

The
Approaching
Storm
HIV/AIDS
in Asia



Special Report

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The Approaching Storm

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HIV/AIDS in Asia

Don Brandt, principal writer



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Abbreviations and Acronyms

ACET	AIDS Care, Educational Training
AIDS	Acquired Immune Deficiency Syndrome
AZT	Ziduvodine
BCC	behavioural change communication
BCI	behaviour change intervention
CDV	community development volunteer
CHW	community health worker
CSW	commercial sex worker
FXB	Francois-Xavier Bagnould Center
GDP	gross domestic product
GP	general practitioner (doctor)
HAART	highly active therapy
HIV	Human Immunodeficiency Virus
IAPAC	International Association of Physicians in AIDS Care
IDU	injecting drug user
IEC	information, education and communication
ILO	International Labour Organisation
<i>JAMA</i>	<i>Journal of the American Medical Association</i>
KAPCCP	first HIV project begun by WV Myanmar
MOPH	Ministry of Public Health
NGO	non-governmental organisation
PLWA	people living with AIDS
STD	sexually transmitted disease
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
WV	World Vision

Executive Summary

Incidences

HIV/AIDS is a pandemic disease for which there is no cure. The virus can rapidly mutate, thereby defeating efforts to produce effective vaccines. People with HIV/AIDS depend on drug therapies to slow the progress of the virus and control opportunistic infections. Yet for most people in developing countries these AIDS “cocktails” are not affordable.

The HIV/AIDS pandemic is truly frightening. Last year 5.6 million of the world’s people became infected with HIV. About 620,000 were children less than 15 years old. In 1999 an estimated 34.3 million people were infected with HIV or developed AIDS; 1.3 million were children under 15. HIV/AIDS is predominantly a Southern disease. The less developed countries and the transitional economies are home to 90 percent of people living with HIV/AIDS.

Countries in the industrial world finally have recognised that HIV/AIDS is a catastrophe of major proportions in much of Africa. What has not registered with most governments and many international agencies is that Asia is the next disaster in waiting. Although the adult prevalence rates are highest in Africa, Asia now accounts for about half the number of new HIV infections each year. Last year 900,000 people in the Asia-Pacific region were infected with the disease and 490,000 died from AIDS (UNAIDS 2001).¹ In 1999 the 7–8 million Asian people with HIV/AIDS constituted over 20 percent of the world’s population with the disease.

Asia’s overall fortunate position as a “nascent” region may have lulled many countries into complacency. Now is the time to confine the disease through preventative programmes that target high-risk populations. Depending on the country, these tend to be injecting drug users (IDUs), mobile groups and commercial sex workers (CSWs). Spread of the disease to male patrons may proceed rapidly due to the high number of clients served per CSW and the low use of condoms in most societies. The “nascent” stage becomes “concentrated” when the disease is spread to spouses or other sex partners, as it has in Cambodia, Myanmar, Thailand, Vietnam and northeastern and western India.

Impact

HIV/AIDS has taken its toll at the individual and household levels in many areas. The rural poor are especially affected. Families must reallocate resources and sell assets to pay for medical care or to compensate for the loss of a working-age adult. People eat less as resources shrink or to help provide for relatives with HIV/AIDS. Children are forced to quit school as families can no longer afford fees and books. Boys are put to work outside the home. Girls become care-givers to ailing relatives.

¹ This number for 2000 may be low. Other sources cited over 1.3 million new cases in 1999.

The overall macroeconomic effect of HIV/AIDS in Asia will be significant but relatively small in the near term, assuming that the prevalence rates do not jump in the future. By 2005 direct cumulative health-related costs will be in the US\$32 to 52 billion range, and this doesn't include losses due to labour shortages. In Thailand alone, lost revenue will be US\$11 billion. In 2000, due to the HIV/AIDS virus, Thailand saw a 9 percent reduction in GDP (gross domestic product). Other Asian countries incurred 5 percent to 7 percent GDP losses due to the disease.

Prevention and Treatment

Across Asia there is a low awareness of what HIV/AIDS is and how it spreads. Most often the focus is on symptoms or illness caused by HIV/AIDS rather than the disease itself. This may be due to the stigma that HIV/AIDS casts across many Asian cultures.

HIV-prevention programmes on the national level vary enormously in Asia. Cambodia, Hong Kong, Malaysia, Singapore, Sri Lanka, Thailand and Vietnam have well-established programmes. HIV prevention in India gets a mixed review. Bangladesh, Nepal and Pakistan have new programmes whose effectiveness has already been called into question.

Most HIV/AIDS drug therapies will offer little help in the next few years. Even with the promised 70–80 percent price reduction by pharmaceutical firms in some countries for anti-retroviral drugs, they will still be too expensive for the rural poor. Broader-based cost reductions are possible if Asian companies are permitted to manufacture generic drugs. Unless subsidised, most people will find the cost of these drugs and necessary monitoring systems unaffordable. Perhaps the best that the poor can expect is palliative treatments.

Issues for Consideration

HIV/AIDS in Asia is a global concern. The continent is home to 60 percent of the world's people. A tiny increase in the HIV prevalence rate translates into thousands of infected people. For example, UNAIDS reports that a 0.1 percent rate increase in India means 500,000 more people with HIV. Those concerned about human development in Asia face a diverse and complex set of challenges. Non-governmental organisations (NGOs) will find a number of important niches to address these problems. They will be expected to help find new ways to reduce the incidence and redress the impact of the disease.

1. *More can be done to save the lives of children.* Governments and NGOs should press drug companies to cut drastically the price or to permit the sale of generic AZT (Zidovudine), Nevirapine and other nucleoside inhibitors. These therapies can reduce the transfer of HIV from infected mothers to their babies. Currently, the "bare bones" prenatal AZT treatment costs about US\$100. The newer Nevirapine is reported to be as effective but with a dramatically lower price of US\$4.
2. *More action will be needed to help AIDS orphans.* There may be over half a million AIDS orphans by the end of 2001 in Asia. This number will steadily increase even if the HIV prevalence rate remains the same as parents die of AIDS. It is more likely that the prevalence rate will grow rapidly in this decade, creating conditions where extended families can no longer provide adequate care for orphaned relatives.

3. *Children may be the real losers.* Care for people with HIV/AIDS quickly depletes the assets of the rural poor, who are the majority of people in Asia. Children are taken out of school to help support their families. The position of girls, particularly, becomes increasingly precarious. Already the “poorest of the poor,” without an education the few options open to girls are closed. As a result, AIDS-induced economic pressures will force more girls into the commercial sex industry.
4. *Health service provision needs to improve.* There is need to develop more specialised health-care clinics that will meet the unique needs of HIV/AIDS patients. In parts of India, hospitals are turning away AIDS patients. The situation in India and other countries will get worse as HIV spreads and the disease enters the “generalised” or more widespread stage.
5. *Thousands of community-based care and treatment programmes are also needed.* The effectiveness of these programmes in which HIV/AIDS is treated with other diseases is stressed in the World Vision case studies.
6. *Prevention depends on behavioural change.* World Vision and other faith-based organisations emphasise abstinence outside of marriage and faithfulness within marriage. Safe sex through delayed sexual activity and condom use is prescribed for those who are unable or unwilling to abstain or be faithful and for married couples if a spouse is or may be HIV positive.
7. *Education is vital.* Prevention remains the best hope for most Asians. Resources are needed to enable both more comprehensive and targeted education campaigns. There is a need for greater political will to keep HIV/AIDS high on the development agendas of industrialised countries and donor agencies.
8. *Hope is possible.* People can live productive lives with HIV/AIDS, provided that:
 - Affordable medications and accompanying delivery and monitoring systems are available to control HIV/AIDS and opportunistic diseases.
 - Community support systems for people with HIV/AIDS and their families are in place.
 - Economic opportunities are given to people with HIV/AIDS, for example, micro-enterprise programmes by NGOs and government agencies that encourage participation by people with HIV/AIDS.
9. *Mobility has a price.* Poverty pushes young people to leave their communities and cultural roots in search of jobs. Lonely, homesick and often discouraged, they frequently become receptive to adventures that may be detrimental to their health. Examples include engaging in promiscuous sex and chemical abuse.

Section One

General Information

Introduction

The Disease

Acquired Immune Deficiency Syndrome (AIDS) is a fatal disease with no cure and no vaccine to curb its spread. The best that medical science can offer are therapies to retard the invasion of opportunistic diseases and to prolong life. AIDS is caused by the human immunodeficiency virus (HIV). HIV is a retrovirus transmitted from an infected person through exchange of body fluids, principally through blood transfusions, infected needles, or sex with an infected person.² HIV may also be transmitted from mothers to infants during pregnancy, childbirth or breast feeding.

Some people who have HIV do not feel sick and may not know they are infected until years later, when the symptoms of AIDS finally appear. In other cases the interval between the HIV and AIDS stages is very short. For the poor this is particularly true, as malnutrition is known to quicken the onset of AIDS. As people with AIDS usually lose weight, it is sometimes called the “slim disease” or “body shrinker.” Besides weight loss, several other symptoms associated with AIDS include deterioration of the central nervous system, chronic fatigue, diarrhoea, thrush, respiratory problems and swelling of lymph nodes. HIV/AIDS damages the immune system allowing opportunistic diseases, such as tuberculosis, pneumonia and meningitis, to weaken and kill.

Devising therapies or discovering a cure for HIV is made very difficult because the disease is complex and adapts rapidly to changing conditions. Complexity is reflected by the types and strains of HIV. For example, there are nine clades (sub-types) and numerous strains of HIV-1, the more common and deadlier variety³ in Asia and most other world regions.⁴

Epidemiologists have learned a great deal about the spread of HIV/AIDS over the past years. The disease disperses rapidly through a core of high-risk people who practise unprotected sex with multiple partners (Africa, Asia) or drug use through infected needles (parts of Asia, Eastern Europe and Russia). Examples of vulnerable groups include sex workers, long-haul truck drivers, migrant labourers, fishing folk, military personnel, agricultural estate workers and miners. A characteristic of most of these groups is that they are absent from their homes for long periods of time.

After an initial or nascent period, the disease can spread to the general population as workers return to their home communities. Once HIV/AIDS begins to infect rural districts, it becomes extremely difficult to stop. Prevention measures that may require behavioural changes will be difficult to introduce and manage across large numbers of scattered farming and fishing villages where most Asians live.

² HIV causes cells to translate viral RNA (ribonucleic acid) material to DNA (deoxyribonucleic acid) that the virus uses to attack white cells (T lymphocytes).

³ Usually three times as many incidences are required to become infected with HIV-2 than HIV-1.

⁴ A survey of HIV-positive female sex workers in Pune, India, reported that 88 percent contracted HIV-1, 2.3 percent HIV-2, and 9.2 percent had both varieties (JAMA 1997).

Global Scene

In 1999, an estimated 34.3 million people were infected with HIV or developed AIDS; 1.3 million were children under 15. Developing countries and the transitional economies are home to over 90 percent of these people (UNAIDS 1996b, 3; UNAIDS 2000b, 6; *BBC News* 1999, 2).

One tragedy of HIV/AIDS is that the disease is growing at an exponential rate. In 1985 there were about 1.2 million adults with the HIV virus. By 1995 the number of infections grew to 17 million (Ainsworth and Over 1999, 15, 47). A second tragedy is that in most developing countries the disease is almost always fatal. AIDS now accounts for 9 percent of adult deaths in developing countries. In five years the disease will rank as the third cause of death, and by 2020, AIDS will be the leading killer, responsible for 37 percent of adult deaths. The huge number of AIDS orphans is a third tragedy. The 13.2 million AIDS orphans today will soar to 42 million by 2010 (World Bank, 1999d, 11; Squire 1999, 16; *Economist* 1998, 79; UN Wire 2000f).

Incidences

Asia in General

Although the adult prevalence rates⁵ are highest in Africa, Asia now accounts for about half the number of new HIV infections each year. In 1999, the 7–8 million Asian people with HIV/AIDS constituted over 20 percent of the world's population with the disease (Cohen 1998, 1; Cohen 1996, 42; *BBC News* 2000a, 1; *JAMA* 1998, 1).⁶

HIV/AIDS occurs unevenly across the continent. With an adult prevalence rate of 0.69 percent, the preponderance of the disease (95 percent) is in South and Southeast Asia. In contrast, East Asia and the Pacific generally report a very low HIV/AIDS prevalence rate (.068 percent). As expected, most (92 percent) new HIV infections in 1999 occurred in South and Southeast Asia, 1.3 million, compared to 120,000 in East Asia and the Pacific (UNAIDS 1999b, 6).

Data on the location of people with HIV/AIDS is complicated by a lack of information and under-reporting. For example, UNAIDS gives the HIV population in South and Southeast Asia as 5.6 million in 1999 (UNAIDS 2000b) while *Oxford Analytica* states that it is conceivable that the people with HIV in 2000 in Southeast Asia alone is close to 3–4 million (1999, 1). The primary reason for the difference is because Thailand's infected population may be closer to 2.4 million than the commonly accepted 800,000–1 million. Another case of possible under-reporting is China. The country is estimated to have an HIV/AIDS population of 500,000, but the true figure may be as high as 4 million. That is an eightfold difference in numbers but a very small change in the prevalent rate, given China's huge population. Thus, it is conceivable that the total HIV/AIDS population in Asia today is 15–16 million, more than double the 1999 estimate.

Even if the 7–8 million figure is accepted, the time to act was yesterday. Fortunately, today isn't too late. As stressed by the World Bank, now is the time to take action, while three-fourths of Asians do not live where HIV/AIDS is well established (1999c, 4). Already the time for basic containment measures has passed in some of the Indian states, Myanmar and Cambodia.

⁵ The adult prevalence rate is the percent of the 15 to 49 year old population that is HIV positive.

⁶ A recent UNAIDS report gives a 6.13 million figure for people with HIV in Asia (UNAIDS 2000b, 6).

HIV/AIDS in Asia may be viewed in epidemic stages or categories. Probably no Asian country is in the “generalised” stage, meaning that the disease is widespread in the high-risk groups and over 5 percent of women visiting antenatal clinics are HIV positive.⁷ However, there are substantial populations in Asia in the “concentrated” category, meaning over 5 percent of the highest risk groups are infected with HIV, but the incidence of the disease is low in the general population. Included are Cambodia, about half of India, Malaysia, Myanmar, Pakistan, Singapore, Thailand, Vietnam and Yunnan Province in China. Fortunately, the predominant numbers of Asian people are found in the “nascent” class; that is, less than 5 percent of the highest risk groups are infected. Found in this stage are Afghanistan, Bangladesh, Bhutan, most of China, Hong Kong, half of India, Indonesia, Japan, both Koreas, Laos, Mongolia, Nepal, Philippines, Sri Lanka, Fiji, Papua New Guinea and Taiwan (Ainsworth and Over 1999, 96–97; Ainsworth 1998, 20).

Asia’s overall position as a nascent region may have lulled many countries into complacency. But now is the time to confine the disease through preventative programmes that target high-risk populations. Depending on the country, these include injecting drug users (IDUs) and commercial sex workers (CSWs). The spread of HIV through infected needles is a growing problem in Nepal and Bhutan. Soon, infected individuals will begin to spread the disease through sexual activity, and the province or country moves into the concentrated category. This is the case of Myanmar, Manipur State in India and Yunnan Province in China (Ainsworth and Over 1999, 96).

An analogous situation may be found with high HIV infection rates among CSWs. The disease may spread rapidly to male patrons due to the high number of clients served per CSW and the low condom use in most Asian societies. Exacerbating the potential spread of HIV is frequent use of CSWs by men of all ages and statuses in many Asian countries.⁸ Other contributing factors are the high incidence of sexually transmitted diseases (STD) and poverty. Some of the most infected places are rural areas in South and Southeast Asia where the HIV rate approaches 50 percent (*Oxford Analytica* 1999, 2). Nascent becomes concentrated when the disease is spread to wives or other sex partners, as in Cambodia, Thailand, Singapore and western India.⁹

The preponderant number of HIV/AIDS cases in Asia are men. This is probably a reflection of the generally early stage of the disease that has made men more susceptible to infection than women.¹⁰ In South and Southeast Asia about 30 percent of adults infected are women; in East Asia and the Pacific the rate is 15 percent (UNAIDS 1999b, 6). However, as the disease becomes more widespread, the difference in the male and female prevalence rates will diminish. For example, in some Indian states the HIV rate in females has risen rapidly due to infection of women by their husbands.

HIV/AIDS infection rates for children are preliminary. Given the large population of Asia, the total number of children with HIV in 1999 was low (205,200),¹¹ Accurate figures are hard to obtain because governments tend to disregard the threat of the disease on children. In South Asia, children younger than 15 account for 5.7 percent of the reported HIV/AIDS cases. In Nepal, that number climbs to 17.3 percent if children 18 and younger are counted (Ahmed 1998, 2). Save the Children believes that the 17 percent rate may mirror the actual children and youth rate for South Asia. Perhaps so, but the IDU rate is higher in Nepal than Bangladesh, Sri Lanka and most parts of India.

⁷ This assumes that the HIV adult prevalence rate is 2.23 percent in Thailand. If the number of people infected with HIV/AIDS is 2.4 million rather than .8 million, the country may be in the generalised stage.

⁸ As in other regions, certain groups of men are in particularly high-risk categories. These include long-haul truck drivers, military personnel, plantation workers and others who spend considerable time away from their homes.

⁹ To complicate matters, often both IDUs and CSWs are the prime infection sources. Such was the situation in Cambodia, Malaysia, Pakistan and Vietnam. Bangladesh, among the nascent countries, is in that situation today.

¹⁰ This reflects the predominance of men as IDUs and the high number of male clients per CSW. Only a small percent of HIV infections are due to homosexual behaviour (sex between men) in Asia.

¹¹ See Table 1. Figures listed as <100 were counted as 100.

Countries in General

Table I portrays the HIV/AIDS situation in Asian countries at the end of 1999, unless another year is specified.¹²

Table I: Incidences of HIV/AIDS in Asian Countries

Country	Adults with HIV	Adult HIV rate, % 15-49	Children with HIV	AIDS cases (1997)	Cumulative deaths to 1997	Deaths in 1999	Cumulative orphans	Orphans living (1997)
Afghanistan	<100	<.01	N/A	N/A	N/A	N/A	N/A	N/A
Bangladesh	13,000	.02	130	4,900	4,300	1,000	610	720
Bhutan	<100	<.01	N/A	N/A	N/A	N/A	N/A	N/A
Cambodia	210,000	4.04	5,400	18,000	15,000	14,000	13,000	6,900
China	500,000	.07	4,800	9,000	6,400	17,000	4,500	700
Fiji	300	.07	N/A	<100	<100	N/A	N/A	<100
Hong Kong	2,500	.06	<100	560	490	<100	N/A	100
India	3,700,000	0.7	160,000	430,000	350,000	310,000	N/A	110,000
Indonesia	52,000	.05	680	4,800	3,900	3,100	2,000	940
Japan	10,000	.02	<100	1,900	1,700	150	N/A	<100
Korea, N. *	<100	.001	N/A	N/A	N/A	N/A	N/A	N/A
Korea, S.	3,800	.012	<100	310	250	180	<100	<100
Laos	1,300	.05	<100	240	210	130	280	140
Malaysia	48,000	0.42	550	6,900	5,700	1,900	680	1,500
Mongolia	<100	<.01	N/A	N/A	N/A	N/A	N/A	N/A
Myanmar	510,000	1.99	14,000	100,000	86,000	48,000	43,000	13,000
Nepal	33,000	0.29	930	2,100	1,700	2,500	2,500	710
Pakistan	73,000	0.1	1,600	17,000	15,000	6,500	7,900	4,500
Papua New Guinea	5,200	0.22	220	2,400	2,200	440	1,300	1,100
Philippines	26,000	.07	1,300	160	1,300	1,200	1,500	460
Singapore	3,900	0.19	<100	290	<500	210	120	<100
Sri Lanka	7,300	.07	200	1,900	1,700	490	600	390
Thailand	740,000	2.15	13,900	260,000	230,000	66,000	75,000	44,000
Vietnam	99,000	0.24	2,500	8,700	7,200	2,500	3,200	1,800

*1997 data

Sources: UNAIDS 1998; UNAIDS 2000b; Bernard 1998.

¹² 1999 is the latest year that data are available for all Asian countries (UNAIDS 2000b).

India dominates every number in Table 1 except for the HIV infection rate. India accounts for over half of the 6.13 million adults with HIV and 205,200 HIV-infected children. India also registered almost half of the cumulative AIDS deaths by 1997. India's immense size, combined with a moderately high (for Asia) prevalence rate explains the country's preeminent position. The nation that receives the most notoriety in the popular press, Thailand, is a distant second in most of the categories except the prevalence rate.¹³

Other countries that are of particular concern are:

- Bangladesh, because there are 25,000 IDUs, 40 percent of whom are HIV positive.
- Cambodia, due to its high general prevalence rate and the elevated rate of infection among CSWs.
- Nepal, if the rate of infection among IDUs increases.
- China, due to its tremendous size, potential under-reporting and 4 million CSWs.
- Myanmar, because drug users passed the disease to their sex partners. HIV contracted through heterosexual intercourse now exceeds that of IDUs. Recent reports indicate an increased HIV rate among CSWs.
- Papua New Guinea, due to the skyrocketing increase in HIV. By 2010, up to 30 percent of the women will be infected (*UN Wire* 2000d).
- Vietnam's current low rate is climbing fast due to IDUs and rising infection rates of CSWs (UNAIDS 2000a, 2).

The increasing HIV prevalence rates for many Asian countries may be seen in Table 2. The actual rates may be higher due to the tendency of many governments to under-report HIV/AIDS data.

Between 1994 and 1997, nine of the 23 (43 percent) countries listed in Table 2 posted 25 percent or more increase in the adult prevalence rate. In descending order, these nations are China,¹⁴ Nepal (500 percent), Vietnam (214 percent), Malaysia (107 percent), India (105 percent), Pakistan (50 percent), Sri Lanka (40 percent), Laos (33 percent) and Cambodia (26 percent). There are two caveats. Most 1994 figures were very small, making a high percentage increase likely. Second, national figures are generally imprecise. However, the likelihood is that both the 1994 and 1997 figures are lower than actual numbers. For small countries such as Cambodia or Mongolia, slight differences in percentage rates won't make much difference. In huge nations such as China and India, a fraction of a percent translates into large numbers of people.

Countries: Some Specific Considerations

The low prevalence rate (0.02–0.03 percent) in **Bangladesh** has lured the country into a state of complacency. Overlooked, except by HIV/AIDS experts, is the high infection rate among drug

¹³ Thailand accounts for 12 percent of adult and 17 percent of children HIV cases, but almost one-third of the cumulative AIDS deaths and about one-fourth of the cumulative orphans. Thailand's HIV prevalence rate is the second highest in Asia.

¹⁴ Assuming some small rate, such as .001, China's increase between 1994 and 1997 was 5900 percent.

Table 2: 1994 and 1997 Prevalence Rates with Complementary 1999 Data
1994 and 1997 rates are rounded.

Country	1994 Adult Rate	1997 Adult Rate	Various Figures (1999 unless stated otherwise)
Afghanistan	N/A	.005	<.01
Bangladesh	.03	.03	.02 (Probably higher)
Bhutan	.005	.005	<.01
Cambodia	1.9	2.4	4.04 (220,000-300,000 infected)
China	0.0	.06	.07 (at least 500,000, but possibly 4 million, living with HIV)
Fiji	.04	.06	.07
India	.4	.82	0.7 (3.7 million reported by UNAIDS 2000b, but possibly 7 million living with HIV)
Indonesia	.05	.05	.05
Japan		.01	.02
Korea, N.	0.0	0.0	<.01
Korea, S.	.01	.01	.01
Laos	.03	.04	.05
Malaysia	.3	.62	0.42 (IDUs account for 75% of infections)
Mongolia	.01	.01	<.01
Myanmar	1.5	1.8	1.99 (530,000 reported but probably over 750,000; 78% between ages 20-34)
Nepal	.04	.24	0.29
Pakistan	.06	.09	0.10
Papua New Guinea	.2	.2	0.22 (up to 22,000 infected; possible 25% reduction in life expectancy by 2010)
Philippines	.05	.06	.07
Singapore		.15	0.19
Sri Lanka	.05	.07	.07
Thailand	2.1	2.2	2.15 (800,000, but possibly as many as 2.4 million HIV cases)
Vietnam	.07	.22	0.24 (IDUs make up over 60% of those infected)

Sources: World Bank 1997; JAMA 2000; UNAIDS 1998, 2000a, 2000b; World Vision 1997; UN Wire 2000d, 2000g, 2000i. The 1999 rates are from UNAIDS 2000b.

users. If it hasn't already, the disease will be soon spread to the sex partners of IDUs, because condoms are seldom used. Unprotected sex also means that HIV may readily spread from CSWs to their male clients. As half the prostitutes may have syphilis, that disease, too, will be introduced into many Bengali homes (UNAIDS 1999, 14; World Bank 1999a, 1).

In contrast to Bangladesh, **Cambodia** has the highest adult HIV rate in Asia. Hawes (1999) puts it at 5 percent. Probably 300,000 people have HIV/AIDS. Over 50 percent of the infections are found in the under 25 age group (*JAMA* 2000, 5). All signs point to worsening conditions, with the country soon joining East and Southern Africa in the general epidemic category.

- 2–5 percent of pregnant women tested positive for HIV. It is estimated that 3.7 percent of all reproductive-age women have HIV. The rate for men is undoubtedly higher (IAPAC 2000, 3; UNAIDS 1999b, 14).
- Among police and soldiers, a high-risk group, the HIV rate is 6 percent (FXB 1997, 1; IAPAC 2000, 3).
- In another high-risk group, CSWs, 40–50 percent are infected. Condom use among sex workers is low. HIV is generally spread through heterosexual sex with multiple partners (FXB 1997, 1; IAPAC 2000; Asia 1998, 2).
- The government admits that 19 percent of “indirect commercial sex workers,” such as “beer girls,”¹⁵ are HIV positive (*UNWire* 2000e).
- HIV/AIDS has probably reduced average life expectancy by at least two years (Ainsworth 1999, 1).

Because of its massive population (1.2 billion), **China** is of particular concern. Conservative figures put the prevalence rate at 0.07 percent, with at least 500,000 people infected. The actual number is likely to be higher, due to both private denial and public under-reporting. Hewitt believes that unless “swift action” is taken, the number of HIV/AIDS cases is likely to reach 10 million by 2010 (Hewitt 2000, 2).¹⁶ Calling the containment of HIV a “national priority,” the Chinese government has promised to do more, including a huge education campaign backed by 400 HIV/AIDS clinics (Ye and Li 1997, 1).

The Chinese government is right to be concerned:

- HIV infections are no longer confined to IDUs. Today's primary culprit is probably unprotected sex among heterosexuals in China's prosperous east (IAPAC 2000, 2).
- The infection rate among IDUs is high, especially in Yunnan. In that province, 70 percent of drug users tested positive for HIV (Asia 1998, 2). Surely many of these people have sexually transmitted the disease to others. So far, only 15 percent of the HIV/AIDS cases are women (Hewitt 2000, 1).
- China is experiencing a great transition from a rural to an urban society. Mobility is a contributing factor in the spread of HIV/AIDS and other sexually transmitted diseases (800,000

¹⁵ Women who serve beer in restaurants and often solicit sex as a side business.

¹⁶ *BBC News* (2000c) reports that the 10 million figure may be reached by 2005.

reported cases in 1999). A related concern is the increase in CSWs, most of whom do not insist that their clients use condoms (Hewitt 2000, 2; Ye and Nuer 1997, 1).

Of even greater concern is the other Asian colossus, **India**. The country has a history of some good but many ineffectual HIV/AIDS prevention programmes. Because of the generally lackadaisical efforts, the public National AIDS Control Organisation said that the spread of AIDS must be checked within the next three years (ACET 1999, 4). The UN estimates that 35–40 million people could be infected by 2006 (*UN Wire* 2000j). In fact, there are really two Indias. Generally high prevalence rates are found in the northeast, south and west. These are areas of a concentrated epidemic. HIV rates in the rest of India are low, closer to that of the East Asia and Pacific sub-region.

Concerning the “concentrated” areas:

- High-risk people include CSWs, long-haul truck drivers, migrant labourers, IDUs and homosexuals (World Bank 1999b, 2).
- The spread of HIV/AIDS in Manipur and Mizram (northeast) is predominantly through sharing “dirty” needles. Perhaps 60 percent of IDUs are infected. They are now spreading the disease to their sex partners (Ainsworth 1998, 19; Ainsworth and Over 1999, 97).
- Maharashtra and Tamil Nadu are the most infected states in the west and south.¹⁷ HIV is mostly spread through unprotected heterosexual sex. IDUs are a distant secondary transmitter of the disease (World Bank 1999b, 2).
- In Tamil Nadu, people infected number 500,000 and include 2 percent of the rural population (*Economist* 1999, 42).
- Mumbai (Bombay) may be the epicentre. *JAMA* (2000) reports that 10 percent of the adults may be infected. High HIV rates are also found in other cities in the south and west.
- One reason for the HIV infection rates is because half the CSWs in Pune (Poona), Madras and Vellore are HIV positive (*JAMA* 1997b, 2; Asia 1998, 1).
- As other STDs are associated with HIV, it should come as no surprise to learn that 20–30 percent of men in southern and western cities have venereal diseases (*JAMA* 1997b, 2).
- The wives and sex partners are the real victims. In Pune, 13.6 percent of non-CSWs tested were HIV positive, despite the fact that over 90 percent were monogamous (*Economist* 1999, 42). The rate of gonorrhoea, syphilis and chancroid was actually higher for non-CSWs than prostitutes (*JAMA* 1997a, 6).
- A recent survey in Vijayawada, Andhra Pradesh, points to another concern. About 30 percent the city’s 25,000 street children are HIV positive. Almost half of them are infected with other sexually transmitted diseases (*UN Wire* 2000b).
- The use of condoms in India is extremely low, even among CSWs.

¹⁷ Other concentrated-infection states are Mysore, Gujarat, Rajasthan and Bengal in the east (Ainsworth and Over 1999, 97). *UN Wire* reports that Andhra Pradesh may be in this stage today (2000b).

In **Malaysia** about 75 percent of HIV/AIDS documented cases are IDUs and their sex partners. HIV among this group has stabilised (Ainsworth and Over 1999, 97; UNAIDS 2000a, 2). While casual sex with CSWs is common, condom use is not. Also, the HIV infection rate of CSWs, 10 percent in 1994, is rising.

Myanmar's (Burma's) story is depressing. The country had an estimated 510,000 HIV cases with a prevalence rate of 1.99 in 1999. Some NGOs estimate the number of infected people may have risen to 1 million today. In 1992, two-thirds of the IDU population, the main HIV carriers at that time, tested positive. In 1995, an estimated 18 percent of the CSW population was infected (Hawes 1999, 2; Asia 1998, 8). UNAIDS reports that the disease is spreading rapidly in the adult population (2000a, 2). This statement is undoubtedly true, as condom use is low and the government has spent no money on prevention and treatment of the disease.

So widespread is the disease that World Vision (WV) HIV/AIDS programmes had to redefine their objectives. While prevention and information on the spread of the disease are not neglected, due to social avoidance and family abandonment of people with AIDS WV projects now concentrate resources on care of AIDS patients. An example is the Kawthaung Project described in Section Two:

Over the past three years interventions have expanded to include support, . . . counseling and support of children orphaned through parents dying from AIDS. The approach used in Kawthaung to achieve results in all these areas has been to train and support local volunteers in the provision of services. Whilst some care to PHA [Persons Having AIDS] has been given, volunteers have, in the main, referred patients to the local hospital. A recent evaluation of the Kawthaung program showed that there was still a high degree of stigmatisation of PHA and that families with PHA preferred to look after them themselves despite a great lack of resources to provide effective support (World Vision Myanmar 1999, 1).

Vietnam seems to be following in the footsteps of Myanmar. Like Myanmar a couple years ago, HIV/AIDS cases are dominated by IDUs (UNAIDS 1999b, 14). Also like Myanmar, the spread of the disease by heterosexual contact is rising rapidly for a number of reasons: transmission of HIV to the sex partners of IDUs; swift rise in the HIV rate of CSWs;¹⁸ and infrequent condom use in a country where casual sex with prostitutes is considered normal (UNAIDS 1999b, 13, 14). A report estimates that between 140,000 and 165,000 people were infected by the end of 2000. Better news is that the government is now taking steps to control the disease. A case study that features preventive measures, WV's Vietnam's Highway One Project, is found in Section Two.

Asia's chief HIV/AIDS success story is **Thailand**. Between the late 1980s and the mid 1990s, the HIV rate of IDUs and CSWs reached 35 percent and 33 percent respectively. By 1995, the HIV prevalence rate among pregnant women was 2.3 percent and the non-HIV STD rate in adult men was 8.6 percent. HIV/AIDS weakens the body and sets the stage for opportunistic diseases, such as tuberculosis (TB). In 1994, 45.5 percent of TB patients were men aged 20–39, most of whom also had HIV/AIDS (JAMA 1998, 1; Asia 1998, 1; JAMA 1996, 2).¹⁹

¹⁸ The rate leaped from 0.5 to 2.6 percent between 1994 and 1998 (UNAIDS 1999b:13). In some areas the infection rate of CSWs was 38 percent in 1995 (Asia 1998, 2).

¹⁹ The mortality rate of Thai men with TB and HIV/AIDS was 68.6 percent. Without HIV/AIDS it was 10 percent (JAMA 1996).

Thailand may have reversed the course of the disease through government policies of mass education combined with cheap condom availability (see “Prevention and Treatment” below). HIV rates fell in CSWs, and the STD rates in men plummeted. The rate for pregnant women dropped from 2.3 percent to 1.68 percent in 1998. For military personnel the HIV rate was halved, from 4 percent in 1993 to 2 percent in 1998 (JAMA 1998, 1).

Yet Thailand must keep vigilant in the HIV/AIDS battle. Surveys warn that some men have given up the use of condoms, believing AIDS is no longer a threat (Streshthaputra 1999, 1). At the same time, funds for HIV/AIDS prevention was curbed during the Asian economic crisis. Government decision-makers need to keep in mind that HIV/AIDS has already shortened the average Thai’s life span by two years (Ainsworth 1999, 2). In addition, HIV/AIDS will shrink the labour force 1 percent by 2010 (ILO 2000, 18). WV’s HIV/AIDS programming phases in Thailand are discussed in Section Two.

AIDS Orphans and Children with HIV

In 1997, the cumulative number of AIDS orphans in Asia was about 204,000.²⁰ The number of AIDS orphans living in 1997 was 187,360.²¹ As expected, India had the largest share (59 percent) followed by Thailand (23 percent). The number of children younger than 15 years with HIV in 1999 was 205,200. Again, the leader is India (78 percent) followed by Myanmar and Thailand (7 percent each). All these figures are likely to be low, as numbers of children affected by HIV/AIDS tend to be under-reported.

These data pale in relation to the global figures of 11.2 million AIDS orphans in 1999 and 3 million HIV-infected children in 1998 (BBC News 1999, 2). The Francois-Xavier Bagnould Center warns, “Asia may see its orphan population triple within the next year” (FXB 2000). That is an alarming statement and implies over half a million orphans by the end of 2001. Perhaps the continent will house as many as 1 million orphans by 2002. Will the number of children with HIV grow proportionally?

Such numbers are possible. The US Census bureau, for example, projected 50,750 maternal and double AIDS orphans in Thailand at the end of 2000. By 2010, the number of AIDS orphans will double to 107,437. If correct, then in 2010 AIDS orphans will make up half of the orphan population in Thailand (Hunter and Williamson 1997, Tables A-4, A-5).

Impact

HIV/AIDS affects individuals, households, communities and nations.²² To date in most Asian countries the effects of the disease have been largely limited to individuals and households. This is primarily because the disease is still in the nascent stage. For those countries that entered the concentrated class, provincial and national effects are also felt. If the generalised category of the HIV epidemic is reached, then entire nations will be seriously affected, judging by the current situation in Africa.

²⁰ An “orphan” is defined as a child under 15 whose mother or both parents are deceased. UNAIDS reports 855,600 cumulative orphans at the end of 1999, a jump of over 600,000 in two years (2000b). The 1999 figure appears excessive, even assuming 200,000–250,000 cumulative orphans in India.

²¹ The main difference between the cumulative and living categories is that children statistically leave the status of “AIDS orphan” when they reach their fifteenth birthday.

²² Former US president Bill Clinton has gone one step further and called the HIV/AIDS epidemic in Africa a global security risk to the United States.

HIV/AIDS has taken its toll at the individual and household levels in many areas. The rural poor are especially effected. Families are forced to reallocate resources and sell assets to pay for medical care or to compensate for the loss of a working-age adult. People have less to eat, children are forced to quit school,²³ boys are put to work outside the home, and girls become care-givers to ailing relatives (Ahmed 1998, 20; Over 1998, 24).

Girls may be the primary victims of the HIV/AIDS pandemic. Girls have the least control over their lives and can make the fewest choices.²⁴ For the most part girls are Asia's "poorest of the poor" (Wanduragala 2000, 2). To compound the problem, in families confronted with AIDS far more girls than boys will drop out of school. If this weren't grave enough, declining family resources will force girls into commercial sex or encourage them to engage in non-commercial sex to achieve a modicum of economic security.

In the health field, the impact of HIV/AIDS can already be seen in some countries at the national level. For example, Southeast Asia is in dire need of "safe" blood. The supply is contaminated because blood is seldom tested for HIV. Potential donors shun clinics in fear of contracting HIV (JAMA 2000). Another health example is the rise of opportunistic diseases. Asia now accounts for 70 percent of the globe's TB cases. Weakening of the body due to HIV/AIDS is associated with 40 percent of TB infections (AP 2000, 1).

In parts of India HIV/AIDS patients are already being turned away from hospitals or receiving minimal care (UNAIDS 1999b, 12). Nishimizu estimates that if India's prevalence rate increases to 5 percent (it was 0.7 in 1999), public health costs will rise 30 percent. If that 5 percent HIV/AIDS rate is reached by 2010, then the country will be paying US\$10.5 billion for public health rather than US\$7.5 billion without the additional HIV/AIDS cases (Nishimizu 1999, 24).

The overall macroeconomic effect of HIV/AIDS in Asia will be significant but small in the short term, assuming that the prevalence rates do not rapidly increase in the future. By 2005 direct health-related costs in Asia will be in the US\$32 to \$52 billion range, and this doesn't include losses due to labour shortages. In Thailand alone lost revenue will be US\$11 billion (Oxford Analytica 1999, 2). This year due to the HIV/AIDS virus, Thailand will see a 9 percent reduction in GDP (gross domestic product). Other Asian countries will see 5–7 percent GDP losses due to the disease (Oxford Analytica 1999, 2).

The impact of HIV/AIDS on other activities or situations may be important, but this remains a matter of conjecture. For example, if or when the disease spreads from high-risk groups to the general population, the prevalence rate among women will increase. This means that the number of children with AIDS will also increase.²⁵ Current treatments to reduce sharply the HIV mother to child transmission rates are available but relatively expensive. Will public health systems provide the resources? What type of care will be provided for the growing number of children with HIV/AIDS?

Other questions of impact concern AIDS orphans. Will relatives be able to take care of them? If so, will orphans be treated like "second-class citizens" and perhaps denied educational opportunities? What roles will the state and NGOs play?

²³ The rule of thumb is that the cost to take care of one AIDS patient is equivalent to the education expenses of 10 primary-school-age children (Nishimizu 1999).

²⁴ UNDP's basic definition of poverty is "lack of choices."

²⁵ About one-third of children born and nursed by HIV-positive mothers contract the disease.

Prevention and Treatment

Prevention Measures

Across Asia there is low awareness of what HIV/AIDS is and how it spreads. Symptoms or illness caused by HIV/AIDS tend to be addressed but not the disease itself (*Oxford Analytica* 1999, 1). This may be due in part to the stigma that HIV/AIDS casts across many Asian societies. Other attitudes that limit preventive programmes are intolerance of homosexuals (as in Singapore) and the opposition to condoms by some church groups (as in the Philippines) (*Oxford Analytica* 1999, 2).

Nevertheless, until there is a cure (vaccine) for HIV, prevention is the only way to curb the spread of the disease. HIV-prevention programmes on the national level vary enormously in Asia. Myanmar's response is inadequate, based on a claim that there are only 25,000 cases of HIV infection in the country (*UNWire* 2000i). Cambodia, Hong Kong, Malaysia, Singapore, Sri Lanka, Thailand and Vietnam have well-established programmes (Fouilloux 1999, 1; Asia 1998, 4). Even so, the results are mixed; the disease is increasing rapidly in Cambodia²⁶ and Vietnam. Bangladesh, Nepal and Pakistan have new programmes, but their effectiveness has already been called into question; for example, in Bangladesh over 90 percent of teenage girls do not know how to protect themselves from HIV (UNAIDS 2000b, 43). HIV programmes in India get mixed reviews. One problem is that mandated sex education is often neglected or incompetently taught (Fouilloux 1999, 1). In any case, relying on schools to educate students about HIV/AIDS may not be effective, as 60 percent of the children in Asia leave school by grade 6 (Wienrawee and Livingstone 1999, 1).

USAIDS highlights different HIV-prevention strategies, depending on a country's prevalence rate. Nascent countries have low prevalence rates, including those in the high-risk categories.²⁷ Targets are high-risk groups with the goal of Behaviour Change Intervention (BCI) that may stress the use of scientifically proven devices and needle exchange programmes. At the concentrated stage, BCI programmes are targeted at gaps in the high-risk groups. Increased use of peer education is recommended, and counselling and testing should be considered (USAID 1999, 3).

The good news is that successful programmes were developed at both the nascent and concentrated levels. Free needle exchanges, combined with easy over-the-counter purchase of needles, halved the number of unsafe injections and kept the IDU infection rate at 2 percent in Nepal (Ainsworth 1998, 1). Making young men more responsible for their sexual behaviour worked in education and condom-use programmes in India's Tamil Nadu State. In two years casual sex was cut in half, while condom use rose from 17 percent in 1996 to 50 percent in 1998 (UNAIDS 1999b, 12).

Additional preventative actions are in the realm of life-style changes for men. For example, indications are that Indian men in the more HIV-infected areas reduced their consumption of alcohol out of fear of HIV/AIDS infection. Heavy drinking often was associated with unprotected visits to CSWs. The threat of AIDS also seems to have increased sexual monogamy among married men (UNAIDS 2000b, 71).

²⁶ Like Myanmar, the Cambodian government provides no resources to prevent or treat HIV/AIDS. Programmes are supported by NGOs and UN agencies, such as the World Health Organisation (WHO) (*Oxford Analytica* 1999, 2).

²⁷ For most Asian countries the HIV risk categories in descending order are CSWs, IDUs, STD patients, long-haul truck drivers and sailors, young military recruits, factory workers, government employees, university students, secondary-school students, women visiting reproductive health clinics (statistical rather than an occupational category) and married women living in rural areas (Ainsworth 1998, 19).

Other successful ways to promote HIV/AIDS awareness include the use of soap operas in Vietnam and MTV in India. The downside is that only the urban elites in India are reached by MTV announcements. The vast number of rural poor remain untouched by television or other HIV/AIDS-prevention programmes that failed not only to reduce the spread of HIV but other sexually transmitted diseases as well (Wienrawee and Livingstone 1999, 1; Asia 1998, 4). STDs have reached epidemic proportions in many areas of India. These diseases are known to exacerbate the rate of HIV, especially in women.

Eyes focus on Thailand as the Asian example of how an HIV concentrated country has controlled the spread of HIV. The basic elements of Thailand's programme include:

- Strong political will of the government, including the royal family, to halt HIV/AIDS.
- Nation-wide campaigns that include sex education in schools, the mass media and attention-grabbing novelties, such as "Mr. Condom" distributing free prophylactics.
- Attention focussed on high risk groups, especially CSWs.²⁸
- Cheap, readily available condoms.

The results exceeded expectations. Because of targeted education programmes, 90 percent of CSWs insist that their clients use scientifically proven devices. Not surprising, STD infections in men dropped 90 percent (Ainsworth 1998, 20).

The HIV programme was altered in 1997 due to the Asian Economic Shock and the deep recession in Thailand that followed. The current lower programming budget targets specific groups rather than mass campaigns, as in the past. This may prove to be a mistake. The result is a more complacent attitude toward HIV/AIDS among young men (Sreshthaputra 1999, 1). It is to be hoped that STD rates will be carefully monitored. If these rates increase, so will HIV.

Asia is filled with HIV/AIDS-prevention programmes that are effective. Good programmes aren't cheap, but they are affordable. *Oxford Analytica* reckons that the regional cost of HIV/AIDS-prevention programmes to be US\$1.5 to \$2 billion annually (1999, 2). The cost is significant, but it only amounts to 0.03 percent of Asia's yearly economic output. Stated differently, US\$2 billion for 60 percent of the world's population is a paltry US65 cents per capita per annum.

Treatment

"The need for a vaccine against HIV is perhaps the most important health issue facing our world today" (Voelker 1999, 7). Starting in late 2000, a vaccine has been under testing in Kenya by Kenyan and UK scientists (*UN Wire* 2000a). Meanwhile, announcements of vaccines have been heard from South Korea and Nigeria. In April 1998 the World Bank commissioned the AIDS Vaccine Task Force, and earlier this year computer mogul Bill Gates promised to contribute millions of dollars for vaccine research. Most scientists remain sceptical, however, and believe that vaccine research has a long way to go before a "magic bullet" is discovered.

²⁸ Here, Thailand has an advantage over other countries as most prostitutes work in brothels. Efforts in Vietnam will be more difficult as most CSWs do business on the street.

On the other hand, tremendous strides have been made to prolong the lives of people with AIDS and to reduce suffering. The trouble is that these therapies are expensive. Even generic drugs are beyond the reach of most Asians. Basic non-generic palliative treatment costs between US\$650 and \$1,000 per person per year in Thailand. Add effective treatment against opportunistic diseases and the bill ranges between US\$1,600 and \$2,000 (Joshi et al. 1999, 6; Over 1999, 23; Ainsworth and Over 1999, 180). For the very successful HAART (highly active therapy) that's widely used in Europe and North America, the cost jumps from US\$3,300 for the cheaper treatment to US\$9,600 for top-of-the-line therapy (Over 1999, 23; Ainsworth and Over 1999, 180).²⁹

Ongoing efforts are being made to develop more powerful therapies. Included are experiments to develop entry or fusion inhibitors for patients resistant to the present combination of anti-retroviral drugs. Scientists hope to block the HIV virus from entering the CD4+T cells (Stephenson 2000, 1). Also in the laboratory stage are TAT (TransActivator of Transcription) experiments. Favourable results may lead both to drugs that control the HIV protein needed for the virus to replicate and to development of a vaccine (Blakeslee 1999, 2). Major pharmaceutical companies have promised to lower the cost of anti-AIDS drugs 70–80 percent (BBC News 2000b). Realistically, these therapies will still be too expensive for most Asians. Further cost reductions are possible if Asian companies are allowed to continue producing generic drugs.³⁰

However, for HAART treatments to be successful, trained personnel manning sophisticated monitoring equipment in HIV/AIDS clinics are needed. Such facilities may eventually serve the urban elite but not the vast numbers of rural poor. A similar problem faces Africa. One solution is to train community health workers (CHWs) to supervise treatments in rural areas. This proposal is criticised because even with training, the medical knowledge base of CHWs will still be low. Yet people will take the anti-retroviral drugs if they are available and affordable. Relatively inexpensive monitoring will certainly be better than the alternative: people dosing themselves without any supervision. Scientists already have expressed concern that drugs not taken in a full dose and a timely fashion may permit HIV viruses to mutate and become resistant to the current crop of anti-retrovirals.

Perhaps the best that can be expected is to make palliative treatments available to all HIV/AIDS patients. At the same time, governments and NGOs should continue to press drug companies to cut the price drastically or permit generics of AZT, Nevirapine and other nucleoside inhibitors in order to reduce the vertical transfer of HIV from infected mothers to their babies. Even the US\$4 price of Nevirapine treatment is expensive for poor families (UNAIDS 2000b, 82). The “bare bones” prenatal AZT treatment costs about US\$100. The price of the three-month, more effective therapy is about US\$1,000.³¹

²⁹ Price differences are primarily based on the cost of medicine and whether monitoring is included. Cheapest are the nucleoside inhibitors, such as the much-used AZT (Zidovudine) and ddi (Didanosine). The price quickly escalates when the newer protease inhibitors are added to the drug “cocktail.” These include IDV (Indinavir), RTV (Ritonavir), Saquinavir, Inivirase and Fortovase (Joshi et al. 1999, 1; Over 1998, 23).

³⁰ On 10 May 2000 US president Bill Clinton said that he would no longer stop African countries from manufacturing or importing generic anti-AIDS drugs (BBC News 2000b). Major pharmaceutical companies promised a 70–80 percent price reduction in drugs sold to poor countries. The drug firms had African countries in mind, but many Asian nations should also qualify. The Thai state-owned drug company began producing Bristol-Myers Squibb's Stavudine (d4t) in June 2000. The drug will be sold for US\$0.28–US\$0.38, about one-tenth the price of the drug in the US (UN Wire 2000h).

³¹ ATZ and aviroprene therapy (UNAIDS 1999a, 8–9).

Closing

A calamity is in the making, especially in many areas of Asia that are now in the concentrated stage of the epidemic. Conditions ripe for the spread of HIV/AIDS to the general population are found in Cambodia, several states in India, Myanmar and Vietnam. Perhaps the greatest service World Vision and other NGOs can offer is to generate worldwide interest in the coming HIV/AIDS crisis in Asia.

HIV/AIDS-reduction programmes modelled after Thailand's national efforts should be considered: special targeting of high-risk groups combined with mass education of the general population. Cost will be a real concern. Yet the bigger problem will be mustering enough political will to get the job done. Strong government-based programmes are successful. Proof may be seen in Thailand, Malaysia and Singapore.

Other countries in Asia are less vulnerable to an HIV/AIDS disaster within the next decade. Still, there are no grounds for contentment. Countries in the nascent stage now have the luxury of not having to develop extensive programmes to combat HIV/AIDS. Nor are they faced with bulging health-care budgets. Resources are needed, though, to target high-risk users, especially CSWs and IDUs.

Section Two

Case Studies

Case I—Learning from Experience, Thailand³²

WV has worked in Thailand since 1991 on HIV/AIDS programmes. During this time both the incidence and prevalence rates have increased significantly, not only in Thailand but also throughout Asia. With eleven projects and a decade of experience WV has overseen a drastic change in HIV/AIDS programming.

The shift in programming activities experienced in Thailand reflects the increase in HIV incidences, the changing modes of transmission of the virus, and the lessons learned over time in effective programming interventions. Three generations of programming may be identified. The first generation focussed on high-risk groups and behaviours, simple information dissemination and training the local Ministry of Public Health (MOPH) officials to provide care and testing for people with AIDS. In the second generation, targeted education was supplemented by back-up services and counselling. Also included was care for people living with AIDS (PLWA). The third-generation programmes focussed on the general community being at risk, home care for AIDS patients, cross border co-operation and a more integrated health programme that included HIV/AIDS.

The First Generation of Projects, 1991–93

The first WV project was in Chiang Mai and had four major objectives. These were a broad-based education campaign, capacity building for the Chiang Mai MOPH, HIV/AIDS training materials and expansion of HIV testing. The primary focus was the use of information, education and communication (IEC) materials to inform people about the virus and ways in which they could protect themselves. While a mass-media campaign aimed to inform the general population about the HIV virus, programme resources were closely linked to high-risk groups and their behaviours.

The programme design called for a number of planned outcomes. The first was that the target group of CSWs and their clients would be aware of the danger of HIV. A related outcome was that both groups would know how to prevent the transmission of the disease. The final evaluation of the project found that knowledge of the disease was quite high. This was attributed to the efforts of community educators (members of the target groups who received training in this information then took the information to their communities). Yet there were some misunderstandings about preventing the transmission of the virus. Men understood that condoms should be used with high-risk behaviour (sex with CSWs). However, men didn't realise that if they engaged in such activities, then condoms should also be used with all sex partners, including their spouses.

A second planned outcome was the reduction of HIV within the project area. This wasn't achieved. The final evaluation noted that the key to reducing the incidence of HIV rates was through behaviour

³² This is an edited version of Matthew Clarke, "A Decade of HIV/AIDS Programming in Thailand: The Experience of World Vision Australia and World Vision Foundation of Thailand from 1991–2000," an unpublished paper.

change. The project initially sought to change behaviour by providing the community (and particularly those practising high-risk behaviours) with information about the dangers of the virus and how to prevent its transmission. By the end of the project, though, it became apparent that information alone would not change people's behaviour.

Behaviour change requires much more than knowledge and awareness of HIV/AIDS. The major strategy of the project was to increase the knowledge and awareness about HIV in the five districts, which is not enough to lead to behaviour change. Secondly, behaviour change often occurs over longer periods of time than the life of the project, so it is perhaps unrealistic to expect reduction in the incidence of HIV in two years.

A third planned outcome was a better attitude in communities towards PLWAs. Due to misinformation regarding the transmission of HIV/AIDS at this time, many communities ostracised people with AIDS. As a result, people were very reluctant to share their virus status with neighbours and even family members. The final evaluation found that community acceptance was achieved. This was seen by an increased number of HIV-positive people and those with AIDS participating in community life. There was also a greater number of people attending funerals of those who had died with AIDS. Unfortunately, more funerals reflected the spreading of HIV/AIDS into the general community.

The Chiang Mai project also aimed to improve the MOPH capacity for surveillance and care of HIV positive people. The accepted thinking at this time was that while some care for people with HIV/AIDS was the obligation of families, ultimate responsibility lay with MOPH. An important lesson learned was the increasing need to find strategies for the care of PLWAs and their families. As the incidence of HIV/AIDS was increasing, there was a greater demand on the resources of the MOPH. This demand was not seen as sustainable. Community acceptance of HIV/AIDS was no longer enough. A more active role in caring for the families and the people affected by AIDS was going to become increasingly important. The project highlighted home care for those with HIV/AIDS as a partial solution.

A number of unplanned project outcomes affected future HIV programming. The first was the introduction of a newsletter to community educators. The newsletter was also used to encourage the community educators in their work and to answer questions from the educators. This feature was replicated in other projects across Thailand.

Another unexpected outcome was the changing role of the community educators. Originally their role was to provide HIV/AIDS education to the community. It soon became apparent that people with HIV/AIDS needed people with whom they could talk. PLWAs increasingly turned to the community educators as counsellors. The community educators were not trained in this role and often felt overwhelmed by these extra demands.

Interestingly, the Project Completion Report did not state the need for new strategies to attain behaviour changes. Given this lack of expression, it can be concluded tentatively that information dissemination was still seen as the preferred method of bringing about behaviour change and that the focus of the information given was on high-risk behaviour and high-risk groups. At this point high-risk behaviour did not expressly include IDUs. It was primarily focussed on transmission through sexual encounters.

The Second Generation, 1993–95

The main purpose of Phase Two was education. Based on previous experience, target groups were widened to include teachers, students, monks, undertakers, traditional medicine men, headmen and factory workers in addition to CSWs and their clients. The geographical area was extended to cover five additional rural areas as well as maintaining activities in five urban districts.

Phase Two specified five specific objectives. The first three were the same as the original project. One of the additional planned objectives was to assist the Chiang Mai MOPH in expanding its counselling and backup services. The other was to mobilise villagers in establishing a network to disseminate AIDS education materials and to start support groups for the care and succour of those already infected.

The project achieved its objective of continuing the broad-based AIDS education programme. The information disseminated covered facts on the virus and how it is transmitted. Materials also discussed ways to help PLWAs and their families live more positively.

Realising that the key goal of changing behaviour was unlikely with basic information alone, the project began to focus on a new target group composed of primary-school children. While not directly at risk, project managers felt that children would soon be in danger of becoming involved in high-risk sexual behaviour. Using flip charts, pamphlets and essay competitions, the topic of HIV/AIDS was introduced to primary schools. Teachers and principals were trained as the educators of this new target group.

More innovative IEC materials were used in Phase Two. Pamphlets and newsletters were employed as well as flip charts, stickers, leaflets and posters. The project also began to develop local dialect audiotapes that could be used over community public address systems and videotapes that could be shown at community meetings. The use of local dialects brought the messages closer to the target groups. There was also an increased effort to tailor the IEC materials used to specific target groups. Obviously, materials for primary school children and for community men likely to frequent brothels should be different. The recognition of this fact makes the information more relevant. As Thai people enjoy competitions, matches were held with HIV/AIDS prevention as the focus.

As the number of PLWAs increased, programme managers realised that there was a desperate need for a support mechanism to be established for PLWAs and their families. Clubs were started in conjunction with the Chiang Mai MOPH. These became known as Thursday Clubs, as this was the day on which they originally met. Like other support groups, the clubs afforded the opportunity to their members to come together with people facing the same concerns and to talk with one another and to offer one another moral support. Activities included such diverse topics as discussions on nutrition and artificial flower-arranging, as well as tours.

Families affected by AIDS also received financial and moral support. Though one of the main messages being spread by the information-dissemination activities was the need to live with and accept PLWAs in their community, often families were left with the entire burden of caring for their sick. The increase in PLWAs was also putting great pressure on the resources of the MOPH. Many patients couldn't obtain the level of care they needed through the MOPH. Consequently, families were left to care for them without much assistance. Family members had no training or resources available to them and often were using unsafe techniques. Disposal of contaminated dressings was

poor, and they often didn't know about nutrition or the care of AIDS-related conditions or secondary illnesses. Peer trainers were instructed in some home-care techniques, but only near the end of the project.

The Third Generation, 1995–96

Phase Three of the Chiang Mai Project went much further than the two previous programmes. The general population now understood the dangers of HIV/AIDS and how to prevent its transmission, but there were increasing numbers of PLWAs who could not access proper health care because MOPH lacked sufficient resources. While Phase Three acknowledged the importance of continuing education, it also saw as a priority the need for an innovative hospital and home health-care programme.

The aim of this project was to enhance the healing process for the patient, both mentally and physically. By working together, the project staff, patients and family designed an appropriate home health care plan which was responsive to the particular needs of the individual patient. By taking the resources away from the hospital and (putting them) into the home, this innovative pilot programme paved the way for new health care strategies for HIV+ patients not only in Chiang Mai but also in Thailand generally.

Home care was a more effective method of using MOPH resources. Instead of having patients seeking treatment at the hospital and using the hospital beds, patients were encouraged to stay at home for as long as possible. Families provided care, supplemented by regular visits from the hospital staff. Not only did patients receive more attention at home but the familiar home environment was more conducive to better health.

This project was the first of its kind in Thailand and had to develop the processes necessary to operate an outpatient care programme. A special register was produced which listed all pertinent information, including address and map, episodes of illness, medication, family members and general health indicators taken regularly, such as blood pressure and body temperature. Relationships needed to be built between the hospital staff and the family members so people would be comfortable with hospital staff visiting them. One member of the project team was a psychologist, who was available to the patients and their family if they needed counselling. This was an innovative addition to the normal staffing levels. Hospital staff were able to provide ongoing treatment to the patients and provide advice to the care-givers on how to administer the medicine. They also gave advice on nutrition and home nursing. This included the proper disposal of contaminated dressings.

By the end of the 12-month pilot programme, over 400 patients at the San Sai hospital were actually living at home. MOPH continued providing for homebound patient care, taking over full responsibility for the project. Support for the Thursday Clubs and the production of newsletters also continued.

The pilot project highlighted the importance of keeping PLWAs at home for as long as possible. Home visits meant that the person's mental and physical state was taken into account. Support was given not only to the patient but to the care-giver as well. It was easier to discuss issues relating to home care at the patient's home rather than through lectures in an office or clinic. This was an improvement in the use of limited MOPH resources.

South Thailand Women and AIDS Project

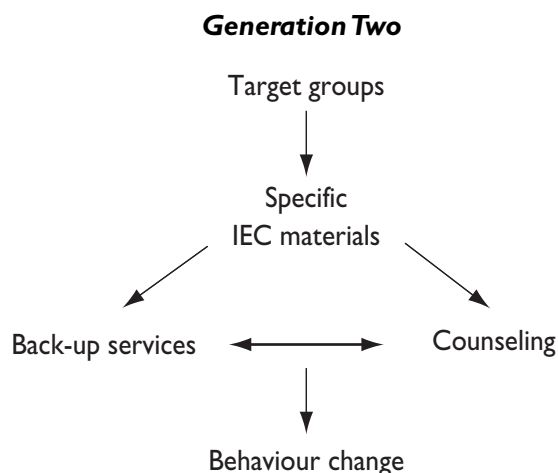
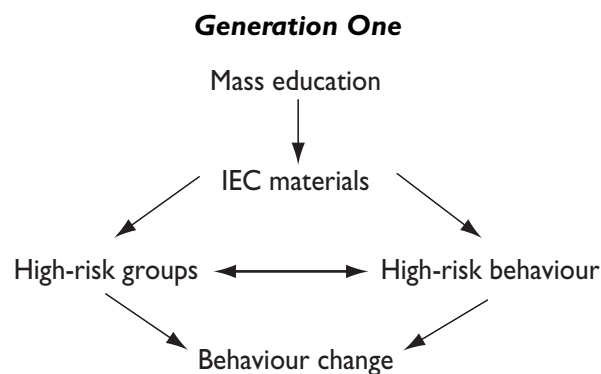
Concurrently with Phase Three of the Chiang Mai Project and the start of the Thai-Burma Border Project, another innovative AIDS project began, this time in southern Thailand. This project grew out of research undertaken by academics from the Nursing Faculties of La Trobe University in Australia and the Prince of Songkhla University in Thailand. These experts proposed an approach to home health care similar to that in the final phase of the Chiang Mai Project.

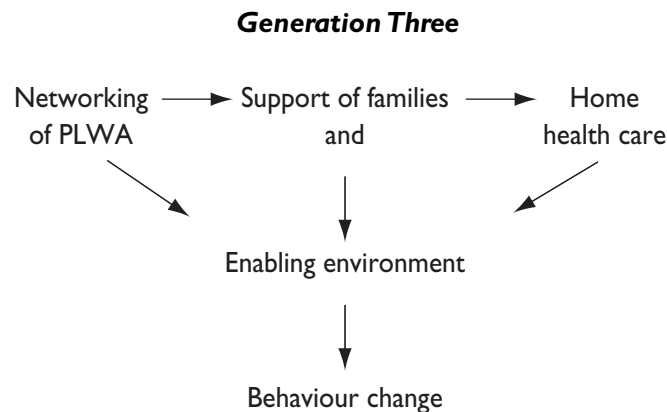
Research undertaken by the universities showed that within southern Thailand there were no programmes that focussed on the caring of PLWAs at home. All AIDS projects focussed on health education, counselling and providing general HIV/AIDS information, while PLWAs were lying sick in poorly equipped hospitals or living at home without adequate care. As females in Thailand are traditional care-givers, the project focussed on training women to prevent the spread of infectious diseases, including STDs and HIV/AIDS.

The project approached the issue of caring for PLWAs and HIV/AIDS related conditions in a creative way. Rather than to centre directly on HIV/AIDS, the project chose to focus on general infectious disease care. This included training on universal precautions when dealing with infectious diseases. This approach was chosen so it would have wide applicability, but also to reduce the chance of stigmatisation of those attending what might come to be seen as “AIDS classes.”

Generational Change—A Shift at a Glance

Through the course of these three programming generations, a number of changes became apparent.





Summary

HIV/AIDS programming has changed dramatically in the last decade. WV Thailand has been at the forefront of that change with innovative home health-care programmes and the implementation of behavioural change strategies. Over this period the situation of HIV/AIDS in Thailand has changed. Its effects are no longer felt only by high-risk groups. Rather, all of Thai society must now be considered at risk.

Behavioural change cannot be assumed to be linked directly with the provision of information. While IEC materials do have their place, they are now seen as playing only one part in behavioural change. There has also been recognition that IEC materials must be tightly targeted to specific communities and should be as assessable as possible. There is now a high awareness about HIV/AIDS and its transmission and prevention in all levels of Thai society because of the use of IEC materials over time.

Enabling environments must now be established and supported in order for change to be achieved and long lasting. This will require a much greater integration of HIV/AIDS programmes with general community development. It also means that there is no single “blueprint” for an HIV/AIDS programme. The needs for an enabling environment are different from one community to another and even different within communities. This is going to require more sophisticated action research by project staff in the future. For some communities, it may include an emphasis on primary health care; for others, poverty alleviation or literacy and numeracy skills. Transmission of the virus is no longer mainly through participating in illegal activities, such as commercial sex work or intravenous drug use. HIV/AIDS has entered society to such a degree that no single activity may be seen as high risk. All activities involving unprotected sexual relations are high risk.

Resources for caring for PLWAs in hospitals do not exist in Thailand. There are too many people with the virus and not enough beds. Home health care is the only way that PLWAs will receive adequate levels of care in a supportive environment. This will entail the shift of MOPH resources from the traditional hospitals to people’s homes. Home-care programmes were successful in Chiang Mai and in South Thailand. Both of these projects highlighted the need for proper support and training for care-givers—not only medical support but counselling as well. As increasing numbers of people with HIV become sick with AIDS, this home health care will be the only way that the MOPH will be able to cope. WV Thailand has developed two models. In Chiang Mai there is a direct link to hospital for the care of AIDS and AIDS-related conditions. In South Thailand there is training on infectious diseases (which includes HIV/AIDS) using universal precautions. Both of these models have been successful.

Case 2—High Risk on Highway One, Vietnam³³

Overview

This is a midterm review of a project designed to influence truck drivers and women along Vietnam's National Highway One. A team of WV staff and an external evaluator did the evaluation in late August 1999. The team went to sites in four provinces and held workshops for provincial project managers and site staff.

Generally the IEC materials developed by the project are an example of international best practises. The community-based model to reach truck drivers provides activities and information to create a safe environment in places that serve drivers. This model could be used in other transport routes in Vietnam.

Part of the strategy to reduce HIV/AIDS in the Highway One communities and among truck drivers is to distribute condoms. Disbursing prophylactics is not an activity in which WV readily engages. Like most faith-based organisations, WV advocates abstinence outside of marriage and fidelity within marriage as cornerstones of its AIDS-prevention policy. WV recognises, though, that many people cannot or will not live celibate or faithful lives. Believing that life is a sacred gift, WV reluctantly views the distribution of condoms as an essential means to prevent HIV/AIDS.

Objectives of the project:

- Operational research using participatory learning and action methodology is conducted. Appropriate behaviour change communication models are developed for truck drivers and women on HIV/AIDS.
- A behaviour change communication programme is implemented for truck drivers in selected districts along Highway One.
- A behaviour change communication programme is implemented incorporating appropriate care strategies among poor women in selected districts along Highway One.
- The Departments of Health and Women's Unions attains improved capacity in research, management and training.

General Findings

IEC materials. The development process for IEC materials is an example of what UNAIDS terms international best practise. The IEC materials produced by project staff and their partners were termed "international quality" by the outside evaluator. The messages are perfectly suited to the groups they are meant to reach, and the media were appropriate to the messages. Extensive needs assessments have been done. The messages were pre-tested. Mock-up field testing was performed. Revisions were made based on the field testing, and revisions were sought for the first reprinting.

³³ This is an edited version of Viet My Ngoc Nguyen et al., "Midterm Review, The National Highway One Project: Developing Community Responses to HIV/AIDS" (September 1999).

The materials produced by the project include a booklet and a strip pamphlet focussed on the lives of truck drivers. Both could fit into drivers' pockets. An extra tire and a condom are the two rubber items that a driver "should never leave home without." The booklet has a sleeve to place a condom on the last page. The key rings had rubber logos of a friendly giant condom carrying his spare tire. A cassette tape has pop songs with short drivers' conversational dramas between songs. Both northern and southern Vietnamese accents are heard.

For community-based truck-driver activities, the IEC materials should be revised and reprinted so that there is always a supply at the distribution points. This will allow people to distribute more without fear of running out. The number of intermediaries that these materials pass through to get to the drivers should be kept to a minimum. Condom supply should be increased. Purchasing condoms within the community creates a market, builds sustainability and has economic benefits for members of the community. IEC materials and scientifically proven devices could also be distributed at tollbooths and filling stations, if they are close to the communities involved.

A mix of static³⁴ and dynamic IEC methods will have the greatest effect on both truck drivers and the communities that provide services to them. All the methods chosen, except for the petrol station billboard, may be used in dynamic or static ways. Small posters, stickers, clothing and videocassettes may also be used both ways. T-shirts and caps may be used by the community in static ways or by drivers in a dynamic one. The project should develop methods that may be used either way.

Progress on outputs and activities findings. In the development of a communication programme for truck drivers aimed at behavioural change, two approaches were used. One was a community-based approach in spots where drivers stop. The other was developing peer educators in trucking companies. The community-based models were established in three of the provinces. Long-distance truck drivers participated at each of these sites. Many lessons were learned that may be used to make the programmes more effective. In contrast, the trucking-company approach has not been fully developed, and few truck drivers had participated.

The development of behaviour-change communication for women was a third programme. Project activities involved both younger and older women. Effective activities were developed to reduce women's economic vulnerability and their need to enter the sex trade.

Capacity building can be defined as building knowledge, skills and competency, as well as the power to apply and practise them in an enabling environment. Capacity building is most evident among local collaborators who have spent the most time working on project activities. There are other staff who have learned new skills and developed new competencies during the implementation of project activities but have not had a chance to practise them in their everyday working environments.

Project staff spend a significant proportion of their working time in administrative activities and working on other non-HIV related project activities. Unfortunately, staff are not left with much time to think creatively in order to implement more innovative activities. The WV team members worked well with one another, and the expatriate's management style and the working modes of

³⁴ Items that do not travel with truck drivers.

the three national staff led to a team spirit and staff developing their skills and implementing activities effectively and efficiently.

Strategy and impact findings. This pioneering programme was the first HIV project implemented in Vietnam in which men were specifically targeted for behaviour change. It was also the first project to address the specific needs of truck drivers. Lessons learned in pioneering gender projects such as this one have the potential to influence future activities and have great impact.

Of the two different strategies used for truck drivers, the community-based model is better developed at this stage. It is also the one that is most likely to have an impact. This model tries to influence behaviour directly by trying to convince men to reduce their risk of HIV infection. This is done through outreach activities, dynamic IEC material and promotion of scientifically proven devices. This strategy also changes the drivers' environment through community action geared to create a setting that enables behavioural change. Finally, the community itself benefits from the strategy as community members may take action on their own risks and vulnerabilities. This threefold approach leads to a situation in which everyone benefits.

There are several features of the sites that lead to success in this approach:

- Sites have many small businesses with well-established relationships with truck drivers; thus economic forces that drive these relationships also drive HIV-prevention activities.
- Sites have large numbers of community members participating in the prevention activities for truck drivers; thus many drivers are contacted and many members of the community can see the direct benefits to the community of the project activities.
- Sites are isolated from towns; thus drivers and community members have few other activities to distract them.
- Sites have effective leadership among local implementers, effective support from the Provincial AIDS Committee and a Project Management Board that is part of the community.

The second model involves trucking companies. The effectiveness of this project is unclear, as most drivers have not been reached. The management staff of the companies have not taken responsibility for the project activities. Management has little financial incentive to protect the health of contracted drivers because these drivers pay their own health-care costs, and drivers are trained through an apprenticeship system.

Strategies to reduce the vulnerability of women are also sound. Women who have more life skills, more formal education and more income are less vulnerable than those who do not have these advantages. Skill development is especially important for younger women, who have longer lives to experience defenceless situations. The midterm review process did not allow enough time to do an assessment of how deeply the changes in the women who were trained have penetrated into the community to reach all women.

The STD check-ups confirmed that the prevalence of the sentinel STD, trichomoniasis, is low in women living in the community of Tam Hiep. The check-ups probably had an impact on raising the awareness of the women to the possibility of being infected by their husbands.

Impact Indicators

The two impact indicators developed for this project were:

- At least 50 percent of targeted truck drivers practising safe sex behaviour consistently in risk situations.
- At least 50 percent of targeted women able to protect themselves in risk situations.

The wording used in these two indicators makes clear an implicit gender difference in impact: men risk and women are vulnerable.

Measuring the practise of safe sex and the ability to protect oneself is extremely difficult. Few truck drivers are actually having sex at the locations of the project. However, locations of drivers' home provinces are easily acquired by noting truck license-plate numbers. It may also be possible to develop numerical measures based on condom sales or used condom packages found in the community. However, "gold standard" (rigorous) measures of condom use are only possible in controlled commercial sex situations, such as brothels.

Although the women reached by the project are living in the project area, it is still hard to measure objectively whether they can protect themselves from the actions of their sexual partners. Self-reported condom use could be determined. Process indicators would also make the impact more visible.

Finally, difficulty of measuring impact does not mean that a project does not *have* an impact. Although subjective, the team's belief is that the impact of the community-based model for truck driver behavioural change is great for both drivers and the community. Several of the activities with women have great impact both for the individual women participants and also for their communities. Many projects for mobile populations, such as drivers in communities along transport routes in Vietnam, will be developed through funding by the UNDP and the Asian Development Bank in the next few years. The impact of replication of the WV models for beneficiaries at other sites may be enormous.

Case 3—Heading off HIV/AIDS at the Border, Myanmar³⁵

Background

KAPCCP was the first HIV project begun by WV Myanmar. The project became fully implemented in February 1995. Kawthaung was initially identified as a key intervention area due to the work of WV Thailand in Ranong. This work—HIV interventions with Burmese fishermen and sex workers in Ranong—identified a strong need to reinforce interventions on the Myanmar side of the border. To enable that, a project was established with the aim of building the capacity of local medical practitioners in the treatment of HIV-related diseases and in the development of key education

³⁵ This is an edited version of Karl Dorning and Tim O'Shaughnessy, "WorldVision Myanmar Kawthaung HIV/AIDS Prevention, Care and Counselling, Final Evaluation Report" (1999).

points (their clinics) for HIV information and condom distribution. As mentioned in the Highway One case study, the endorsement of condoms is an activity that WV reluctantly undertakes in order to preserve life.

This initial strategy met with little success for numerous reasons but primarily because general practitioners (GPs) were reluctant to take time from their own practises to take part in project training and activities; and GPs feared they would be stigmatised as “AIDS Clinics” and lose business.

The initial failure led to the development of a community development volunteer (CDV) strategy. This system remains the foundation of the present phase of the project today. Selection and training of local volunteers in HIV-awareness and information-dissemination skills were begun. Raising awareness and promoting condoms, though important, have taken a secondary role. The primary emphasis is on the need for care and counselling of PLWAs and their relatives.

The present phase of KAPCCP has been in operation for three years. The project forms a vital part of a regional HIV strategy which includes the three Thai-Myanmar points of Kawthaung/Ranong, Mae Sot/Myawaddy and Maesai/Tacheleik; the South Tenasserim Strip of Myanmar; and the Golden Quadrangle. Though some of these areas are yet to have established programmes, each one has a particular significance to the regional approach that is being undertaken. KAPCCP's role is important for the following reasons:

- Kawthaung is a major cross-over point for Burmese citizens seeking work in Thailand. Since the beginning of KAPCCP, there has been cross-border co-operation with WV Thailand's project in Ranong. The existence of these two projects means that interventions can be linked and followed up on each side of the border.
- Kawthaung is part of the Tenasserim Strip (Tanintharyi Division) of Myanmar. Most fishermen, border traders and other mobile populations coming to the border originate from other townships in this division, mainly Myeik and Dawei. WV Myanmar began HIV projects during 1999 in these areas. This expansion will enable greater understanding of the people and the factors that influence the spread of HIV. KAPCCP is a vital link in this sub-regional strategy.

Key Objectives of the Project

- to increase the capacity of local GPs, government and NGOs to respond to HIV/AIDS;
- to develop Behavioural Change Communication (BCC) materials;
- to raise community understanding of HIV;
- to increase community acceptance of PLWAs;
- to contribute to cross-border collaboration and to reducing risk behaviour.

At the time of this evaluation in July 1999 the project implementation team consisted of a full-time project manager, a part-time bookkeeper, two half-time and one full-time community development workers and approximately 55 active, part-time CDVs. This core team was supplemented by many of the peer trainers, such as motorcycle taxi drivers, boat drivers and hospitality girls, who had been receiving training by the project since 1995.

Key Findings of the Project

- The project has made significant contributions to improving local capacity to respond to HIV/AIDS. Perhaps the greatest project achievement was the increased HIV-related knowledge, skills and confidence of the CDVs. The evaluation team was very impressed with the CDVs' ability, commitment and enthusiasm.
- CDVs appear to be strongest in giving health talks, weaker in home care and counselling skills.
- The evaluation team found evidence of increased community awareness of HIV/AIDS, increased community acceptance of PLWAs, increased capacity to provide care for PLWAs and reduced risk behaviour.
- The project and/or WV Myanmar produced some BCC materials. The most exciting was an opera written and produced by a CDV on her own initiative. It was based on her experience of nursing a fisherman dying of HIV/AIDS. She later assisted his orphaned children (his wife had died six months earlier, probably with AIDS).
- Overall, the evaluation team felt it was a good community-based project reliant on the voluntary labour of community members. It is one of the few projects whose activities and key human resources (CDVs) rely on little funding. It is likely that many CDVs will continue their activities with no external funding. The network of CDVs in Kawthaung is unusual and very much admired by national and international institutions in Myanmar, such as the National AIDS Commission.
- The project appears to have made a modest contribution to improving the capacity of the government, GPs and communities to respond to HIV in Kawthaung.

Additional Strengths of the Project

- CDVs with varying degrees of skill do a wide range of HIV prevention and care activities. These include health education, distributing pamphlets and condoms, offering PLWA home and hospital care, helping PLWA visitors and AIDS orphans, collecting data, counselling and giving medicines.
- CDVs creatively initiated additional activities, such as orphan care and helping the poor. These initiatives prompted the evaluation team to suggest broadening the training and community roles of CDVs to include primary health care. Doing so will positively reduce the primary identification of the project and CDVs with HIV/AIDS and related sexual issues.
- CDVs are self-managing a community-development fund to support their efforts. CDVs use this fund to help orphans and the poor.

Challenges of the Project

The project identified many areas where improvements could be made. Not surprising, most of the challenges concerned the critical role of the CDVs. The range of CDVs in terms of age, sex, ethnicity,

religion and occupation needs to be widened. More CDVs from high-risk occupations, under age 20, Christians and Muslims are needed for outreach into these communities. Also desired are CDVs to facilitate peer communication such as men to men, youth to youth, hospitality girl to hospitality girl, fishermen to fishermen and IDUs to IDUs.

The evaluation team also found that the gap between urban and rural activities of CDVs is too wide. Rural districts should not be thought as self-contained areas whose residents are insulated from the risk of HIV. Some rural dwellers go to Kawthaung or Ranong for work or recreation. It is important not to be complacent about areas and communities with lower HIV prevalence or incidence at present. The situation can rapidly worsen.

Another set of findings is that a stand-alone HIV project is not the best entry point for an HIV intervention or CDV roles, given that HIV and sex are sensitive or even taboo topics. It is better to start with non-stigmatised, more community-accepted topics and areas for action to build the credibility and standing of the project and its paid and unpaid workers. One way to do this is to train CDVs for an expanded public-health role. A broader focus to include some non-HIV-related drugs and first-aid equipment in the medical kits was a step in the right direction but needed some fine tuning. The CDVs' home care could also include simple diagnosis of some HIV-associated infections, such as oral thrush, and assistance in obtaining appropriate drugs. For more complex infections such as TB, CDVs should notify a doctor. CDVs could then follow up to see that patients take medication regularly.

Other ways to improve the programme include the following:

- Employ full-time CDVs earlier in projects to promote greater capacity building of talented and committed locals and greater project impact.
- Produce local informal education or "tea talk" training guides under central office supervision in HIV-related projects. Teashops are an important site and opportunity for flexible, informal HIV education in Myanmar.
- Have a GP on staff as a technical specialist in HIV projects. The GP would have a roving, community-based practise rather than clinic-based practise. The GP could spend more time helping to give hands-on training to CDVs in home care and help them to gain community credibility and experience by working hand in hand with a GP in a broader health role.
- Encourage CDVs to become community-based organisations.
- Include PLWA participation in BCC activities and materials. Projects should try to encourage PLWAs to associate with one another for morale raising, self-help and group approaches to counselling. Where possible, local PLWA associations should be encouraged.

Closing

Discussed in Section Two are representative WV HIV/AIDS programmes in Asia. The Thailand projects showed the progression of programming from targeting high-risk individuals in Phase One to the provision of sustainable community health care in Phase Three. While behavioural change remained the principal goal, care for PLWAs and their families became increasingly important.

Community-based or more holistic HIV/AIDS programming was also seen in the Vietnam and Myanmar cases. The “community” of Highway One may be abnormal in its physical dimensions and its transient composition, but it does define groups of people with common ties. Behavioural change in the unsafe sex practises of truck drivers and CSWs was the chief goal. A second aim of the project was skill development among young women that would provide them with employment with decent wages, thereby lowering their susceptibility to prostitution.

Evolution towards this more holistic approach to community health was illustrated by the Myanmar case. Through being flexible and open to community needs, the programme evolved from an emphasis on HIV/AIDS prevention. Behavioural change was still important, but deterrence became mixed with much care and counselling of PLWAs and their families. The project relied on motivated volunteers for its high degree of effectiveness.

WV is recognised as a faith-based organisation that has undertaken serious HIV/AIDS work, particularly in Africa and Asia. Like many other faith-based organisations, WV tries to promote behavioural change through the ABC principals of HIV/AIDS prevention.

- **A**bstinence outside of marriage;
- **B**eing faithful within marriage; and
- **C**ondom use if a person can't or won't practise abstinence or faithfulness, and for married couples if a spouse is or may be HIV positive.

Appendix I:

World Bank Recommendations

In 1999 The World Bank (Bank) recently recommended several ways that the organisation will combat HIV/AIDS in sub-Saharan Africa. Most of these proposals are appropriate in the Asian context as well. They include:

- Assist African leaders to mobilize civil society and the private sector to intensify action against AIDS within their countries.
- Build local capacity in national and local government, civil society, and the private sector to lead and implement effective programs.
- Build capacity within the Bank to intensify action against AIDS in Africa.
- Strengthen activities to reduce the impact of socioeconomic factors influencing epidemic spread [such as education for girls, health reform, and poverty reduction].
- Increase funding for HIV/AIDS prevention, care, and treatment.
- Use a multisectoral approach to retrofit Bank-financed projects to reach more vulnerable populations and to address their long-term needs created by HIV/AIDS.
- Mobilize the international community to leverage additional resources.
- Identify innovative means of financing the development of vaccines and other preventive options, such as microbicides.
- Support research efforts to provide decision-makers with the data and tools needed to intensify efforts, including funding and conducting studies on cost of treatment alternatives.
- Declare HIV/AIDS a national crisis and immediately appoint a high-level national task force to assess the current status of the HIV/AIDS program, identify barriers and needs, and review the current national plan for HIV/AIDS to identify gaps (compiled from World Bank 1999d: 27ff.).

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