International Health

RE: Meeting with Dr. Peter Piot, Director
UNAIDS Program

The AIDS Program of the National Council for International Health would like to invite you or one representative from your organization to a meeting with Dr. Peter Piot, director of the UNAIDS Program. The meeting will be an informal discussion and update on UNAIDS activities. There will be time for questions at the conclusion of Dr. Piot's remarks. Prior to Dr. Piot's presentation, a brief update will be provided on current activities of importance to U.S.-based organizations involved in international AIDS efforts.

The meeting will be held on Wednesday, December 11 at NCIH, 1701 K Street, NW, Suite 600, Washington, DC. The entrance to the building is on 17th Street between K and L Streets. The closest metro stops are Farragut North on the Red Line and Farragut West on the Blue and Orange Lines. The meeting will begin at 10:30 am and conclude at noon. **(Please note this time change.)**

As space is limited, please RSVP by close of business day on Monday, December 11 by leaving a message by phone at 202-833-5900 ext. 209 or fax at 202-833-0075 or email at ncihids@ncihids.org.

Thank you very much and we hope to see you on Wednesday at 10:30 am.





National Council for International Health

1701 K Street, NW - Suite 600
Washington, DC 20006-1503 USA
Tel: 202-833-5900 - Fax: 202-833-0075
E-mail: <ncihids@ncihids.org>

FAX TRANSMITTAL

To: Carmina Parris

Fax: 632-1096

At White House Office of AIDS Policy

Tel: _____

From Julie Michaelson

Date : Tues 03 Dec 96

Dept: AIDS Program

Pages: 3

LHK
200 P
12/10

MEMORANDUM

Dear Ms. Parris:

I have discussed the possibility of an interview with Ms. Fleming with LaHoma Romocki, who informed me that Ms. Fleming may be available next week.

Therefore, I am writing to you to request a half-hour in-person appointment with Ms. Fleming on the morning of December 10. The subject of the appointment is an interview for the newsletter AIDSLink, which is published by the National Council for International Health (NCIH). I have attached a copy of the questions that will be asked, which Ms. Fleming has already received.

The interview will be conducted by myself, Julie Michaelson, editor of AIDSLink, and/or by Mr. Ron MacInnis, Jr., AIDS Program Associate at NCIH.

Please confirm this appointment with me as soon as possible. Also, please verify with Ms. Fleming that we have permission to tape record the interview. We plan to fax her the final edited transcript of her remarks for her approval later that week.

Thank you for making these arrangements. You may contact me at (770) 729-1497 or Mr. Ron MacInnis at (202) 833-5900 ext. 214.

Sincerely,

Julie Michaelson
Editor, AIDSLink

12/5 -
called Ron, left message
on VM. PF is out all day I
will be in touch ASA she is
back. e

1. To increase US funding for global AIDS by increasing AIDS funding within USAID.

Q: What do you consider to be the number one priority of your office in terms of the US global response to AIDS?

Q: How can US-based organizations active in global AIDS efforts assist ONAP in achieving this goal?

Q: What contributions can AIDS organizations from developing countries make towards this goal?

2. To increase US government support for UNAIDS.

Q: Why do you think support by the US government to UNAIDS is critical to an effective response to the AIDS pandemic?

Q: How can US support for UNAIDS be strengthened?

3. To work closely with the winning contractor(s) identified under USAID's recently announced RFP involving centrally funded HIV/AIDS initiatives.

Q: What do you consider the role of your office to be in relationship to major USAID contractors working on international AIDS projects?

4. To strengthen the linkage of US domestic AIDS groups to global AIDS.

Q: Why do you think it is important for US-based domestic AIDS groups to become involved in global AIDS?

Q: What unique contributions do you believe US-based domestic AIDS groups can make to global AIDS efforts?

5. To increase education and advocacy on the Hill in support for global AIDS.

Q: Based on your knowledge of the US Congress and results of the recent US elections, what are the most effective kinds of educational and advocacy activities that *AIDSLink* readers need to undertake in order to increase support for global AIDS?

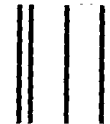
6. To support equitable access to AIDS treatment and care.

Q: At present, over 90 % of HIV infection is among developing country populations and yet, approximately only 8 % of global HIV/AIDS funding is spent in developing

countries. In addition, per capita health related expenditures by health ministries in many developing countries are less than \$2 per year. How do you reconcile these realities with the the strong support you have demonstrated on the issue of equitable access to AIDS treatment and care?

7. To continue support for inactment of the Paris AIDS Summit Declaration.

Q: On World AIDS Day 1994 you were the US representative to the Paris AIDS Summit. At this meeting, the US joined with 42 countries in signing a declaration in which national governments undertook to promote and protect the rights of individuals, particularly people living with HIV/AIDS. To date, the US government still has a travel ban in place restricting people living with HIV/AIDS from entering the country. Will elimination of this restriction be a priority of your office during the next four years?



National Council for International Health
c/o First American Bank
Department 5100
Washington, D.C. 20061-5100





1996 Job Connection

The Annual NCIH job fair is a 3-day networking and recruitment event
for job seekers and employers.

Where: Hyatt Regency Hotel, Crystal City, Arlington, Virginia

When: June 10 and 11 – 9:30 am to 6:00 pm, and

June 12 – 9:30 am to 12:30 pm

R E G I S T R A T I O N

EMPLOYERS: Please return this form by May 6, 1996.

Please include 22 copies of each job announcement.

Contact person: _____

Organization: _____

Phone: _____ Fax: _____

NCIH Organizational Member: ____ Yes ____ No

Non-member organization: \$50 processing fee.

Member organization: FREE.

I am submitting _____ different job announcements (include 22
copies of each announcement which include qualifications,
experience, salary, etc.)

My organization would like to use the interview booths:

____ Yes ____ No

If yes, please indicate days and number of hours. The booths will be
available from 9:30am- 6:00pm June 10 & 11 and 9:30am-12:00pm
on June 12.

Monday, June 10, 1996 for ____ hours. I prefer: am / pm

Tuesday, June 11 1996 for ____ hours. I prefer: am / pm

Wednesday, June 12, 1996 for ____ hours

(9:30 am until 12 pm only)

JOB SEEKERS: Please return this form by May 6, 1996.

Please include 17 copies of your resume (which should be no
longer than 1 page front and back.)

Name: _____

I am a member of NCIH: ____ Yes ____ No

If no, please include your \$50 processing fee.

Attending Conference ____ Yes ____ No

Phone: _____

To gain entrance to the Job Connection in the Exhibit Area,
Employers and Job Seekers must be registered at the Conference.

Job Announcement Binders and Resume Binders will be available for sale after the
Conference for \$50 each. If you would like to reserve (a) Job Announcement Binder or
(b) Resume Binder, please check here: _____

PAYMENT

☐ Check Enclosed
(U.S. Dollars made
payable to NCIH)

☐ Visa
☐ MasterCard

Return with payment to:

Credit Card No.: _____

Exp. Date: _____

Signature: _____

Phone: _____

NCIH Job Connection
1701 K Street, NW
Suite 600

Washington, DC 20006-1503 USA

Fax: (202) 833-0075

Tel: (202) 833-5900

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Delegates Discuss "Hopes and Challenges" in Kampala

by Kelly Forrest, AIDSLink Editor

More than 3,000 delegates from all parts of Africa and the world gathered in Kampala, Uganda for the IXth International Conference on AIDS and STDs in Africa. "We constitute the faces of AIDS and our presence is the expression of the human character of AIDS," stated As Sy, coordinator of AfriCASO, one of the co-sponsoring organizations. For the first time, people living with HIV/AIDS (PWAs) were involved in the planning of this conference from the very beginning. This involvement was reflected in every part of the program, from keynote speakers to roundtable discussions in each of the four tracks.

The conference was opened with speeches from Sam Okware, Chairman, IXth International Conference on AIDS and STDs in Africa (ICASA); Bishop Misaeri Kawuma, Chairman Uganda AIDS Commission; Winnie Chikafumbwa, International Community of Women Living with HIV/AIDS; Dr. Hiroshi Nakajima, Director General, World Health Organization (WHO); Dr. Helene Gayle, US Centers for Disease Control and Prevention (CDC); Dr. Peter Piot, UN Joint and Co-sponsored Programme on AIDS (UNAIDS); Hon. Dr. James Makumbi, Ugandan Minister of Health; and H.E. the President of Uganda, Yoweri Kaguta Museveni.



Simon Nkoli of the Township AIDS Project, South Africa, displays his organization's posters in the ICASA NGO exhibit area.

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research in Africa and the need to build the capacity of African researchers and research institutions. All researchers must assure informed consent and not assume that one definition is applicable in all situations. Research must benefit those who participate in trials first. Drugs and vaccines developed on the basis of these trials must be available and affordable to the poorest communities and countries, especially those participating in research. He was hopeful that important research would continue to be conducted in his and other African countries, but stressed the need to confront the challenges head on and involve African researchers and African communities in the development and implementation of research.