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Letter ID	Writer First Name	Writer Last Name	Received Date	Subject
10989	Sandra	Thurman	6/23/98	call for emergency

☐ Response Required?

Response Type	Response Date	Responder ID	Responder Name	Action Promised
			APIAHF	
Action Completed	Action Date	Addressed To		

Notes

Asian and Pacific Islander Statement of Solidary and Support for the Congressional Black Caucus' call for a national state of emergency on HIV and AIDS.

Sender's Organization	Sender's Street1	Sender's Street2
Sender's City	Sender's State	Sender's Zip

APIAHF

*Asian & Pacific
Islander American*
Health Forum

May 29, 1998

Sandra Thurman
Office of National AIDS Policy
808-17th Street N.W. Suite 820
Washington, D.C. 20006

Dear Ms. Thurman:

Please find enclosed an Asian and Pacific Islander Statement of Solidarity and Support for the Congressional Black Caucus' call for a national state of emergency on HIV and AIDS in the African American community signed by over thirty Asian and Pacific Islander community leaders. We look forward to continuing to work together to increase our governmental and public commitment to HIV/AIDS prevention and services in all communities of color. If you have any questions regarding the statement, please do not hesitate to contact me at phone 415/954-9951 or by e-mail at <ibau@apiahf.org>. Thank you for your attention.

Sincerely,



Ignatius Bau
HIV Program Coordinator

942 Market Street

Suite 200

San Francisco CA 94102

415•954•9988

Fax 415•954•9999

E-mail: hforum@apiahf.org

<http://www.apiahf.org/apiahf>

National Advocates for Asian & Pacific Islander Health

ASIAN AND PACIFIC ISLANDER STATEMENT OF SOLIDARITY AND SUPPORT FOR THE CALL FOR A NATIONAL STATE OF EMERGENCY ON HIV AND AIDS IN THE AFRICAN AMERICAN COMMUNITY

We, the undersigned Asians and Pacific Islanders, express our solidarity and support for the Congressional Black Caucus' call for a national state of emergency on HIV and AIDS in the African American community. As leaders in HIV prevention and services in our own Asian and Pacific Islander communities, we want to add our voices to this call for increased governmental and public action. We do so not to overlook or minimize the need for similar actions, services and resources for HIV and AIDS prevention and services in our Asian and Pacific Islander communities but because we believe that refocusing government and public attention and resources on HIV and AIDS will benefit all our communities and the nation's public health.

In particular, we strongly believe that increased funding and resources for HIV prevention and client services that are culturally and linguistically appropriate are vital for their success in all communities. We also strongly support the specific focus on HIV prevention, care, treatment and support services for gay men at risk for HIV and AIDS. Nationally, nearly 70% of the AIDS cases being reported in our Asian and Pacific and Islander communities are among gay and bisexual Asian and Pacific Islander men. At the same time, we support the development and implementation of targeted programs for women, youth, transgendered individuals, recent immigrants and refugees and other populations at highest risk for HIV and AIDS. We also support the increased coordination and linkage between HIV prevention and treatment programs and substance abuse and mental health services. Finally, we strongly support a comprehensive plan, accompanied by sufficient government funding, to conduct both clinical and behavioral research through research projects that are based in the community and involve community agencies and researchers of color as partners.

HIV and AIDS has long been a crisis in our communities of color. We share and join the urgency of the Congressional Black Caucus in their call for a declaration of a national state of emergency and renewed government and public action on HIV and AIDS. Many in our communities have still not received basic HIV prevention interventions that are culturally appropriate and effective. Those who are living with HIV and AIDS in our communities continue to face cultural, linguistic, social, economic, political and legal barriers to accessing care and services.

As Asians and Pacific Islanders, we join in this call for real and substantive change and significantly increased investment by our federal, state and local governments and by the public in HIV and AIDS prevention and care that will effectively reach our communities.

Signed,

Rene Astudillo, Filipino Task Force on AIDS, San Francisco, CA
Ignatius Bau, Asian and Pacific Islander American Health Forum, San Francisco, CA
Virginia Bourassa, National Minority AIDS Council, Washington, D.C.
Greg Chen, Washington, D.C.
S. Patrick Chong, Lansing Area AIDS Network, Lansing, MI
Prescott Chow, Asian and Pacific Islander American Health Forum, San Francisco, CA
Vince Crisostomo, Asian and Pacific Islander Wellness Center, San Francisco, CA
Gem Daus, Asian and Pacific Islander Partnership for Health and National Minority AIDS Council,
Washington, D.C.
Ricahrd K. Ehara, National Minority AIDS Council, Washington, D.C.
Kevin Fong, Bainbridge Island, WA

Jaime Geaga, Los Angeles, CA
Dean Goishi, Asian Pacific AIDS Intervention Team, Los Angeles, CA
Martin Hiraga, Asian and Pacific Islander Affairs Commission, Washington, D.C.
Paul A. Kawata, National Minority AIDS Council, Washington, D.C.
Raymond Kram, Asian and Pacific Islander Affairs Commission, Washington, D.C.
Kiyoshi Kuromiya, Critical Path AIDS Project, Philadelphia, PA
Edd Lee, State Council on Asian Pacific Minnesotans, Minneapolis, MN
Gee Lee, Asian and Pacific Islander Affairs Commission, Washington, D.C.
Steve Lew, Asian and Pacific Islander Wellness Center, San Francisco, CA
Richard Liu, AIDS Services in Asian Communities, Philadelphia, PA
John Manzon-Santos, Asian and Pacific Islander Wellness Center, San Francisco, CA
Oliver Mateo, Search to Involve Pilipino Americans, Los Angeles, CA
Suki Terada Ports, Family Health Project, New York, NY
Bernadette Provideo, Coral Life Foundation, Guam
Therese R. Rodriguez, Asian and Pacific Islander Coalition on HIV/AIDS, New York, NY
Jess San Roque, Asian and Pacific Islander Community AIDS Project, San Diego, CA
Lina Sheth, Massachusetts Asian AIDS Prevention Project, Boston, MA
Joel Barraquiel Tan, Asian Health Services, Oakland, CA
Vilma Simlote, National Minority AIDS Council, Washington, D.C.
Shalini C. Vallabhan, National Minority AIDS Council, Washington, D.C.
Frank Wong, Fenway Community Health Center, Boston, MA
Helen Ye, San Francisco, CA
Jarret Yoshida, National Minority AIDS Council, Washington, D.C.

Signatories as of May 29, 1998

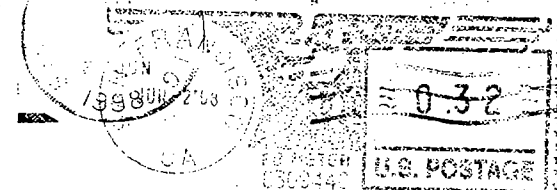
APIA HF

942 Market Street
Suite 200
San Francisco CA 94102

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*Asian & Pacific
Islander American*
Health Forum

National Advocates for Asian & Pacific Islander Health

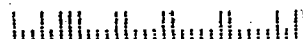


736 JACKSON PLACE

Sandra Thurman
Office of National AIDS Policy
808 17th St. N.W., Ste. 820
Washington, D.C. 20006

20003

20006/3310



APIAHF

*The Asian & Pacific Islander American Health Forum
is pleased to provide you with the enclosed material.*

Todd -

Sorry this took so long
to get to you -

A list of Asian & Pacific
Islander CBO's and info
on signatories to the
API statement of solidarity -

Ignatius

942 Market Street, Suite 200

San Francisco, CA 94102

Tel: (415) 954-9988 • Fax: (415) 954-9999

E-mail: hforum@apiahf.org

<http://www.apiahf.org/apiahf>

Directory of API-CBOs

Organization	A Positive Alternative Center (APAC), Bread & Roses	Office	203/855-1485
Address	50 Water Street	Fax	203/855-1280
	Norwalk CT 06854		

Organization	Action for a Better Community, Action Front Center	Office	(716) 546-6180
Address	150 North Clinton Avenue, Suite 300	Fax	(716) 546-5669
	Rochester NY 14604		

Organization	AIDS Resources & Information Service	Office	408/293-2747
Address	1550 The Alameda, Suite 100	Fax	408/293-0341
	San Jose CA 95126		

Organization	AIDS Services In Asian Communities (ASIAC)	Office	215/563-2424
Address	1201 Chestnut St. Ste. 501	Fax	215/563-1296
	Philadelphia PA 19107		

Organization	Alaska AIDS Assistance Association	Office	907/263-2055/2050
Address	1057 West Fireweed Lane, Ste. 102	Fax	907/263-2051
	Anchorage AK 99503		

Organization	All Saints AIDS Service	Office	
Address	40 E Verdugo Avenue	Fax	
	Burbank CA 91502		

Organization	Asian American AIDS Services	Office	773/989-7220
Address	4750 North Sheridan Road, Suite 429	Fax	773/989-7769
	Chicago IL 60640		

Organization	Asian American AIDS Services	Office	(312) 989-7220
Address	4750 North Sheridan Road, Suite 429	Fax	(312) 989-7769
	Chicago IL 60640		

Organization	Asian American Drug Abuse Program	Office	(213) 293-6284
Address	5318 South Crenshaw Blvd.	Fax	(213) 295-4075
	Los Angeles CA 90043		

Organization	Asian American Recovery Services, Inc	Office	(415) 541-9285
Address	785 Market Street, 19th Floor	Fax	(415) 541-9886
	San Francisco CA 94103		

Organization	Asian Americans for Community Involvement	Office	408/975-2730
Address	2400 Moorpark Avenue, Suite 300	Fax	408/975-2745
	San Jose CA 95128		

Directory of API-CBOs

Organization	Asian Health Services	Office	510/986-6876
Address	818 Webster Street	Fax	510/986-6890
	Oakland CA 94607		

Organization	Asian Pacific AIDS Council	Office	206/405-3278
Address	P.O. Box 3161	Fax	(206) 467-1072
	Seattle WA 98114		

Organization	Asian Pacific AIDS Intervention Team	Office	(213) 553-1830
Address	605 West Olympic Blvd., Suite 610	Fax	(213) 553-1833
	Los Angeles CA 90015		

Organization	Asian Pacific Development Center	Office	(303) 393-0304
Address	1825 York Street	Fax	(303) 388-1172
	Denver CO 80226		

Organization	Asian Pacific Family Center	Office	(818) 287-2988
Address	9353 East Valley Blvd.	Fax	(818) 287-1937
	Rosemead CA 91770		

Organization	Asian & Pacific Islander Coalition on HIV/AIDS	Office	212/620-7287
Address	275 7th Avenue, 12th Floor	Fax	(212) 620-7323
	New York NY 10001		

Organization	Asian Pacific Islander Community AIDS Project - Ohana Jamii	Office	619/229-2828
Address	4776 El Cajon Blvd., Ste. 205	Fax	619/229-2831
	San Diego CA 92115		

Organization	Asian & Pacific Islander Partnership for Health	Office	(202) 986-2393
Address	P.O. Box 18964	Fax	(202) 628-1893
	Washington D.C. 20036		

Organization	Asian & Pacific Islander Wellness Center	Office	415-292-3400
Address	730 Polk St, 4th Fl	Fax	415-292-3404
	San Francisco CA 94109		

Organization	Asian & Pacific Islanders for Reproductive Health	Office	562/427-5272
Address	3620 Long Beach Blvd	Fax	562/427-5268
	Long Beach CA 90807		

Organization	Asian Youth Center	Office	626/309-0622
Address	100 West Clary Avenue	Fax	626/309-0717
	San Gabriel CA 91776		

Directory of API-CBOs

Organization	Association of Asian Pacific Islander Community Health	Office	(510) 272-9539
Address	1440 Broadway, Suite 510	Fax	(510) 272-0817
	Oakland CA 94612		
Organization	Big Island AIDS Project	Office	808/935-6711
Address	Box 11510	Fax	808/969-9329
	Hilo HI 96721-6510		
Organization	Cambodian Community of Greater Fall River	Office	(508) 676-8225
Address	P. O. Box 5085 Flint Station	Fax	(508) 676-1477
	Fall River MA 02723		
Organization	Center for Pan Asian Community Services, Inc.	Office	(404) 936-0969
Address	5302 Buford Hwy., Suite B-4	Fax	(770) 458-9377
	Doraville GA 30340		
Organization	Chinatown Health Clinic	Office	212/226-1661
Address	125 Walker Street	Fax	212/226-2289
	New York NY 10013		
Organization	Chinatown Service Center	Office	(213) 253-0870
Address	600 North Broadway, Suite A	Fax	(213) 680-9427
	Los Angeles CA 90012		
Organization	Chinatown Youth Center	Office	(415) 775-2636
Address	1693 Polk Street	Fax	(415) 775-1345
	San Francisco CA 94109		
Organization	Chinese-American Planning Council, HIV/AIDS Services	Office	(212) 941-0030/7992
Address	365 Broadway, Ground Fl	Fax	(212) 226-5351
	New York NY 10013		
Organization	Coral Life Foundation Guam	Office	?
Address	P.O. Box 5183	Fax	(671) 734-1475
	Agana GU 96932		
Organization	Critical Path AIDS Project	Office	(215) 545-2212
Address	2062 Lombard Street	Fax	(215) 735-2762
	Philadelphia PA 19146		
Organization	East Dallas Counseling Center	Office	214/821-5393
Address	4306 Bryant Street	Fax	214/821-0810
	Dallas TX 75204		

Directory of API-CBOs

Organization	Family Health Project	Office	(212) 344-0195 x 341
Address	90 Washington Street, 27th Floor	Fax	(212) 344-1230
	New York NY 10006		
Organization	Fenway Community Health Center	Office	617/267-1831 ext. 229
Address	7 Haviland Street	Fax	(617) 536-8602
	Boston MA 02115		
Organization	Filipino HIV/AIDS Prevention Program	Office	808/395-8041
Address	715 Kapaia Street	Fax	808/395-8041
	Honolulu hi 96825		
Organization	Filipino Task Force on AIDS	Office	(415) 703-9880
Address	1540 Market Street, Suite 325	Fax	(415) 864-7482
	San Francisco CA 94102		
Organization	Filipinos for Affirmative Action	Office	(510) 487-8552
Address	310-8th Street, Suite 308	Fax	(510) 465-7548
	Oakland CA 94607		
Organization	Gay Asian Pacific Support Network	Office	
Address	P.O. Box 461104	Fax	(213) 477-6393
	Los Angeles CA 90046		
Organization	God's Love We Deliver	Office	(212) 865-6500
Address	166 Avenue of the Americas	Fax	(212) 865-4901
	New York NY 10013		
Organization	Greater Fresno Health Organization	Office	(209) 255-6476
Address	4929 East Kings Canyon Road	Fax	(209) 255-7906
	Fresno CA 93727		
Organization	Healthier Solutions, Inc.	Office	(213) 935-5055
Address	5055 Wilshire Blvd., #930	Fax	(213) 935-5170
	Los Angeles CA 90036		
Organization	Indochinese Community Center	Office	(703) 241-5477
Address	6131 Willston Drive, Ste. 8	Fax	(703) 241-2968
	Falls Church VA 22044		
Organization	Indochinese Community Center	Office	(202) 462-4330
Address	1628 16th Street, N.W.	Fax	(202) 462-2774
	Washington D.C. 20009		

Directory of API-CBOs

Organization	Indochinese Youth Center	Office	(310) 768-8064
Address	14112 South Kingsley Drive	Fax	(310) 768-2779
	Gardena CA 90247		

Organization	Intercultural Family Services, Inc.	Office	(215) 386-1298
Address	4225 Chestnut Street	Fax	(215) 386-9348
	Philadelphia PA 19104		

Organization	International Community Health Services	Office	(206) 461-3617
Address	720 8th Avenue South, Suite 100	Fax	(206) 461-4857
	Seattle WA 98104		

Organization	Ke Ola Mamo	Office	808/533-0035
Address	1130 North Nimitz Highway, Ste. 221	Fax	
	Honolulu HI 96817		

Organization	Khmer Health Advocates	Office	(203) 233-0313
Address	1028 Boulevard	Fax	(203) 233-1831
	West Hartford CT 06119-1801		

Organization	Kokua Kalihi Valley Health Center	Office	(808) 848-0976
Address	1846 Gulick Avenue	Fax	(808) 848-0979
	Honolulu HI 96819		

Organization	Korean Community Development	Office	(215) 276-8830
Address	6055 North Fifth Street	Fax	(215) 224-8150
	Philadelphia PA 19120		

Organization	Korean Community Services Center	Office	(202) 882-8270
Address	7720 Alaska Avenue	Fax	(202) 882-8660
	Washington D.C. 20012		

Organization	Korean Health Education, Information & Referral Ctr	Office	(213) 427-4000
Address	545 South Gramercy Place	Fax	(213) 427-4008
	Los Angeles CA 90020		

Organization	Korean Youth and Community Center	Office	
Address	680 South Wilton Place	Fax	(213) 383-1280
	Los Angeles CA 90005		

Organization	LA Free Clinic	Office	(213) 462-8632
Address	6043 Hollywood Blvd.	Fax	(213) 462-6734
	Hollywood CA 90028		

Directory of API-CBOs

Organization	Lambda Legal Defense & Education Fund, Inc.	Office	312/663-4413
Address	11 East Adams, Suite 1008	Fax	312/663-4307
	Chicago IL 60603-6303		

Organization	Lambda Legal Defense & Education Fund, Inc.	Office	212/809-8585
Address	120 Wall St., Ste. 1500	Fax	212/809-0055
	New York NY 10005-3904		

Organization	Lambda Legal Defense & Education Fund, Inc.	Office	404/897-1880
Address	1447 Peachtree St., NE, Ste. 1004	Fax	404/897-1884
	Atlanta GA 30309-3027		

Organization	Lambda Legal Defense & Education Fund, Inc.	Office	213/937-2728
Address	6030 Wilshire Blvd., Ste. 200	Fax	213/937-0601
	Los Angeles CA 90036-3617		

Organization	Lao Family Community of Minnesota	Office	(612) 221-0069
Address	320 West University Avenue	Fax	(612) 221-0276
	St. Paul MN 55103		

Organization	Life Foundation	Office	(808) 521-2437
Address	233 Keawe Street, Suite 226	Fax	(808) 521-1552
	Honolulu HI 96813-5405		

Organization	LLEGO	Office	
Address	1612 K Street, N.W. Suite 500	Fax	
	Washington, D.C. 20006		

Organization	Los Angeles Gay and Lesbian Community Services Center	Office	(213) 993-7674
Address	1625 North Schrader Blvd.	Fax	(213) 993-7699
	Los Angeles CA 90028		

Organization	Malama Pono - The HIV Service Agency of Kaua'i	Office	(808) 822-0878
Address	4778 Kawaihau Road	Fax	(808) 822-0664
	Kapa'a HI 96746		

Organization	Massachusetts Asian AIDS Prevention Project	Office	617/262-2900
Address	100 Massachusetts Ave., Ste. 402	Fax	617/262-2939
	Boston MA 02115		

Organization	Maui AIDS Foundation	Office	(808) 242-4900
Address	1844 Wili Pa Loop, P.O. Box 858	Fax	(808) 242-1968
	Wailuku HI 96793		

Directory of API-CBOs

Organization	Multicultural Educational Project	Office	619/279-9675
Address	6973 Linda Vista Road	Fax	619/278-1896
	San Diego CA 92111		

Organization	National Asian Pacific American Families Against Substance Abuse	Office	213/625-5795
Address	300 West Cesar Chavez Avenue, Suite B	Fax	213/625-5796
	Los Angeles CA 90012		

Organization	National Asian Pacific American Families Against Substance Abuse	Office	213/625-5795
Address	300 West Cesar Chavez Avenue, Suite B	Fax	213/625-5796
	Los Angeles CA 90012		

Organization	National Asian Women's	Office	(415) 989-9747
Address	250 Montgomery Street, Suite 410	Fax	(415) 989-9758
	San Francisco CA 94104		

Organization	National Minority AIDS Council	Office	(202) 483-6622
Address	1931 13th Street, N.W.	Fax	(202) 483-1135
	Washington D.C. 20009		

Organization	National Task Force on AIDS Prevention	Office	(415) 356-8100
Address	973 Market Street, Suite 550	Fax	(415) 356-8103
	San Francisco CA 94103		

Organization	Orange County Asian & Pacific Community Alliance	Office	714/663-9313
Address	12377 Lewis Street, Suite 205	Fax	714/663-9324
	Garden Grove CA 92840		

Organization	Pacific Asian Language Services	Office	(213) 553-1818
Address	605 West Olympic Blvd., Suite 600	Fax	(213) 551-1822
	Los Angeles CA 90015		

Organization	Pacific Islander Community Council	Office	(562) 401-7202
Address	17230 South Figueroa Street	Fax	(562) 803-4362
	Gardena CA 90248		

Organization	Papa Ola Lokahi- Native Hawaiian HIV/AIDS Case Management	Office	808/242-4900 x 110
Address	P.O. Box 858	Fax	808/242-1968
	Wailuku HI 96793		

Organization	People of Color Against AIDS Network	Office	
Address	607 19th Avenue E	Fax	(206) 322-7204
	Seattle WA 98112-4008		

Directory of API-CBOs

Organization **Pilipinos For Community Health**
Address 308 Westwood Plaza
Los Angeles CA 90024

Office 310/825-2415
Fax

Organization **ROCA Revere Project**
Address 103 Shirley Avenue
Revere MA 02151

Office (617) 284-6281
Fax (617) 889-2145

Organization **San Francisco AIDS Foundation**
Address 995 Market Street
San Francisco CA 94103

Office (415) 487-8086
Fax (415) 487-8089

Organization **SE Asian Transgender AIDS Prevention Project -- SE Asian**
Address 875 O'Farrell
San Francisco CA 94109

Office 415/922-4667
Fax 415/885-3753

Organization **Southeast Asian Community Center**
Address 875 O'Farrell Street
San Francisco CA 94109

Office (415) 885-2743
Fax (415) 885-3253

Organization **Southeast Asian Mutual Assistance**
Address 4601 Market Street
Philadelphia PA 19139

Office (215) 476-9640
Fax (215) 471-8029

Organization **St. Louis Effort for AIDS**
Address 1425 Hampton
St. Louis MO 63139

Office 314/645-6451
Fax 314/645-6502

Organization **State Council on Asian Pacific Minnesotans**
Address 200 University Ave., Ste. 100
St. Paul MN 55193

Office 612/296-7481
Fax 612/297-8735

Organization **State HIV Prevention Group**
Address 94-304 Lupua Place
Mililani HI 96789

Office 808/623-3690
Fax 808/623-3690

Organization **T.H.E. Clinic Asian Health Project**
Address 3860 West Martin Luther King Jr., Blvd.
Los Angeles CA 90008

Office (213) 295-6571
Fax (213) 295-6577

Organization **Tenderloin AIDS Resource Center**
Address 187 Golden Gate Avenue
San Francisco CA 94103

Office (415) 431-7476
Fax (415) 431-3959

Directory of API-CBOs

Organization	Tulay Project of PACEC, Inc.	Office	(212) 423-6823
Address	1636 3rd Avenue, #260	Fax	(212) 423-8334
	New York NY 10029		

Organization	United Cambodian Association of Minnesota	Office	(612) 222-3299
Address	529 Jackson Street, Suite 221	Fax	(612) 222-3599
	St. Paul MN 55101		

Organization	Waianae Coast Comprehensive	Office	(808) 696-5561
Address	86-260 Farrington Hwy	Fax	(808) 696-1533
	Waianae HI 96792		

Organization	Waikiki Health Center	Office	(808) 922-3028
Address	277 Ohua Avenue	Fax	(808) 922-4794
	Honolulu HI 96815		

Organization	West bay Pilipino Multi-Services Center, Inc.	Office	415/431-9336
Address	170 7th Street	Fax	415/431-7324
	San Francisco CA 94103		

Organization	West Hawaii AIDS Foundation	Office	(808) 322-1718
Address	P.O. Box 846	Fax	(808) 322-0762
	Kealahou HI 96750		

Organization	Women's Foundation	Office	(415) 837-1133
Address	340 Pine Street, Suite 302	Fax	(415) 837-1144
	San Francisco CA 94104		

Total: 95

API Statement of Solidarity & Support

Name	Bernadette Provido	Office	(671) 735-7311 (671)
Organization	Coral Life Foundation Guam	Fax	(671) 734-1475
Address	P.O. Box 5183		
	Agana GU 96932		

Name	Daniel Bao	Office	415-292-3420
Organization	Asian & Pacific Islander Wellness Center	Fax	415-292-3404
Address	730 Polk St, 4th Fl		
	San Francisco CA 94109		

Name	Dean Goishi	Office	(213) 553-1830
Organization	Asian Pacific AIDS Intervention Team	Fax	(213) 553-1833
Address	605 West Olympic Blvd., Suite 610		
	Los Angeles CA 90015		

Name	Edd Lee	Office	612/296-7481
Organization	State Council on Asian Pacific Minnesotans	Fax	612/297-8735
Address	200 University Ave., Ste. 100		
	St. Paul MN 55193		

Name	Francisco Sy	Office	(803) 777-2273
Organization	Dept. of Epidemiology & Biostatistics School of Public Health	Fax	(803) 777-8004
Address	University of South Carolina		
	Columbia SC 29208		

Name	Frank Wong	Office	(617) 267-1831 ext. 229
Organization	Fenway Community Health Center	Fax	(617) 536-8602
Address	7 Haviland Street		
	Boston MA 02115		

Name	Gee Lee	Office	
Organization	Commission on Asian and Pacific Islander Affairs	Fax	
Address	Washington, D.C.		

Name	Gem Daus	Office	202/483-6622
Organization	Asian & Pacific Islander Partnership for Health	Fax	202/483-1135
Address	4163 South Four Mile Run Drive #30		
	Arlington VA 22204		

Name	Greg Chen	Office	
Organization		Fax	
Address	Washington, D.C.		

Name	Helen Ye	Office	415/487-5777
Organization	Health Initiatives for Youth	Fax	415/487-5771
Address	1242 Market St., 3rd Floor		
	San Francisco CA 94102		

API Statement of Solidarity & Support

Name	Hue-Sun Ahn	Office	215/204-3120
Organization	Temple University Counseling Services,	Fax	215/204-5419
Address	1330 W. Berks Street		
	Philadelphia PA 19122-6087		

Name	Ignatius Bau	Office	415/954-9951
Organization	Asian & Pacific Islander American Health Forum	Fax	415/954-9999
Address	942 Market Street, Suite 200		
	San Francisco Ca 94102		

Name	Jaime Geaga	Office	(213) 666-3947
Organization		Fax	
Address	1005 1/2 Sanborn Avenue		
	Los Angeles CA 90029		

Name	Jarret Yoshida	Office	(202) 483-6622
Organization	National Minority AIDS Council	Fax	(202) 483-1135
Address	1931 13th Street, N.W.		
	Washington D.C. 20009-4432		

Name	Jess San Roque	Office	(619) 229-2828
Organization	Asian Pacific Islander Community AIDS Project	Fax	619/229-2831
Address	4776 El Cajon Blvd., Ste. 205		
	San Diego CA 92115		

Name	Joel B. Tan	Office	(510) 986-6876
Organization	Asian Health Services	Fax	(510) 986-6890
Address	818 Webster Street		
	Oakland CA 94607		

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API Statement of Solidarity & Support

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API Statement of Solidarity & Support

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**ASIAN AND PACIFIC ISLANDER STATEMENT OF SOLIDARITY AND SUPPORT
FOR INCREASED RYAN WHITE CARE ACT TITLE I FUNDING
FOR AFRICAN AMERICANS AND LATINOS**

We, the undersigned Asians and Pacific Islanders, express our solidarity and support for increased Ryan White CARE Act Title I funding for African Americans and Latinos. We understand that Congress appropriated an additional \$5 million in Fiscal Year 1999 for Eligible Metropolitan Areas (EMA) where the percentage of reported HIV/AIDS cases among African Americans and Latinos exceed 30% of all cases in that EMA. As leaders in HIV prevention and services in our own Asian and Pacific Islander communities, we want to add our support for this increased funding for African American and Latino communities most heavily impacted by HIV and AIDS. We do so not to overlook or minimize the need for similar resources for HIV and AIDS prevention and services in our Asian and Pacific Islander communities but because we believe that refocusing government and public attention and resources on HIV and AIDS in communities of color will benefit all our communities and the nation's public health.

In particular, we strongly believe that increased funding and resources for HIV prevention and client services that are culturally and linguistically appropriate are vital for their success in all communities. We also strongly support the specific focus on HIV prevention, care, treatment and support services for gay men at risk for HIV and AIDS. Nationally, nearly 70% of the AIDS cases being reported in our Asian and Pacific and Islander communities are among gay and bisexual Asian and Pacific Islander men. At the same time, we support the development and implementation of targeted programs for women, youth, transgender individuals, recent immigrants and refugees and other populations at highest risk for HIV and AIDS. We also support the increased coordination and linkage between HIV prevention and treatment programs and substance abuse and mental health services. Finally, we strongly support a comprehensive plan, accompanied by sufficient government funding, to conduct both clinical and behavioral research through research projects that are based in the community and involve community agencies and researchers of color as partners.

HIV/AIDS has long been a crisis in our communities of color. We share and join the urgency of the Congressional Black Caucus, the Congressional Hispanic Caucus and the Department of Health and Human Services in their efforts to focus renewed government and public attention on HIV/AIDS in communities of color. Many in our communities have still not received basic HIV prevention interventions that are culturally appropriate and effective. Those who are living with HIV and AIDS in our communities continue to face cultural, linguistic, social, economic, political and legal barriers to accessing care and services. As Asians and Pacific Islanders, we continue to support these efforts to make real and substantive changes and significantly increase the investments by our federal, state and local governments and by the public in HIV and AIDS prevention and care that will effectively reach our communities.

Signed,

Puaalaokalani D. Aiu, Papa Ola Lokahi, Honolulu, HI
Joy Alumit, Asian Health Services, Oakland, CA
Eric J.C. Astacaan, Sacramento, CA
Rene Astudillo, San Francisco, CA
Daniel Bao, Asian and Pacific Islander Wellness Center, San Francisco, CA
Ignatius Bau, Asian and Pacific Islander American Health Forum, San Francisco, CA
Virginia Bourassa, National Minority AIDS Council, Washington, D.C.

Sean Bui, AIDS Services in Asian Communities, Philadelphia, PA
 Kevin R. Conare, ActionAIDS, Philadelphia, PA
 Chwee Lye Chng, University of North Texas, Denton, TX
 S. Patrick Chong, Department of Community Health, Lansing, MI
 Prescott Chow, Asian and Pacific Islander American Health Forum, San Francisco, CA
 Vincent Crisostomo, Asian and Pacific Islander Wellness Center and Gay Asian Pacific Alliance, San Francisco, CA
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 Quang H. Dang, Center for AIDS Prevention Studies, San Francisco, CA
 Gem P. Daus, National Minority AIDS Council, Washington, D.C.
 Trang Duong, Anchorage, AL
 Heng L. Foong, Pacific Asian Language Services, Los Angeles, CA
 Kevin Fong, Banbridge Island, WA
 Jaime Geaga, Los Angeles, CA
 Diosdado Gica, San Francisco, CA
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 Agnes Harley, Philadelphia FIGHT, Philadelphia, PA
 Gayle Isa, Asian Arts Initiative, Philadelphia, PA
 Ezer Kang, Boston University Medical Center, Boston, MA
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 Sam Keohavong, Texas Health Resources, Arlington, TX
 Kiyoshi Kuromiya, Critical Path AIDS Project, Philadelphia, PA
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 Teresa Lau, Massachusetts Asian AIDS Prevention Project, Boston, MA
 Steve Lew, President's Advisory Council on HIV and AIDS, San Francisco, CA
 Richard C. Liu, Philadelphia, PA
 Steven W. Louie, AIDS Services in Asian Communities, Philadelphia, PA
 Andrew Ma, Asian Pacific Health Care Venture, Los Angeles, CA
 John Manzon-Santos, Asian and Pacific Islander Wellness Center, San Francisco, CA
 Gilda Martinez, Operation Samahan, National City, CA
 Kim-Leiloni Nguyen, San Diego, CA
 Ernest G. Ong, Alhambra, CA
 Billy Pick, Department of Public Health, San Francisco, CA
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 Suki Terada Ports, Family Health Project, New York, NY
 Aurora C. Puliclo, North County Health Services, San Marcos, CA
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 Lina Sheth, Massachusetts Asian AIDS Prevention Project, Boston, MA
 Janet Soo Hoo, Asian Counseling and Referral Service, Seattle, WA
 Francisco S. Sy, University of South Carolina, Columbia, SC
 Ronald T. Sy, AIDS Services in Asian Communities, Philadelphia, PA
 Paul Tamura, Queer and Asian, Seattle, WA
 Joel B. Tan, Asian Health Services, Oakland, CA
 Shalini C. Vallabhan, National Minority AIDS Council, Washington, D.C.
 Frank Y. Wong, The Fortune Society, New York, NY
 Jason Yaris, Malama Pono: The HIV Service Agency of Kauai, Kapaa, HI
 Gust A. Yep, San Francisco State University, San Francisco, CA
 Garrett Yoshida, National Minority AIDS Council, Washington, D.C.

Dated: January 13, 1999

stigma extending beyond the homosexual or bisexual individual to affect their extended families. The powerful social forces of shame and fear of isolation have made it difficult for African American communities to identify and address the HIV epidemic in their midst and mount effective prevention strategies. The concurrent devastation that illegal drug use has brought to many African American communities also affects the ability of families to tolerate these destructive behaviors which also increase the risk of HIV. There are dual currents of resentment directed toward the drug user for bringing stresses into the home and at the government for not working hard enough to eradicate the menace of drug use in their communities. With the national leadership of the Black Caucus and new leadership among religious and community leaders, the level of discourse and ownership of HIV as an urgent problem within African American communities is increasing, often linked to the dual epidemic.

Distinct from the issues of accessible health care, health seeking behaviors among persons at high risk or, or those living with, HIV disease are affected by perceptions of the health care delivery system. Many people first experience HIV disease when someone they know becomes sick, is diagnosed with AIDS and dies within a year or two. Hospitals in particular are often viewed as a place to go to die. This leads to little perceived benefit in knowing one's HIV status and reinforces a natural denial response to learning bad news.

Historical distrust of medical care systems, including the effects of new therapies and a fear of being experimented on, are deep-seated perceptions that also condition the frequency and quality of primary care and specialty services sought by persons of color. A considerable number of African Americans have chosen natural or holistic therapies over or in addition to allopathic treatments. Another factor for some individuals, related in part to competing life priorities and ready accessibility of services, is a pattern of enduring ill health and physical symptoms for long periods without engaging the medical delivery system. Patterns of delay in attending to personal health have persisted even in settings where minority health professionals serve in publicly funded clinics.

Allocation Processes for Federal Funds

The primary discretionary federal resources for HIV/AIDS health care and prevention purposes are the Ryan White CARE Act and the HIV Prevention Community Planning cooperative agreements, administered by HRSA and CDC respectively. The majority of these funds are conditioned through State or local planning processes that set priorities for resource allocation. The role of planning bodies in influencing funding decisions varies across the PHS programs as noted below; actual grant awards are made on the basis of a competitive application process in the majority of cases.

Under the Ryan White CARE Act, Title I provides for emergency grants to large metropolitan areas with significant AIDS caseloads. Within each grantee area, an HIV planning council conducts a needs assessment and establishes priorities for proportional allocation of funds to address gaps in services. There is clear guidance that resource allocations should address those

areas of need defined in the needs assessment, but within a context of limited resources, **which** need is addressed and to **what** degree is a decision made by the planning council. Ethnic diversity in the composition of planning councils is required to the extent that representatives living with HIV/AIDS reflect the demographics of the local AIDS epidemic. However, planning councils have historically had a majority of white members reflective of the leadership of prominent health care institutions and community based organizations that served the early epidemic among gay white men. Recruitment of people of color who are comfortable and skilled in articulating the needs of their community and negotiating with local power structures for resources remains a challenge. Both getting a seat at the table in sufficient numbers, and using it effectively are important goals for African American communities. HRSA supports these goals through its policies but all implementation is ultimately local.

Within CDC's prevention community planning groups, which advise states on priorities for HIV prevention investments, sustaining vocal minority representation to advance and plan for the needs of African American communities has also been a challenge. Unlike the Ryan White Title I grants, final decisions on resource prioritization and allocation of CDC HIV prevention community planning funds rests with the State health department. This is also true for Ryan White State Title II grants to States and SAMHSA block grant funds for substance abuse prevention and treatment programs.

Allocation decisions for State and local revenues are impacted to a greater degree by local political processes and historic patterns of investment in health care infrastructure and service mix. Inequities among the availability of comparable services across neighborhoods and communities reflect both resource investment patterns as well as other complex manpower and sociodemographic trends, as will be described below.

A cross-cutting issue affecting all revenue sources is commonly an inherent tension between the provision of services to persons of color through mainstream organizations and the capacity of minority based organizations to serve these same populations. A perceived lack of ability to access and influence available federal funding streams was the predominant frustration expressed by African American activists at the April CBC meeting.

Manpower Shortages

A key barrier to care in many communities is the inadequate supply of primary care providers and capacity for expert referral and consultations to address the needs of increasingly complex HIV clinical care. The ability to attract and retain medical, nursing and social work professionals is affected by salary levels, the economic stability of a medical practice/community based organization, cultural competency of professionals with the population to be served, the personal costs of dealing with complex progressive diseases, and personal safety factors in some poor urban communities. The proportion of entrants to graduate training in the health professions does not reflect the demographics of the nation, and practicing professionals select their

specialties and locations on a broad number of criteria. Once in training programs, there are relatively few mentors committed to serving the primary care needs of minority underserved communities. In addition, those who are on medical school faculties and committed to primary care in minority communities are often overlooked for promotion to Associate and Full Professor faculty positions.

Another component of the manpower issue is the lack of a strong infrastructure of African American community based organizations (CBOs) addressing HIV/AIDS-related issues within most communities. A challenge for many African American CBOs is the development and submission of grant applications. The scope and nature of RFPs vary from state to state, and city to city. Many CBOs still lack the capacity to develop RFPs/RFAs and do not score well enough to be awarded a grant or achieve funding above a nominal level. In spite of the fact that over 20 national and regional minority organizations provide technical assistance to providers of HIV/AIDS prevention services and many Ryan White program budgets set aside some capacity building funds, the ability to design highly competitive grant applications and proposals remains a point of consternation for many African American providers.

Administrative caps imposed on Ryan White CARE Act grantees in the 1996 reauthorization have been particularly difficult for small CBOs with few non-federal resources to sustain their operating capacity. Within mainstream AIDS service organizations, the availability of a cadre of organized volunteers has often supported the fiscal base of the organization, in some cases doubling or tripling its capacity to provide services. This level of organized volunteerism is not commonly experienced among minority CBOs.

Another facet of provider capacity relates to the development of a strong research field of minority researchers. The federal investment in research supported by the NIH competitively targets resources to a cadre of scientists and academic institutions involved in basic laboratory, clinical or behavioral research. There are very few AIDS Clinical Trials Groups (ACTGs) located within minority institutions with African American principal investigators, with the unintended effect of reducing access to a very large potential research population that frequently is mistrustful of clinical trials. There is a need to both encourage and build up a strong group of African American researchers, and to provide opportunities for participation in clinical research trials within communities of color.

In summarizing resource issues, uneven investments in infrastructure and inadequate numbers of health care providers have resulted in an incomplete medical care and social service support structure for heavily impacted communities of color. The lack of specific points of access, and the lack of a complete continuum of medical care and support services, negatively impacts on entry and retention of HIV positive African Americans in care and the delivery of effective prevention services.

Other Factors Impacting on Urban Populations

A number of sociodemographic, political and infrastructure characteristics are shared by urban communities in which African Americans are highly impacted by HIV/AIDS. The combined effects of declining investments in inner cities and health and income support programs for poor individuals have ramifications far beyond HIV/AIDS, but clearly impact on the ability to effectively address the prevention and treatment needs associated with HIV/AIDS. These go beyond an inadequate distribution of skilled personnel and health care resources, such as health clinics and hospitals within minority communities to include a lack of critical enabling services such as transportation, day care and other support services that facilitate access to, and retention in, health care.

Inner city and urban communities are buffeted by the effects of change in federal and state welfare programs, supplemental security income, Medicaid programs, delivery systems increasingly oriented towards profitable managed care, and growing immigrant populations. The concentration of many urban ills is reflected in a revolving prison population, which has amplified HIV transmission and complicated medical management of those infected in many cities. Large neighborhood populations characterized by the working poor and near poor have historically been excluded from the political system, and cultural factors as discussed above have constrained effective community based responses to the rise in HIV/AIDS.

In most large urban neighborhoods heavily impacted by HIV/AIDS, private dollars from traditional resources are now going down. Within the gay community the ability to mobilize new dollars for AIDS organizations has diminished, in part due to donor fatigue and a lesser sense of urgency as new treatments have shown effectiveness in prolonging life. Concurrently, the larger traditional organizations are also being called upon to serve larger caseloads for longer periods as prevalent HIV infections grow and death rates decline. There is concern among existing minority organizations that the diminished "trickling down" of resources gained through AIDS community advocacy efforts will result in even fewer resources available to them. There is a growing view among some that African American communities must start looking within themselves for nontraditional sources for support and resources, defining new partnerships to sustain HIV-related community based activities.

CONGRESSIONAL BLACK CAUCUS REQUESTS

On May 15, 1998, the Congressional Black Caucus (CBC) requested Secretary Shalala to declare the HIV/AIDS crisis in the black community as a "public health emergency" (42 U.S.C. Sec. 247(d)). The specific components of this crisis which CBC says must be addressed include:

- Resources are not connected with the epidemic. There needs to be technical assistance and a reform of the planning process so that the funding follows the epidemic.

- African American women and children make up the fastest growing AIDS/HIV caseload. AIDS/HIV resources and strategies must be targeted towards them.
- There is a need to integrate substance abuse treatment with HIV prevention and care
- There currently is no strategy to deal with HIV infected prison populations either inside of prison or after they are discharged.
- There is an absence of health care professionals and researchers with an interest and commitment to serve African American communities.
- There is a need to spearhead a comprehensive strategy to engage our leadership and the federal government to combat anti-gay bias.

Congressman Stokes has introduced the Disadvantaged Minority Health Improvement Amendments Act, which includes a strong focus on supporting the development of minority health care professionals, and grants to States for demonstration programs to increase the availability of primary care in health professional shortage areas.

OPTIONS TO RESPOND TO CBC

State of Emergency

Section 319 (a) and (b) of the Public Health Service Act gives the Secretary the authority to make the determination that a public health emergency exists and authorizes such actions as may be appropriate to respond to such an emergency, including making grants and entering contracts, conducting and supporting investigations into the cause, treatment, or prevention of a disease or disorder triggering the public health emergency. The Public Health Emergency Fund in Section 319(b)(1) authorizes an appropriation of \$45,000,000 in each fiscal year. No money has been appropriated for this section in FY 98.

Some assessments with the CBC are relevant in preparing a Department response to the CBC request, involving the scope of an expected response, and what features of a response are most important to them. The scope of a response could range from a national effort across all programs and initiatives with national organizations, or a more targeted effort in a defined number of highly impacted communities. Specific features that need to be assessed would be the primary goals behind requesting a declaration of emergency, i.e. the relative importance/utility of relaxing current restrictions on use of funds, the targeting of resources to communities of color, and achieving the goal of rallying the broader African American community to aggressively own and act to reduce the devastation of the HIV epidemic. The specific importance of declaring an official state of emergency versus acknowledging an emergency exists should be discussed.

Two factors to consider regarding the use of the term "emergency" are (1) Title I Ryan White CARE Act grants are called Emergency Relief for Areas with Substantial Need for Services, and

(2) the budget implications of declaring a state of emergency would probably involve pushing funding to a high enough level so that it was not viewed as a token investment.

Listed here are a range of options for short term interventions and longer term strategies to address the urgent problems of HIV/AIDS in African American communities. These are not listed in any order of preference.

Short Term Rapid Intervention Strategies

(1) The Department would offer a technical assistance team to a defined set of localities (highly impacted, defined by CDC), at the invitation of the locality, to develop strategies to increase effective HIV prevention and health care delivery within neighborhoods that are predominantly African American. TA could include, but not be limited to, helping local community-based organizations gain administrative and financial management expertise and familiarity with the competitive grant process. (This could be done through contractors; New York City had a model to build CBO expertise through intensive TA.)

(2) The Department could support adding funds to the SPNS line item in Ryan White CARE Act as part of June 1998 Appropriations (possible budget amendment), to support demonstration programs targeted to highly impacted African American communities. A range of issues for study could be developed.

(3) Support Appropriations report language that serves to highlight the impact of HIV among communities of color:

- o Prevention: support CDC's actions to raise the bar on effective use of appropriated HIV prevention funds, ensuring that HIV program interventions, services and funding allocations reflect the epidemiologic HIV surveillance data of the State
- o Care: Highlight the "Severity of Need" provision under Title I supplemental grants, the purpose of which is to highlight those areas where the constellation of service needs is particularly intense. This provision is particularly relevant for some minority communities where high rates of STDs, drug abuse, and specific populations with HIV disease are growing. The intent would not be to establish race or racial disparities as a stand-alone criteria under severity of need, but to highlight the Severity of Need provision with examples how it can be viewed with a resource benefit attached.

- o Women with HIV: strongly support the replication and implementation of one-stop-shopping models developed under Title IV that provide care to women and children, in other Title I and II areas not served by Title IV grantees.

Long Term Intervention Strategies

The options here respond more comprehensively to the multiple factors underlying the growing HIV epidemic among African Americans. These are grouped by federal programmatic initiatives, manpower and financing issues, and working collaboratively with new partnerships within African American communities for a strong community response to HIV/AIDS.

Federal Programs

(1) Better Integration of Drug Treatment with HIV Prevention and Care

(a) As part of HIV prevention community planning, emphasize CDC support for targeted outreach for active substance abusers and linkages with drug treatment programs, including HIV testing strategies which take HIV tests out into the streets. Example: L.A. buying oral HIV test kits for IDUs and finding enormous demand. CDC has recently negotiated a lower public price to purchase the ORASURE test. Prevention intervention messages must be tailored to maximally impact on those populations most actively participating in high risk behaviors. This is an essential component of any effort to increase HIV awareness in impacted communities and bring these individuals into counseling and testing situations to identify new HIV infections.

(b) Review HRSA application guidances for Titles I and II to strengthen focus in the needs assessment and comprehensive planning process on grantees' plan for addressing the health care needs of the HIV+ substance abuser, including linkages with drug treatment programs, methadone clinics, etc. Application guidances for Title III and IV should also specify identification of linkages with local drug treatment programs to facilitate HIV care access for those with drug problems.

© HIV setaside in SAMHSA block grant -- can prescriptive guidance be given within the limits of the statute?

(2) Funding Targeted Populations

(a) Increase SPNS in the FY2000 budget; define some targeting criteria to address the unique needs of some highly impacted African American communities

(b) Increase investment in CDC's 704 program targeting CBOs serving minority populations; option to increase the proportion of funds going directly to minority

organizations; include a defined TA component to strengthen minority organizations in the areas of fiscal management, administrative ability, etc.

- © Option to define a "heavily impacted population" category for preferential allocation consideration within federally funded programs (could be problematic, technically Ryan White should do this through needs assessment, CDC might be able to do it in prevention)

(3) Integrating HIV Prevention and Care: Demonstration Project in Limited Number of Cities

This demonstration project would assist a small number of interested cities to develop a coordinated HIV prevention and health care delivery system that is responsive to the needs of high risk groups and particularly the African American community. Projects would bring related service delivery systems for STDs, TB and drug treatment into formal relationships with HIV prevention and health care systems, address gaps in enabling services that serve as barriers to care, and support community outreach strategies to increase awareness and acceptance of HIV counseling/testing and new therapeutic options. Coordination of existing funding lines would be supplemented with \$4 mil/city/year, which also buys a strong evaluation component.

Manpower and Infrastructure Support

(1) Technical Assistance Strategies to Increase Infrastructure for Service Delivery

A formal initiative could be drawn up (possibly part of SPNS program) to offer African American communities a technical assistance package targeted to developing expertise in administrative and management skills and familiarity with the RFP and grant writing process. The purpose would be to simultaneously provide and study this intervention as a way to increase the availability of HIV-related health care services in highly impacted communities of color. Both federal TA and peer-based TA models could be studied. Within this it may also be possible to design an organizational mentoring program to assist minority CBOs to build strong management capacities.

(2) National Health Service Corps: Identify highly impacted minority communities that qualify as health professional shortage areas and target National Health Service Corps personnel to increase provider capacity

(3) AIDS Education and Training Centers: Target AETC efforts to support already existing health professionals engaged in HIV care. Geographic targeting of highly impacted areas for special curricula development, addressing cultural issues as well as the specific health care needs of particular populations. AETCs have an important role to play in addressing quality of care issues and standards of care among the provider community. Identifying effective ways to disseminate information to both professionals, community organizations and the patients they serve is important for better health outcomes among African Americans with HIV disease.

(4) **Empowerment Zones:** Define linkages with the Empowerment Zone cities to support development of enhanced health care access: bricks and mortar, funding targeted strategies like fully equipped medical vans (talk with Jim Gatz, EZs). There has been some interest in incorporating a health component into the EZs.

Reimbursement Issues

(1) **Medicaid:** Explore option to enhance reimbursement rates for HIV-related care in carefully defined "heavily HIV-impacted communities" as a tool to increase willing capacity of existing providers (use some density factor for AIDS cases). (Medicaid matching rates have been expanded for special outreach purposes such as family planning services.)

(2) **Health Professions Shortage Areas:** Are many inner city minority communities eligible as HPSA areas qualified for higher payments? What is widely known about HPSA benefits?

National and Community Partnerships

(1) Outreach to National African American Leadership

The Secretary could convene a meeting with the leadership of major African American organizations to engage their organizations in a national and grassroots effort to raise awareness and involvement of the Black community around HIV/AIDS. Business and civic groups, NAACP, SCLC, Urban League, etc should be asked to participate.

(2) African American Awareness Campaign

The Secretary could provide leadership in stimulating broad-based awareness of HIV as a health issue within the African American community by convening a series of small meetings with the leadership of black media organizations (radio, TV, print -- BET, Ebony, Essence, JET, etc.). Offer Dept. assistance in providing statistics or content, and seek a commitment for them to run a regular feature in each issue, show or program that addresses and raises awareness of HIV. Precedent for this was series of Secretarial meetings with press around violence, drugs, youth, teen pregnancy arranged by Marty Davis early in the Administration.

(3) Building Community Partnerships

The Department should seek to encourage and support non-traditional partnerships within communities at the local level who are interested in the quality of community life. Initiate discussions with nonprofit and private foundations (Kaiser Family Foundation, Ford Foundation, Robert Wood Johnson, Kellogg Foundation, Magic Johnson Foundation) around working with minority organizations at the national and local level to support the development of partnerships.

Rationale: Unlike the response of the gay community to the emergence of HIV in the 1980's, there hasn't been a corresponding sense of urgency and ownership, with a concomitant mobilization of resources, within African American communities impacted by HIV/AIDS. As

federal resources will always be inadequate to meet the needs, there is a need to rethink our approach to filling the gaps in care and services for African Americans living with HIV/AIDS.

Partnerships among local institutions such as religious organizations, Board of Trade, Kiwanis Clubs, fraternities and sororities, neighborhood associations, and professional associations all bring a unique set of services, human resources (volunteers, professionals, etc) and connections with community members who may be far outside the health care and social services arena. As the AIDS epidemic is so complex and encompasses a vast array of needs, engaging or partnering with any mix of organizations can result in a wider base to disperse AIDS information, garner new infusion of volunteers to organizations in need of human resources, and potentially tap a new reservoir of funds to augment federal, state and local government dollars. Another benefit is the opportunity to work with new groups of individuals to continue the work of dispelling the myths and fears about HIV, instilling a renewed compassion for people with AIDS, and potentially address cultural issues related to homophobia and substance abuse within communities.

Although not well defined yet as a discrete action step, this activity may be the most central of the Department's initiatives in substantively enhancing the African American communities' ability to respond to the AIDS epidemic and develop a capacity to move prevention forward.

Other Administrative Actions

(1) Send a letter to every Governor outlining the severity of the HIV/AIDS epidemic among communities of color and seek their support to join with Department in focusing attention and resources to reduce this epidemic.

ASIAN AND PACIFIC ISLANDER AMERICAN HEALTH FORUM (APIAHF)

**HIV PREVENTION TECHNICAL ASSISTANCE AND TRAINING PROGRAM
PROGRAM EVALUATION**

We are completing the final year of our six-year HIV prevention technical assistance and training program funded by the Centers for Disease Control and Prevention, the Empowerment through Training and Technical Assistance (ETTA) Program. Please help us to evaluate our program by giving us your honest feedback and suggestions for improvement. Please try to respond on behalf of all your organization's staff and not just yourself. However, since we would like your comments on activities during the past five and a half years of our program, we recognize that you may not have information to respond to all the questions.

Your responses are CONFIDENTIAL. We will separate this cover page and not identify any specific individual or organization in reporting the responses to this evaluation.

This information also will help us to prepare our application for renewing and improving the program, beginning later this year. Please return this evaluation to APIAHF by fax at 415/954-9999 or by mail to 942 Market Street, Suite 200, San Francisco, CA 94102, no later than Friday, June 11, 1999.

Thank you very much for your continuing cooperation.

.....

Please Complete (For Internal APIAHF Use Only):

AGENCY NAME:

PERSON RESPONDING:

DATE:

A handwritten signature in dark ink, appearing to be a stylized name, located at the bottom right of the form.

Technical Assistance and Training Conferences

Did your organization attend the East Coast Regional Conference in New York in *August 1995*?

Yes No Don't Know/Don't Remember

Do you remember any lessons or skills learned?

Did your organization attend the West Coast Regional Conference in Seattle in *July 1996*?

Yes No Don't Know/Don't Remember

Do you remember any lessons or skills learned?

Did your organization attend the National Summit on Technology Transfer of HIV Prevention Interventions for Asian and Pacific Islander Men Who Have Sex With Men in Sonoma in *March 1997*?

Yes No Don't Know/Don't Remember

Do you remember any lessons or skills learned?

Did your organization attend the APIAHF "Voices from the Community" Conference in San Francisco in *September 1997*? Yes No Don't Know/Don't Remember

Do you remember any lessons or skills learned?

Did your organization attend the Asian and Pacific Islander Institute at the U.S. Conference on AIDS in Miami in *September 1997*? Yes No Don't Know/Don't Remember

Do you remember any lessons or skills learned?

Did your organization attend the San Francisco International Summit on Filipinos and HIV/AIDS in San Francisco in *July 1998*? Yes No Don't Know/Don't Remember

Do you remember any lessons or skills learned?

Did your organization attend the National Asian and Pacific Islander Summit on HIV/AIDS in San Diego in *September 1998*? Yes No Don't Know/Don't Remember

Do you remember any lessons or skills learned?

Did your organization attend the research conference after the National Asian and Pacific Islander Summit on HIV/AIDS in San Diego in *September 1998*?

Yes No Don't Know/Don't Remember

Do you remember any lessons or skills learned?

Did your organization attend the Asian and Pacific Islander Institute at the U.S. Conference on AIDS in Dallas in *October 1998*? Yes No Don't Know/Don't Remember

Do you remember any lessons or skills learned?

Technical Assistance and Training from APIAHF Staff

Have you received TAT directly from APIAHF staff? Yes No Don't Know/Don't Remember

If yes, what type of TAT did you receive from APIAHF staff?

Please comment on the usefulness of the TAT received from APIAHF staff:

Any other comments on the TAT received from APIAHF staff?

Technical Assistance and Training Partners

Have you received TAT from any of our TAT partners? (please check all that apply)

- ☐ Asian and Pacific Islander Wellness Center, San Francisco, CA
- ☐ Asian AIDS Project, San Francisco, CA
- ☐ Living Well Project/Gay Asian Pacific Alliance Community HIV Project, San Francisco, CA
- ☐ Asian Health Services, Oakland, CA
- ☐ Asian Pacific AIDS Intervention Team, Los Angeles, CA
- ☐ Search to Involve Pilipino Americans, Los Angeles, CA
- ☐ Asian Pacific AIDS Council, Seattle, WA
- ☐ Asian and Pacific Islander Coalition on HIV/AIDS, New York, NY
- ☐ Indochinese Community Center, Washington, DC and Arlington, VA

If yes, what type of TAT did you receive?

Please comment on the usefulness of the TAT:

Any other comments on the TAT received from our TAT partners?

National Working Groups

Have you participated in any of our national working groups on (please check all that apply):

- ☐ Cultural competency
- ☐ HIV prevention community planning
- ☐ Asian and Pacific Islander youth
- ☐ Asian and Pacific Islander women
- ☐ National Filipino AIDS Advocacy Network
- ☐ HIV/AIDS public policy/advocacy

If yes, how has your participation in these working groups been useful in your HIV prevention program?

Local/Regional Coalitions

Has your organization participated in any of these local/regional coalitions (please check all that apply)?

- ☐ Asian/Pacific AIDS Coalition, San Francisco, CA
- ☐ Hana Like, Alameda, CA
- ☐ Asian and Pacific Islander HIV/AIDS Caucus, Los Angeles, CA
- ☐ Southern California Pilipino AIDS Task Force, Los Angeles, CA
- ☐ Asian Pacific AIDS Education Team, Seattle, WA
- ☐ HIV/AIDS Leadership Network, New York, NY
- ☐ Southeast Asian Health Coalition, Washington, DC
- ☐ Cultural Core Group, HI

If yes, what are the most important purposes for these local/regional coalitions?

How could these local/regional coalitions be more effective?

Written Program Materials

Have you received our written materials on (please check all that apply):

- ☐ Directories of Asian and Pacific Islander HIV prevention programs and organizations
- ☐ Bibliography on Asians and Pacific Islanders and HIV/AIDS issues
- ☐ Cultural competency training materials
- ☐ Asian and Pacific Islander language glossaries of HIV prevention vocabulary
- ☐ Materials on HIV prevention community planning and Asians and Pacific Islanders
- ☐ HIV/AIDS surveillance data
- ☐ Materials on HIV/AIDS public policy
- ☐ General materials on Asian and Pacific Islander health
- ☐ Census information about Asians and Pacific Islanders

If yes, please comment on the usefulness of our written materials:

Any other comments on our written materials?

Asian and Pacific Islander Language Reviews

Has your organization participated in our reviews of Asian and Pacific Islander language HIV prevention materials? Yes No Don't Know/Don't Remember

If yes, for which languages?

How have you used the recommendations and glossaries from our reviews of Asian and Pacific Islander language HIV prevention materials?

API HIV Forum Newsletter

Do you receive our *API HIV Forum* newsletter? Yes No Don't Know/Don't Remember

If yes, do you read our *API HIV Forum* newsletter:

- ☐ All of it
- ☐ Most of it
- ☐ Skim it only
- ☐ Don't read it

Do you share the *API HIV Forum* newsletter with others?

- ☐ Share with other staff
- ☐ Share with other organizations
- ☐ Don't share it others

Do you remember any specific article(s) from the *API HIV Forum* newsletter that was useful to you?
Which one(s)?

How have you used the information from the *API HIV Forum* newsletter in your HIV prevention program?

API-HIVinfo Electronic Mailing List

Do you subscribe to the API-HIVinfo electronic mailing list?

Yes No Don't Know/Don't Remember

If yes, how have you used the information from the API-HIVinfo electronic mailing list in your HIV prevention program?

APIAHF Internet Website

Have you used our APIAHF internet website? Yes No Don't Know/Don't Remember

If yes, how have you used the information from our APIAHF internet website in your HIV prevention program?

Future Program Suggestions (use back page if needed)

What types of technical assistance and training activities would be most useful to your HIV prevention program?

How could we improve our technical assistance and training program to better meet your needs?

Please return this evaluation to APIAHF by fax at 415/954-9999 or by mail to 942 Market Street, Suite 200, San Francisco, CA 94102, no later than Friday, June 11, 1999. Thank you again for your continuing participation in our program.

API HIV FORUM

A quarterly newsletter published by the Empowerment through Training and Technical Assistance (ETTA) Program, a national program of the Asian and Pacific Islander American Health Forum (APIAHF) funded by the Centers for Disease Control and Prevention through Cooperative Agreement No. U22/CCU929841-25.

HIV Prevention Materials in Asian and Pacific Islander Languages: A Summary of Review Panel Findings

By Prescott Chow

During the past four years, the ETTA Program has convened national panels to review existing HIV prevention materials in Asian & Pacific Islander languages. The main objective of the reviews was to examine such materials in terms of information and translation accuracy. Members of the review panels were asked to recommend brochures that were appropriate to specific target populations, and to identify gaps in HIV prevention materials for each language reviewed. The panels also developed a language-specific glossary of common HIV/AIDS terminology. Finally, each panel developed concepts for new materials based on a priority gap they identified.

"Some of the materials perpetuated, rather than dispelled, misconceptions about HIV/AIDS..."

In 1996 national review panels were convened for Chinese, Tagalog and Vietnamese materials. In 1997 national review panels were convened for

Korean, Cambodian and Japanese materials. In 1998 national review panels were convened for Thai, Hmong, Lao and Samoan materials. This year national review panels were convened for Bengali, Gujarati, Hindi and Urdu.

The panels reviewed 12 Bengali materials, 19 Cambodian materials, 39 Chinese materials, 12 Gujarati materials, 16 Hindi materials, 4 Hmong materials, 21 Japanese materials, 17 Korean materials, 13 Lao materials, 7 Samoan materials, 18 Tagalog materials, 13 Thai materials, 13 Urdu materials and 29 Vietnamese materials. A total of 233 materials have been reviewed by the 14 national review panels.

Panel members were a diverse group of people (in respect to gender, sexual orientation, class, geography etc). Panelists were chosen for their ability to represent their communities. Most

panel members had some HIV prevention background (as staff or volunteer). And because the groups were reviewing written and oral/visual materials (videos), panel members had to be able to speak, read, and write in the language of the materials that they are reviewing, as well as in English. Panel members were identified through referrals from CBOs and NAPICAS member agencies.

Findings and recommendations from these panels were compiled into a report, *HIV Prevention Materials in Asian and Pacific Islander Languages: A Summary of Review Panel Findings*, which is going through final draft revisions. This final report will be disseminated to the Centers for Disease Control and Prevention, AIDS service organizations, social service agencies, other community-based organizations and health departments. APIAHF will work to develop a national strategy to develop and produce Asian and Pacific Islander language HIV prevention materials using the findings and recommendations of the review panels that can be available to all community-based organizations and health departments providing HIV prevention targeting Asians and Pacific Islanders.

Below are a few of the review panels' findings.

1. There was a noticeable difference in the quality of brochures originally written in targeted language and brochures developed in English and then translated into these languages. There was a strong and consistent recommendation from all the review panels to use focus groups convened from the target population to develop an original text for any future brochures.
2. Many of the materials were outdated, referring to archaic terminology (eg ARC). Also, most pieces failed to mention new treatment options for individuals living with HIV.
3. Some of the materials perpetuated, rather than dispelled, misconceptions about HIV/AIDS (e.g., AIDS as a

LANGUAGE REVIEW continued on page 2

The *API HIV Forum* is a quarterly newsletter published by the Empowerment through Training and Technical Assistance (ETTA) Program, a national program of the Asian and Pacific Islander American Health Forum (APIAHF) funded by the Centers for Disease Control and Prevention through Cooperative Agreement No. U22/CCU909841-05.

We welcome your comments, suggestions, and/or contributions. Please send to: APIAHF-ETTA Program, 942 Market St., Suite 200, San Francisco, CA 94102.

You may also call us at 415/954-9969
Our fax number: 415/954-9999
Our e-mail address: etta@apiahf.org
Our website address: www.apiahf.org

ETTA Program Staff:
Ignatius Bau, Health Policy Director
Prescott Chow, Program Coordinator
Antonio Salas, Program Assistant



ETTA Partner Agencies:

*Asian and Pacific Islander
Coalition on HIV/AIDS (APICHA)*
275 Seventh Ave., 12th Floor
New York, NY 10001
212/620-7287
www.apicha.org

*Asian & Pacific Islander
Wellness Center (A&PIWC)*
730 Polk St., 4th Floor
San Francisco, CA 94109
415/292-3400
www.apiwellness.org

Asian Health Services (AHS)
818 Webster St.
Oakland, CA 94607
510/986-6830
www.ahschc.org

Asian Pacific AIDS Intervention Team (APAIT)
605 West Olympic Blvd., Suite 610
Los Angeles, CA 90015
213/553-1830

Indochinese Community Center (ICC)
6131 Willston Drive, Suite 8
Falls Church, VA 22044
703/241-5491

*Asian Pacific AIDS Council (APAC),
a program of the
International Community Health Service (ICHS)*
P.O. Box 3161
Seattle, WA 98114
206/467-0884

Search to Involve Filipino Americans (SIPA)
3200-A West Temple St.
Los Angeles, CA 90026
213/382-1819

LANGUAGE REVIEW continued from page 1

- "foreigner's disease, or HIV as a disease must be "hidden" from friends or co-workers).
- Most brochures need more appropriate and relevant graphics. Most of the brochures used generic "oriental" motifs that were not appropriate for our cultures. Other materials had little or no graphics and therefore were unappealing or uninteresting.
 - Panels suggested more appropriate formats of materials to disseminate HIV information. Materials need to be formatted for cultures that rely on oral communication over written media. For example, Hmong language videos would be more appropriate to use than brochures, as Hmong is a relatively new written language. However, out of the four Hmong HIV prevention materials available, only one was a video.
 - Most of the brochures reviewed targeted the general population; therefore the information conveyed was general and basic.
 - Some panels suggested the materials targeting youth should be bilingual in English, as many youth are bilingual and bicultural yet don't identify with HIV prevention materials targeting the mainstream English-speaking youth population.

The full report *HIV Prevention Materials in Asian and Pacific Islander Languages: A Summary of Review Panel Findings* will be available in July, 1999 through the ETTA Program.



Thai Materials Development Project

The ETTA Program piloted our first HIV prevention materials development project on February 26-27, 1999 in North Hollywood, California. The Thai Materials Development Project is the direct result of the Thai Language Materials Review Panel convened by the ETTA Program in April 1998. The review panel identified the need to develop Thai HIV/AIDS materials that are culturally and linguistically appropriate to various target groups within the Thai community (e.g., youth, women, men, gays and bisexuals). The materials development panelists took these recommendations and created materials targeting two populations: Thai women and Thai men (inclusive of gays and bisexuals). Within two days, the panelists completed two drafts that are currently under community review. Final revisions, printing and dissemination are forthcoming. The six panelists were Timmy Promlack, Lee Genovese, and Chompol Saengchuangchot of the Asian & Pacific Islander Wellness Center, San Francisco; Paweena Theinpong of Asian Pacific Healthcare Venture, Nirun Thitirakpanit of Asian Pacific AIDS Intervention Team and Nid Tiaprasith of Pacific Asian Language Services, all based in Los Angeles. We thank all our panelists for their support and dedication to this project. We would also like to thank the Wat Thai Buddhist Temple of Los Angeles for providing the space for our meetings.

For more information, please contact Antonio Salas (APIAHF) at 415/954-9969 or etta@apiahf.org.

Inquire About... Strengthening HIV Prevention Through Technology Diffusion

The Report on the National Summit on Technology Transfer of HIV Prevention Interventions for Asian and Pacific Islander Men Who Have Sex With Men, March 29-31, 1997, is available. For more information, please contact:

ETTA Program: 415/954-9969
etta@apiahf.org

POLICY UPDATE

by Ignatius Bau

The success of the Congressional Black Caucus in securing \$156 million in new funds for Fiscal Year 1999 for HIV/AIDS programs in African American and other communities of color has refocused attention on the disproportionate impact of HIV/AIDS on communities of color, especially among African Americans and Latinos. These disparities have been evident from the very beginning of the AIDS epidemic. However, whatever political, social and other influences that have come together at this point in time to focus national attention on these disparities have created new opportunities for coalition-building as well as for highlighting HIV/AIDS issues among Asians and Pacific Islanders.

Asians and Pacific Islanders have issued several statements of support and solidarity for an emergency response to HIV/AIDS in the African American and Latino communities. More recently, Asians and Pacific Islanders advocated with the CDC to ensure that it followed the intent of Congress to target its \$18 million in new prevention funds for African American communities while urging the CDC to secure additional funds for all communities of color. Ultimately, Department of Health and Human Services (DHHS) Secretary Donna Shalala allocated an additional \$21 million in prevention funds to be distributed by the CDC for HIV prevention efforts targeting gay men of color, women and adolescents of color and incarcerated minority populations.

Meanwhile, Asians and Pacific Islanders have forged a coalition with Native Americans to develop an Action Plan on HIV/AIDS for Native Americans, Asian Americans and Pacific Islanders. To date, the Action Plan has been endorsed by over sixty Native American, Asian American and Pacific Islander national, regional and local organizations and other supporters. In March 1999, the Action Plan was presented to both the DHHS Office of HIV/AIDS Policy (OHAP) and the White House Office of National AIDS Policy (ONAP). DHHS' OHAP has agreed to formally request DHHS agencies to respond to the proposed action steps in the Action Plan.

Efforts also are being made to ensure that the priority needs of Asians and Pacific Islanders and Native Americans are included in the Fiscal Year 2000 appropriations process. Asians and Pacific Islanders are working with members of the Congressional Asian Pacific Caucus, the National Native American AIDS Prevention Center and the National Minority AIDS Council to highlight our community priorities for any new prevention, treatment and research funds that might become available.

Finally, there has been a continuing dialogue with the CDC and state health departments on several critical surveillance issues. The CDC is preparing a manuscript for publication on Asians and Pacific Islanders and AIDS that has resulted in much discussion about CDC's collection and analysis of data regarding Asians and Pacific Islanders. The need for consistent reporting of HIV/AIDS surveillance data regarding Asians and Pacific Islanders from all health departments as required by Office of Budget and Management Statistical Policy Directive No. 15, the need for data disaggregated by Asian and Pacific Islander ethnicities/subpopulations and the need for accurate and current data regarding population growth and language access have repeatedly been emphasized in numerous consultations with and presentations made to the CDC. For example, a recent survey of health departments by APIAHF indicates the lack of HIV testing and counseling services in Asian and Pacific Islander languages in several areas with large number of Asian and Pacific Islander residents (e.g. Chicago, Texas, Florida, and Minnesota). Many of these issues will be presented again by APIAHF at a meeting of state health department surveillance coordinators in June 1999.

For more information on these policy issues, please contact APIAHF Policy Director Ignatius Bau at phone 415/954-9951 or by e-mail at <ibau@apiahf.org>.



In memoriam...

The ETTA program would like to take this time to remember

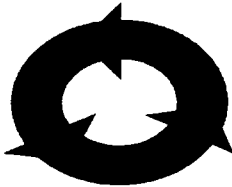
Catherine Taito

of American Samoa who passed away in February. Cathy has been an integral part of HIV/AIDS/STD prevention intervention efforts in American Samoa and was an advocate of Pacific Islander HIV prevention needs on the federal level. Cathy will be missed.

API-HIVInfo Survey Findings

by Antonio Salas

The Asian and Pacific Islander HIVInfo (*API-HIVInfo*) is a closed and non-moderated electronic mailing list established and managed by the Empowerment through Training and Technical Assistance (*ETTA*) Program of the Asian & Pacific Islander American Health Forum (*APIAHF*).



The purpose for *API-HIVInfo* is to create a network for disseminating and sharing HIV and AIDS information, resources and policy issues among individuals working with the Asian and Pacific Islander American communities. As *ETTA* approaches its 3rd year of the *API-HIVInfo* electronic mailing list, the program seeks feedback and ways that could improve the informational needs of *API-HIVInfo* subscribers.

METHODOLOGY

In January 1999, the *ETTA* Program disseminated a 12-question *API-HIVInfo* survey via the electronic mailing list and the first quarter *API HIV FORUM* newsletter. Most completed surveys were submitted through e-mail while very few were either faxed or mailed. The quantitative data were manually tabulated and the qualitative data documented. Of the 135 *API-HIVInfo* subscribers, 17% (23 subscribers) responded to the survey.

FINDINGS

Of the 23 respondents, 61% check their e-mail 1-5 times per day. Of all the respondents, 61% have not posted, contributed, nor shared information on *API-HIVInfo*. Some reasons cited were "too busy," "never really thought about it," "nothing to post about," "lack of training on how to post stuff," and "didn't know I could post anything."

Respondents were asked if they utilized the information that was shared through *API-HIVInfo*, and how they used it. Most indicated that they forwarded or shared information with others. For example, some stated that "materials dealing with treatment I have passed on to our direct care services coordinator," "sharing it with other people (staff members, friends, task force members)," "shared info with oversight committee for continuing education/update," and "forwarded to working groups in other cities." Others explained how they "used the information in the development of prevention services and policy," and now "know more about resources & programs in other states that are doing similar work." Some have used the information in presentations, curriculum development, research for masters thesis, state-planning groups and in local newsletters.

All respondents disseminated information obtained from the *API-HIVInfo* by verbally telling others about the information, with 78% forwarding messages and 65% printing out and giving away copies of the message to others.

When asked to list the top three types of information that they found most useful posted on *API-HIVInfo*, respondents indicated *funding* information, *conference* information/update and, *policy* and *treatment* news, respectively.

When asked what other information they would include on *API-HIVInfo*, *program development* information was often asked for:

"I would like to get mailing on the "new most common questions." For instance, here we see that questions are becoming more biological in nature, i.e., "How big is the virus." These are the types of questions which are not commonly asked, and that often don't have easily found answers. You usually have to swim through tons of materials to find our anything."

"Designing appropriate programs"

"More info on gay, bi[sexual]/trans[transgender] issues on Asians & Pacific Islander communities"

"Research news; news from other API countries & territories"

"International sharing of program development, research findings, epi[demiological] data, needs assessments of our counterparts from Asian and Pacific Island nations, especially the Philippines and Pacific Island. We are the entry-point for these groups. It's important to know what is going on there to provide continuity of services. To understand their issues and plan programs that can address these."

Of the messages received from *API-HIVInfo*, 22% indicated that they read "all of the messages," 56% read "most of the messages," 22% read "some of the messages" and none for "few or none of the messages."

API-HIVInfo Survey continued on page 5...

API-HIVInfo Survey continued from page 4

About 75% said that information disseminated in the mailing list was "just right" while 25% indicated "too man."

When asked if they thought about commenting on the messages received from API-HIVInfo, 52% answered YES while 39% said NO. Of those who did not reply to messages, reasons cited were "lack of time," "If a response is requested," "Too busy," "No time! Plus, no one else seems to post responses or opinions," "It didn't seem appropriate," "Didn't feel I needed to send a comment," "Felt that it may not be appropriate," and "Did not have time to generate comprehensive responses."

About 13% subscribe to only one electronic mailing list, 39% between 2-4, and 13% subscribe to 5 or more with 35% not responding. Thirteen percent subscribe to the API-Health Info and about 4% subscribe to the API-SAMH mailing list. About 61% indicated that the mailing lists they subscribe to address HIV/AIDS issues, 34% address API issues, 30% focus on health issues, and 39% on policy issues. Others have identified being on mailing lists that are Buddhist focused, Gay/lesbian/ transgender/queer issues/news, women's issues, RFA announcements, and/or academic research on communities of color

When asked to compare API-HIVInfo to the other mailing lists in terms of the usefulness and volume of the information, responses varied from "I don't subscribe to enough to be able to fairly evaluate" to "generally have more information relevant to my needs."

Other comments were made around the content of API-HIVInfo:

- *Very useful, I sometimes receive duplicate messages*
- *As a student, I find that the info is geared towards professionals, which is helpful for me to see the most current work being done and available for evaluation*
- *Very useful in terms of providing the means of national organizing of Asians & Pacific Islanders on HIV/AIDS related issues*
- *More directly useful for my work than the others*
- *Pretty useful and its more API-specific*
- *Perfect*
- *Good because its streamlined to some of my issues*
- *API-HIVInfo focuses on API and the others focus on general issues about HIV*

In sum, the responses were positive and constructive. The results demonstrate the effectiveness of such a medium in the dissemination and access of relevant and useful information around HIV/AIDS as they affect our diverse Asian and Pacific Islander communities. For the most part, racial/ethnic specificity is what draws providers to this medium. In terms of content, data around funding, conferences, treatment and policy were applauded and prioritized respectively. In terms of improvement, the need for more program development information was expressed.

The ETA program is confident that, through this elaborate network in the age of information, collaboration and concrete action with others, we could effectively change the tide around HIV/AIDS that adequately serves all communities of color on the federal, state and local levels.

HAFA ADAI (Greetings)

Interested in Subscribing to API-HIVInfo?

Send an e-mail to etta@apiabf.org and indicate your interest in being included in the API-HIVInfo Electronic Mailing list. Provide brief information about yourself, your agency and/or community affiliation.

Si Yu'os Ma'ase

22nd National Conference on
Women and HIV/AIDS
October 9-12, 1999
Los Angeles Convention Center
Los Angeles, California

Forum for Collaboration
HIV
1999

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CONFERENCE ON
WOMEN AND HIV/AIDS

To Request and Abstract Form or More information, Contact:
Women's Conference Meeting Department
19 Mantua Road
Mt. Royal, NJ 08061
Phone: (609) 423-7222, ext. 350
FAX: (609) 423-3420

HIV Prevention Needs Assessment Report

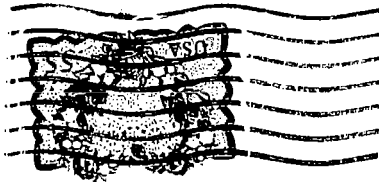


APIAHF's needs assessment report, along with chapters written by other National/Regional Minority Organizations, will be published later this spring by the CDC. For more information about the needs assessment, please contact *Ignatius Bau* at 415/954-9951 or at [<ibau@apiahf.org>](mailto:ibau@apiahf.org).

Sandy Thurman
Office of National AIDS Policy
763 Jackson Place
Washington, D.C. 20503

942 Market Street, Suite 200 San Francisco, CA 94102
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

APIAHF
HIV prevention & education
ETA



"The entire premise of cultural competency is a contemporary response to the history and ongoing practice of culturally incompetent providers and researchers. Each affected community brings to this issue its own history and perceived injury and negligence by the research and service delivery sectors. In the current context, this circumstance is especially highlighted by the reality that these are the same communities that have been affected disproportionately by HIV/AIDS (page 42)."

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*HIV Seroprevalence, Risk Behaviors, and Cognitive Factors Among
Asian and Pacific Islander Americans Men Who Have Sex with Men:
A Summary and Critique of Empirical Studies and Methodological Issues*
Nemoto T, Wong FY, Ching A, Chng CL,
Bouey P, Henrickson M, and Sember RE

Recent Publication

Special Supplement

AIDS EDUCATION AND PREVENTION

***HIV Prevention Among Asian and Pacific Islander American Men Who Have Sex With Men:
Theories, Research, Applications, and Policies***

Volume 10 Supplement A June 1998

Governments of Asia and the Pacific responding to the HIV/AIDS pandemic

Daniel Tarantola, Jonathan Mann, Mechai Viravaidya*,
Rob Moodie† and S. Sundararaman‡

AIDS 1994, 8 (suppl 2):S183–S198

Keywords: HIV, AIDS, government policies,
government programs, national programs, Asia, Pacific

Introduction

Much has already been written throughout this supplement to illustrate the vastness of Asia and the Pacific—stretching across 12 time zones—its enormous population—more than half of the world's total—and its diverse political, social, economic and cultural features. The HIV/AIDS pandemic has not only demonstrated profound disregard for geographic boundaries, it has also shown remarkable capacity to flourish as a consequence of many forms of stigmatization, discrimination and denial. HIV/AIDS is a mosaic, a complex assembly of a myriad small epidemics evolving side by side, each with its own characteristics and velocity, with bridges among them fueling their spread [1].

Early and limited response in Asia and the Pacific

A typology of the HIV/AIDS pandemic, proposed in 1986 by the US Institute of Medicine and later adopted by the World Health Organization (WHO), was intended to facilitate analysis of the world pandemic [2]. Australia and New Zealand conformed to the first pattern of the epidemic, with features characteristic of countries in North America and Europe: early and rapid HIV spread via homosexual contact and injecting drug use (most of which involved men), as shown by the high proportion of men among infected people. Other countries in Asia and the Pacific conformed to the third pattern of the pandemic: late introduction of HIV, low level of HIV prevalence, and infection traceable to contacts

with infected people from outside the region. In the mid-1980s, no country in the region fitted the second pattern, characterized by the predominance of heterosexual transmission of HIV, with consequent mother-to-infant transmission.

Although the three-pattern division proved useful in giving initial shape to the global pandemic, it had the adverse effect of suggesting to governments of Asian and Pacific Pattern III countries that their region was, if not forever at least for a long time, to be spared by the epidemic. It also focused those governments' HIV detection efforts on foreign nationals, particularly foreign students and groups in possible contact with them, such as sex workers and injecting drug users (IDU). Therefore, most government responses until the late 1980s were limited to HIV surveillance systems that screened population groups by their country of origin or their likelihood of contact with foreign nationals. These measures, often associated with coercive or punitive actions towards HIV-infected people, were, and in some cases still are, maintained in certain countries despite the World Health Assembly resolution of May 1988 [3,4].

For example, in the Philippines, concern about HIV focused on US servicemen and other foreign nationals. Although US servicemen, together with diplomats and journalists, were exempted from mandatory testing, a strong effort was made to impose screening on other aliens. In India, under the guidance of the Indian Medical Research Council, HIV testing was imposed on foreign students enrolled in or matriculating to universities in the country. By the end of October 1989, 61 HIV-infected foreign students had been deported. By November 1989, at great cost, India had administered almost

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365 000 HIV tests: of the 1650 people diagnosed with HIV infection, only about 100, or 6%, were foreign nationals [5].

Other countries also required testing of migrants, travelers, students or returning nationals (China, Pakistan, Mongolia, Myanmar, North Korea, the Philippines, South Korea, Sri Lanka) and/or screening of certain professionals (seafarers in Burma, China, South Korea, Pakistan, the Philippines, Sri Lanka and Vietnam, and entertainers in Indonesia, Japan, North Korea, the Philippines, Sri Lanka and Vietnam). Concurrently with the HIV pandemic, an epidemic of Highly Inefficient Laws (HIL), so named by Justice Michael Kirby, affected many of the world's countries, with a strong focus in Asia [6].

The slow emergence of national AIDS programs

Until 1987, little preventive education for society at large was undertaken by governmental programs in Asia and the Pacific (with the exception of Australia and New Zealand). Early efforts tended to reinforce the widespread belief that the epidemic was inherent to behaviors largely attached to Western cultures (homosexuality, bisexuality, sexual promiscuity, injecting drug use) and that, therefore, as long as vigilance was maintained, there was little cause for concern.

Several explanations may be proposed for the approach taken by Asian governments. First, only a few cases of HIV infection and AIDS had been diagnosed in Asia before 1987 and most of them could be traced to contact with an infected person from outside the region, or to imported blood products. Second, acknowledging the general population's vulnerability implied accepting that substance use and sexual behaviors that predisposed to HIV infection existed in Asian countries. Third, the region had achieved significant progress in implementing primary health care activities such as childhood disease prevention, control of certain communicable diseases, and family planning. In this context, any other initiatives were perceived as potentially diverting attention and resources from such programs. Fourth, the economic priorities of several countries were powerful deterrents—and still are—to embarking on high-visibility education campaigns that might negatively affect international travel, trade or domestic industry. Examples include Thailand and Nepal, where tourism was rapidly expanding; India, with growing international trade through Bombay; and the Philippines, Indonesia, and Bangladesh, with a large migrant labor force to the Middle East. Finally, the low HIV prevalence rates found in Asia and the Pacific at that time meant that the epidemic

remained generally invisible. Notwithstanding, the mounting voice of community-based organizations (CBO), non-governmental organizations (NGO) and activists was a counterforce to Asian governments' reassuring messages about HIV/AIDS.

Thus, denial of the global nature of the pandemic and reluctance to confront HIV/AIDS in realistic ways (other than expanding case finding and enacting restrictive laws) characterized the Asian governments. In July 1987, a conference of ministers of health of Asian and Pacific countries, held in Sydney, Australia, followed by the global Summit of Ministers of Health in January 1988 helped convince governments that information, education, and protection of human rights were essential to HIV/AIDS prevention [7,8].

By 1986, WHO had created the Programme on AIDS, renamed Global Programme on AIDS (GPA), to provide global leadership and coordination in policy and program development, research promotion and exchange of information [9]. This new program made a strong financial commitment to supporting national AIDS programs: in 1988, this activity absorbed nearly half of the GPA budget of US\$ 70 million. GPA encouraged countries to formulate short-term (3–6 months) plans of action, followed by 3–5-year medium-term plans, to be reformulated on the basis of periodic evaluation. By the end of 1987, 30 countries had developed a short-term program with the help of WHO/GPA, and had received financial support from WHO and/or from official development agencies of affluent countries.

The net effect of this initiative was the creation of national AIDS programs—usually at the initiative of communicable disease units of ministries of health—and formulation of a plan by each country, providing a framework within which all entities working on HIV/AIDS within the nation were expected to align and coordinate activity [10]. At last, external resources flowed towards programs for which little or no national financing was available, because of low commitment, insufficient urgency, depleted economies, and the administrative imperative of rigid budgeting cycles. A vital step towards addressing the global HIV/AIDS problem had been taken.

First programs: centralism of ministries of health

The development of government programs was, however, constrained in at least four ways. First, with few exceptions, programs created in collaboration with WHO were focused strongly on this inter-governmental organization's normal partners—the ministries of health—which traditionally had lim-

ited influence within governments, and operated on meager budgets. As United Nation Agencies other than WHO had minimal or no involvement in HIV/AIDS, the focus of preventive programs on ministries of health became even stronger over time.

Most ministries of health in Asia and the Pacific were unable to generate sufficient awareness and urgency among other government sectors about the severity of the emerging HIV/AIDS problem. They regarded the development of national AIDS programs as their exclusive prerogative. Other ministries and NGOs had little opportunity to participate in policy and program formulation.

Second, the paucity of government resources and highly limited services for marginalized groups (sex workers, IDUs, homosexual men), whose very *existence* was generally denied, resulted in the major portion of available resources being allocated to blood transfusion safety, mass information campaigns, surveillance, health personnel training and central program management.

Third, because government programs were uncomfortable dealing with NGOs, which abounded in the region even before the onset of AIDS, the national AIDS programs provided very little funding for their support, despite evidence of their effectiveness in other health areas and their clear role in confronting HIV/AIDS.

Finally, government programs were highly centralized. In large countries with federal political structures, WHO/GPA attempted to support the formulation of programs at the state/provincial level, leading to the elaboration of a federal/central umbrella plan. This approach met with short-lived success in Indonesia, where provincial plans were formulated and regrouped under an ambitious federal plan, which later was not sufficiently funded to implement the new program fully. The approach experienced long delays in India, where the Federal Government initially favored it and provided some support to the formulation of 17 individual state plans. However, in 1990, only five were finalized because of fear of excessive financial demands for the Federal Government. The process was later revived: by 1993, 30 of the 32 states in India had developed a plan of operations approved by the central government, but funds promised, for example, to the states of Tamil Nadu and Karnakata were still awaited by mid-1994.

In China, following a national conference on AIDS held in Beijing in August 1989 in cooperation with GPA, provincial programs were created along uniform guidelines developed centrally, producing plans that varied only slightly from a national blueprint.

Overall, decentralization and delegation of authority, both operational and financial, from central/federal AIDS programs units to peripheral po-

litical echelons, to other ministries or to NGOs was limited and more often the result of internal and external pressure on ministries of health than of deliberate strategy. In 1992, countries that completed their first medium-term plan undertook reformulation of programs along new GPA guidelines calling for a multistage, enlarged, consultative process. It is not yet clear whether this promising approach will transform ministry of health programs on AIDS into truly national programs providing a suitable framework for diverse organizations and the full range of people concerned with HIV/AIDS prevention and care. Because of the resistance by some ministries of health to create and enlarge a true partnership on HIV/AIDS programs, major international or national NGOs and international agencies bypassed these ministries to create their own program outside the national plan.

The first decade: typology of government responses

The region's diversity requires an analysis of governmental responses to HIV/AIDS in Asia and the Pacific according to broadly defined patterns. Some governments' responses do not fit any of these patterns well. Nevertheless, it is hoped that a coherent picture will emerge from this analysis, highlighting successes and shortcomings in the broad context of a gradual mobilization against the HIV pandemic in this part of the world.

Early partnership and pragmatism

Australia and New Zealand exemplify this response, marked by prompt mobilization of the urban gay community in the early 1980s and creation of a partnership among governments, the health professions, academic institutions, and CBOs either within a formal framework (Australia) or informally (New Zealand) [11]. This type of interaction developed gradually, and not without difficulty. It created a favorable ground for policy dialogue and helped shape a pragmatic response to the epidemic both in its content (education, condom promotion, needle exchange, blood safety) and its organization (cooperation between federal and state government, nationwide networking of CBOs, level of federal and state funding). Early participation and targeting of prevention and care activities towards people who were particularly vulnerable to HIV (gay men, sex workers, IDUs) contributed to the relative success of these programs, resulting in a declining trend in HIV incidence in these populations and a limited spread of HIV beyond them. However, in Australia, groups who remain at a higher than average risk of becoming infected have a history of having been stigma-

tized for ethnic reasons (Aborigines) or marginalized because of unclear legal status (Asian sex workers).

From denial to commitment

The history of the HIV/AIDS pandemic in Thailand and India reveals both remarkable similarities and great differences. Both governments responded slowly to the pandemic. At present, both are experiencing a complex pattern of HIV spread in a series of epidemics, affecting consecutively gay men and IDUs, male and female sex workers and their clients, and increasingly, other sexually active adults and their offspring. Both countries gradually recognized the vulnerability of their population to the pandemic. Initially this led to restrictive policies: India continued to test students and sex workers and Thailand developed (and later rejected) an 'infamous bill' allowing the violation of privacy and mandatory screening of populations identified as endangering public health. However, both countries gradually moved towards strategies designed to reach vulnerable groups and reduce discrimination towards them. At the same time, while this process was unfolding, both countries affirmed the presence and prevalence of risk behaviors within their population that had until then been excluded from public debate.

It took longer for India's government (1990) than Thailand's (1987) to acknowledge publicly the severity of indigenous HIV transmission. Nevertheless, once this recognition had been achieved, each government made a commitment to developing sound public-health programs. This was reflected not only in public statements but also in the development of policies, formulation of programs, creation of structures and allocation of substantial international and national resources.

In Thailand, a national plan was drafted in 1987, and a 3-year medium-term plan (the first in Asia) in August 1988; by 1990 the Ministry of Public Health was operating a national AIDS program mostly implemented through the government health care system [12,13]. Until 1991, the Ministry of Public Health and NGOs were struggling with limited means and only small successes were possible against a dynamic epidemic. But in that year, the National Committee on AIDS was placed under the chairmanship of the Prime Minister and, within a few months, a large-scale national response to the HIV/AIDS pandemic began, with participation from all ministries, many NGOs and the corporate sector. Government funds budgeted for AIDS and shared by all ministries amounted to US\$ 44 million in 1993—a 17-fold increase since 1990—to which were added US\$ 12 million from international sources. In response to a perceived need for improved coordination and evaluation, a national AIDS prevention plan for 1992–1996 was incorporated into the seventh national 5-year plan [14].

In 1993, however, responsibility for coordinating the programs was transferred back to the Ministry of Public Health. The sustained participation of other sectors will require continued pressure by Thailand's politicians and the Prime Minister's office, along with reinforced vigilance on the part of NGOs.

In India, following a period of denial lasting at least through 1986, there were several attempts between 1987 and 1990 to formulate state and federal plans. Then, in 1992, increasing recognition of the rapid expansion of the spread of HIV led to the creation of the National AIDS Control Organization (NACO) [15]. Established within the Ministry of Health and Family Welfare, and involving eight other ministries, NACO's mandate includes: coordination of decentralized surveillance systems; promotion of behavior change through information, education and communication; expansion of counseling activities; control of sexually transmitted disease (STD); condom programming; and support for expansion of blood safety. Increases in allocation of national funds attest to greater emphasis on combating HIV/AIDS. Between 1991 and 1992, annual allocation of national funds to the government AIDS program increased eightfold, to IR 70 crores (US\$ 22.5 million). In addition, during 1990–1993, the National AIDS Program received US\$ 7.7 million from international organizations and official development agencies through WHO, and during 1992–1997, a loan of US\$ 85 million from the World Bank. However, the channeling of these resources to state programs is difficult: funds are slow to reach the states and, as a result, are under-spent.

The Indian Government is now moving with determination to catch up with an epidemic that threatens to run out of control. This recent response to HIV/AIDS has already stimulated more open debates on sexual behaviors and social issues that increase people's vulnerability to HIV infection and other STDs [16].

To a lesser extent, because of scarce internal resources and the complexities of international aid, Myanmar has repeated this pattern of denial to commitment [17]. Following a phase of several years (1987–1993) during which it documented a sharp increase in HIV in IDUs and sex workers (and starting in 1992, among women attending antenatal clinics), the government recently became more proactive against HIV/AIDS. It sought support from United Nations agencies for a multisectoral response to the pandemic, and has invited international NGOs and the few local NGOs to participate. Unfortunately, however—constrained by political isolation, competing domestic priorities, and weak infrastructure—Myanmar has yet to see results commensurate with its government's stated high priority for AIDS prevention.

Other countries in Asia seem to follow a similar trend. Indonesia is developing a national strategy that, involving the Ministry of Health and 15 other ministries, is expected to be moved to a specially designated coordinating ministry. In China, HIV/AIDS has been taken up at the State Council level, arising out of a United Nations Development Program (UNDP)/Ford Foundation-sponsored sub-regional seminar on the Social and Economic Impact of AIDS held in Kunming in 1992. Initially due in 1993 but still awaited, a new policy emphasizes the participation of all sectors in HIV/AIDS prevention. Vietnam has recognized its high vulnerability to HIV/AIDS. A draft strategic plan has responded to earlier criticism from NGOs in recognizing the special nature of HIV and in unlinking HIV preventive efforts from those applied to curb prostitution and injecting drug use [18].

High vulnerability and widening gap

Other countries in Asia have still not come to terms with the growing evidence of their vulnerability to large-scale HIV epidemics. In the second decade of the world's response to the pandemic, the commitment of their governments remains weak, if it exists at all. It is important to recognize that while many Asian countries are progressing towards a 21st century world economic order, their growing wealth is unevenly distributed. As a result, economic gaps between successful communities and others are deepening. This inequity intensifies the marginalization of certain communities that have long been subjected to discrimination for reasons of ethnicity, religion, or poverty. For example, in China and Vietnam, current moves towards a market economy are likely to create large internal economic disparities. In Cambodia and Sri Lanka, years of armed conflict have contributed to population displacements, and to economic survival strategies that exacerbate individual and collective vulnerability to HIV infection. In certain areas of Nepal and Laos, as in many other countries of the Asian subcontinent in which clusters of disadvantaged communities are forming, young women are easy targets for a booming sex trade, fueled by regional and international economic disparity [19,20]. In many countries, men seeking or carrying out work (truck drivers, construction workers, fishermen, sailors and the military) have become increasingly mobile, creating a concomitant demand for commercial sex. The relatively recent epidemic of injecting drug use, now that heroin is refined locally, has also contributed to the spread of HIV in the region.

At the same time, these governments may not have embraced the need to establish constructive dialogue with those who, because of economic imperatives or self-determined choice, have adopted behaviors placing them at higher than average risk of

acquiring HIV infection. In Bangladesh, Cambodia, Indonesia, Japan, South Korea, Malaysia, Pakistan, the Philippines and Vietnam, governments are documenting rising HIV prevalence in sex workers and their clients, and in patients attending STD clinics. In these countries, preventive efforts lag far behind and the gap between the pandemic and the response marshaled by governments is widening rapidly.

Insularity and a threatening pandemic on the horizon

Until now, small Pacific Island populations have been relatively untouched by the epidemic. In 1988, the governments of these countries/territories began to formulate AIDS prevention programs, through a series of workshops followed by GPA team site visits. A strategy of isolating HIV-infected people returning to the islands with HIV infection was contemplated (the geography of the area unavoidably triggered such temptations), but governments rejected this approach in favor of sound and well-considered prevention programs, as exemplified in the Kingdom of Tonga. Nevertheless, there is a risk of complacency because so few HIV/AIDS infections have so far been diagnosed in these island countries. This complacency, if combined with a sudden apparent increase in the HIV infection rate, could revive temptations to impose unduly restrictive and inappropriate measures. In 1993, courses conducted by GPA on the role of NGOs in HIV prevention and on counseling may have strengthened small island countries' ability to prepare for, and ultimately to cope with, future indigenous spread of HIV. The high rates of STDs found in several island countries is a testimony of the vulnerability of their population to the HIV pandemic [21]. High rates of STDs and dynamic spread of HIV have already been documented in Papua New Guinea [22].

Current government response

As of January 1994, all countries in the region have developed HIV/AIDS prevention plans and appointed AIDS advisory committees reporting, in most cases, to the ministry of health. They have, with varying degrees of extensiveness, established blood safety programs. In addition, they have launched information and education campaigns, some directed to the general public, and others to those most vulnerable to HIV/AIDS.

For the second volume of its publication *AIDS in the World*, the Harvard-based Global AIDS Policy Coalition conducted a worldwide survey of national AIDS programs up to and including 1993. The responses of heads of national AIDS programs to this survey, which addressed policy and program issues, are shown in Tables 1-5 of the Appendix.

Several governments in the region have embarked on HIV/AIDS programs that attempt to broaden the boundaries of national programs and foster collaboration among sectors other than health, including NGOs. The programs are increasing the national budget allocation to participating groups outside the ministries of health. In these programs, preventive strategies have been devised in accordance with GPA guidelines, in which the focus of action remains the ministry of health, with participation of other sectors [23]. A global strategy document developed by GPA reiterates the three objectives of the Global Strategy: (1) to prevent HIV transmission, (2) to alleviate the personal and social impact of HIV infection and AIDS, and (3) to mobilize and unify national and international efforts [24]. This document includes sub-objectives oriented towards specific prevention and care issues, but fails to articulate a strategy capable of minimizing social and economic factors that determine individual and collective vulnerability to HIV. However, the need for a coherent and credible AIDS strategy will be reconsidered in the joint co-sponsored United Nations program on HIV/AIDS, to be administered by WHO. This new initiative is intended to bring together six United Nations organizations: the United Nations Children's Fund (UNICEF), UNDP, the United Nations Educational, Scientific, and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the World Bank, and WHO. They will coordinate and expand AIDS-related activities in the health, social and economic sectors. Prevention approaches must nevertheless be adjusted and tactics varied to respond appropriately to the state of the pandemic and to population groups considered at higher risk in each country [25,26].

Although United Nations agencies are sustaining or expanding their aid to HIV/AIDS prevention and care efforts in the region, bilateral agencies and international NGOs are playing an increasing role in supporting governmental and non-governmental programs. To cite only a few examples: USAID, several international NGOs and the Australian International Development Assistance Bureau (AIDAB) support the Indonesian program; Save the Children Federation is active in Vietnam; international NGOs including CARE, several Red Cross societies and Save the Children Federation (with the support of UNDP) are working in Laos and Cambodia; Papua New Guinea receives support from the Government of Australia; USAID and the American Foundation for AIDS Research have ongoing programs in Nepal; and Thailand collaborates with an ever-increasing number of partners, including bilateral agencies, international NGOs, academic groups, and the European Commission. The growing diversity of sources of support to AIDS programs multiplies opportunities for action but, concomitantly, creates a risk of fragmentation of efforts.

Towards the future: building on strengths

Asia has the capability both to respond more effectively to the pandemic and to do so in new and innovative ways. This region has many strengths and enormous experience that can be built upon. At the same time, several specific issues must be addressed in order to generate a creative and effective response to the HIV pandemic. In so doing, the region can ensure that the largest proportion of the world's population is protected.

Power and responsibility of governments

Governments can make the difference between successful mobilization against HIV/AIDS and a devastating pandemic in this region, where the interdependence of government power and responsibility is clearly perceived. The response to HIV/AIDS surely lies in a government response that will have the power, dynamism and creativity of ongoing economic reforms in Asia. Most critical to the success of AIDS programs is the leadership that powerful ministries within the government machinery (ministries of planning, defense, finance) are committed to exercise. Previous attempts made in the health and social sectors to secure the participation of several ministries in concerted actions have often suffered from a declining level of efficiency as officers of lower echelons were mandated to represent their ministry on coordinating meetings. Learning from the leap forward achieved in Thailand once the national AIDS committee was placed under the direct chairmanship of the Prime Minister, governments should take similar steps to ensure that the representation of ministries on decision-making and coordinating bodies that oversee the national response to HIV/AIDS—a national cause of paramount importance—remains at the top executive level. Under the leadership of the government's highest executive, the government social and economic development board—or planning ministry, or its equivalent—must be responsible for the *formulation* of a truly multisectoral, interministerial, national plan. Collaborating with the private sector and NGOs, all ministries should have their own distinct *implementation* responsibility. Among them, the ministry of health should play a leading and coordinating role in order to ensure that all activities implemented under the national plan are sound and effective from a public-health perspective, that the national response to HIV/AIDS achieves the expected impact and that it accrues incremental benefits to the physical, mental and social well-being of the population. A critical issue in government revolves around budget allocation and accountability: mechanisms must be clearly set out to generate and channel governmental and international resources to ministries and other participating entities, in particular NGOs, with, in return, a commitment to full financial and operational ac-

countability. The creation of a peer group of political leaders in Asia, engaging actively in the advocacy of sound policy options in the region could play a useful role in this respect.

Strength of health services and past successful programs

Most countries in Asia have developed extensive health service networks. These networks have achieved high childhood immunization coverage; primary health care development; and, for at least some countries, effective population programs. The lessons learnt from these successes that can be applied to HIV/AIDS programs include the optimal balance between streamlined management and integration of services, enhancing staff skills and motivation, generating community interest and participation, and applying epidemiological surveillance to the monitoring and evaluation of health programs. Government STD programs are generally weak in the region, most STD diagnosis and care being provided by the private sector. The response to HIV (and other STDs) may well create an opportunity for re-examining the role that public and private sectors should play to achieve maximum impact.

Extensive information networks

Information networks in Asia are extensive, facilitated by generally high literacy rates and good coverage by radio and television networks. In many Asian countries, the media are under some form of government control, which could either limit the type of AIDS-related information disseminated to the public, or facilitate greatly the communication of effective preventive and anti-discriminatory messages. Training workshops on HIV/AIDS reporting have already been held for media professionals. The quality of reporting on the pandemic has generally improved, but several governments have not always sought, or been willing to accept, useful feedback and criticism carried by the media about HIV/AIDS policies or program content. Greater and more liberal use of the media as an open, two-way information channel would greatly benefit HIV/AIDS prevention efforts.

A wealth of NGOs

With the exception of few nations, such as China, Vietnam, Laos, Myanmar and Papua New Guinea, an abundance of NGOs existed in Asia and the Pacific long before HIV/AIDS began to spread in the region. Although NGOs have been at the forefront of the response to HIV/AIDS, this wealth remains largely untapped. The development of a productive partnership between governments and NGOs can build on the principles of clearly delineated responsibilities and mutual accountability within the framework of a national strategy for HIV/AIDS. There is a definite trend in this direction in many countries in the region. However, as the collaboration between gov-

ernments and NGOs progresses, there is a risk that the exclusive responsibility to attend to the needs of certain marginalized groups, such as sex workers, IDUs, homosexual men, exploited children, or disadvantaged communities, will be delegated exclusively to NGOs. This approach could threaten the capacity to help those who are most in need. It could also contribute to perpetuating the governmental complacency that continues to restrict the access of marginalized communities to government-provided or -supported services and programs. NGOs can contribute immensely to HIV/AIDS prevention and care in developing and testing innovative approaches and, once these have been shown to be effective, in advocating their adoption and replication by government programs [27]. The dual role of NGOs as innovators and advocates is central to the long-term sustainability of national efforts against the pandemic. Realizing the great contribution that NGOs can make to alter the course of the pandemic, governments should provide some of the resources they need to perform this important task.

Dynamism of economic development

The economies of several countries in the region have progressed considerably over the past decade. In addition to the many positive benefits of economic development, societal changes may contribute to increasing the vulnerability to HIV infection among some segments of the population. The pandemic may also jeopardize economic gains acquired through heavy investments of resources and human capital. Several studies have demonstrated the substantial long-term economic impacts of HIV/AIDS. Indeed, Thai studies of economic impact played an important role in motivating the government to greatly accelerate its prevention efforts [28].

The debate on social and economic impacts of the pandemic should stimulate more analytical work. This work should not only focus on the results of various scenarios, but also examine how social and economic factors may influence individual and collective vulnerability to HIV, and how that vulnerability can be reduced [29].

As the potential consequences of economic development on the environment are gaining importance in the process of deciding on new economic initiatives, the impact that such initiatives may have in reducing or enhancing people's vulnerability to HIV/AIDS should be systematically assessed. Decisions made at the project planning stage may influence considerably people's vulnerability to HIV. For example, encouraging worker migration to urban centers, generating high concentrations of employment opportunities reserved for men, and creating income disparity on the basis of sex will enhance people's vulnerability to HIV. In contrast, locating project sites in areas that have an available

labor force, enabling workers to reside by a project site together with their families, and offering equal employment opportunities and income to men and women will reduce their vulnerability to HIV.

Social strength

Asian societies have demonstrated both enormous resilience and tremendous capacity for change. In order to confront the diverse challenges of HIV/AIDS, both of these societal qualities will be needed. The powerful links that exist throughout Asia and the Pacific between individuals, their family and their community represent a large potential for community-based HIV/AIDS prevention and care. This potential may prove to be a major source of strength in combating the HIV pandemic as long as its realization avoids the two extremes of promoting unconsidered social transformations and resisting to change through rigid adherence to traditions that have become irrelevant.

Reducing individual and collective vulnerability to HIV/AIDS in Asia and the Pacific

The experience from over a decade of HIV preventive efforts from throughout the world, including North and South America, the Caribbean, Africa and Europe, must be critically evaluated so that lessons can be derived and applied most relevantly in Asia.

The concept of vulnerability can be a useful organizing principle for understanding why existing HIV/AIDS efforts have been only partly successful, and for design of more effective approaches. In this context, vulnerability to HIV has three dimensions: personal, programmatic and societal.

The goal of HIV prevention work is to support each person's ability to learn about HIV and to apply that knowledge and information meaningfully, fully and freely in their own lives.

Programmatic vulnerability occurs when necessary information, education, or health and social services are not made available. For example, if a population has not been provided with essential information about HIV, prevention at the personal level cannot really occur. Alternatively, if information about preventing HIV infection through condom use is not linked with availability of condoms (at reasonable cost and of good quality), then the education cannot achieve its goal. In this respect, lessons drawn from the difficult experience with HIV/AIDS in India, Thailand and Myanmar point to the compelling need for government HIV/AIDS programs throughout Asia and the Pacific to:

- (1) respond quickly to the HIV pandemic, mobilizing all sectors and all echelons of government;
- (2) recognize and collaborate with NGOs and the private sector;
- (3) involve most vulnerable groups, people with HIV and people with AIDS at every step of policy and program development and implementation;
- (4) recognize the realities of sexual and drug-using behaviors that are likely to be much more prevalent in the current economic climate in Asia, and provide the supportive social and legal environments that allow those at risk to access information, counseling, treatment (for STDs and for HIV-related illnesses) and means to adopt safer behavior (for example condoms and sterile injecting equipment);
- (5) extend information and education on sexuality, reproductive health and prevention of HIV and other STDs to young people in and out of school *before* they become sexually active.

If, worldwide, AIDS efforts to reduce vulnerability to HIV have so far largely focused on personal behaviors and on ensuring programmatic support, it has now become clear that the societal dimension may be at least as important, if not more important, than the programmatic dimension.

Societal vulnerability expresses the idea that certain individuals and groups are at greater risk of exposure to HIV as a result of the societal context. Societal vulnerability is directly linked with the scope, intensity and nature of discrimination, stigmatization and marginalization within each society. Societal discrimination occurs when individuals are treated only as members of a group (on the basis of, for example, low social and economic status, sex, ethnicity, religion, or sexual preference) and, on the basis of this group identification, people are denied equal services, opportunity, social support, rights, freedoms or measures of protection.

Therefore, reduction of personal and societal vulnerability to HIV infection, such as assurance of appropriate AIDS care, involves HIV/AIDS-specific programs, yet also invokes broader societal dimensions. It requires both a short-term and a long-term approach.

In the short term, vulnerability can be reduced by identifying the gaps in information/education, health and social services, or social support that create or enhance personal vulnerability to HIV. Then, it is essential to direct priority and resources towards filling these critical gaps. Also important is to ensure that existing and new HIV prevention and care programs are firmly anchored in what is already known and has been demonstrated to be effective, while

adapting these approaches to each specific societal context.

In the longer term (which means work beginning now but addressing more complex and therefore longer-term objectives), personal vulnerability can be reduced by defining personal factors/situations that increase vulnerability to HIV and helping people to recognize such factors/situations. Examples in Asia include the local rites of passage of initiation into sex, and lack of employment opportunities in rural areas combined with willing exploiters of rural poverty, such as brothel recruiters and opiate distributors.

Yet the major challenge for the medium and long term is to identify the forms of discrimination and other violations of human rights and dignity that can be directly linked with failures of HIV/AIDS prevention and care. Ultimately, the ability to succeed in HIV prevention will depend upon the extent to which societies in Asia and in the rest of the world confront these deep, pre-existing and underlying societal problems. The fundamental problem—that societal structure and action makes some people more vulnerable to HIV/AIDS—must be addressed directly, in light of social, cultural and religious values. Then, working with institutions and organizations concerned with social issues, including human rights, appropriate changes can be promoted. Examples of positive societal changes that also make important contributions to HIV/AIDS control include (1) increasing educational attainment for women, (2) removing racial/ethnic discrimination for employment or education, (3) increasing the participation of marginalized or stigmatized groups in decisions that affect them, and (4) ensuring access to the full range of health and social services for everybody.

HIV/AIDS prevention and care within a broad and modern perspective of health and society

HIV/AIDS work can only be successful, and must be implemented, in a manner that promotes a larger vision of health. Application of the WHO definition of health, involving physical, mental and social well-being, would dramatically reposition health as a central societal value [30]. HIV/AIDS work must contribute to a redefining and strengthening of the societal approach to health. Specifically, HIV/AIDS creates the obligation to raise the status and standards of existing health systems, rather than simply integrating HIV/AIDS prevention and care within inadequate health services.

This approach also calls for short-term and long-term actions. Short-term measures include redefin-

ing health issues and re-orienting health services on the basis of societal vulnerability and extending the analysis of individual and collective vulnerability to other health issues, such as cancer, injuries, cardiovascular and infectious diseases.

Long-term actions include developing health strategies that are closely linked to human and societal development goals, defining health as a human right, applying this definition to national and international policies and programs for human development, and ensuring that health is articulated as a central value in societal debate at the community, national and global levels.

In conclusion, it has become apparent that an HIV prevention strategy that fails to deal directly with the societal dimension cannot succeed. What is being done in most countries (in Asia and outside the region) to prevent HIV infection can be considered necessary, but in no way sufficient, to bring the epidemic under control.

Throughout Asia, it is likely that as the pandemic continues to spread, and as the enormous personal and societal burdens of the HIV epidemic become more evident, there will be a temptation to react out of fear. The costly mistakes made in other parts of the world risk being repeated in Asia.

The emergence of the HIV/AIDS pandemic in Asia offers a remarkable opportunity to draw upon the traditional strengths and the boundless energy, creativity and dynamism that characterizes the most populous region of the world.

The daunting difficulties ahead will command no less from Government leaders in the region than a bold re-examination of present social structures, values and practices in an attempt to define which of these can be acted upon to decrease vulnerability to the HIV pandemic and mitigate its impact.

To build effective programs based on a deep understanding of HIV/AIDS and society, and to harness societal energies to strengthen respect for human rights and dignity, is a challenge worthy of Asia. One can only hope that out of Asia will come new wisdom for a successful human resistance to HIV/AIDS, and for promotion of that state of physical, mental and social well-being that is the object of health and the goal of every society.

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Appendix

Tables 1-5 show the results of a worldwide survey of national AIDS programs up to and including 1993.

Table 1. AIDS policies and programs: response of governmental national AIDS programs (GNAP) in selected Asian and Pacific countries, 1993, as reported by government AIDS programs*.

	1	2	Content of national policy/program document						Participation of other groups/sectors in policy/program development						Needs assessment		Receipts of reports on human rights violations by GNAP					
			3a	3b	3c	3d	3e	3f	4a	4b	4c	4d	4e	4f	5a	5b	6a	6b	6c	6d	6e	6f
Large/medium-size countries																						
High-income economies																						
Australia	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Brunei	+	+	+	+	-	+	-	-	+	-	+	+	-	+	+	-	-	-	-	-	-	
Hong Kong	-	-	...	...	...	...	...	...	...	...	...	...	...	...	...	+	-	+	-	+	-	
Japan	+	+	+	+	+	+	+	-	+	+	+	...	...	+	+	+	-	-	+	-	+	
New Zealand	-	+	+	+	+	+	+	+	+	+	+	+	+	-	+	-	-	+	+	-	-	
Singapore	+	+	+	+	+	+	-	+	+	-	...	+	+	+	+	+	-	-	+	-	-	
Middle-income economies (upper-middle and lower-middle)																						
Malaysia	+	+	+	+	-	+	+	+	+	-	+	-	-	+	-	-	-	-	+	-	+	
Papua New Guinea	-	+	+	+	+	+	+	+	+	-	+	+	+	-	+	-	-	-	-	-	-	
Solomon Islands	+	+	+	+	-	+	-	+	+	-	-	+	+	-	-	-	-	-	-	-	-	
Thailand	+	+	+	+	+	...	+	+	+	+	+	+	+	-	+	-	+	+	+	-	-	
Low-income economies																						
Bhutan	-	-	...	...	...	...	...	...	...	...	...	...	...	...	...	-	-	-	-	-	-	
China	-	+	+	+	+	+	-	+	+	...	+	+	+	-	+	+	-	-	-	-	-	
India	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	-	+	+	-	-	-	
Nepal	+	+	+	+	+	+	+	+	-	-	-	-	-	-	-	-	-	-	-	-	-	
Sri Lanka	-	+	+	-	-	-	-	-	+	-	-	-	-	-	-	+	+	-	+	-	+	
Vietnam	+	+	+	+	+	+	+	+	+	+	+	+	...	...	+	+	-	-	-	-	-	
Pacific Island countries																						
Lower-middle-income economies																						
Cook Islands	+	+	+	+	+	+	-	-	+	-	+	+	-	-	+	+	-	-	-	-	-	
Fiji	+	+	+	+	+	+	+	+	+	-	-	+	+	-	-	-	-	-	-	-	-	
Kiribati	+	+	...	...	...	...	...	...	...	...	...	...	...	...	...	-	-	-	-	-	-	
Micronesia, Fed. Sts	+	+	+	+	+	+	+	+	+	-	+	+	+	+	+	-	-	-	-	-	-	
Niue	+	-	...	...	...	...	...	...	...	...	...	...	...	...	...	-	-	-	-	-	-	
Tokelau	+	-	...	...	...	...	...	...	...	...	...	...	...	...	...	-	+	+	+	+	+	
Tuvalu	+	+	...	...	...	...	...	...	...	...	...	...	...	...	...	-	-	-	-	-	-	
Vanuatu	+	+	+	+	+	+	-	+	+	+	+	+	+	+	+	-	-	-	-	-	-	
Western Samoa	+	+	+	+	+	+	+	+	+	-	+	+	+	+	+	-	-	-	-	-	-	
Upper-middle-income economies																						
American Samoa	+	+	+	-	-	+	-	-	+	-	+	+	+	+	+	+	-	-	-	-	-	
Guam	-	-	...	...	...	...	...	...	...	...	...	...	...	...	...	-	-	-	-	-	+	
New Caledonia	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	-	-	-	-	-	+	
</																						

Table 1. Footnotes.

- 1 Top governmental authority has made a public address to the nation on the topic of HIV/AIDS
- 2 A document exists outlining the government's current policy and program on HIV/AIDS
- 3 The document includes the following:
 - 3a Statement of national policies on HIV/AIDS
 - 3b Description of strategic approaches for the health sector
 - 3c Description of strategic approaches for the health and other sectors, such as the ministries of development, education and justice
 - 3d Description of specific activities for the health and other sectors
 - 3e Proposed budget for central/federal expenditures on HIV/AIDS
 - 3f Evaluation plan for governmental activities
- 4 Consultations/discussions with the following groups in the development of the document:
 - 4a Professionals in the health sector
 - 4b People with HIV/AIDS
 - 4c State or regional (provincial or district) authorities
 - 4d Other agencies (i.e. private foundations, research institutions)
 - 4e Other government departments/ministries
 - 4f The parliament
- 5 Surveys conducted in the development of the document:
 - 5a Needs assessment surveys for prevention
 - 5b Needs assessment surveys for care
- 6 Issues for which the GNAP received reports of allegations of human rights violations:
 - 6a Mandatory or compulsory HIV testing
 - 6b Violation of confidentiality of HIV status
 - 6c Discrimination in the workplace against HIV-infected people
 - 6d Restriction of housing rights to HIV-infected people
 - 6e Discrimination against children/young people with HIV infection in the educational system
 - 6f Restrictions of health service entitlements to people with HIV infection
- 7 GNAP conducted targeted training on how to manage HIV/AIDS programs
- 8 Proportion of the following groups having received such training:
 - 8a GNAP managers
 - 8b Managers of other governmental programs/departments
 - 8c Region/province district managers
 - 8d Non-governmental organization managers
- 9 Problems faced by the GNAP in implementing programs and providing services in 1993 (opinion requested):
(O, not a problem; L, minor problem; M, major problem; H, very severe problem)
 - 9a Governmental financial support
 - 9b International financial support
 - 9c Political support
 - 9d Personnel issues (i.e. burnout, staff turnover, recruitment)
 - 9e Supplies (i.e. HIV testing kits, condoms, educational materials)
 - 9f Internal coordination within the GNAP
 - 9g Coordination with other government programs/departments
 - 9h Coordination with non-governmental organizations
 - 9i Public/social support and/or opinion
 - 9j Media coverage
 - 9k Capacity of government to provide care for the number of people with HIV or AIDS
- 10 Programs on HIV/AIDS have been developed by:
 - 10a Individual states, regions or provinces
 - 10b Individual districts, counties, prefectures within the states, regions or provinces
- 11 Mobilization against AIDS has affected other health initiatives, such as the following health programs:
 - 11a Maternal and Child Health
 - 11b Family Planning
 - 11c Tuberculosis
 - 11d Sexually transmitted diseases.

*Survey conducted for *AIDS in the World*. Source: Jonathan Mann, Daniel Tarantola, editors, *AIDS in the World*, vol II, Oxford University Press: forthcoming, 1995. Countries have been divided into economies following the structure used by the International Bank for Reconstruction and Development as published in *The World Bank Atlas*, 1994.

Table 2. Responses by governmental national AIDS programs (GNAP) to prevention needs in selected Asian and Pacific countries, 1993, as reported by government AIDS programs*.

	Predominant HIV transmission mode					Government-allowed condom distribution sites												
	1a	1b	1c	1d	1e	2	3	4	5	6a	6b	6c	6d	6e	6f	7	8	
Large/medium-size countries																		
High-income countries																		
Australia	1	...	2	...	...	+	-	...	...	+	+	+	+	+	+	E	H	
Brunei	2	1	...	...	...	-	-	...	...	...	...	...	...	...	...	E	H	
Hong Kong	2	1	...	...	...	+	+	M	...	+	+	-	-	+	-	E	H	
Japan	...	2	...	1	...	-	...	...	...	+	-	+	+	+	+	E	H	
New Zealand	1	2	...	...	...	-	-	...	...	+	+	+	+	+	+	E	H	
Singapore	2	1	...	...	...	+	...	...	...	+	+	-	+	+	-	E	H	
Taiwan	2	1	...	...	...	...	...	...	...	...	...	...	...	...	...	E	...	
Middle-income economies (upper-middle and lower-middle)																		
Malaysia	...	2	1	...	...	+	-	...	...	+	+	-	+	+	-	E	L	
Papua New Guinea	...	1	...	...	2	+	+	L	...	+	+	-	+	+	-	U	L	
Solomon Islands	...	...	...	...	...	+	-	...	...	...	...	...	...	...	...	U	...	
Thailand	...	1	2	...	...	+	+	M	4.5	+	+	...	+	+	+	E	LM	
Low-income economies																		
Bhutan	...	1	...	...	...	-	+	M	15	+	+	+	+	+	...	U	LM	
China	...	2	2	...	...	+	-	...	...	+	...	...	...	+	...	E	L	
India	...	1	2	...	...	+	-	...	...	...	...	...	...	...	...	E	L	
Nepal	...	1	2	...	...	-	+	M	...	+	+	-	-	+	-	U	...	
Sri Lanka	2	1	...	...	...	+	+	...	...	+	+	...	+	+	...	U	L	
Vietnam	...	2	1	...	...	+	+	M	10	+	+	...	...	+	...	E	LM	
Pacific Island countries																		
Lower-middle-income economies																		
Cook Islands	...	...	...	...	...	-	+	M	10	+	-	-	-	+	-	U	HM	
Fiji	2	1	...	...	...	-	-	...	...	+	-	-	-	+	-	E	HM	
Kiribati	...	1	...	...	...	+	+	M	...	+	+	-	+	+	+	U	L	
Micronesia, Fed. Sts	...	...	...	...	...	-	+	M	2	+	+	+	+	+	...	U	LM	
Niue	...	...	...	...	...	-	+	M	...	+	-	-	+	-	-	E	L	
Tokelau	...	...	...	...	...	-	-	...	...	+	-	-	-	-	-	O	...	
Tuvalu	2	1	...	...	...	-	+	...	...	+	+	-	-	+	-	U	L	
Vanuatu	...	...	...	...	...	+	+	...	...	+	+	+	+	+	+	U	L	
Western Samoa	...	...	...	...	...	-	+	M	2	+	+	-	-	+	-	U	H	
Upper-middle-income economies																		
American Samoa	...	...	...	...	...	-	+	M	2	+	+	...	...	...	...	E	LM	
Guam	1	2	...	...	...	+	+	M	2	+	+	+	...	+	-	E	H	
New Caledonia	2	1	...	...	...	-	+	M	2-3	+	+	-	+	+	+	E	H	

1 The first (1) and second (2) most prevalent transmission modes in the country in 1993

1a Homo/bisexual

1b Heterosexual

1c Injection drug use

1d Transfusion/receipt of blood products

1e Prenatal (mother-to-child)

2 One or more sexual behavior surveys (also called sex surveys) have been carried out in the country since 1 January 1990

3 The GNAP distributed condoms to regional/district/local programs in 1992

4 The GNAP distributed more (M) or fewer (L) condoms in 1992 than in 1990

5 Condoms distributed: number of times more in 1992 than in 1990

6 The federal/central government allowed the distribution of condoms in the following sites/facilities in 1992:

6a Sexually transmitted disease clinics or other health clinics

6b Hotels, bars or brothels

6c High schools or colleges

6d Department stores

6e Pharmacies/drug stores

6f Public places (i.e. bathrooms, bus stations)

7 Where voluntary HIV testing is now offered

(E, everywhere in the country; U, only in the capital city or other large cities; O, nowhere in the country)

8 Estimated proportion of people receiving voluntary HIV testing who also receive counseling in the country

(L, 0-25%; LM, 26-50%; HM, 51-75%; H, 76-100%)

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Table 3. Participation of sectors other than health in national prevention activities in selected Asian and Pacific countries, 1993, as reported by government AIDS programs*.

	Other government sectors with AIDS programs								Primary responsibility for HIV/AIDS programs				
	1	2	3	4	5a	5b	5c	5d	6a	6b	6c	6d	6e
Large/medium-size countries													
High-income economies													
Australia	+	11	4	...	...	+	+	...	P	P	P	P	P
Brunei	+	7	0	0	-	+	-	na	P	P	P	P	P
Hong Kong	+	20	9	7	-	-	-	-	P	P	P	P	P
Japan	+	14	4	4	na	+	+	na	S	S	S	S	S
New Zealand	+	...	...	...	na	-	+	-	P	P	P	P	P
Singapore	+	18	4	7	+	+	+	na	P	P	P	S	P
Middle-income economies													
(upper-middle and lower-middle)													
Malaysia	+	15	5	2	...	+	+	+	PS	P	P	PS	P
Papua New Guinea	+	17	3	3	na	+	+	+	PS	S	PS	PS	...
Solomon Islands	+	10	4	4	-	-	-	-	P	P	P	P	P
Thailand	+	39	3	6	+	+	+	na	S	S	P	S	P
Low-income economies													
Bhutan	+	16	2	1	-	-	-	na	P	P	P	P	P
China	+	36	9	...	...	...	+	+	P	P	P	S	P
India	+	7	0	3	+	+	+	+	P	P	P	P	P
Nepal	+	15	2	2	+	+	+	na	S	...	...	...	...
Sri Lanka	+	19	...	2	+	+	+	+	P	P	P	P	P
Vietnam	+	16	4	4	+	+	+	+	S	P	S	S	S
Pacific Island countries													
Lower-middle-income economies													
Cook Islands	+	6	3	1	...	...	+	...	S	P	P	P	P
Fiji	+	16	4	3	-	-	+	-	P	P	P	P	P
Kiribati	+	16	3	7	...	...	+	+	P	P	...	PS	P
Micronesia, Fed. Sts	+	12	4	3	-	na	+	+	P	S	S	S	S
Niue	+	7	4	4	-	-	+	-	P	P	P	P	P
Tokelau	+	9	5	12	na	na	+	+	P	P	P	P	P
Tuvalu	+	10	3	4	-	-	-	-	P	P	P	P	P
Vanuatu	+	10	4	4	-	-	+	+	S	P	...	S	P
Western Samoa	+	14	4	5	-	-	-	-	P	P	P	P	P
Upper-middle-income economies													
American Samoa	+	25	12	10	na	na	+	+	S	S	P	S	S
Guam	+	8	6	3	-	+	+	-	P	P	P	P	P
New Caledonia	+	16	5	1	-	-	+	-	P	P	P	P	P

1 National AIDS Advisory Committee or a similar body created in the country

2 Number of members (total) serving on the National AIDS Advisory Committee

3 Number of women members serving on the National AIDS Advisory Committee

4 Number of members of the National AIDS Advisory Committee representing non-governmental organizations

5 Ministries other than the Ministry of Health that have developed their own AIDS programs:

5a Planning/Economic Development or Tourism

5b Internal/Home Affairs or Defense

5c Education or Youth

5d Family Affairs or Women's Affairs

6 Areas in which HIV/AIDS activities have been primarily the responsibility of the governmental national AIDS programs (P) or have been shared among other ministries (S):

6a Planning HIV/AIDS activities

6b Managing HIV/AIDS activities

6c Financing HIV/AIDS activities

6d Implementing HIV/AIDS activities

6e Evaluating HIV/AIDS activities

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Table 4. Evaluation of governmental national AIDS programs (GNAP) in selected Asian and Pacific countries, 1993, as reported by government AIDS programs*.

	Policy change resulting from evaluation									
	1a	1b	2	3a	3b	3c	3d	3e	3f	3g
Large/medium-size countries										
High-income economies										
Australia	+	+	1986	m	m	m	m	M	M	M
Brunei	-	-		...	...	...	...	...	...	...
Hong Kong	-	-		...	...	...	...	...	...	...
Japan	...	...		...	...	...	...	...	...	...
New Zealand	-	+	1986	O	O	O	O	O	O	O
Singapore	+	+		O	m	m	O	m	O	M
Taiwan	...	...		...	...	...	...	...	...	...
Middle-income economies (upper-middle and lower-middle)										
Malaysia	+	+	1985	...	M	M	...	M	...	...
Papua New Guinea	+	+	1992	O	O	O	O	m	O	m
Solomon Islands	+	+	1989	O	O	m	...	m	O	O
Thailand	+	+	1987	M	M	m	M	M	m	M
Low-income economies										
Bhutan	+	...	1993	O	O	O	O	O	O	O
China	+	+	1993	m	m	...	...	M	...	m
India	+	+	1992	O	O	O	O	O	O	O
Nepal	...	...		...	...	...	...	...	...	...
Sri Lanka	+	-		...	...	...	...	...	...	...
Vietnam	+	+	1991	...	...	...	...	...	...	...
Pacific Island countries										
Lower-middle-income economies										
Cook Islands	-	-		...	...	...	...	...	...	...
Fiji	+	+	1993	O	M	m	m	M	M	m
Kiribali	+	-	1993	m	O	m	...	...	...	...
Micronesia, Fed. Sts	+	+	1988	M	M	O	M	M	O	O
Niue	-	-		...	...	...	...	...	...	...
Tokelau	-	-		...	...	...	...	...	...	...
Tuvalu	+	+	1993	...	...	...	...	...	...	...
Vanuatu	+	+	1990	...	...	...	...	...	...	...
Western Samoa	+	-	1992	O	O	O	...	m	...	m
Upper-middle-income economies										
American Samoa	-	-	1990	m	m	M	m	M	M	m
Guam	+	+	1989	O	O	M	O	M	O	O
New Caledonia	-	-		...	...	...	...	...	...	...

1 The GNAP has:

1a Evaluated its own HIV/AIDS programs/projects

1b Evaluated the groups which it funds or required that these groups evaluate their own work

2 The year in which HIV/AIDS program evaluation for the GNAP and/or the programs/groups it funds began

3 Indicates significant change in policy resulting from an evaluation of the GNAP and/or one of the organizations which it funds

(M, major change; m, minor change; O, no change):

3a Change in program strategies

3b Reformulation of the national HIV/AIDS plan

3c Personnel changes

3d Redirection of a specific needed service

3e Change of a certain project focus

3f Ending a program component

3g Beginning a new program component

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Table 5. Expenditures (US\$) on AIDS by governmental national AIDS programs (GNAP) in selected Asian and Pacific countries, 1 fiscal year circa 1993, as reported by government AIDS programs*.

	Spending		Management (%)	Prevention (%)	Laboratory and care (%)	Support for other organizations (%)	Research (%)
	Total	Per capita					
Large/medium-size countries							
High-income economies							
Japan	98 398 000	0.79	0 (0)	32 471 000 (33)	19 680 000 (20)	0 (0)	46 247 000 (47)
Australia	62 658 000	3.52	3 759 000 (6)	8 772 000 (14)	38 848 000 (62)	3 759 000 (6)	7 519 000 (12)
New Zealand	2 492 000	0.72	...	...	...	...	...
Middle-income economies (upper-middle and lower-middle)							
Malaysia	8 889 000	0.47	711 000 (8)	1 778 000 (20)	5 867 000 (66)	89 000 (1)	444 000 (5)
Thailand	56 000 000	0.97	1 120 000 (2)	8 400 000 (15)	43 120 000 (77)	2 240 000 (4)	1 120 000 (2)
Low-income economies							
India	20 266 000	0.02	...	...	...	...	...
Nepal	354 000	0.02	46 000 (13)	142 000 (40)	106 000 (30)	53 000 (15)	7000 (2)
Bhutan	246 000	0.16	41 000 (17)	145 000 (59)	53 000 (22)	7000 (3)	0 (0)
Pacific Island countries							
Upper-middle-income economies							
Guam	170 000	1.10	136 000 (80)	8500 (5)	25 500 (15)	0 (0)	0 (0)
Lower-middle-income economies							
Fiji	54 000	0.07	7000 (13)	31 000 (57)	13 000 (24)	3000 (6)	0 (0)
Western Samoa	375 000	2.30	94 000 (25)	131 000 (35)	113 000 (30)	19 000 (5)	19 000 (5)
Vanuatu	71 000	0.45	11 000 (15)	57 000 (80)	4000 (5)	0 (0)	0 (0)
Micronesia, Fed. Sts	58 000	0.52	9000 (15)	29 000 (50)	12 000 (20)	9000 (15)	0 (0)
Kiribati	12 000	0.15	2000 (17)	3000 (28)	3000 (28)	3000 (22)	< 1000 (6)
Cook Islands	30 000	1.74	6000 (20)	12 000 (40)	9000 (30)	3000 (10)	0 (0)
Tuvalu	2000	0.20	< 1000 (20)	1000 (60)	< 1000 (10)	0 (0)	< 1000 (10)
Niue	3000	1.50	3000 (85)	< 1000 (10)	< 1000 (5)	0 (0)	0 (0)

*Survey conducted for *AIDS in the World*. Source: Jonathan Mann, Daniel Tarantola, editors, *AIDS in the World*, vol II, Oxford University Press: forthcoming, 1995. Countries have been divided into economies following the structure used by the International Bank for Reconstruction and Development as published in *The World Bank Atlas, 1994*. Figures may not add up in every row because of rounding-off to the nearest thousand above 1000.

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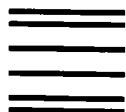
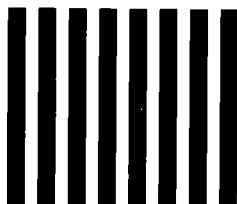
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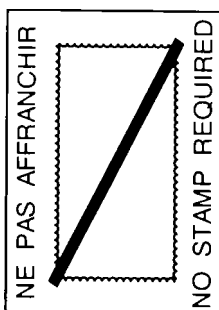
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Governments of Asia and the Pacific responding to the HIV/AIDS pandemic

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Introduction

Much has already been written throughout this supplement to illustrate the vastness of Asia and the Pacific—stretching across 12 time zones—its enormous population—more than half of the world's total—and its diverse political, social, economic and cultural features. The HIV/AIDS pandemic has not only demonstrated profound disregard for geographic boundaries, it has also shown remarkable capacity to flourish as a consequence of many forms of stigmatization, discrimination and denial. HIV/AIDS is a mosaic, a complex assembly of a myriad small epidemics evolving side by side, each with its own characteristics and velocity, with bridges among them fueling their spread [1].

Early and limited response in Asia and the Pacific

A typology of the HIV/AIDS pandemic, proposed in 1986 by the US Institute of Medicine and later adopted by the World Health Organization (WHO), was intended to facilitate analysis of the world pandemic [2]. Australia and New Zealand conformed to the first pattern of the epidemic, with features characteristic of countries in North America and Europe: early and rapid HIV spread via homosexual contact and injecting drug use (most of which involved men), as shown by the high proportion of men among infected people. Other countries in Asia and the Pacific conformed to the third pattern of the pandemic: late introduction of HIV, low level of HIV prevalence, and infection traceable to contacts

with infected people from outside the region. In the mid-1980s, no country in the region fitted the second pattern, characterized by the predominance of heterosexual transmission of HIV, with consequent mother-to-infant transmission.

Although the three-pattern division proved useful in giving initial shape to the global pandemic, it had the adverse effect of suggesting to governments of Asian and Pacific Pattern III countries that their region was, if not forever at least for a long time, to be spared by the epidemic. It also focused those governments' HIV detection efforts on foreign nationals, particularly foreign students and groups in possible contact with them, such as sex workers and injecting drug users (IDU). Therefore, most government responses until the late 1980s were limited to HIV surveillance systems that screened population groups by their country of origin or their likelihood of contact with foreign nationals. These measures, often associated with coercive or punitive actions towards HIV-infected people, were, and in some cases still are, maintained in certain countries despite the World Health Assembly resolution of May 1988 [3,4].

For example, in the Philippines, concern about HIV focused on US servicemen and other foreign nationals. Although US servicemen, together with diplomats and journalists, were exempted from mandatory testing, a strong effort was made to impose screening on other aliens. In India, under the guidance of the Indian Medical Research Council, HIV testing was imposed on foreign students enrolled in or matriculating to universities in the country. By the end of October 1989, 61 HIV-infected foreign students had been deported. By November 1989, at great cost, India had administered almost

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365 000 HIV tests: of the 1650 people diagnosed with HIV infection, only about 100, or 6%, were foreign nationals [5].

Other countries also required testing of migrants, travelers, students or returning nationals (China, Pakistan, Mongolia, Myanmar, North Korea, the Philippines, South Korea, Sri Lanka) and/or screening of certain professionals (seafarers in Burma, China, South Korea, Pakistan, the Philippines, Sri Lanka and Vietnam, and entertainers in Indonesia, Japan, North Korea, the Philippines, Sri Lanka and Vietnam). Concurrently with the HIV pandemic, an epidemic of Highly Inefficient Laws (HIL), so named by Justice Michael Kirby, affected many of the world's countries, with a strong focus in Asia [6].

The slow emergence of national AIDS programs

Until 1987, little preventive education for society at large was undertaken by governmental programs in Asia and the Pacific (with the exception of Australia and New Zealand). Early efforts tended to reinforce the widespread belief that the epidemic was inherent to behaviors largely attached to Western cultures (homosexuality, bisexuality, sexual promiscuity, injecting drug use) and that, therefore, as long as vigilance was maintained, there was little cause for concern.

Several explanations may be proposed for the approach taken by Asian governments. First, only a few cases of HIV infection and AIDS had been diagnosed in Asia before 1987 and most of them could be traced to contact with an infected person from outside the region, or to imported blood products. Second, acknowledging the general population's vulnerability implied accepting that substance use and sexual behaviors that predisposed to HIV infection existed in Asian countries. Third, the region had achieved significant progress in implementing primary health care activities such as childhood disease prevention, control of certain communicable diseases, and family planning. In this context, any other initiatives were perceived as potentially diverting attention and resources from such programs. Fourth, the economic priorities of several countries were powerful deterrents—and still are—to embarking on high-visibility education campaigns that might negatively affect international travel, trade or domestic industry. Examples include Thailand and Nepal, where tourism was rapidly expanding; India, with growing international trade through Bombay; and the Philippines, Indonesia, and Bangladesh, with a large migrant labor force to the Middle East. Finally, the low HIV prevalence rates found in Asia and the Pacific at that time meant that the epidemic

remained generally invisible. Notwithstanding, the mounting voice of community-based organizations (CBO), non-governmental organizations (NGO) and activists was a counterforce to Asian governments' reassuring messages about HIV/AIDS.

Thus, denial of the global nature of the pandemic and reluctance to confront HIV/AIDS in realistic ways (other than expanding case finding and enacting restrictive laws) characterized the Asian governments. In July 1987, a conference of ministers of health of Asian and Pacific countries, held in Sydney, Australia, followed by the global Summit of Ministers of Health in January 1988 helped convince governments that information, education, and protection of human rights were essential to HIV/AIDS prevention [7,8].

By 1986, WHO had created the Programme on AIDS, renamed Global Programme on AIDS (GPA), to provide global leadership and coordination in policy and program development, research promotion and exchange of information [9]. This new program made a strong financial commitment to supporting national AIDS programs: in 1988, this activity absorbed nearly half of the GPA budget of US\$ 70 million. GPA encouraged countries to formulate short-term (3–6 months) plans of action, followed by 3–5-year medium-term plans, to be reformulated on the basis of periodic evaluation. By the end of 1987, 30 countries had developed a short-term program with the help of WHO/GPA, and had received financial support from WHO and/or from official development agencies of affluent countries.

The net effect of this initiative was the creation of national AIDS programs—usually at the initiative of communicable disease units of ministries of health—and formulation of a plan by each country, providing a framework within which all entities working on HIV/AIDS within the nation were expected to align and coordinate activity [10]. At last, external resources flowed towards programs for which little or no national financing was available, because of low commitment, insufficient urgency, depleted economies, and the administrative imperative of rigid budgeting cycles. A vital step towards addressing the global HIV/AIDS problem had been taken.

First programs: centralism of ministries of health

The development of government programs was, however, constrained in at least four ways. First, with few exceptions, programs created in collaboration with WHO were focused strongly on this inter-governmental organization's normal partners—the ministries of health—which traditionally had lim-

ited influence within governments, and operated on meager budgets. As United Nation Agencies other than WHO had minimal or no involvement in HIV/AIDS, the focus of preventive programs on ministries of health became even stronger over time.

Most ministries of health in Asia and the Pacific were unable to generate sufficient awareness and urgency among other government sectors about the severity of the emerging HIV/AIDS problem. They regarded the development of national AIDS programs as their exclusive prerogative. Other ministries and NGOs had little opportunity to participate in policy and program formulation.

Second, the paucity of government resources and highly limited services for marginalized groups (sex workers, IDUs, homosexual men), whose very *existence* was generally denied, resulted in the major portion of available resources being allocated to blood transfusion safety, mass information campaigns, surveillance, health personnel training and central program management.

Third, because government programs were uncomfortable dealing with NGOs, which abounded in the region even before the onset of AIDS, the national AIDS programs provided very little funding for their support, despite evidence of their effectiveness in other health areas and their clear role in confronting HIV/AIDS.

Finally, government programs were highly centralized. In large countries with federal political structures, WHO/GPA attempted to support the formulation of programs at the state/provincial level, leading to the elaboration of a federal/central umbrella plan. This approach met with short-lived success in Indonesia, where provincial plans were formulated and regrouped under an ambitious federal plan, which later was not sufficiently funded to implement the new program fully. The approach experienced long delays in India, where the Federal Government initially favored it and provided some support to the formulation of 17 individual state plans. However, in 1990, only five were finalized because of fear of excessive financial demands for the Federal Government. The process was later revived: by 1993, 30 of the 32 states in India had developed a plan of operations approved by the central government, but funds promised, for example, to the states of Tamil Nadu and Karnakata were still awaited by mid-1994.

In China, following a national conference on AIDS held in Beijing in August 1989 in cooperation with GPA, provincial programs were created along uniform guidelines developed centrally, producing plans that varied only slightly from a national blueprint.

Overall, decentralization and delegation of authority, both operational and financial, from central/federal AIDS programs units to peripheral po-

litical echelons, to other ministries or to NGOs was limited and more often the result of internal and external pressure on ministries of health than of deliberate strategy. In 1992, countries that completed their first medium-term plan undertook reformulation of programs along new GPA guidelines calling for a multistage, enlarged, consultative process. It is not yet clear whether this promising approach will transform ministry of health programs on AIDS into truly national programs providing a suitable framework for diverse organizations and the full range of people concerned with HIV/AIDS prevention and care. Because of the resistance by some ministries of health to create and enlarge a true partnership on HIV/AIDS programs, major international or national NGOs and international agencies bypassed these ministries to create their own program outside the national plan.

The first decade: typology of government responses

The region's diversity requires an analysis of governmental responses to HIV/AIDS in Asia and the Pacific according to broadly defined patterns. Some governments' responses do not fit any of these patterns well. Nevertheless, it is hoped that a coherent picture will emerge from this analysis, highlighting successes and shortcomings in the broad context of a gradual mobilization against the HIV pandemic in this part of the world.

Early partnership and pragmatism

Australia and New Zealand exemplify this response, marked by prompt mobilization of the urban gay community in the early 1980s and creation of a partnership among governments, the health professions, academic institutions, and CBOs either within a formal framework (Australia) or informally (New Zealand) [11]. This type of interaction developed gradually, and not without difficulty. It created a favorable ground for policy dialogue and helped shape a pragmatic response to the epidemic both in its content (education, condom promotion, needle exchange, blood safety) and its organization (cooperation between federal and state government, nationwide networking of CBOs, level of federal and state funding). Early participation and targeting of prevention and care activities towards people who were particularly vulnerable to HIV (gay men, sex workers, IDUs) contributed to the relative success of these programs, resulting in a declining trend in HIV incidence in these populations and a limited spread of HIV beyond them. However, in Australia, groups who remain at a higher than average risk of becoming infected have a history of having been stigma-

tized for ethnic reasons (Aborigines) or marginalized because of unclear legal status (Asian sex workers).

From denial to commitment

The history of the HIV/AIDS pandemic in Thailand and India reveals both remarkable similarities and great differences. Both governments responded slowly to the pandemic. At present, both are experiencing a complex pattern of HIV spread in a series of epidemics, affecting consecutively gay men and IDUs, male and female sex workers and their clients, and increasingly, other sexually active adults and their offspring. Both countries gradually recognized the vulnerability of their population to the pandemic. Initially this led to restrictive policies: India continued to test students and sex workers and Thailand developed (and later rejected) an 'infamous bill' allowing the violation of privacy and mandatory screening of populations identified as endangering public health. However, both countries gradually moved towards strategies designed to reach vulnerable groups and reduce discrimination towards them. At the same time, while this process was unfolding, both countries affirmed the presence and prevalence of risk behaviors within their population that had until then been excluded from public debate.

It took longer for India's government (1990) than Thailand's (1987) to acknowledge publicly the severity of indigenous HIV transmission. Nevertheless, once this recognition had been achieved, each government made a commitment to developing sound public-health programs. This was reflected not only in public statements but also in the development of policies, formulation of programs, creation of structures and allocation of substantial international and national resources.

In Thailand, a national plan was drafted in 1987, and a 3-year medium-term plan (the first in Asia) in August 1988; by 1990 the Ministry of Public Health was operating a national AIDS program mostly implemented through the government health care system [12,13]. Until 1991, the Ministry of Public Health and NGOs were struggling with limited means and only small successes were possible against a dynamic epidemic. But in that year, the National Committee on AIDS was placed under the chairmanship of the Prime Minister and, within a few months, a large-scale national response to the HIV/AIDS pandemic began, with participation from all ministries, many NGOs and the corporate sector. Government funds budgeted for AIDS and shared by all ministries amounted to US\$ 44 million in 1993—a 17-fold increase since 1990—to which were added US\$ 12 million from international sources. In response to a perceived need for improved coordination and evaluation, a national AIDS prevention plan for 1992–1996 was incorporated into the seventh national 5-year plan [14].

In 1993, however, responsibility for coordinating the programs was transferred back to the Ministry of Public Health. The sustained participation of other sectors will require continued pressure by Thailand's politicians and the Prime Minister's office, along with reinforced vigilance on the part of NGOs.

In India, following a period of denial lasting at least through 1986, there were several attempts between 1987 and 1990 to formulate state and federal plans. Then, in 1992, increasing recognition of the rapid expansion of the spread of HIV led to the creation of the National AIDS Control Organization (NACO) [15]. Established within the Ministry of Health and Family Welfare, and involving eight other ministries, NACO's mandate includes: coordination of decentralized surveillance systems; promotion of behavior change through information, education and communication; expansion of counseling activities; control of sexually transmitted disease (STD); condom programming; and support for expansion of blood safety. Increases in allocation of national funds attest to greater emphasis on combating HIV/AIDS. Between 1991 and 1992, annual allocation of national funds to the government AIDS program increased eightfold, to IR 70 crores (US\$ 22.5 million). In addition, during 1990–1993, the National AIDS Program received US\$ 7.7 million from international organizations and official development agencies through WHO, and during 1992–1997, a loan of US\$ 85 million from the World Bank. However, the channeling of these resources to state programs is difficult: funds are slow to reach the states and, as a result, are under-spent.

The Indian Government is now moving with determination to catch up with an epidemic that threatens to run out of control. This recent response to HIV/AIDS has already stimulated more open debates on sexual behaviors and social issues that increase people's vulnerability to HIV infection and other STDs [16].

To a lesser extent, because of scarce internal resources and the complexities of international aid, Myanmar has repeated this pattern of denial to commitment [17]. Following a phase of several years (1987–1993) during which it documented a sharp increase in HIV in IDUs and sex workers (and starting in 1992, among women attending antenatal clinics), the government recently became more proactive against HIV/AIDS. It sought support from United Nations agencies for a multisectoral response to the pandemic, and has invited international NGOs and the few local NGOs to participate. Unfortunately, however—constrained by political isolation, competing domestic priorities, and weak infrastructure—Myanmar has yet to see results commensurate with its government's stated high priority for AIDS prevention.

Other countries in Asia seem to follow a similar trend. Indonesia is developing a national strategy that, involving the Ministry of Health and 15 other ministries, is expected to be moved to a specially designated coordinating ministry. In China, HIV/AIDS has been taken up at the State Council level, arising out of a United Nations Development Program (UNDP)/Ford Foundation-sponsored sub-regional seminar on the Social and Economic Impact of AIDS held in Kunming in 1992. Initially due in 1993 but still awaited, a new policy emphasizes the participation of all sectors in HIV/AIDS prevention. Vietnam has recognized its high vulnerability to HIV/AIDS. A draft strategic plan has responded to earlier criticism from NGOs in recognizing the special nature of HIV and in unlinking HIV preventive efforts from those applied to curb prostitution and injecting drug use [18].

High vulnerability and widening gap

Other countries in Asia have still not come to terms with the growing evidence of their vulnerability to large-scale HIV epidemics. In the second decade of the world's response to the pandemic, the commitment of their governments remains weak, if it exists at all. It is important to recognize that while many Asian countries are progressing towards a 21st century world economic order, their growing wealth is unevenly distributed. As a result, economic gaps between successful communities and others are deepening. This inequity intensifies the marginalization of certain communities that have long been subjected to discrimination for reasons of ethnicity, religion, or poverty. For example, in China and Vietnam, current moves towards a market economy are likely to create large internal economic disparities. In Cambodia and Sri Lanka, years of armed conflict have contributed to population displacements, and to economic survival strategies that exacerbate individual and collective vulnerability to HIV infection. In certain areas of Nepal and Laos, as in many other countries of the Asian subcontinent in which clusters of disadvantaged communities are forming, young women are easy targets for a booming sex trade, fueled by regional and international economic disparity [19,20]. In many countries, men seeking or carrying out work (truck drivers, construction workers, fishermen, sailors and the military) have become increasingly mobile, creating a concomitant demand for commercial sex. The relatively recent epidemic of injecting drug use, now that heroin is refined locally, has also contributed to the spread of HIV in the region.

At the same time, these governments may not have embraced the need to establish constructive dialogue with those who, because of economic imperatives or self-determined choice, have adopted behaviors placing them at higher than average risk of

acquiring HIV infection. In Bangladesh, Cambodia, Indonesia, Japan, South Korea, Malaysia, Pakistan, the Philippines and Vietnam, governments are documenting rising HIV prevalence in sex workers and their clients, and in patients attending STD clinics. In these countries, preventive efforts lag far behind and the gap between the pandemic and the response marshaled by governments is widening rapidly.

Insularity and a threatening pandemic on the horizon

Until now, small Pacific Island populations have been relatively untouched by the epidemic. In 1988, the governments of these countries/territories began to formulate AIDS prevention programs, through a series of workshops followed by GPA team site visits. A strategy of isolating HIV-infected people returning to the islands with HIV infection was contemplated (the geography of the area unavoidably triggered such temptations), but governments rejected this approach in favor of sound and well-considered prevention programs, as exemplified in the Kingdom of Tonga. Nevertheless, there is a risk of complacency because so few HIV/AIDS infections have so far been diagnosed in these island countries. This complacency, if combined with a sudden apparent increase in the HIV infection rate, could revive temptations to impose unduly restrictive and inappropriate measures. In 1993, courses conducted by GPA on the role of NGOs in HIV prevention and on counseling may have strengthened small island countries' ability to prepare for, and ultimately to cope with, future indigenous spread of HIV. The high rates of STDs found in several island countries is a testimony of the vulnerability of their population to the HIV pandemic [21]. High rates of STDs and dynamic spread of HIV have already been documented in Papua New Guinea [22].

Current government response

As of January 1994, all countries in the region have developed HIV/AIDS prevention plans and appointed AIDS advisory committees reporting, in most cases, to the ministry of health. They have, with varying degrees of extensiveness, established blood safety programs. In addition, they have launched information and education campaigns, some directed to the general public, and others to those most vulnerable to HIV/AIDS.

For the second volume of its publication *AIDS in the World*, the Harvard-based Global AIDS Policy Coalition conducted a worldwide survey of national AIDS programs up to and including 1993. The responses of heads of national AIDS programs to this survey, which addressed policy and program issues, are shown in Tables 1-5 of the Appendix.

Several governments in the region have embarked on HIV/AIDS programs that attempt to broaden the boundaries of national programs and foster collaboration among sectors other than health, including NGOs. The programs are increasing the national budget allocation to participating groups outside the ministries of health. In these programs, preventive strategies have been devised in accordance with GPA guidelines, in which the focus of action remains the ministry of health, with participation of other sectors [23]. A global strategy document developed by GPA reiterates the three objectives of the Global Strategy: (1) to prevent HIV transmission, (2) to alleviate the personal and social impact of HIV infection and AIDS, and (3) to mobilize and unify national and international efforts [24]. This document includes sub-objectives oriented towards specific prevention and care issues, but fails to articulate a strategy capable of minimizing social and economic factors that determine individual and collective vulnerability to HIV. However, the need for a coherent and credible AIDS strategy will be reconsidered in the joint co-sponsored United Nations program on HIV/AIDS, to be administered by WHO. This new initiative is intended to bring together six United Nations organizations: the United Nations Children's Fund (UNICEF), UNDP, the United Nations Educational, Scientific, and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the World Bank, and WHO. They will coordinate and expand AIDS-related activities in the health, social and economic sectors. Prevention approaches must nevertheless be adjusted and tactics varied to respond appropriately to the state of the pandemic and to population groups considered at higher risk in each country [25,26].

Although United Nations agencies are sustaining or expanding their aid to HIV/AIDS prevention and care efforts in the region, bilateral agencies and international NGOs are playing an increasing role in supporting governmental and non-governmental programs. To cite only a few examples: USAID, several international NGOs and the Australian International Development Assistance Bureau (AIDAB) support the Indonesian program; Save the Children Federation is active in Vietnam; international NGOs including CARE, several Red Cross societies and Save the Children Federation (with the support of UNDP) are working in Laos and Cambodia; Papua New Guinea receives support from the Government of Australia; USAID and the American Foundation for AIDS Research have ongoing programs in Nepal; and Thailand collaborates with an ever-increasing number of partners, including bilateral agencies, international NGOs, academic groups, and the European Commission. The growing diversity of sources of support to AIDS programs multiplies opportunities for action but, concomitantly, creates a risk of fragmentation of efforts.

Towards the future: building on strengths

Asia has the capability both to respond more effectively to the pandemic and to do so in new and innovative ways. This region has many strengths and enormous experience that can be built upon. At the same time, several specific issues must be addressed in order to generate a creative and effective response to the HIV pandemic. In so doing, the region can ensure that the largest proportion of the world's population is protected.

Power and responsibility of governments

Governments can make the difference between successful mobilization against HIV/AIDS and a devastating pandemic in this region, where the interdependence of government power and responsibility is clearly perceived. The response to HIV/AIDS surely lies in a government response that will have the power, dynamism and creativity of ongoing economic reforms in Asia. Most critical to the success of AIDS programs is the leadership that powerful ministries within the government machinery (ministries of planning, defense, finance) are committed to exercise. Previous attempts made in the health and social sectors to secure the participation of several ministries in concerted actions have often suffered from a declining level of efficiency as officers of lower echelons were mandated to represent their ministry on coordinating meetings. Learning from the leap forward achieved in Thailand once the national AIDS committee was placed under the direct chairmanship of the Prime Minister, governments should take similar steps to ensure that the representation of ministries on decision-making and coordinating bodies that oversee the national response to HIV/AIDS—a national cause of paramount importance—remains at the top executive level. Under the leadership of the government's highest executive, the government social and economic development board—or planning ministry, or its equivalent—must be responsible for the *formulation* of a truly multisectoral, interministerial, national plan. Collaborating with the private sector and NGOs, all ministries should have their own distinct *implementation* responsibility. Among them, the ministry of health should play a leading and coordinating role in order to ensure that all activities implemented under the national plan are sound and effective from a public-health perspective, that the national response to HIV/AIDS achieves the expected impact and that it accrues incremental benefits to the physical, mental and social well-being of the population. A critical issue in government revolves around budget allocation and accountability: mechanisms must be clearly set out to generate and channel governmental and international resources to ministries and other participating entities, in particular NGOs, with, in return, a commitment to full financial and operational ac-

countability. The creation of a peer group of political leaders in Asia, engaging actively in the advocacy of sound policy options in the region could play a useful role in this respect.

Strength of health services and past successful programs

Most countries in Asia have developed extensive health service networks. These networks have achieved high childhood immunization coverage; primary health care development; and, for at least some countries, effective population programs. The lessons learnt from these successes that can be applied to HIV/AIDS programs include the optimal balance between streamlined management and integration of services, enhancing staff skills and motivation, generating community interest and participation, and applying epidemiological surveillance to the monitoring and evaluation of health programs. Government STD programs are generally weak in the region, most STD diagnosis and care being provided by the private sector. The response to HIV (and other STDs) may well create an opportunity for re-examining the role that public and private sectors should play to achieve maximum impact.

Extensive information networks

Information networks in Asia are extensive, facilitated by generally high literacy rates and good coverage by radio and television networks. In many Asian countries, the media are under some form of government control, which could either limit the type of AIDS-related information disseminated to the public, or facilitate greatly the communication of effective preventive and anti-discriminatory messages. Training workshops on HIV/AIDS reporting have already been held for media professionals. The quality of reporting on the pandemic has generally improved, but several governments have not always sought, or been willing to accept, useful feedback and criticism carried by the media about HIV/AIDS policies or program content. Greater and more liberal use of the media as an open, two-way information channel would greatly benefit HIV/AIDS prevention efforts.

A wealth of NGOs

With the exception of few nations, such as China, Vietnam, Laos, Myanmar and Papua New Guinea, an abundance of NGOs existed in Asia and the Pacific long before HIV/AIDS began to spread in the region. Although NGOs have been at the forefront of the response to HIV/AIDS, this wealth remains largely untapped. The development of a productive partnership between governments and NGOs can build on the principles of clearly delineated responsibilities and mutual accountability within the framework of a national strategy for HIV/AIDS. There is a definite trend in this direction in many countries in the region. However, as the collaboration between gov-

ernments and NGOs progresses, there is a risk that the exclusive responsibility to attend to the needs of certain marginalized groups, such as sex workers, IDUs, homosexual men, exploited children, or disadvantaged communities, will be delegated exclusively to NGOs. This approach could threaten the capacity to help those who are most in need. It could also contribute to perpetuating the governmental complacency that continues to restrict the access of marginalized communities to government-provided or -supported services and programs. NGOs can contribute immensely to HIV/AIDS prevention and care in developing and testing innovative approaches and, once these have been shown to be effective, in advocating their adoption and replication by government programs [27]. The dual role of NGOs as innovators and advocates is central to the long-term sustainability of national efforts against the pandemic. Realizing the great contribution that NGOs can make to alter the course of the pandemic, governments should provide some of the resources they need to perform this important task.

Dynamism of economic development

The economies of several countries in the region have progressed considerably over the past decade. In addition to the many positive benefits of economic development, societal changes may contribute to increasing the vulnerability to HIV infection among some segments of the population. The pandemic may also jeopardize economic gains acquired through heavy investments of resources and human capital. Several studies have demonstrated the substantial long-term economic impacts of HIV/AIDS. Indeed, Thai studies of economic impact played an important role in motivating the government to greatly accelerate its prevention efforts [28].

The debate on social and economic impacts of the pandemic should stimulate more analytical work. This work should not only focus on the results of various scenarios, but also examine how social and economic factors may influence individual and collective vulnerability to HIV, and how that vulnerability can be reduced [29].

As the potential consequences of economic development on the environment are gaining importance in the process of deciding on new economic initiatives, the impact that such initiatives may have in reducing or enhancing people's vulnerability to HIV/AIDS should be systematically assessed. Decisions made at the project planning stage may influence considerably people's vulnerability to HIV. For example, encouraging worker migration to urban centers, generating high concentrations of employment opportunities reserved for men, and creating income disparity on the basis of sex will enhance people's vulnerability to HIV. In contrast, locating project sites in areas that have an available

labor force, enabling workers to reside by a project site together with their families, and offering equal employment opportunities and income to men and women will reduce their vulnerability to HIV.

Social strength

Asian societies have demonstrated both enormous resilience and tremendous capacity for change. In order to confront the diverse challenges of HIV/AIDS, both of these societal qualities will be needed. The powerful links that exist throughout Asia and the Pacific between individuals, their family and their community represent a large potential for community-based HIV/AIDS prevention and care. This potential may prove to be a major source of strength in combating the HIV pandemic as long as its realization avoids the two extremes of promoting unconsidered social transformations and resisting to change through rigid adherence to traditions that have become irrelevant.

Reducing individual and collective vulnerability to HIV/AIDS in Asia and the Pacific

The experience from over a decade of HIV preventive efforts from throughout the world, including North and South America, the Caribbean, Africa and Europe, must be critically evaluated so that lessons can be derived and applied most relevantly in Asia.

The concept of vulnerability can be a useful organizing principle for understanding why existing HIV/AIDS efforts have been only partly successful, and for design of more effective approaches. In this context, vulnerability to HIV has three dimensions: personal, programmatic and societal.

The goal of HIV prevention work is to support each person's ability to learn about HIV and to apply that knowledge and information meaningfully, fully and freely in their own lives.

Programmatic vulnerability occurs when necessary information, education, or health and social services are not made available. For example, if a population has not been provided with essential information about HIV, prevention at the personal level cannot really occur. Alternatively, if information about preventing HIV infection through condom use is not linked with availability of condoms (at reasonable cost and of good quality), then the education cannot achieve its goal. In this respect, lessons drawn from the difficult experience with HIV/AIDS in India, Thailand and Myanmar point to the compelling need for government HIV/AIDS programs throughout Asia and the Pacific to:

- (1) respond quickly to the HIV pandemic, mobilizing all sectors and all echelons of government;
- (2) recognize and collaborate with NGOs and the private sector;
- (3) involve most vulnerable groups, people with HIV and people with AIDS at every step of policy and program development and implementation;
- (4) recognize the realities of sexual and drug-using behaviors that are likely to be much more prevalent in the current economic climate in Asia, and provide the supportive social and legal environments that allow those at risk to access information, counseling, treatment (for STDs and for HIV-related illnesses) and means to adopt safer behavior (for example condoms and sterile injecting equipment);
- (5) extend information and education on sexuality, reproductive health and prevention of HIV and other STDs to young people in and out of school *before* they become sexually active.

If, worldwide, AIDS efforts to reduce vulnerability to HIV have so far largely focused on personal behaviors and on ensuring programmatic support, it has now become clear that the societal dimension may be at least as important, if not more important, than the programmatic dimension.

Societal vulnerability expresses the idea that certain individuals and groups are at greater risk of exposure to HIV as a result of the societal context. Societal vulnerability is directly linked with the scope, intensity and nature of discrimination, stigmatization and marginalization within each society. Societal discrimination occurs when individuals are treated only as members of a group (on the basis of, for example, low social and economic status, sex, ethnicity, religion, or sexual preference) and, on the basis of this group identification, people are denied equal services, opportunity, social support, rights, freedoms or measures of protection.

Therefore, reduction of personal and societal vulnerability to HIV infection, such as assurance of appropriate AIDS care, involves HIV/AIDS-specific programs, yet also invokes broader societal dimensions. It requires both a short-term and a long-term approach.

In the short term, vulnerability can be reduced by identifying the gaps in information/education, health and social services, or social support that create or enhance personal vulnerability to HIV. Then, it is essential to direct priority and resources towards filling these critical gaps. Also important is to ensure that existing and new HIV prevention and care programs are firmly anchored in what is already known and has been demonstrated to be effective, while

adapting these approaches to each specific societal context.

In the longer term (which means work beginning now but addressing more complex and therefore longer-term objectives), personal vulnerability can be reduced by defining personal factors/situations that increase vulnerability to HIV and helping people to recognize such factors/situations. Examples in Asia include the local rites of passage of initiation into sex, and lack of employment opportunities in rural areas combined with willing exploiters of rural poverty, such as brothel recruiters and opiate distributors.

Yet the major challenge for the medium and long term is to identify the forms of discrimination and other violations of human rights and dignity that can be directly linked with failures of HIV/AIDS prevention and care. Ultimately, the ability to succeed in HIV prevention will depend upon the extent to which societies in Asia and in the rest of the world confront these deep, pre-existing and underlying societal problems. The fundamental problem—that societal structure and action makes some people more vulnerable to HIV/AIDS—must be addressed directly, in light of social, cultural and religious values. Then, working with institutions and organizations concerned with social issues, including human rights, appropriate changes can be promoted. Examples of positive societal changes that also make important contributions to HIV/AIDS control include (1) increasing educational attainment for women, (2) removing racial/ethnic discrimination for employment or education, (3) increasing the participation of marginalized or stigmatized groups in decisions that affect them, and (4) ensuring access to the full range of health and social services for everybody.

HIV/AIDS prevention and care within a broad and modern perspective of health and society

HIV/AIDS work can only be successful, and must be implemented, in a manner that promotes a larger vision of health. Application of the WHO definition of health, involving physical, mental and social well-being, would dramatically reposition health as a central societal value [30]. HIV/AIDS work must contribute to a redefining and strengthening of the societal approach to health. Specifically, HIV/AIDS creates the obligation to raise the status and standards of existing health systems, rather than simply integrating HIV/AIDS prevention and care within inadequate health services.

This approach also calls for short-term and long-term actions. Short-term measures include redefin-

ing health issues and re-orienting health services on the basis of societal vulnerability and extending the analysis of individual and collective vulnerability to other health issues, such as cancer, injuries, cardiovascular and infectious diseases.

Long-term actions include developing health strategies that are closely linked to human and societal development goals, defining health as a human right, applying this definition to national and international policies and programs for human development, and ensuring that health is articulated as a central value in societal debate at the community, national and global levels.

In conclusion, it has become apparent that an HIV prevention strategy that fails to deal directly with the societal dimension cannot succeed. What is being done in most countries (in Asia and outside the region) to prevent HIV infection can be considered necessary, but in no way sufficient, to bring the epidemic under control.

Throughout Asia, it is likely that as the pandemic continues to spread, and as the enormous personal and societal burdens of the HIV epidemic become more evident, there will be a temptation to react out of fear. The costly mistakes made in other parts of the world risk being repeated in Asia.

The emergence of the HIV/AIDS pandemic in Asia offers a remarkable opportunity to draw upon the traditional strengths and the boundless energy, creativity and dynamism that characterizes the most populous region of the world.

The daunting difficulties ahead will command no less from Government leaders in the region than a bold re-examination of present social structures, values and practices in an attempt to define which of these can be acted upon to decrease vulnerability to the HIV pandemic and mitigate its impact.

To build effective programs based on a deep understanding of HIV/AIDS and society, and to harness societal energies to strengthen respect for human rights and dignity, is a challenge worthy of Asia. One can only hope that out of Asia will come new wisdom for a successful human resistance to HIV/AIDS, and for promotion of that state of physical, mental and social well-being that is the object of health and the goal of every society.

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Appendix

Tables 1-5 show the results of a worldwide survey of national AIDS programs up to and including 1993.

Table 1. AIDS policies and programs: response of governmental national AIDS programs (GNAP) in selected Asian and Pacific countries, 1993, as reported by government AIDS programs*.

	1	2	Content of national policy/program document						Participation of other groups/sectors in policy/program development						Needs assessment		Receipts of reports on human rights violations by GNAP					
			3a	3b	3c	3d	3e	3f	4a	4b	4c	4d	4e	4f	5a	5b	6a	6b	6c	6d	6e	6f
Large/medium-size countries																						
High-income economies																						
Australia	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Brunei	+	+	+	+	-	+	-	-	+	-	+	+	-	+	+	-	-	-	-	-	-	
Hong Kong	-	-	...	...	...	...	...	...	...	...	...	...	...	...	...	+	-	+	-	+	-	
Japan	+	+	+	+	+	+	+	-	+	+	+	...	...	+	+	-	-	+	-	-	+	
New Zealand	-	+	+	+	+	+	+	+	+	+	+	+	+	-	+	-	-	+	+	-	-	
Singapore	+	+	+	+	+	+	-	+	+	-	...	+	+	+	+	+	-	-	+	-	-	
Middle-income economies (upper-middle and lower-middle)																						
Malaysia	+	+	+	+	-	+	+	+	+	-	+	-	-	+	-	-	-	-	+	-	-	
Papua New Guinea	-	+	+	+	+	+	+	+	+	-	+	+	+	-	+	-	-	-	-	-	-	
Solomon Islands	+	+	+	+	-	+	-	+	+	-	+	+	-	-	-	-	-	-	-	-	-	
Thailand	+	+	+	+	+	...	+	+	+	+	+	+	+	-	+	-	+	+	+	-	-	
Low-income economies																						
Bhutan	-	-	...	...	...	...	...	...	...	...	...	...	...	...	...	...	-	-	-	-	-	
China	-	+	+	+	+	+	-	+	+	...	+	+	+	-	+	+	-	-	-	-	-	
India	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	-	+	+	-	-	
Nepal	+	+	+	+	+	+	+	+	-	-	-	-	-	-	-	-	-	-	-	-	-	
Sri Lanka	-	+	+	-	-	-	-	-	+	-	-	-	-	-	-	-	+	+	-	+	+	
Vietnam	+	+	+	+	+	+	+	+	+	+	+	+	...	...	+	+	-	-	-	-	-	
Pacific Island countries																						
Lower-middle-income economies																						
Cook Islands	+	+	+	+	+	+	-	-	+	-	+	+	-	-	+	+	-	-	-	-	-	
Fiji	+	+	+	+	+	+	+	+	+	-	-	+	+	-	-	-	-	-	-	-	-	
Kiribati	+	+	...	...	...	...	...	...	...	...	...	...	...	...	...	...	-	-	-	-	-	
Micronesia, Fed. Sts	+	+	+	+	+	+	+	+	+	-	+	+	+	+	+	-	-	-	-	-	-	
Niue	+	-	...	...	...	...	...	...	...	...	...	...	...	...	...	...	-	-	-	-	-	
Tokelau	+	-	...	...	...	...	...	...	...	...	...	...	...	...	...	...	-	+	+	+	+	
Tuvalu	+	+	...	...	...	...	...	...	...	...	...	...	...	...	...	...	-	-	-	-	-	
Vanuatu	+	+	+	+	+	+	-	+	+	+	+	+	+	+	+	+	-	-	-	-	-	
Western Samoa	+	+	+	+	+	+	+	+	+	-	+	+	+	+	+	+	-	-	-	-	-	
Upper-middle-income economies																						
American Samoa	+	+	+	-	-	+	-	-	+	-	+	+	+	+	+	+	-	-	-	-	-	
Guam	-	-	...	...	...	...	...	...	...	...	...	...	...	...	...	...	-	-	-	-	+	
New Caledonia	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	-	-	-	-	-	
Proportion of groups receiving training (%)																						
Major problems encountered by GNAP																						
Decentralization																						
Impact of GNAP on other health programs																						
	7	8a	8b	8c	8d	9a	9b	9c	9d	9e	9f	9g	9h	9i	9j	9k	10a	10b	11a	11b	11c	11d
Large/medium-size countries																						
High-income economies																						
Australia	+	...	...	...	...	O	...	L	L	O	O	L	L	L	L	O	all	half+	-	+	+	+
Brunei	...	...	...	...	...	O	...	O	O	O	O	L	L	L	O	O	...	...	-	-	-	-
Hong Kong	-	...	...	...	...	L	...	M	L	O	L	M	L	M	L	L	...	...	-	-	-	+
Japan	+	100	10	100	3	L	O	L	L	O	L	L	M	M	L	M	all	half+	-	+	+	-
New Zealand	-	...	...	...	...	L	O	O	O	O	L	O	L	L	L	L	none	none	-	+	+	+
Singapore	+	100	15	...	...	O	O	O	O	O	O	O	O	L	O	O	all	...	+	+	+	+
Middle-income economies (upper-middle and lower-middle)																						
Malaysia	+	95	60	95	70	O	O	O	L	L	O	O	O	O	O	L	few	few	+	-	+	+
Papua New Guinea	+	98	10	20	20	M	L	L	L	L	L	O	O	O	O	L	few	...	-	-	-	-
Solomon Islands	-	...	...	...	...	...	L	L	M	M	M	L	L	L	O	...	none	none	-	+	-	+
Thailand	+	...	...	...	...	L	L	O	...	L	O	L	L	L	L	H	all	all	-	-	+	+
Low-income economies																						
Bhutan	-	...	...	...	...	L	L	O	L	L	O	O	L	O	O	L	none	half+	-	+	-	+
China	+	100	50	60	50	M	M	L	O	M	O	L	...	M	...	...	half+	few	-	+	+	+
India	+	90	50	50	20	H	O	O	L	L	L	L	M	M	O	M	all	...	-	-	+	+
Nepal	+	60	5	10	10	M	M	L	M	M	O	L	M	M	M	L	...	few	-	+	-	+
Sri Lanka	+	70	0	70	0	M	M	L	M	L	L	L	L	L	O	L	half+	half+	-	-	+	+
Vietnam	+	100	100	100	100	O	M	O	L	M	O	O	O	O	O	M	all	few	+	+	-	+
Pacific Island countries																						
Lower-middle-income economies																						
Cook Islands	+	50	50	75	60	H	L	L	L	L	O	O	O	O	O	H	all	all	+	+	-	+
Fiji	+	100	25	100	50	M	M	L	M	L	L	M	L	L	O	M	none	none	-	+	-	+
Kiribati	+	25	0	0	0	H	M	L	O	M	M	L	O	L	L	O	...	...	-	-	-	-
Micronesia, Fed. Sts	+	100	60	100	45	M	L	M	M	M	L	O	O	L	O	M	all	...	+	+	+	+
Niue	-	...	...	...	...	O	O	O	O	O	O	O	O	O	O	...	all	all	-	-	-	-
Tokelau	+	90	50	50	90	M	H	L	L	H	L	O	O	L	M	O	all	all	-	-	-	-
Tuvalu	+	...	...	...	...	O	O	H	M	O	O	O	O	O	O	O	all	...	-	-	-	-
Vanuatu	-	...	...	...	...	M	L	M	H	O	O	L	L	L	L	...	none	none	+	+	+	+
Western Samoa	+	60	15	5	20	M	M	M	M	L	M	L	L	L	M	L	none	none	-	-	-	+
Upper-middle-income economies																						
American Samoa	-	...	...	...	...	O	O	L	L	L	L	O	L	L	L	L	all	half+	+	+	+	+
Guam	+	100	10	...	10	M	H	H	H	H	O	M	M	H	H	H	half+	...	+	+	+	+
New Caledonia	+	80	10	20	20	L	L	L	M	L	M	M	L	L	L	L	all	all	-	-	-	+

Table 1. Footnotes.

- 1 Top governmental authority has made a public address to the nation on the topic of HIV/AIDS
- 2 A document exists outlining the government's current policy and program on HIV/AIDS
- 3 The document includes the following:
 - 3a Statement of national policies on HIV/AIDS
 - 3b Description of strategic approaches for the health sector
 - 3c Description of strategic approaches for the health and other sectors, such as the ministries of development, education and justice
 - 3d Description of specific activities for the health and other sectors
 - 3e Proposed budget for central/federal expenditures on HIV/AIDS
 - 3f Evaluation plan for governmental activities
- 4 Consultations/discussions with the following groups in the development of the document:
 - 4a Professionals in the health sector
 - 4b People with HIV/AIDS
 - 4c State or regional (provincial or district) authorities
 - 4d Other agencies (i.e. private foundations, research institutions)
 - 4e Other government departments/ministries
 - 4f The parliament
- 5 Surveys conducted in the development of the document:
 - 5a Needs assessment surveys for prevention
 - 5b Needs assessment surveys for care
- 6 Issues for which the GNAP received reports of allegations of human rights violations:
 - 6a Mandatory or compulsory HIV testing
 - 6b Violation of confidentiality of HIV status
 - 6c Discrimination in the workplace against HIV-infected people
 - 6d Restriction of housing rights to HIV-infected people
 - 6e Discrimination against children/young people with HIV infection in the educational system
 - 6f Restrictions of health service entitlements to people with HIV infection
- 7 GNAP conducted targeted training on how to manage HIV/AIDS programs
- 8 Proportion of the following groups having received such training:
 - 8a GNAP managers
 - 8b Managers of other governmental programs/departments
 - 8c Region/province district managers
 - 8d Non-governmental organization managers
- 9 Problems faced by the GNAP in implementing programs and providing services in 1993 (opinion requested):
(O, not a problem; L, minor problem; M, major problem; H, very severe problem)
 - 9a Governmental financial support
 - 9b International financial support
 - 9c Political support
 - 9d Personnel issues (i.e. burnout, staff turnover, recruitment)
 - 9e Supplies (i.e. HIV testing kits, condoms, educational materials)
 - 9f Internal coordination within the GNAP
 - 9g Coordination with other government programs/departments
 - 9h Coordination with non-governmental organizations
 - 9i Public/social support and/or opinion
 - 9j Media coverage
 - 9k Capacity of government to provide care for the number of people with HIV or AIDS
- 10 Programs on HIV/AIDS have been developed by:
 - 10a Individual states, regions or provinces
 - 10b Individual districts, counties, prefectures within the states, regions or provinces
- 11 Mobilization against AIDS has affected other health initiatives, such as the following health programs:
 - 11a Maternal and Child Health
 - 11b Family Planning
 - 11c Tuberculosis
 - 11d Sexually transmitted diseases.

*Survey conducted for *AIDS in the World*. Source: Jonathan Mann, Daniel Tarantola, editors, *AIDS in the World*, vol II, Oxford University Press: forthcoming, 1995. Countries have been divided into economies following the structure used by the International Bank for Reconstruction and Development as published in *The World Bank Atlas, 1994*.

Table 2. Responses by governmental national AIDS programs (GNAP) to prevention needs in selected Asian and Pacific countries, 1993, as reported by government AIDS programs*.

	Predominant HIV transmission mode					Government-allowed condom distribution sites											7	8
	1a	1b	1c	1d	1e	2	3	4	5	6a	6b	6c	6d	6e	6f			
Large/medium-size countries																		
High-income countries																		
Australia	1	...	2	...	...	+	-	...	...	+	+	+	+	+	+	E	H	
Brunei	2	1	...	...	...	-	-	...	...	...	...	...	...	...	...	E	H	
Hong Kong	2	1	...	...	...	+	+	M	...	+	+	-	-	+	+	E	H	
Japan	...	2	...	1	...	-	...	...	...	+	-	+	+	+	+	E	H	
New Zealand	1	2	...	...	...	-	-	...	...	+	+	+	+	+	+	E	H	
Singapore	2	1	...	...	...	+	...	...	...	+	+	-	+	+	-	E	H	
Taiwan	2	1	...	...	...	...	...	...	...	...	...	...	...	...	...	E	...	
Middle-income economies																		
(upper-middle and lower-middle)																		
Malaysia	...	2	1	...	...	+	-	...	...	+	+	-	+	+	-	E	L	
Papua New Guinea	...	1	...	...	2	+	+	L	...	+	+	-	+	+	-	U	L	
Solomon Islands	...	...	...	...	...	+	-	...	...	...	...	...	...	...	...	U	...	
Thailand	...	1	2	...	...	+	+	M	4.5	+	+	...	+	+	+	E	LM	
Low-income economies																		
Bhutan	...	1	...	...	...	-	+	M	15	+	+	+	+	+	...	U	LM	
China	...	2	2	...	...	+	-	...	...	+	...	...	...	+	...	E	L	
India	...	1	2	...	...	+	-	...	...	...	...	...	...	...	...	E	L	
Nepal	...	1	2	...	...	-	+	M	...	+	+	-	-	+	-	U	...	
Sri Lanka	2	1	...	...	...	+	+	...	...	+	+	...	+	+	...	U	L	
Vietnam	...	2	1	...	...	+	+	M	10	+	+	...	...	+	...	E	LM	
Pacific Island countries																		
Lower-middle-income economies																		
Cook Islands	...	...	...	...	...	-	+	M	10	+	-	-	-	+	-	U	HM	
Fiji	2	1	...	...	...	-	-	...	...	+	-	-	-	+	-	E	HM	
Kiribati	...	1	...	...	...	+	+	M	...	+	+	-	+	+	+	U	L	
Micronesia, Fed. Sts	...	...	...	...	...	-	+	M	2	+	+	+	+	+	...	U	LM	
Niue	...	...	...	...	...	-	+	M	...	+	-	-	+	-	-	E	L	
Tokelau	...	...	...	...	...	-	-	...	...	+	-	-	-	-	-	O	...	
Tuvalu	2	1	...	...	...	-	+	...	...	+	+	-	-	+	-	U	L	
Vanuatu	...	...	...	...	...	+	+	...	...	+	+	+	+	+	+	U	L	
Western Samoa	...	...	...	...	...	-	+	M	2	+	+	-	-	+	-	U	H	
Upper-middle-income economies																		
American Samoa	...	...	...	...	...	-	+	M	2	+	+	...	...	...	...	E	LM	
Guam	1	2	...	...	...	+	+	M	2	+	+	+	...	+	-	E	H	
New Caledonia	2	1	...	...	...	-	+	M	2-3	+	+	-	+	+	+	E	H	

1 The first (1) and second (2) most prevalent transmission modes in the country in 1993

1a Homo/bisexual

1b Heterosexual

1c Injection drug use

1d Transfusion/receipt of blood products

1e Prenatal (mother-to-child)

2 One or more sexual behavior surveys (also called sex surveys) have been carried out in the country since 1 January 1990

3 The GNAP distributed condoms to regional/district/local programs in 1992

4 The GNAP distributed more (M) or fewer (L) condoms in 1992 than in 1990

5 Condoms distributed: number of times more in 1992 than in 1990

6 The federal/central government allowed the distribution of condoms in the following sites/facilities in 1992:

6a Sexually transmitted disease clinics or other health clinics

6b Hotels, bars or brothels

6c High schools or colleges

6d Department stores

6e Pharmacies/drug stores

6f Public places (i.e. bathrooms, bus stations)

7 Where voluntary HIV testing is now offered

(E, everywhere in the country; U, only in the capital city or other large cities; O, nowhere in the country)

8 Estimated proportion of people receiving voluntary HIV testing who also receive counseling in the country

(L, 0-25%; LM, 26-50%; HM, 51-75%; H, 76-100%)

*Survey conducted for *AIDS in the World*. Source: Jonathan Mann, Daniel Tarantola, editors, *AIDS in the World*, vol II, Oxford University Press: forthcoming, 1995. Countries have been divided into economies following the structure used by the International Bank for Reconstruction and Development as published in *The World Bank Atlas*, 1994.

Table 3. Participation of sectors other than health in national prevention activities in selected Asian and Pacific countries, 1993, as reported by government AIDS programs*.

	Other government sectors with AIDS programs								Primary responsibility for HIV/AIDS programs				
	1	2	3	4	5a	5b	5c	5d	6a	6b	6c	6d	6e
Large/medium-size countries													
High-income economies													
Australia	+	11	4	...	...	+	+	...	P	P	P	P	P
Brunei	+	7	0	0	-	+	-	na	P	P	P	P	P
Hong Kong	+	20	9	7	-	-	-	-	P	P	P	P	P
Japan	+	14	4	4	na	+	+	na	S	S	S	S	S
New Zealand	+	...	...	...	na	-	+	-	P	P	P	P	P
Singapore	+	18	4	7	+	+	+	na	P	P	P	S	P
Middle-income economies													
(upper-middle and lower-middle)													
Malaysia	+	15	5	2	...	+	+	+	PS	P	P	PS	P
Papua New Guinea	+	17	3	3	na	+	+	+	PS	S	PS	PS	...
Solomon Islands	+	10	4	4	-	-	-	-	P	P	P	P	P
Thailand	+	39	3	6	+	+	+	na	S	S	P	S	P
Low-income economies													
Bhutan	+	16	2	1	-	-	-	na	P	P	P	P	P
China	+	36	9	...	...	...	+	+	P	P	P	S	P
India	+	7	0	3	+	+	+	+	P	P	P	P	P
Nepal	+	15	2	2	+	+	+	na	S	...	...	...	...
Sri Lanka	+	19	...	2	+	+	+	+	P	P	P	P	P
Vietnam	+	16	4	4	+	+	+	+	S	P	S	S	S
Pacific Island countries													
Lower-middle-income economies													
Cook Islands	+	6	3	1	...	...	+	...	S	P	P	P	P
Fiji	+	16	4	3	-	-	+	-	P	P	P	P	P
Kiribati	+	16	3	7	...	...	+	+	P	P	...	PS	P
Micronesia, Fed. Sts	+	12	4	3	-	na	+	+	P	S	S	S	S
Niue	+	7	4	4	-	-	+	-	P	P	P	P	P
Tokelau	+	9	5	12	na	na	+	+	P	P	P	P	P
Tuvalu	+	10	3	4	-	-	-	-	P	P	P	P	P
Vanuatu	+	10	4	4	-	-	+	+	S	P	...	S	P
Western Samoa	+	14	4	5	-	-	-	-	P	P	P	P	P
Upper-middle-income economies													
American Samoa	+	25	12	10	na	na	+	+	S	S	P	S	S
Guam	+	8	6	3	-	+	+	-	P	P	P	P	P
New Caledonia	+	16	5	1	-	-	+	-	P	P	P	P	P

1 National AIDS Advisory Committee or a similar body created in the country

2 Number of members (total) serving on the National AIDS Advisory Committee

3 Number of women members serving on the National AIDS Advisory Committee

4 Number of members of the National AIDS Advisory Committee representing non-governmental organizations

5 Ministries other than the Ministry of Health that have developed their own AIDS programs:

5a Planning/Economic Development or Tourism

5b Internal/Home Affairs or Defense

5c Education or Youth

5d Family Affairs or Women's Affairs

6 Areas in which HIV/AIDS activities have been primarily the responsibility of the governmental national AIDS programs (P) or have been shared among other ministries (S):

6a Planning HIV/AIDS activities

6b Managing HIV/AIDS activities

6c Financing HIV/AIDS activities

6d Implementing HIV/AIDS activities

6e Evaluating HIV/AIDS activities

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Table 4. Evaluation of governmental national AIDS programs (GNAP) in selected Asian and Pacific countries, 1993, as reported by government AIDS programs*.

	Policy change resulting from evaluation									
	1a	1b	2	3a	3b	3c	3d	3e	3f	3g
Large/medium-size countries										
High-income economies										
Australia	+	+	1986	m	m	m	m	M	M	M
Brunei	-	-		...	...	...	...	...	...	...
Hong Kong	-	-		...	...	...	...	...	...	...
Japan	...	...		...	...	...	...	...	...	...
New Zealand	-	+	1986	O	O	O	O	O	O	O
Singapore	+	+		O	m	m	O	m	O	M
Taiwan	...	...		...	...	...	...	...	...	...
Middle-income economies										
(upper-middle and lower-middle)										
Malaysia	+	+	1985	...	M	M	...	M	...	...
Papua New Guinea	+	+	1992	O	O	O	O	m	O	m
Solomon Islands	+	+	1989	O	O	m	...	m	O	O
Thailand	+	+	1987	M	M	m	M	M	m	M
Low-income economies										
Bhutan	+	...	1993	O	O	O	O	O	O	O
China	+	+	1993	m	m	...	...	M	...	m
India	+	+	1992	O	O	O	O	O	O	O
Nepal	...	...		...	...	...	...	...	...	...
Sri Lanka	+	-		...	...	...	...	...	...	...
Vietnam	+	+	1991	...	...	...	...	...	...	...
Pacific Island countries										
Lower-middle-income economies										
Cook Islands	-	-		...	...	...	...	...	...	...
Fiji	+	+	1993	O	M	m	m	M	M	m
Kiribati	+	-	1993	m	O	m	...	...	...	...
Micronesia, Fed. Sts	+	+	1988	M	M	O	M	M	O	O
Niue	-	-		...	...	...	...	...	...	...
Tokelau	-	-		...	...	...	...	...	...	...
Tuvalu	+	+	1993	...	...	...	...	...	...	...
Vanuatu	+	+	1990	...	...	...	...	...	...	...
Western Samoa	+	-	1992	O	O	O	...	m	...	m
Upper-middle-income economies										
American Samoa	-	-	1990	m	m	M	m	M	M	m
Guam	+	+	1989	O	O	M	O	M	O	O
New Caledonia	-	-		...	...	...	...	...	...	...

1 The GNAP has:

1a Evaluated its own HIV/AIDS programs/projects

1b Evaluated the groups which it funds or required that these groups evaluate their own work

2 The year in which HIV/AIDS program evaluation for the GNAP and/or the programs/groups it funds began

3 Indicates significant change in policy resulting from an evaluation of the GNAP and/or one of the organizations which it funds

(M, major change; m, minor change; O, no change):

3a Change in program strategies

3b Reformulation of the national HIV/AIDS plan

3c Personnel changes

3d Redirection of a specific needed service

3e Change of a certain project focus

3f Ending a program component

3g Beginning a new program component

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Table 5. Expenditures (US\$) on AIDS by governmental national AIDS programs (GNAP) in selected Asian and Pacific countries, 1 fiscal year circa 1993, as reported by government AIDS programs*.

	Spending		Management (%)	Prevention (%)	Laboratory and care (%)	Support for other organizations (%)	Research (%)
	Total	Per capita					
Large/medium-size countries							
High-income economies							
Japan	98 398 000	0.79	0 (0)	32 471 000 (33)	19 680 000 (20)	0 (0)	46 247 000 (47)
Australia	62 658 000	3.52	3 759 000 (6)	8 772 000 (14)	38 848 000 (62)	3 759 000 (6)	7 519 000 (12)
New Zealand	2 492 000	0.72	...	...	...	...	...
Middle-income economies (upper-middle and lower-middle)							
Malaysia	8 889 000	0.47	711 000 (8)	1 778 000 (20)	5 867 000 (66)	89 000 (1)	444 000 (5)
Thailand	56 000 000	0.97	1 120 000 (2)	8 400 000 (15)	43 120 000 (77)	2 240 000 (4)	1 120 000 (2)
Low-income economies							
India	20 266 000	0.02	...	...	...	...	...
Nepal	354 000	0.02	46 000 (13)	142 000 (40)	106 000 (30)	53 000 (15)	7000 (2)
Bhutan	246 000	0.16	41 000 (17)	145 000 (59)	53 000 (22)	7000 (3)	0 (0)
Pacific Island countries							
Upper-middle-income economies							
Guam	170 000	1.10	136 000 (80)	8500 (5)	25 500 (15)	0 (0)	0 (0)
Lower-middle-income economies							
Fiji	54 000	0.07	7000 (13)	31 000 (57)	13 000 (24)	3000 (6)	0 (0)
Western Samoa	375 000	2.30	94 000 (25)	131 000 (35)	113 000 (30)	19 000 (5)	19 000 (5)
Vanuatu	71 000	0.45	11 000 (15)	57 000 (80)	4000 (5)	0 (0)	0 (0)
Micronesia, Fed. Sts	58 000	0.52	9000 (15)	29 000 (50)	12 000 (20)	9000 (15)	0 (0)
Kiribati	12 000	0.15	2000 (17)	3000 (28)	3000 (28)	3000 (22)	< 1000 (6)
Cook Islands	30 000	1.74	6000 (20)	12 000 (40)	9000 (30)	3000 (10)	0 (0)
Tuvalu	2000	0.20	< 1000 (20)	1000 (60)	< 1000 (10)	0 (0)	< 1000 (10)
Niue	3000	1.50	3000 (85)	< 1000 (10)	< 1000 (5)	0 (0)	0 (0)

*Survey conducted for *AIDS in the World*. Source: Jonathan Mann, Daniel Tarantola, editors, *AIDS in the World*, vol II, Oxford University Press: forthcoming, 1995. Countries have been divided into economies following the structure used by the International Bank for Reconstruction and Development as published in *The World Bank Atlas, 1994*. Figures may not add up in every row because of rounding-off to the nearest thousand above 1000.

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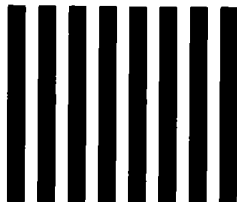
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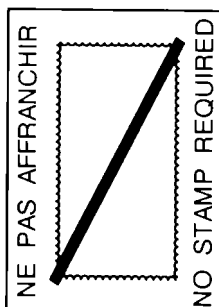
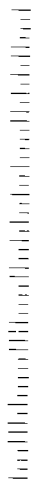


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FACT SHEET: ASIANS AND PACIFIC ISLANDERS AND HIV/AIDS

Asian and Pacific Islander community-based organizations provide HIV prevention and services to Asian and Pacific Islander communities in HI, WA, CA, CO, MN, IL, TX, GA, NY, MA, PA, VA, Washington, D.C. and Guam

ASIAN AND PACIFIC ISLANDER HIV/AIDS DATA

- Nationally, as of June 1998, Asians and Pacific Islanders are approximately 1% of the reported AIDS cases (CDC, 1998); some areas report higher rates (e.g. 27% of reported AIDS cases in Hawai'i, 1998)
- Among the cumulative reported Asian and Pacific Islander male AIDS cases nationally, 74% are among men who have sex with men (CDC, 1998)
- Among the cumulative reported Asian and Pacific Islander female AIDS cases nationally, about half are due to heterosexual contact but 18% do not have a risk identified (the highest percentage of unidentified risk among all racial/ethnic populations) (CDC, 1998)
- Studies have reported HIV seroprevalence rates as high as 27% for Asian and Pacific Islander gay men in San Francisco and Orange County, California (Osmond et al, 1994; Gellert et al, 1994)
- Many state and local health departments still report Asian and Pacific Islander HIV/AIDS data in an "other" category; the CDC itself only stopped using the "other" category for Asian and Pacific Islander AIDS data in 1988
- Very few state and local health departments follow OMB Directive No. 15 and CDC/Council of State and Territorial Epidemiologists guidelines and report HIV/AIDS data disaggregated by Asian and Pacific Islander ethnicities/national origins; when such disaggregated data is available, there are regional differences among which Asian and Pacific Islander ethnicities/national origins have the highest number or percentages of reported cases

HIV PREVENTION FOR ASIANS AND PACIFIC ISLANDERS

The CDC is currently directly funding Asian and Pacific Islander community-based organizations in HI, CA, PA, NY and MA to conduct HIV prevention (CDC Program Announcement 704); other organizations are funded through their state or local health departments

- HIV prevention efforts must take into consideration the rapid population growth (a national increase of 95% from 1980 to 1990) and the diversity of languages and cultures among Asians and Pacific Islanders
- Since 1994, the CDC has required state and local health departments to implement a community planning process for HIV prevention that includes a comprehensive epidemiological profile and community needs assessment; however, many epidemiological profiles or needs assessments fail to include data about Asians and Pacific Islanders (Bau, 1998)
- Asians and Pacific Islanders continue to be underrepresented in the HIV prevention community planning process; in many community planning groups, there are no or only one Asian and Pacific Islander member; Asians and Pacific Islanders are prioritized for HIV prevention only in the six U.S.-affiliated Pacific jurisdictions and Hawai'i (Bau, 1998)
- A national review of HIV prevention materials available in Asian and Pacific Islander languages found significant gaps in the materials available, outdated materials and errors in translation (*API HIV Forum*, 1997); the only material ever translated into Asian and Pacific Islander languages by the CDC for national distribution was the Surgeon General's brochure "Understanding AIDS" sent to every household in 1988
- Few health departments provide HIV prevention information in Asian and Pacific Islander languages; some health departments with significant Asian and Pacific Islander populations do not provide HIV test counseling in Asian and Pacific Islander languages (APIAHF, 1998)

- Although many HIV prevention programs for Asians and Pacific Islanders focus on gay men or youth, few of these programs have been evaluated; even less is known about HIV risk and effective programs for other Asians and Pacific Islanders at risk for HIV, including women, drug users, transgender persons, commercial sex workers and the incarcerated
- Current HIV prevention science, based primarily on theoretical models of individual knowledge and behavior change, may not be culturally appropriate for Asians and Pacific Islanders (Choi, Yep and Kumekawa, 1998)
- Individuals with HIV are excludable from the U.S. under immigration laws (unless a waiver is granted); many Asian and Pacific Islander immigrants are deterred from seeking information about their HIV status or accessing HIV prevention programs because of concerns about their immigration status
- Although there have been few HIV and AIDS cases reported in the six U.S.-affiliated Pacific jurisdictions, rapid population growth, high teen pregnancy and STD rates and increased mobility, immigration and tourism all point to a potential epidemic; HIV prevention is critical for the region's health

The Asian and Pacific Islander American Health Forum in San Francisco is the only organization funded as a National/Regional Minority Organization (NRMO) to provide technical assistance and training (TAT) to community-based organizations and health departments targeting Asians and Pacific Islanders with HIV prevention programs

HEALTH SERVICES FOR ASIANS AND PACIFIC ISLANDERS LIVING WITH HIV

Only Asian and Pacific Islander community-based organizations in HI, WA, CA, PA and NY currently receive government funding to provide services for Asians and Pacific Islanders living with HIV

- Each year between 1984-1994, a higher proportion of Asians and Pacific Islanders with AIDS were diagnosed with *pneumocystis carinii* pneumonia (PCP) as the presenting opportunistic infection compared with all other racial/ethnic populations, despite an overall decrease in the incidence of PCP during that decade (Eckholdt and Chin, 1997)
- Despite the complexities of current treatment options for persons living with HIV, no information about HIV-related treatment and medication currently is available in Asian and Pacific Islander languages
- Despite repeated requests, the Agency for Health Care Policy and Research (AHCPR) declined to oversample for Asians and Pacific Islanders in its Health Care Services Utilization Study (HCSUS); as a result, this national study will provide no useable data about the needs of Asians and Pacific Islanders living with HIV
- The Health Resources and Services Administration (HRSA) is currently funding the Asian and Pacific Islander Coalition on HIV/AIDS in New York to evaluate the effectiveness of multilingual/multicultural case management services for Asians and Pacific Islanders living with HIV
- HRSA also is funding the Asian and Pacific Islander Wellness Center in San Francisco to develop a manual for health services providers who provide care to Asians and Pacific Islanders living with HIV; there is no additional funding for disseminating or training providers to use the manual
- The 1996 welfare and immigration laws restricted the eligibility of legal immigrants for many health and social services; these legal barriers limit the accessibility of health services for Asians and Pacific Islanders living with HIV

**Complete references available upon request.
Updated January 1999**