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In the News

AIDS Cases Up 60%

The estimated number of people with AIDS rose by 60 percent during the past year, from 2.5 million to about 4 million, the World Health Organization (WHO) reported July 1. The greatest regional increase occurred in Asia, where the number of AIDS cases jumped from 30,000 to about 250,000 in 12 months.

"The global AIDS epidemic is now spreading in Asia faster than anywhere in the world," said Dr. Michael Merson, executive director of WHO's Global Programme on AIDS. "While Africa experiences increases in AIDS cases as a result of HIV infections that occurred about 10 years ago, south and southeast Asia are seeing an explosive increase in infections among vulnerable populations."

WHO estimates that 16 million adults and over 1 million children have been infected with HIV since the beginning of the epidemic. Adult infections have increased by about 3 million since July 1, 1993. Almost half the new infections occurred in women.

FHI to Highlight AIDS in Women at Cairo Conference

Family Health International is sponsoring a panel on HIV/AIDS prevention for women at the International Conference on Population and Development, which will be held in Cairo September 5-13. Entitled "AIDS: Generating a Movement for Prevention in Women," the panel will highlight the social, economic and cultural factors that fuel women's vulnerability to HIV; the connections between HIV/AIDS in women and population and development issues, including demographic impact, reproductive health and women's rights; and the policy and program options for preventing AIDS in women. Panel members will include representatives from the United Nations Development Programme and the Society for Women and AIDS in Africa.

It is impossible to discuss reproductive health, population or women's role in development without considering AIDS, noted E. Maxine Ankrah, director of the AIDSCAP Women's Initiative, who will chair the panel. More than 5 million women and 1 million children have already been infected with HIV worldwide.

FHI will also offer a panel on sexually transmitted diseases and family planning and another on barrier methods and spermicides at the conference. The Cairo conference marks the fifth international population conference held under the auspices of the United Nations. The last International Conference on Population and Development was held in Mexico City in 1984.

TB Underestimated in HIV Wasting

HIV wasting syndrome, or "slim disease," is caused by tuberculosis more often than previously thought, according to a British study.

HIV patients who have wasting syndrome shed much of their body weight. This syndrome, which is particularly common in Africa, had been attributed to intestinal parasites or lack of food.

Researchers examined the bodies of more than 200 deceased AIDS patients in the Ivory Coast and found that almost half of the 93 patients with wasting syndrome had also been infected with tuberculosis, although TB treatment was not noted on the patients' medical records. Those who had had the most severe cases of wasting syndrome also had the most severe cases of TB. The researchers concluded that TB, rather than intestinal parasites or lack of food, is probably the cause of the wasting syndrome. *British Medical Journal 308:1531-1533, June 11, 1994.*

HIV/AIDS Prevention for Rwandan Refugees

In collaboration with CARE International, Population Services International (PSI) and John Snow, Inc. (JSI), AIDSCAP is launching a pilot AIDS prevention program for Rwandan refugees in the Kagera region of Tanzania. The program will reach more than 60,000 people in a CARE-operated refugee camp on the Tanzania-Rwanda border.

"Of course the refugees immediate priorities are food, clean water, shelter and safety, but once the camp population becomes more stable, basic public health measures will be essential," AIDSCAP Dr. Peter Lamptey said. "Given the high prevalence of HIV in Rwanda, providing prevention services for the refugees is extremely important."

HIV prevalence is as high as 30 percent among Rwanda's urban populations. Infections rates of 9 to 10 percent have been reported in rural areas in the northern part of the country.

Until civil war broke out, AIDSCAP was implementing a four-year USAID prevention project in Rwanda. As part of this project, AIDSCAP supported a community-based prevention activity implemented by Care and a PSI program to promote and sell affordable condoms. AIDSCAP and its collaborators will draw on this experience in Rwanda to quickly establish sexually transmitted disease services, a reliable condom distribution network and an effective HIV prevention education campaign using trained peer educators.

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COVER Courtesy of the Center for Development and Population Studies

Slowing AIDS: Lessons from a Decade of Prevention Efforts

by Peter Lamptey

Dr. Peter Lamptey, AIDSCAP Director

> The most important lesson learned during the past decade is that prevention programs can—and do—work.

We are in the third decade of the AIDS epidemic, but only in the first decade of a serious prevention effort. The epidemic was not detected until its second decade, and most countries and communities chose to deny its existence for many years.

The virus continues to expand throughout the world, threatening the lives of tens of millions of people. We have no time to waste. After 10 years of prevention efforts, we need to ask ourselves what we have learned about HIV and how we can apply these lessons now to slow the spread of the epidemic during the next decade.

Lessons Learned

During the past decade, our knowledge of the virology and epidemiology of HIV has increased by leaps and bounds, but a vaccine or cure still remains elusive. We have also learned a great deal about how HIV is spread and about the biological and behavioral factors that enhance its transmission. This knowledge has helped us design the prevention programs that are our only hope for controlling the spread of AIDS in the foreseeable future.

Epidemiology and Prevention

Perhaps the most important epidemiological finding about AIDS is that sexual transmission accounts for about three-fourths of HIV infections worldwide. Even though parenteral transmission (blood and injections) plays a key role in the spread of HIV in some countries, it is not a major factor driving the pandemic. Programs designed to reduce sexual transmission will therefore have the greatest impact.

We have also learned that women are particularly vulnerable to AIDS and that prevention programs must address their special needs (see story p. 26). Biologically, women are more susceptible to HIV infection than men. They are also more likely to have undetected and untreated sexually transmitted diseases (STDs) that increase their risk of acquiring HIV infection, in part because STDs are often asymptomatic in women. But the major factors that put women at risk of HIV infection are social and economic, such as poverty, gender discrimination, lack of power in negotiating sex and lack of educational and economic opportunities.

Epidemiologic studies of perinatal transmission point to another important reason for designing prevention programs that target women. Twenty-five to 30 percent of babies born to the estimated 6 million infected women worldwide will be infected either at birth or through breastfeeding. The only practical and feasible way to protect children from HIV is to prevent mothers from becoming infected.

Another key finding that has changed the strategy for HIV prevention is the important role of other STDs in HIV transmission. Studies in various parts of the world have demon-

strated that a history of STD or the presence of an STD such as genital ulcer disease, gonorrhea and chlamydia enhance the transmission of HIV. As a result of these findings, STD care and prevention has become a major strategic approach to controlling HIV.

Behavior and Prevention

One of the most useful lessons learned during the first decade of AIDS prevention is the importance of behavioral research. Such research has given us a better understanding of why people engage in behavior that puts them at risk of HIV infection and has revealed promising approaches for changing that behavior. We know that people need a realistic perception of their own risk before they will take precautions against HIV infection. We also know that peer groups play an important role in creating an environment that supports behavior change.

We have learned that knowledge of the basic facts about AIDS is not sufficient to change behavior. For behavior modification to occur, individuals need to understand what constitutes high-risk behavior and recognize their individual risk and vulnerability, as well as the severity of the consequences of risk-related sexual behavior. In addition to imparting the benefits of low-risk behavior, prevention programs need to give people the skills required to practice safer sex.

Prevention programs in San Francisco and elsewhere have shown that relapses in behavior are common and interventions must be sustained in order to maintain desired changes in behavior. To enable individuals to sustain behavior change, we also need to address community and societal factors, policies, and structural issues that influence and shape behavior. These societal factors include social pressures and cultural expectations for risk-taking sexual behavior, lack of skills in sexual negotiation, and gender discrimination. Ultimately, structural and political changes such as better economic opportunities for women and general socioeconomic development are required.

Research shows that certain risk-taking behaviors are primarily responsible for the rapid spread of HIV throughout the world. The most important of these behaviors are: frequent change of sex partners and sex with a partner who has multiple partners.

Targeting subpopulations who are most likely to engage in such high-risk behavior or who have unusually high HIV prevalence can be an effective approach to slowing the spread of HIV. The majority of successful AIDS prevention programs reviewed by the World Health Organization's Global Programme on AIDS in 1992 were designed to reach special segments of the population. The advantages of this approach include a more efficient use of resources, the ability to design targeted interventions that are relevant to the audience, and better opportunities for involving the community.

In Africa condom sales increased from 1 million to 70 million in four years.

A Limited Arsenal

One of the most difficult lessons learned during the past decade has been that tremendous gains in scientific knowledge about HIV and its transmission do not necessarily result in rapid development of technological weapons against the virus.

Many people continue to pin their hopes on the "magic bullet" of a preventive HIV vaccine. Several candidates are under study, but a commercially available vaccine is probably many years away. The ideal vaccine would be safe, orally administered in a single dose, stable, inexpensive and effective against all HIV strains and would confer permanent lifetime immunity. The chances of such a vaccine in the foreseeable future are slim.

There have been only modest advances in the development of a cure or therapeutic vaccine. AZT and other antiretroviral therapy can slow the progression of HIV to AIDS and may also reduce the risk of perinatal and sexual transmission. However, even if antiretroviral therapy proves safe and useful in prevention, the current high cost makes its use impractical in developing countries.

The male latex condom continues to be the mainstay for prevention of HIV and other STDs. Other options are being field tested, including plastic condoms for men and women. If these new condoms are to be of use in HIV prevention, they must be acceptable and affordable to users. Research must be intensified to find additional prevention methods that women can control, including safe and effective microbicides.

Prevention Works

Our prevention options are limited, but we are not losing the battle to AIDS simply for lack of a technological fix. The most important lesson learned during the past decade is that prevention programs can—and do—work.

A comprehensive AIDS prevention program should include three approaches: 1) behavior change communication to reduce high-risk sexual behavior, improve STD symptom recognition and care-seeking, encourage proper and consistent use of condoms, and promote low-risk sexual norms; 2) improved STD diagnosis and treatment; and 3) provision of acceptable, affordable and accessible

L. Gabb/WHO

A YOUNG WOMAN AND HER BABY IN TANZANIA. THE ONLY PRACTICAL WAY TO PROTECT CHILDREN FROM HIV IS TO PREVENT MOTHERS FROM BECOMING INFECTED.

condoms to target populations. Each approach alone leads to reduction in HIV transmission, but mathematical modeling of the epidemic has shown that a combination of all three interventions produces the maximum benefit.

Success Stories

A 1992 review of STD/HIV prevention programs worldwide revealed large observed changes in sexual behavior and marked increases in condom use in a number of programs. A few programs actually showed a correlation between behavior change and changes in biological indicators such as STD and HIV incidence.

One of the most promising intervention strategies is condom social marketing (CSM). In Zaire, with funding from USAID, Population Services International used both mass media and social marketing to reach youth and young adults between the ages of 20 and 30. Condom sales increased from 100,000 at the start of the program in 1987 to over 18 million five years later.

Condom social marketing programs in Haiti, Cameroon, Burkina Faso, Côte d'Ivoire and Ethiopia have had similar levels of success. In 1993 nearly 12 million condoms were sold in Ethiopia, 6 million in Cameroon and 5 million in Haiti. In Africa, overall condom sales increased from less than 1 million in 1988 to almost 70 million in 1992.

CSM illustrates the successful use of marketing principles by the private sector for a social and health benefit. It changes behavior and sells condoms. The main advantages of this approach are that it is cost-effective, improves coverage of the general population, ensures partial cost recovery and employs innovative and culturally appropriate mechanisms to promote desired behavior.

In Thailand, another successful program promoted 100 percent condom use in many of the country's sex entertainment establishments. The program involved the brothel owners, sex workers and clients, as well as the local government. Marked increases in condom use have been reported from several sites. In Samut Sakhon, a province south of Bangkok, the rate of condom use in brothels approaches 100 percent. The monthly number of condoms used by sex workers in the province increased from less than 15,000 to over 50,000, and the STD incidence among sex workers dropped from 13 percent to 0.3 to 0.5 percent.

An AIDS-in-the-workplace program involving two major transport companies and seven truck stops, launched in Tanzania in 1989, trained truck drivers, barmaids and hotel personnel to provide AIDS education and distribute condoms. One thousand five hundred bars, hotels and guest rooms were equipped with "condoms prevent AIDS" stickers and condoms. Nearly six million condoms were distributed over 30 months, and reported use of condoms by men increased from 54 to 74 percent. Both men and women reported increases in condom use with commercial and regular partners.

A community-based intervention in Mexico targeted sex workers, clients and men who have sex with men. Over 200 peer educators provided AIDS education in bars, dance halls, brothels and the streets in Mariscal and La Paz. Over a period of 12 months, the number of sex workers reporting that they had not used condoms during their previous 10 acts of intercourse decreased from 17 to 1 percent, and those who had used condoms in all 10 acts increased from 50 to 80 percent.

Future Challenges

If prevention programs work, why does AIDS continue to spread so rapidly? To date, prevention programs have not been sufficiently comprehensive, large or sustained to have a measurable impact on the epidemic. Most successful interventions have been small-scale and limited to selected communities or geographic areas. If AIDS prevention programs are to have a national impact, they must cover a large proportion of the populations at risk for a long period of time.

The weakest components of AIDS prevention programs in developing countries are STD care and the availability of affordable and accessible condoms. Unless these services are improved in all interventions, the impact on the AIDS epidemic at the national level may be limited. Other challenges in AIDS prevention include the urgent need for increased resources, supportive policies and greater involvement of the private sector and community-based organizations.

Before the year 2000, as many as 40 million people may be infected with HIV worldwide, with over 40 percent of infections in Asia and another 30 percent in Africa. Despite these grim projections, donor funding for AIDS prevention worldwide is on the decline. To avoid this terrible but preventable doomsday scenario, communities, businesses, governments, nongovernmental organizations, donor agencies and development banks must increase the resources devoted to HIV prevention.

According to WHO, a comprehensive prevention package for countries in the developing world would cost between US$ 1.5 billion and $2.9 billion a year, which is approximately 10 times more than is spent today. WHO predicts that this "package" would halve the number of new HIV infections between now and the year 2000.

Without additional resources, AIDS prevention efforts will continue to be small-scale, patchy, short-lived and ineffective in slowing the epidemic. Eventually both prevention and care will cost far more if adequate resources are not provided now.

WHO estimates that developing countries will spend more than $US 1 billion on health care for AIDS patients during the remaining years of this decade. AIDS treatment costs will be dwarfed by the indirect economic and socials costs resulting from the premature deaths of workers and parents throughout the world. Unless we provide adequate resources for AIDS prevention now, we will pay a very high price indeed in the years ahead.

Peter Lamptey, M.D., Dr.P.H., is director of the AIDS Control and Prevention Project and senior vice-president of AIDS programs, Family Health International.

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SPECIAL SECTION

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AIDS in Asia: Facing the Epidemic

by Stephen Mills

Richard Ford

> The number of annual HIV infections in Asia is expected to surpass those in Africa in the mid- to late 1990s.

Even before its discovery in 1983, the human immunodeficiency virus had already begun its rapid spread, largely unnoticed, throughout several continents of the world. Because of international travel and migration patterns, the late 1970s and early 1980s witnessed the spread and establishment of substantial HIV epidemics, most notably in sub-Saharan Africa, but also in North America, Latin America, Europe and Australia.

In HIV's progression from continent to continent, Asia—home to half the world's population—has become the virus' last epidemiologic frontier. Although infection rates in certain Asian populations are already among the highest in the world, visible health and economic effects of the HIV epidemic are still negligible because relatively few infections have progressed to AIDS. Even in Thailand, where the epidemic is most advanced in Asia, over 5,000 cases of AIDS and AIDS-related complex had been reported by the end of 1993 out of an estimated 600,000 HIV infections.[1]

In developed and developing countries alike, experience with the HIV epidemic has demonstrated that the appearance of significant numbers of AIDS cases triggers prevention responses from both individuals and policy makers. Condom use increases and funding for HIV prevention is granted more readily after a visible threshold of HIV-infected individuals convert to AIDS.

This pattern of delayed response to HIV presents Asia with its greatest challenge in facing the epidemic. HIV's incubation period in which no symptoms occur — estimated now at an average of 10 years — has permitted the disease to spread silently throughout many Asian countries. The inability of individuals and policy makers to recognize and respond to an invisible problem remains the most formidable barrier to prevention.

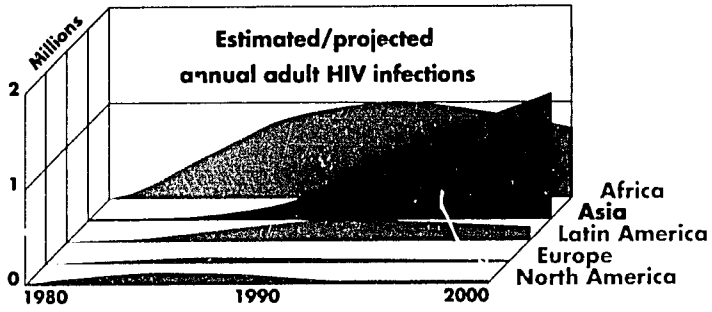
An Explosive Epidemic

At the end of 1993 the World Health Organization (WHO) estimated that more than 14 million people had become infected with HIV since the beginning of the epidemic.[2] Although the virus seems to have spread later in Asia than elsewhere, the rapid rate of transmission in heavily populated South and Southeast Asia has produced more HIV infections than anywhere else except sub-Saharan Africa.

In fact, the number of annual infections in Asia are expected to surpass those in Africa in the mid- to late 1990s. Projections of the HIV/AIDS epidemic though the year 2000 devel-

oped by Dr. James Chin, formerly chief of surveillance, forecasting and impact assessment for the WHO Global Programme on AIDS, suggest that the annual number of new infections in Africa will soon begin to decline, while HIV seroprevalence will continue to rise in Asia (see the figure below).

Dr. Chin, now clinical professor of epidemiology at the School of Public Health, University of California, Berkeley, attributes these trends to both the effectiveness of prevention programs in certain parts of Africa as well as the epidemic reaching saturation levels there. Conversely, South and Southeast Asia are at an early stage of the epidemic, with infection rates increasing rapidly and beginning to spread from core groups of people whose behavior puts them at high-risk of acquiring the virus to the general population.



"During the first decade of HIV, a few AIDS cases were detected in Asia, but most of them were imported from elsewhere," Dr. Chin said. "This led to a lot of denial and speculation that AIDS would never be a significant public health problem—that it was an African, European, and U.S. problem. Now, finally, it's being recognized that we have explosive outbreaks in Asia as well."

Although it is currently estimated that approximately 65 percent of HIV in Asia is among males,[2] the ratio of male-to-female infections may be narrowing as more women become infected. This is especially apparent in Thailand, where surveillance data indicate that rates among antenatal clinic clients — representative of a broad segment of Thai women — are increasing. In southern Asia, the low average age of marriage and high fertility rates may contribute to women's higher susceptibility to HIV in that region.

AIDS' Impact Varies

As on other continents, where two neighboring countries can have different rates of HIV infection because of differences in migration patterns, levels of injection drug use, and social norms that govern sexual behavior, Asian countries are not experiencing uniform HIV epidemics.

Currently the most severe HIV epidemics in Asia are in Thailand, India and Myanmar (formerly Burma). In these countries, HIV has progressed well beyond core groups, such as commercial sex workers (CSWs), injection drug users and male clients of sexually transmitted disease (STD) clinics, to the general population.

Even within these countries, the extent of the epidemic varies, with Thailand reporting the highest levels of infection in Asia. The epidemic progressed rapidly among injection drug users in the early to mid-1980s, but HIV prevalence in this group appears to have stabilized at approximately 35 percent.[1] This stabilization may be due to outreach efforts and increased access to sterile injection equipment.

In other groups monitored at sentinel surveillance sites to track the epidemic in Thailand, HIV infection rates increased nationally from 3.5 percent in June 1989 to 26.1 percent in December 1993 among brothel-based sex workers and from 0 to 7.7 percent among male clients of STD clinics during the same period.[1]

Sentinel surveillance at antenatal clinics provides firm evidence that HIV is spreading to the general population. Seroprevalence increased nationwide from 0 percent in June 1989 to 1.5 percent in December 1993 among women attending these clinics. Furthermore, in a related study, HIV seroprevalence increased from 0.5 percent in 1989 to 4 percent among 1993 Thai army conscripts, who are representative of the young, lower-income male population. In all surveyed groups, rates are highest in the northern, rural area of the country.[1]

Despite these alarming rates of HIV infection, there are some encouraging signs that people are beginning to change their behavior, suggesting that the Thai government's commitment to 100 percent condom use in brothels is having its desired effect. New cases of sexually transmitted diseases at government clinics declined by 75 percent from 1989 to 1993.[1]

In India, as in Thailand, sentinel surveillance has revealed rapid increases in HIV seroprevalence among groups who engage in high-risk sexual activity. Infection rates among sex workers in Bombay increased from 1 percent in 1987 to 41 percent in 1992.[1] In Madras, similar studies of STD clinic clients showed infection rates rise from 0.6 to 1.4 percent in 1986-1989 to 8.5 percent in 1991-1992.[5,6]

Seroprevalence studies among antenatal clinic clients and blood donors have shown limited HIV infection, but this data may indicate the beginning of a substantial epidemic in the general population.

Partially because of the country's large population, WHO estimates that India may have more HIV-infected individuals than any other country in the world by the year 2000.[2]

Recent seroprevalence surveys from Myanmar indicate an advancing HIV epidemic, with infection rates climbing among injection drug users, STD clients and general population groups such as antenatal clients. In 1992, 58 percent of injection drug users in sentinel surveillance surveys were found to be HIV-infected. Furthermore, seroprevalence among STD clients increased from 0.5 percent in 1989 to 11.0 percent in 1991. In 1989, none of the women tested at antenatal

clients were infected, but by 1992, 2.2 percent were HIV-positive.

Other countries in Asia are reporting more limited HIV infection, although many have yet to establish surveillance systems that could capture HIV rates at an early stage. One common trajectory of the HIV epidemic is initial low rates in core transmitter groups, followed by a rapid increase, which then transfers the epidemic to the general population — sometimes within two to three years.

Indonesia may prove to be an example of this pattern. Few seroprevalence studies have been conducted, but the HIV and AIDS cases found to date (174 as of December 1993) suggest that the country may actually have between 25,000 to 40,000 infections. Indonesia has the conditions conducive to rapid, widespread transmission: a thriving commercial sex industry with a broad client base, low condom use rates and high rates of STDs.

Border Traffic and HIV Transmission

HIV moves where people move. This is how the epidemic spreads from a high-prevalence area to a low-prevalence area, where it can develop into an indigenous epidemic.

It is highly probable that HIV gained momentum in Myanmar through the international trade of prostitutes and heroin in border towns near and in Thailand. These border areas have some of the highest infection rates in the world because of the sexual networks between the two countries.

Likewise, most of the 38 people known to be HIV-infected in Laos have been identified as returnees or refugees from Thailand or from provinces bordering Thailand. While a new bridge across the Mekong River between Laos' capital city, Vientiane, and Thailand is expected to increase trade between the two countries, it is also expected to increase the flow of HIV into Laos—and back into Thailand.

In fact, another dimension of cross-border transmission is the periodic reintroduction of HIV and other STDs from a low-prevalence country to the neighboring high-prevalence country. This may occur in the case of Thailand and its three poorest neighbors —Cambodia, Laos and Myanmar — who cannot afford proper STD treatment and aggressive condom promotion.

Mobile populations between Nepal and India are thought to contribute to HIV in both countries. Nepali prostitutes often work in northern Indian cities, and some are reported to have been infected with HIV, then sent back to Nepal, only to engage in prostitution in their home country. Similarly, truck drivers and other transportation workers move frequently and freely along routes between India and Nepal and often visit sex workers stationed along these routes.

Most of the HIV infections in China have been reported from Yunnan, a southwestern province on the Burma-Laos border and near the Thai border — an area becoming increasingly known as the "Golden Rectangle" because of its economic potential. It is also home to a high rate of injection drug use fueling the HIV epidemic. Since 1990, HIV has been found in 19 Chinese provinces, counties and urban areas.

As Vietnam opens its borders to international trade and tourism, HIV will likely gain in that country as well. Already Vietnamese prostitutes in Cambodia have been reported to be HIV-infected, and it is likely that some of them will return to Vietnam and unwittingly spread the epidemic. To date the most severely affected population in Vietnam has been injection drug users; seroprevalence among this group in Ho Chi Minh City rose from 2.4 percent in late 1992 to 34.8 percent in early 1994.[8]

Cambodia, still recovering from civil war, has only recently begun to consider AIDS a potential problem for monitoring. A 1992 survey of CSWs revealed an HIV infection rate of 9.2 percent. In the same year 0.84 percent of 3,584 blood donors were found to be HIV-positive.[9] Heavy border activity with Thailand, high rates of STDs among United Nations troops formerly stationed in Cambodia, and a continual recirculating stream of prostitutes from Vietnam may contribute to a sizable epidemic in the future.

Looking Ahead

Because of the early stage of HIV in Asia, the health and economic impact of the epidemic is still not apparent to many policy makers in Asian countries. However, the burdens befalling Africa today—the maintenance of prevention programs, individual relapse into non-condom use after temporary adherence, burgeoning care costs, HIV orphans —will be experienced by Asian countries in the future.

Dr. Tim Brown of the University of Hawaii's East-West Center and Dr. Werasit Sittitrai of the Thai Red Cross Society already predict that as many as 140,000 children in Thailand will be orphaned by HIV by the year 2000.

"In 1991, the Department of Public Welfare provided institutional care for only about 8,000 children," Dr. Brown noted. "The increase will be a great burden on public-sector social services and on nongovernmental organizations that work with orphans."

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Evolution of the Response to AIDS in Thailand

Wiwat Rojanapithayakorn, Ministry of Public Health, Thailand

Thailand's response evolved from early denial that AIDS was a serious problem to one of the world's most agressive, comprehesive control programs.

A WOMAN AND HER BABY FROM NORTHERN THAILAND, WHERE HIV PREVALENCE IS PARTICULARLY HIGH.

G Diez/WHO

The first case of AIDS in Thailand was reported in September 1984. By April 1994 a cumulative total of 5,990 cases had been reported,[1] and it was estimated that over 600,000 people in the country had asymptomatic HIV infection.

Although HIV has been with us for more than a decade, most of the AIDS cases in Thailand were detected during the past two years —3,959 (66.1 percent) of them in 1993.[1] Many more cases are expected in the future as the people with asymptomatic infections begin to fall ill.

During the early years of the epidemic, all detected cases of AIDS were among homosexual or bisexual men. After an explosive HIV epidemic among injection drug users beginning in 1988 and a rapid increase in HIV prevalence among female sex workers in 1989, the virus spread to heterosexual men and their female partners and newborns. Today heterosexual intercourse is the most common mode of HIV transmission in Thailand.

The profile of the AIDS situation in Thailand has changed rapidly. As a result, the government has continuously adapted and refined its policies and strategies to combat AIDS. Over the first decade of the epidemic, this response evolved from early denial that AIDS was a serious problem for Thailand to one of the world's most aggressive, comprehensive programs to control HIV/AIDS.

Early Response (1983 - September 1987)

Action began in 1983 in the form of basic public education through some government sexually transmitted disease (STD) clinics.[2] Until September 1987, the government concentrated on assessing the extent of the AIDS problem in the country and warning people perceived to be at risk of infection about its dangers. The Ministry of Public Health (MOPH) investigated reported cases and established serosurveillance among groups of people whose behavior put them at

The number of condoms supplied through the public sector increased from 4 million in 1987 to 60 million in 1994.

high risk of acquiring HIV, including homosexual and bisexual men, injection drug users and commercial sex workers.

In August 1987 the Department of Communicable Disease Control (CDC) of the MOPH requested financial support from the government to carry out an AIDS prevention and control plan from 1987 to 1991. Approved for launch in October 1987, the plan called for HIV serosurveillance among many target groups, AIDS education activities for the public, and training of health personnel.

All these activities were carried out independently by different units of the government located mostly within the health sector. Although an AIDS committee was established in 1985, the coordination among relevant agencies was very limited due to the low level of AIDS awareness among them.

Centralization (October 1987 to mid-1989)

To improve coordination of AIDS activities, the MOPH established the Center for Prevention and Control of AIDS in October 1987. Although this center had a small staff and limited office facilities, it undertook many AIDS surveillance and prevention activities.

In 1988 the MOPH began universal testing of blood donations, prompted by public concern about a widely publicized case of HIV infection through blood transfusion in 1987. Blood donations had been tested as a surveillance activity since 1985; in 1987, only five units of blood were found positive among over 140,000 units tested. Due to a delay in procuring testing equipment, nationwide coverage of this measure was not achieved until mid-1989.

Thailand received its first financial and technical assistance for AIDS from an international organization during this period when the MOPH developed a short-term plan for prevention and control of AIDS in 1988 with the support from the World Health Organization (WHO).

Also for the first time, government funds were used to procure condoms, which were considered essential to prevent HIV transmission in Thailand's many commercial sex outlets. The number of condoms supplied through the public sector was increased from 4 million donated by the U.S. Agency for International Development in 1987 to 60 million — all procured with government funds — in 1994.

Intrasectoral Collaboration (mid-1989 to mid-1991)

The government soon realized that to rapidly implement the AIDS program, it needed to integrate AIDS activities into the existing health system, empowering more personnel to help run the program. Therefore the MOPH shifted activities such as planning, health education, epidemiological surveillance and training from the AIDS Center to the divisions responsible for those areas within the ministry.

The program was expanded nationwide by assigning AIDS activities to all provincial health authorities. HIV education and condom distribution were integrated into the activities of the 73 provincial health offices. The disadvantage of this measure was that the provincial health authorities were not adequately prepared to implement the program.

During this period, several measures helped raise the priority given to AIDS interventions. Perhaps the most important of these was the appointment of the permanent secretary of the Ministry of Public Health (who is a political appointee and the highest-level civil servant in the MOPH) as chairperson of the National AIDS Committee (NAC). As a result, each MOPH department was required to develop an AIDS plan in addition to and in coordination with the CDC Department program.

In 1989, government funding for the national AIDS control program was only US$ 442,000. A medium-term plan (MTP) for prevention and control

Laboratory officers in Bangkok participate in an AIDSCAP-supported training session to improve STD diagnosis. AIDSCAP

of AIDS for 1989-91 attracted more than US$ 7 million from international donors.

To monitor the epidemic, the MOPH developed a sentinel surveillance system in 14 provinces in mid 1989 and expanded this system nationwide the following year. Blood samples were collected from all drug rehabilitation, STD and provincial antenatal clinics and from some randomly selected sex establishments. The information collected by this system has been used to estimate the number of HIV infections in the country, formulate appropriate strategies for each province, and convince policy makers to approve the funding required for the control program.

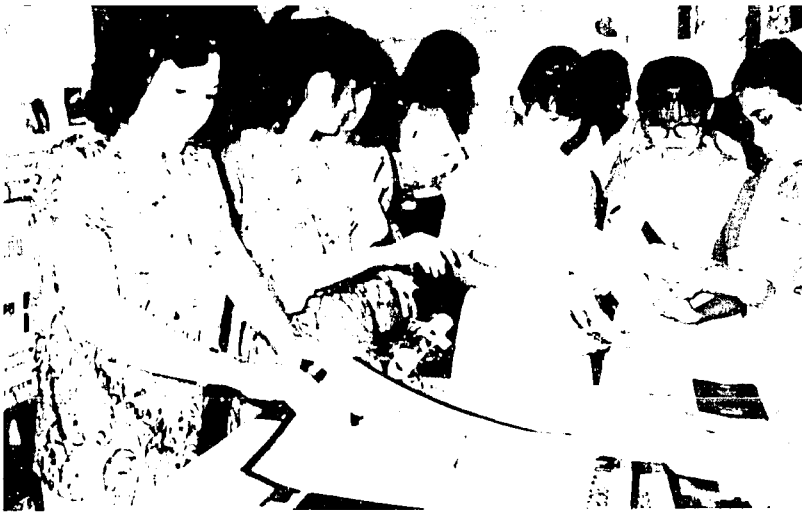
The MOPH also made efforts to involve other government ministries in the program. With the exception of the Ministry of Education, however, the involvement of other ministries was very limited until 1991.

Involving Other Sectors (since mid 1991)

In 1991 the AIDS challenge was brought to permanent national attention when the Prime Minister assumed the chairmanship of the recently revised NAC. As a result, AIDS became a top issue for the government and media. This commitment was reflected in the overall government budget for AIDS, which increased from US$ 200,000 in 1988 to $45 million in 1993.

Some of the increased AIDS funding went to other government ministries to enable them to apply their particular strengths to the anti-AIDS campaign. Prior to this phase, AIDS had been viewed in Thailand primarily as a health problem that should be solely the responsibility of the Ministry of Public Health.

With a broader mandate and increased funding, the AIDS program made significant progress. Millions of people were reached through national mass media campaigns to promote AIDS prevention, and anonymous counseling and testing services were expanded to all 89 provincial hospitals and over 500 community hospitals. STD units were established in 130 of the country's 600 community hospitals, and an extensive condom quality control program was put in place.



Nurses attending a workshop on AIDS Prevention. WHO

AIDS Prevention Policies

100 Percent Condom Programs

The first 100 percent condom program was established in 1989 in a province south of Bangkok. Health officials, local administrators and police collaborated to convince managers of sex establishments to ensure that free condoms were available and that all clients were told to use them. If clients did not comply, managers were supposed to ask them to leave (with a full refund if money had been collected before the act).

The program was copied in many provinces. Because of its effectiveness in these provinces, a 100 percent condom policy became the official policy of the NAC in August 1991 and provincial health officers were charged with working with local authorities and managers of sex establishments to enforce it.

Medical Care and Counseling

At the early stage of the AIDS epidemic, hospital personnel were not prepared to care for HIV/AIDS patients. In 1987 the Infectious Disease Hospital of the CDC Department was assigned to provide these services. Many problems emerged, such as massive referral of cases to this one hospital, ignorance of personnel in other hospitals, and suffering imposed on AIDS patients who had to travel to the assigned hospital.

To resolve these problems, the MOPH formulated a policy to provide medical care and counseling services in all provincial hospitals. Training courses and sessions on AIDS care and counseling were organized and supplies of drugs and protective equipment were distributed, along with guidelines and handbooks on counseling and universal precautions against occupational exposure.

In addition, to improve quality of life of people with HIV/AIDS, in 1992 the NAC approved a policy to provide free antiviral drugs to all patients with full-blown AIDS who are unable to afford them.

Confidentiality and Antidiscrimination

In 1987, a case of blood-transfused AIDS was announced to the public. The patient faced prolonged suffering from discrimination until he died in 1990. Recognizing the problem, the government issued policies on confidentiality and antidiscrimination. These policies were enforced through regulations requiring confidential reporting of cases, prohibiting HIV screening without consent, promoting universal precautions instead of blood testing to protect medical personnel, and prohibiting discrimination in providing care to AIDS patients.

Lessons Learned

As the first nation in Asia to face an explosive AIDS epidemic, Thailand has learned many valuable lessons that could help other countries just beginning to feel the impact of AIDS. Some of the most important lessons include the following:

Measures to emulate

- ***Strong commitment from the highest government policy-making body.***
  The NAC should be led by the highest-ranking government authority possible, such as the deputy prime minister or prime minister.
- ***Effective nation-wide condom promotion.***
  A measure similar to the Thai 100 percent condom program should be considered. Adequate condom supply and regular quality assurance measures should be an integral part of the AIDS control program.
- ***Sentinel surveillance.***
  Establish a good sentinel surveillance program to provide accurate information on prevalence of HIV among target populations.
- ***AIDS education should be integrated into formal education at all levels.***
  This is much more economical than operating many expensive AIDS awareness campaigns.
- ***Mandatory testing of blood donations.***
  Where affordable, this is a very effective prevention measure.
- ***Strong involvement of NGOs and the private sector.***
  An NGO consortium and a national NGO subcommittee can be very useful in guiding NGOs' participation in the national AIDS program.

Pitfalls to avoid

- ***Avoid delay in integrating AIDS into the regular health service system.***
  Efforts should be made to eliminate denial of the urgency and relevance of the problem to speed integration of AIDS into the general health infrastructure. This will also speed the adoption of a multisectoral approach.
- ***Avoid providing unnecessary public AIDS education.***
  Massive education campaigns by all ministries are costly and result in confusion and duplication. Information campaigns should be properly coordinated to share resources and should be closely evaluated. Repeated education activities to provide general messages should be avoided. More attention should be paid to designing education programs that are effective in changing the behavior of the target population.
- ***Monitor HIV prevalence in rural areas early in the epidemic and develop appropriate interventions to reach rural populations.***
  Despite the extensive efforts to control the AIDS epidemic in Thailand, infection rates continue to increase, especially among the sexually active population in rural areas. In some areas of the country, rural prevalence of HIV now exceeds urban prevalence. This finding indicates that more comprehensive interventions are needed to reduce the risk of rural

Major Achievements

- With a high-level political commitment, through and by the NAC, the AIDS prevention program has achieved more active multisectoral involvement and greater resource availability. In 1989, foreign donors funded 90 percent of the AIDS efforts in Thailand. By 1994 the Thai government contribution had increased to US $53.5 million — far more than the $8-10 million provided by foreign and international donors.
- Over 90 percent of the workers in sex establishments report consistent use of condoms.[5] This is largely the result of the nationwide 100 percent condom use policy. Strong evidence for the impact of this program comes from the abrupt decrease in STD incidence at government clinics from 6.5 per 1,000 population in 1989 to 1.6 in 1993, the lowest level in the past 20 years.[6]
- The blood supply in the country is now highly safe from HIV due to the government policy requiring mandatory testing of all blood donations, rational use of blood, donor selection and deferral of donors who are HIV positive.

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Officials at a police post distribute condoms and AIDS prevention education to transport workers at this small police post along the Tribhuwan Highway.

Using Local Resources to Fight HIV/AIDS in Nepal

by Mahesh Bhatterai, General Paper Industry

A small police post along the Tribhuwan Highway is the gateway to and from Nepal's Kathmandu Valley. Every day an average of 1,400 trucks, buses and private cars stop here for a few minutes to register with traffic police.

The highway post is also the site of a unique AIDS prevention effort by a local nongovernmental organization (NGO) funded entirely by corporate contributions from a Nepalese paper company. This effort to reach transport workers with AIDS prevention messages is the first of several AIDS programs carried out by the NGO, General Welfare Pratisthan (GWP).

As one of the directors of General Welfare Pratisthan and general manager of its corporate donor, I believe that the best and only vaccine available to fight HIV/AIDS is to educate people about prevention. GWP's efforts are focused on creating awareness of the virus among vulnerable communities in Nepal.

Getting Involved

GWP began providing community development services in 1991 with funding from General Paper Industry, a private, family-owned company that produces paper products and packaging materials from recycled paper and cloth materials. General Paper Industry exports the majority of its products to The Body Shop International, the United Kingdom-based cosmetics company. Its philanthropic associations with the local community were initially inspired by Body Shop Managing Director Anita Roddick's corporate philosophy of support for community development. Currently our company contributes 10 percent of its annual export value to GWP.

Since its inception, GWP has concentrated on improving health, education and the environment. GWP health camps bring basic health services and simple AIDS awareness information to four remote, mountainous villages. In these four villages and several others, GWP encourages families to educate their girls as well as boys by providing scholarships for girls in 120 families. In the environmental area, GWP has helped organize local community-managed forest protection schemes and supported the development and use of innovative wood stoves that use less wood and emit less smoke.

Joining the Battle Against AIDS

In Nepal these three sectors — health, education and the environment — require continuing assistance from groups like GWP. But in the view of our organization, the most important issue is the threat of HIV/AIDS. Nepal is a small, landlocked country dependent upon the Indian transport system for international trade. Our country shares an open border with our large neighbor to the south, where it is estimated that 1 million people may be infected with HIV by the year 2000. Hundreds of thousands of Nepalese men seek work as migrant laborers in India. Up to 100,000 Nepalese women work as commercial sex workers in Bombay, Calcutta and Delhi, as well as smaller Indian cities and towns close to the Nepalese border.

In Nepal HIV/AIDS is perceived as a new problem. In early 1993 124 cases of HIV infection had been reported. A year later, the number of known HIV-positive individuals totaled 201, but it is estimated that many more people are infected with the virus.

Over a year ago, GWP reevaluated its community activities and made a strategic decision to devote a greater portion of its social contributions to HIV/AIDS prevention. Given that HIV does not recognize international borders and that thousands of Nepalese

and Indians cross our shared border every day, and knowing that the majority of people have little knowledge of HIV/AIDS, we felt that it was critical for our organization to become more involved in spreading basic prevention messages in Nepal.

More and more men are willing to speak openly to outreach staff about HIV/AIDS and STDs.

To kick off our AIDS awareness efforts in early 1993, GWP sponsored a half-page advertisement in the most widely circulated national newspaper, Gorkha Patra, with the message "Use Condoms to Protect Yourself Against AIDS." The message was simple and the advertisement did not include an illustration. At that time we thought Nepal's conservative society was not ready to accept an illustration of a condom on the front page of its most popular daily paper.

Reaching Transport Workers

GWP's first target group for AIDS awareness was an important "community" untouched by other AIDS prevention efforts in Nepal: the nation's transport workers. We believed that by starting an awareness program on Nepal's major transport route among one of the country's largest transient groups, we would be able to disseminate our messages to distant parts of the country from a few sites.

Since GWP had never worked directly with this group, we talked to transport union officials, community leaders and traffic police to determine where and how to place our intervention. Based on their advice, we chose the police post on the Tribhuwan Highway at Thankot. Since the post consisted of a chair and a simple shelter, we offered to build a weather-proof building for the police and an adjacent post for GWP's outreach staff. The police were happy to be offered an all-weather shelter and supported GWP's plan to distribute condoms and AIDS awareness messages to all passersby.

GWP's program began with a staff of two trained outreach workers — one man and one woman — who gave prevention packages to drivers and vehicle crews as they queued to complete the required traffic registration. Each package contains two condoms, a simple brochure describing HIV transmission and its prevention, and a matchbox inscribed with the message, "Use a condom to protect yourself against AIDS."

At first the primary attraction of our outreach efforts were the free matchboxes. In Nepal a matchbox is an essential item. But over time people became more interested in the other items in the package and began to ask for the condoms.

After a month of outreach, however, a group of transport workers protested against our efforts, complaining to GWP staff and the police. They also voiced their complaints in a newspaper article, saying that "some well-dressed and good-looking individuals are distributing condoms and talking about AIDS at Thankot, thinking that we, transport workers, are the only culprits to visit prostitutes. We are very dishonored by this program."

GWP continued its outreach work but immediately launched a new initiative to directly involve transport workers in our efforts. We announced a Transport Workers AIDS Prevention Suggestion Campaign and solicited advice from transport workers nationwide. To encourage participation, we offered prizes for winning suggestions, including a top prize of a black and white television (a luxury in Nepal).

Almost 1,000 transport workers entered the competition. To fairly evaluate the suggestions and to further involve other important communities in our AIDS prevention efforts, we asked a panel of judges representing the Nepal Journalist Association to choose the winners. The results of the competition were announced at a special ceremony held near the Thankot outreach site, which was well-attended by truck drivers, bus drivers, transport union officials, traffic police and the press.

The winning entry, submitted by a 28-year old truck driver from Mechi Zone, addressed the problem of prostitution and the need for sex education in schools. "In districts such as Sindhupalchok, Nuwakot, etc., there is a prevalence of prostitution because of ignorance, low education and unemployment," he wrote. "There should be provisions for strict punishment for the people who sell and force young girls and women to work in prostitution....There should be compulsory sex education in the curriculum of middle-level schools."

The second place winner suggested painting AIDS prevention slogans on the bodies of buses and trucks, and said that transport workers "are happy to be involved in the publicity work against AIDS." The third place entry also advocated AIDS education in schools.

Transport workers' enthusiastic participation in the contest and the positive publicity it received, as well as continued efforts to consult with transport workers and involve them in prevention efforts, reduced opposition to GWP's program. Drivers stopping at the police post are now more likely to react positively to condom distribution efforts, and some will even ask for condom packets. More and more men are willing to speak openly to our outreach staff about HIV/AIDS and sexually transmitted diseases (STDs). When the GWP outreach post closes for the day, traffic police officers working the night shift often offer packages of condoms to passing drivers.

Reaching Youth

These experiences with transport workers encouraged GWP to involve other communities in AIDS prevention. Our next activity was to recruit student volunteers from 23 college campuses in the Kathmandu Valley to serve as motivators at the Thankot highway outreach post during the school holiday. The volunteers were given a small transportation allowance and trained by our permanent outreach staff.

The student volunteers were well accepted by the passing transport workers. More important, the students shared their experiences as outreach volunteers with their university friends when they returned from holiday, playing a critical role in informal discussions and in meetings organized to discuss the role of HIV/AIDS in Nepal. The final round of a student essay competition, held on World AIDS Day in December 1993, was attended by the volunteers and other students from the 23 campuses as well as officials from the Ministry of Education.

On World AIDS Day we published a second AIDS awareness message in Gorkha Patra, but this time we included an illustration of a condom in the advertisement. While there was some discussion of the advertisement, no public complaints were voiced.

The public's positive reaction to the advertisement inspired GWP to spread the condom protection message on an even wider scale. In an effort to reach young people, we asked the Nepal Motion Picture Association to provide free public service advertising space for a simple prevention message suitable for general audiences. After some negotiation, association members agreed to provide the advertising space. Currently a slide with a condom illustration and the message, "Use condoms to protect yourself from HIV/AIDS" is projected in at least 50 cinema halls nationwide, reaching 30,000 to 45,000 people every day.

In another effort to reach young people, GWP is sponsoring a national essay competition for secondary school students. In association with the National AIDS Control and Prevention Project and the Ministry of Education, students in classes 9 and 10 (15-18 years old) have been asked to write essays on the theme: "My Duty is to Control HIV/AIDS in Nepal." Prizes will be awarded for winning essays from each of Nepal's five development regions.

GWP's BANNER IS DISPLAYED AT THE ENTRANCE TO AN AIDS PREVENTION POSTER EXHIBIT.

Expanding Efforts

GWP is working with a local NGO in the city of Bhairahawa to apply an outreach model similar to the one used at Thankot on the Siddhartha Highway at the international border, which is a major transit point to and from North India. We hope to reach transport workers, migrant laborers and travelers crossing the border with AIDS awareness messages and condoms.

Most recently, GWP began working with local industries to promote AIDS awareness and share our organization's philosophy of social responsibility. Industrial managers have agreed to support workplace-based AIDS prevention programs at the Lumbini Sugar Mill in Nawalparasi, Bhrikuti Paper Industry in Rupandehi District, Gorkha Brewery near Bhairahawa, the Butawal Thread Industry and the Bhairahawa Sugar Mill. GWP will provide AIDS awareness materials, condoms and outreach training, and the company management will contribute staff time for continuing AIDS prevention programs.

It is both my personal dream and the mission of General Welfare Pratisthan to continue to support community-based efforts that will help all our communities become aware of and overcome the HIV/AIDS crisis facing our country.

Mahesh Bhatterai is general manager of General Paper Industry and one of the founders of General Welfare Pratisthan, both located in Kathmandu. The AIDS Control and Prevention (AIDSCAP) program in Nepal is working with GWP to develop HIV/AIDS and STD prevention interventions to reach high-risk transient populations in Nepal's Central Region.

Dallying with Death
The impending crisis in India

by Jaya Shreedhar

J Marshall/WHO

Many Indian women are at risk of acquiring HIV because of their husbands "sexual networking" outside of marriage.

Behavior change or bust is the writing on the wall. More than one million Indians are already infected with human immunodeficiency virus (HIV), the causative agent of AIDS.[1] According to Stephen Mills, epidemiologist at the AIDS Control and Prevention (AIDSCAP) Project's regional office in Bangkok, India will have the largest HIV-positive population in the world by 1995.

If such predictions have not already triggered alarm bells across the subcontinent, Dr. Mills said in a presentation to Asian journalists, it is because "we are struggling to convince people about something that just doesn't seem to exist."

To the average Indian strolling down the street or shopping in a crowded marketplace, things appear perfectly normal, whereas chances are that one or more people around him are infected with HIV. This is because people with HIV are active, healthy and appear no different from uninfected people.

For those who still harbor the impression that HIV infection could only happen to limited groups of people — namely men and women in prostitution (commercial sex workers), people who inject drugs or homosexuals — it may come as a shock to learn that the global picture now emerging is different. Analysis of the changing HIV pandemic in 1994 reveals a shift from homosexual to heterosexual transmission in many areas and rapidly rising rates of infection among housewives and other women outside commercial sex activities.

Sexual Networking

In-depth studies illustrate how HIV reaches out to infect people who generally do not consider themselves to be at risk. In one such study in Thailand,[2] researchers interviewed a group of single and married men representing a range of different occupations, including bus conductors, construction workers, teachers, bank clerks and students. The men were selected for their high-risk sexual behavior: each had been involved with more than one woman during the past year.

In the course of the study researchers learned that only some members of the group had restricted their sexual

Young men "prepare" themselves for marriage by visiting a commercial sex worker to get some experience.

activity to non-commercial sex partners. Twice as many men had sex only with commercial sex workers. The majority had sex with wives, girlfriends and commercial sex workers.

Get acquainted with the latest buzzword in AIDS: sexual networking. Here the term refers to the practice of having sexual relationships with two or more partners, either serially (one affair after another) or concurrently (several affairs at the same time).

Almost all the Thai men interviewed said that having sex with commercial sex workers was socially acceptable, besides being an important social activity that one engaged in with friends.

Single men consider commercial sex the most convenient outlet for their sex drive and some even justify it as a means of preventing the "corruption" of women who are not sex workers: "If I went looking for a regular girl to have sex with, the experience might damage her, so it's better for me to have sex with prostitutes."

Yet two-thirds of the single men had had sex with a non-commercial partner in the previous year. The number of these partners ranged from one to as many as 40 women.

Though Thai society smiles indulgently at the married man with more than one partner, it does not give women the sanction to do likewise. For example, Thai divorce law allows a man to divorce his wife if she is unfaithful, but the woman has to produce conclusive proof that her husband has taken another woman as his de facto wife before she can obtain a divorce.

Sex in Tamil Society

While Thai society is openly tolerant about men with multiple sex partners, a World Health Organization (WHO) study in Madras among commercial sex workers, clients and brokers found that "Tamil sexual culture displays a strong division between public and private behavior. Monogamy and sex within marriage only are stressed in public, and there is a strong condemnation of any display of sex appeal in public."[1]

The reality is that nearly 4,600 men visit commercial sex workers every day in Madras. As in Thailand, friends often visit commercial sex establishments together. The difference is that in Madras it is largely a group event, where the same sex worker is shared by all the friends because of the cost involved.

Several factors lead to men opting for paid sex outside marriage. One of the most important is the continuous flow of young men who come to work in the city, leaving their wives or betrothed behind in the village. Some, like dock workers, are paid relatively high wages and use the extra cash to buy sex.

Another important reason for the popularity of commercial sex is that Indian men marry much later than they used to. Young men have to finish their education first and earn a living. Many are 26 or 30 years old by the time they get married. Monogamy and chastity were much easier to adhere to in the old days when child/teen marriages were commonplace. It may be unrealistic today to expect men and women over 25 to remain celibate till marriage in a social milieu that consistently promotes high-risk sexual behavior.

Owing to the segregation of men and women in Tamil society "men do not know how to behave socially or sexually with women," according to the WHO study. Marriages are arranged by parents to facilitate male-female relations, but they fail to bridge the emotional and social barriers between, say, their son and the "arranged daughter."

It is not only young women who are afraid of losing their virginity on the first night of marriage. Young men suffer similar fears and "prepare" themselves for marriage by visiting a commercial sex worker to get "some experience." Loss of male virginity with a commercial sex worker before an arranged marriage is a common practice in Tamil Nadu.

Men live their social lives with other men, while women socialize with other women and with their children, especially their daughters. Usually after a couple of years men go to other women. The wife assumes a sacred position as the mother of their children, and married men prefer to experiment sexually with commercial sex workers "who do whatever you want" for a price.

The breakdown of the joint family system, along with urbanization and travel, makes traditional supervision by elders of one's community or family impossible. In crowded cities there is ample scope for secrecy and anonymity, which are impossible in one's village or hometown.

India will have the largest HIV-positive population in the world by 1995.

E. Mandelmann WHO

An AIDS prevention drama by a street theater troupe from India, where an estimated 1.5 million people are infected with HIV.

Compared to Bombay, Calcutta or New Delhi, southern India is considered conservative when it comes to sexuality. This, however, is only the perceived orthodoxy at home or at work.

The WHO study explains that a rational man adopts a totally different persona to become a "client." He goes through a gradual transformation before he has commercial sex: "He goes to one of the 132 cinemas in the city, he has drinks in one of the 650 wine shops and bars. He has something to eat in a restaurant and has a few drinks again. He is picked up by a broker. He goes to a brothel. Even when this is planned, a lot of alcohol flows, so AIDS messages need to appeal to the irrational man who is often under the influence of alcohol."

The studies in India and Thailand both found that commercial sex patronage was frequently accompanied by drinking alcohol, often to the point of intoxication.

Risk Perception and Condoms

Even within sexual networks, the risk of acquiring or transmitting HIV can be greatly reduced by consistent and correct use of condoms. Several studies have proved that using condoms correctly during every act of sexual intercourse protects one from HIV and other sexually transmitted infections.

Over half the Thai men reported they usually used condoms with commercial sex workers, but condom use was very low among regulars who frequently patronized commercial sex workers. The greatest barrier to condom use during commercial sex was the feeling that "condoms are not natural."

Most of the men believed they could screen out "dangerous" partners judging by how clean the girl or the

A longer version of this article, published in the May 7-20, 1994 issue of the Indian magazine *Frontline*, won first prize in a journalists' contest sponsored by the AIDSCAP Asia Regional Office to encourage accurate reporting on HIV/AIDS in Asia. AIDSCAP will support Dr. Shreedhar's participation in the Xth International Conference on AIDS in Yokohama, where she will receive her award.

Jaya Shreedhar is with the Media Foundations, Madras. Dr. Shreedhar was one of 19 journalists from nine Asian countries who participated in an AIDSCAP workshop, Reporting on HIV/AIDS in Asia: Facing the Facts, in Bangkok in March.

brothel looked. Some mistakenly believed germs could only enter their bodies when they ejaculated, and protected themselves by practicing withdrawal.

Others took antibiotics or even diuretics before commercial sex, thinking these would protect them from disease. "Before sex I will take a diuretic pill and after sex I will wash myself with water and eye lotion. With this precaution there is no need for a condom." In Tamil Nadu, soda, lime juice and even urine are used for the same purpose.

Another worrying trend is the lack of motivation to use condoms with non-commercial partners. Many of the Thai men said they didn't use condoms with women who were not prostitutes. Others thought married women were less dangerous, not realizing that a woman's husband might have infected her.

In short, HIV risk assessment was based almost entirely on the man's perception of whether the woman was promiscuous or not, or vice versa. Nobody mentioned having a blood test to screen potential partners because they fully believed that they could recognize who had HIV or another STD and who did not.

While the Thai study pertains to a select group of men and may not reflect the behavior of the general Thai population, the researchers pointed out that how widespread such behavior is in a society may not be important because each community has some men who conform to this pattern. "If men with high levels of commercial sexual activity also have sexual contact with girlfriends and wives, there is a real risk of a more disseminated and much larger epidemic occurring," the authors warned.

In Madras one commercial sex worker may be taken for the night by two to five men, with each averaging at least two sexual encounters. Nearly 9,200 such encounters take place every day in Madras. Complete condom use in commercial sex in Madras would require at least 9,200 condoms a day, or 276,000 condoms a month.

In a UNICEF-funded survey among the general population, conducted by the Operations Research Group in Tamil Nadu in September 1993, most respondents said they perceived having sexual affairs with many people as risky, but 70 percent said HIV spreads "only through prostitutes," not clients. Half the respondents knew that condoms protect one from HIV, yet only 15 percent had ever used a condom.

Stark Lessons

India has the opportunity to learn from the experience of countries like Thailand. The lessons are simple and stark: sexual networking is the prime corridor through which HIV accesses large populations with a multiplier effect. Condoms act as roadblocks on these expressways, but they do not work unless they are used correctly and consistently.

In an environment of sexual networking, any call for abstinence sounds shrilly hypocritical and moralistic. Worse, such calls turn away the very people one wants to target for behavior change. However, avoiding sexual intercourse altogether or restricting sex to partners known to be uninfected will prevent infection, and this needs to be widely promoted as the most effective strategy for avoiding HIV infection.

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Myths About AIDS in Cambodia

by Moeun Chhean Narith

One evening I overheard a chat between a young HIV-positive man and his friend.

"My AIDS is gone and my swollen neck is disappearing," the man told his friend. "There's no such disease as AIDS, it's just the worst state of syphilis."

He said he had spent US $1,500 for 30 different drugs he had taken to cure the illness.

The belief that AIDS can be cured is just one of the many myths about AIDS in Cambodia, said Dr. Richard Renas, technical officer with the World Health Organization's Global Programme on AIDS (WHO/GPA). "The man's $1,500 expenditure was wasted."

"People feel terrible accepting that the disease has come into their community, so instead they adapt their beliefs to the situation," explained Dr. Tea Phala, head of the National AIDS Committee (NAC). "They believe that because syphilis can be cured, therefore AIDS can be cured."

Whenever the NAC holds workshops, trainers and educators emphasize that AIDS and syphilis are different diseases. In many cases they must also convince people that AIDS is a real threat.

"The fact that AIDS victims generally show no symptoms during the early stages of the disease helps people believe AIDS does not exist, but really, it does exist," Dr. Phala said. "It is difficult to convince even knowledgeable people to accept this."

According to WHO, as of March 1994 a total of 382 people infected with HIV had been reported in Cambodia. But many infections are not detected. The national AIDS program estimates that between 2,000 and 4,000 Cambodians may be HIV-positive.

The first HIV-positive test results in Cambodia were documented in 1991 through screening of volunteer blood donors at the National Blood Transfusion Center. By December 1993 the rate of positive results from blood donors had increased to 1.97 percent — a twenty-fold increase since 1991.

Pharmacist Tea Soky, deputy director of the National Blood Transfusion Center, said she expected the rate of HIV infections among blood donors to double this year to about 4 percent.

"We must confront AIDS like we would confront enemies in a war," she said.

In 1992 small surveys identified HIV infection rates of 4.5 percent among patients in sexually transmitted disease (STD) clinics and 9.2 percent among commercial sex workers. The rate among STD patients and others requesting testing in 1993 was 4.3 percent.

HIV has been reported in the capital city of Phnom Penh as well as the four northwestern provinces of Banteay Meanchey, Battambang, Pursat and Kompong Chhnang. There have also been unofficial reports of HIV infection in three northeastern provinces.

Cambodian people still consider AIDS a problem of other countries, Dr. Phala said. "The epidemic has just come to Cambodia, so it is difficult to find the people with the symptoms."

Another common misconception about AIDS is that it can be transmitted by mosquitoes, Dr. Renas said. "The only way you can get HIV is by sharing body fluids, blood or dirty needles."

Other myths abound: healthy people do not have HIV, there is a cure for AIDS, and you can get the disease only from commercial sex workers.

These beliefs are not true, Dr. Renas emphasized. "There is no cure for AIDS, everybody can be infected. And of course commercial sex workers get the disease from men, so it takes two people to dance."

Many people think information about AIDS is just propaganda put out by condom producers to market their products, Dr. Phala noted.

But beliefs can be changed through health education campaigns, videos,

Roger Lemoyne/UNICEF

posters and accurate reporting in the media, Dr. Renas said. "The most effective way of spreading information is probably simply through people talking to each other, but they need to be informed correctly," he said.

Approximately 20 international and local nongovernmental organizations (NGOs) are working on AIDS education programs in Cambodia. Once a month, all the interested NGOs participate in a meeting coordinated by the AIDS Cooperation Committee of the Cooperation Committee for Cambodia. A representative of the National AIDS Program also attends these meetings.

The National AIDS Program provides advice, information and direction, Dr. Renas explained. "Part of the national program's role is to support and work closely with all the NGOs — both international and local."

In addition to education programs, the Ministry of Health, in cooperation with WHO and the British Volunteer Service Overseas, has set up a clinic in Toul Kok, Phnom Penh's red light district. Established in June 1993, the Toul Kok Community Clinic provides free medical services and is designed to cater to the needs of commercial sex workers.

Every Tuesday evening Dr. Ouk Vongvathiny, the chief of the clinic, invites ten to 15 brothel owners and prostitutes to a meeting to brief them on AIDS. According to her informal survey, only about 40 percent of the customers in the district use condoms, but the sex workers can persuade up to 60 percent to use condoms.

However, she adds, some men, especially when they are drunk, never use condoms and threaten not to pay a sex worker if she insists on condom use.

"Many school boys, normally when they are on school guard at night away from their parent's eyes, come as a group to have sex with prostitutes," Dr. Vongvathiny said. "According to many girls, most young men do not use condoms."

> The belief that AIDS can be cured is just one of many myths about AIDS in Cambodia.

The first big step was to educate the brothel owners, Dr. Vongvathiny said. "If we talk to an owner it is like talking to seven or eight girls," she said. "A number of brothel owners have cooperated with us and advised their girls not to accept any customers who do not want to use condoms."

But others are not very cooperative, she added. "Many brothel owners tell their girls the old Khmer saying, 'being a pig, you must not be afraid of hot water,' meaning they must not be afraid of AIDS."

Virtually every prostitute has at least two to three STDs, which could also be prevented through correct, consistent condom use, Dr. Vongvathiny noted.

Ung Kim Sour, AIDS program officer for the Norwegian organization Redd Barna, lives near the Phnom Penh red light district. The spread of HIV/AIDS is most critical among travelers and traders from the countryside, he said. "About 95 percent of country men who come to town to sell their products visit prostitutes, and they bring AIDS back home, infecting their wives."

Women are often unable to stop the spread of the disease because of the tradition in Khmer society, where men are more powerful, Mr. Kim Sour explained.

AIDS awareness is particularly low in rural areas, where health education has not been available. "Education through the media only reaches a limited range of people," Mr. Kim Sour said. "National television, which has the most education programs, can be seen only in Phnom Penh and the surrounding provinces."

Nic Dunlop/Panos Pictures

[illegible] "Panos Pictures [illegible] Phnom Penh.

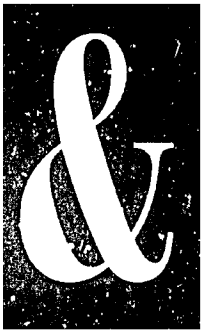
Even when health education programs and activities are able to reach people, it is very difficult to change behavior, Dr. Phala noted.

"People do not like to give up behavior they enjoyed in the past, which included having many partners, or having sex with prostitutes without wearing condoms," he said. "They have enjoyed this behavior for a long time, so they tend to deny any kind of information that will discourage or stop past practices."

"Through health education we can make people aware and improve their knowledge, but changing beliefs and practices is difficult," Dr. Phala added. "A person may know and understand, but still not believe."

Moeun Chhean Nariddh is a Cambodian journalist who participated in AIDSCAP's recent workshop for Asian journalists, Reporting on HIV/AIDS in Asia: Facing the Facts. A version of this article appeared in the Phnom Penh Post *March 19, 1994.*

USAID's HIV/AIDS Strategy for Asia: *Promoting Early Intervention*



An interview with Kerri-Ann Jones of the of the U.S. Agency for International Development's Asia Bureau about the USAID HIV/AIDS Strategic Plan for Asia, which was adopted in June 1993.

Why did the Asia Bureau decide to develop an HIV/AIDS strategic plan for Asia?

We wanted to address the unique circumstances of the emerging epidemic in Asia with a strategic and coherent regional approach that would make the best use of our resources.

And what are those circumstances?

First of all, more than half the world's population lives in the region. Asia has some unique characteristics that lead to the very rapid spread of HIV, including rapid urbanization, a lot of movement of populations, and large commercial sex and transport industries in most countries.

Also, it looks like the HIV/AIDS epidemic has only recently arrived in Asia. We felt that since it may be only the beginning of the epidemic in Asia, there's a real opportunity to do something now, to use preventive interventions when they can really be effective.

What is the purpose of the strategic plan?

If you look at the number of people in Asia and at how quickly HIV can spread, it's clear that no one agency or government can cover all that needs to be done. This plan is designed to determine what is the best strategic approach and to maximize the use of our resources.

Another reason for the plan is to work more closely with AIDSCAP. AIDSCAP is a worldwide program but concentrates most of its resources on AIDS prevention in a limited number of designated priority countries in order to have a significant impact on the epidemic in those countries. India and Thailand are priority countries in Asia.

We wanted to supplement the AIDSCAP program by initiating HIV prevention in additional countries to start preventive activities before the numbers become very large, before the epidemic really takes hold. So we're trying to have a significant impact despite limited resources.

What do you mean by limited resources?

The nature of the epidemic immediately makes one realize that resources are limited. Given the number of people in Asia, if the epidemic takes off as predicted, it would take an enormous amount of resources to address the problem.

The World Health Organization (WHO) estimates that $1.5 to $2.9 billion per year is needed to provide adequate support for global HIV/AIDS prevention. Currently less than $200 million a year is spent on HIV prevention in the developing world. USAID resources are shrinking and we're being asked to do more things with fewer resources. That makes a strategic, coherent and coordinated program especially important.

How was the plan developed?

The plan was a real collaboration with USAID's field missions, HIV/AIDS Division and the AIDSCAP Project. We've built on USAID's worldwide

Michael Hong AIDS AP

Kerry Ann Jones

experience in AIDS prevention and the experience of USAID missions in Asian countries.

The missions were already thinking about AIDS and beginning to identify approaches. We began by asking them, "What is the latest information about the epidemiology of AIDS and the government response to the problem?"

And what did you learn?

We found there was a wide variation in what was known about the epidemic and many questions about the credibility of surveillance in different countries. There was also wide variation in how governments were responding to the problem. Some countries have established sentinel surveillance and launched public education campaigns, while other countries had initiated no activities.

If surveillance is poor in many Asian countries, do we know which countries are already in the midst of an AIDS epidemic?

You really don't know. If a country has few reported cases of AIDS, it could be a good sign that the country hasn't had much exposure to HIV or it could be a bad sign that surveillance is not detecting the transmission that is occurring.

Surveillance is definitely improving, and that's usually the first area we look at. We also look at proxy indicators for HIV, such as STD rates and contributing factors such as population movement. You have to know the situation before you can begin your intervention.

What interventions does the plan recommend?

Everything is targeted on prevention — that's the focus. We based the plan on the six major interventions that USAID and AIDSCAP have identified as the most effective strategies for AIDS prevention. These are policy dialogue, communication to promote behavior change, improving management of sexually transmitted disease services, improving access to condoms, monitoring and evaluation, and behavioral research.

The situation is so variable across countries that it wasn't easy to develop a uniform guidance system that would be useful to all our missions. What we did is offer a scheme that would help missions and governments decide what they should be doing given the situation in a country. It gives them a framework for choosing the right mix of interventions based on the epidemiology of HIV/AIDS in that country and the groups most affected by the epidemic.

How does USAID coordinate its efforts with those of other donors supporting HIV in the region?

Most of the coordination happens at the country level, where our missions work with governments and other donors to complement the government's overall plan for AIDS. For example, the German government is helping the Indonesian government establish systems to ensure the safety of blood banks. Therefore, we decided to put our resources in prevention of sexual transmission, where we believe we can have the most impact. We try to complement other programs. At the regional level, AIDSCAP also coordinates its efforts with WHO/GPA [WHO's Global Programme on AIDS].

And how does the Asia plan coordinate its activities with other AIDS prevention efforts that are already under way in a country?

Again, we try to complement other programs, and we use regional funds to fill gaps in country programs — for example, a mission might not be dealing with HIV transmission along national borders, or areas of affinity.

What are areas of affinity?

The concept of areas of affinity refers to a group of neighboring countries that share common cultural, geographic, demographic and economic characteristics relevant to the spread of HIV/AIDS. Two countries may have similar HIV/AIDS epidemiology, or share a trading route. It's often difficult for a country where there's a bilateral [government-to-government] program to address problems that cross borders.

One example of an area of affinity is along the India-Nepal border, where there is a lot of traffic between the two countries. Or the state of Tamil Nadu in India, which has a lot cultural similarities with Sri Lanka.

How have missions responded to the strategic plan?

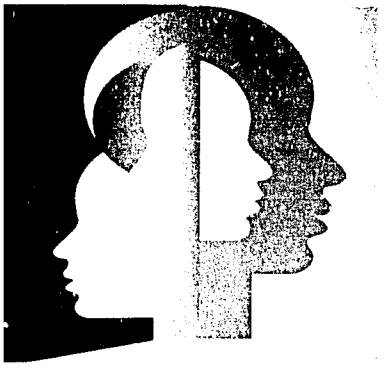
Missions are very interested in the plan because it gives them a chance to do more and to have some flexibility. Some of the Asia regional funds support the AIDSCAP regional office, which provides the missions with an established technical assistance resource and serves as an information clearinghouse.

Are Asia governments beginning to take more interest in AIDS prevention?

I think there's a real recognition that this disease is out there. However, there are many of the same policy problems that we face in our country — denial, limited resources and reluctance to openly confront the difficult issues involved.

How is the strategic plan carried out?

AIDSCAP is USAID's global prevention effort to address HIV. AIDSCAP is really the foundation. The Asia plan tries to build on that. It guides AIDSCAP as it carries out activities in Asia by spelling out what activities are most needed or most appropriate to the region.



AIDSCAP

In Asia

Educating policy makers about the need for early intervention is particularly important in Asia.

How can we know whether people are changing their sexual behavior and how can we encourage them to maintain safer sexual behavior? What can we do if worksite managers won't give outreach teams access to their workers? How can we talk to motorcycle taxi drivers about AIDS prevention on loud, busy urban street corners?

These are the kinds of questions AIDS outreach workers in Thailand wrestle with every day. In Bangkok teams of full-time outreach workers from different HIV prevention projects meet regularly to discuss these problems and share solutions. Their primary challenge is to extend effective prevention services to workers in small factories, garages, restaurants, construction sites, motorcycle taxi stalls and city bus terminals.

At their latest retreat in June, field staff from several factory outreach projects compared their experiences, successes and failures in persuading managers to allow them to have access to workers. The outreach workers also shared techniques for choosing peer educators at worksites and identified participatory group activities that seem to work best.

According to Dr. Neil Brenden, AIDSCAP Asia Regional Director, these retreats are invaluable for tapping the "street smarts" of outreach workers, who must break through innumerable kinds of resistance among factory workers and other laborers to facing the reality of the risk of HIV infection.

The outreach workers are part of the Comprehensive Bangkok Program, AIDSCAP's largest program in Asia. The project also has programs in Nepal, India and the Philippines, and will soon begin supporting a five-year HIV prevention project in Indonesia.

Most of these programs, like other AIDSCAP programs in Africa, Latin America and the Caribbean, combine the three measures that have proved most effective in preventing sexual transmission of HIV: communication to encourage safer sexual behavior, improved treatment and prevention of the sexually transmitted diseases (STDs) that make people more susceptible to HIV infection, and condom promotion and distribution.

In the Philippines, however, AIDSCAP complements the national HIV prevention program by working with the Department of Health to strengthen STD services.

"In each country we work very closely with the government, local nongovernmental organizations (NGOs), the USAID missions and other donors to coordinate our assistance," Dr. Brenden explained. "In Thailand, after consulting with the Ministry of Public Health and other donors, we decided to concentrate our efforts in Bangkok. In the Philippines, STD control was the gap that needed to be filled."

With special funding from the Asia Bureau of the U.S. Agency for International Development, AIDSCAP is

supporting USAID field missions in their assistance to governments in Bangladesh, Mongolia, Papua New Guinea and Sri Lanka by identifying ways to slow the spread of HIV.

AIDSCAP also designs programs that, like the AIDS virus itself, cross national boundaries. In Asia the project has identified five "areas of affinity" where countries share a common HIV/AIDS problem, including the Thai-Laos border, the South Pacific Islands, and the major truck routes between Calcutta and Kathmandu on the Indian subcontinent.

"HIV does not travel by plane; it travels by bus, by motorcycle, by truck and by small boats across borders in Asia," explained Tony Bennett, AIDSCAP's senior program officer for Asia. "This strategy allows us to reach transport workers, business travelers, commercial sex workers, migrant laborers and other border migrants, who may be at higher risk of acquiring HIV than more stable populations."

Asia Bureau support has also helped AIDSCAP expand regional training and information dissemination efforts. Recent workshops organized by AIDSCAP's Asia Regional Office include one on AIDS reporting for Asian journalists and another for government officials and other decision makers from nine countries to build support for HIV/AIDS prevention policies and interventions.

Educating policy makers and business, community and religious leaders about the need for early intervention and helping them develop policies to support HIV prevention are particularly important in Asia, where many countries have yet to feel the impact of the epidemic, Dr. Brenden said.

"In Indonesia, for example, the prevalence of HIV is still relatively low," he said. "But fortunately the leadership of the Government of Indonesia and of the USAID mission in Jakarta have recognized that it's important to develop an aggressive program before there are massive numbers of infected people."

During 1993 and 1994 AIDSCAP sponsored a series of "policy tours" to Thailand for Indonesian government and NGO officials.

"These tours provide a good opportunity for decision makers to look at the epidemic in a more mature phase in Thailand and to see first hand the impact of national policies that reflect what we think is an enlightened approach to HIV/AIDS control," Dr. Brenden said.

"While we recognize the unique situations of the different countries in Asia, HIV is spreading with a remarkably similar pattern and pace," he added. "The prevention experience in Thailand, Nepal and other countries where AIDSCAP is implementing comprehensive programs can be applied now in nations that are beginning to grapple with the threat on their doorstep."

AN AIDSCAP HIV/AIDS PREVENTION SESSION WITH YOUNG MEN IN BANGKOK. AIDSCAP

WOMEN CAN HELP EACH OTHER LEARN HOW TO TALK TO THEIR HUSBANDS ABOUT SEX AND CONDOMS (S.L.)

P. Almasy/WHO

WOMEN'S FORUM

Women and AIDS Prevention: Assessing the Options

by Kathleen Henry

Abstinence. Monogamy. Consistent condom use.

The options for protection against sexual transmission of HIV are few. But for many women, the choices are even more limited.

Throughout the world, women are learning that their own fidelity is no guarantee of safety. The first woman reported with AIDS in Mexico City was a 52-year-old housewife whose husband was her only sexual partner.[1] Preliminary results from African studies suggest that more than 60 percent of infected women have only one partner.[2]

Condoms may be the most practical prevention method available. But persuading men to wear condoms is not an easy task for most women, particularly poor, uneducated women who rely on men for economic security. These women are likely to be accused of infidelity if they try to convince their partners to wear condoms and may even risk physical abuse. Refusing sex may prompt the same reactions, and may actually increase a woman's risk if her partner turns to other sexual partners while she abstains, then insists on resuming sexual relations with her.

With limited prevention options, women are becoming infected in increasing numbers. In some countries women — particularly young women — are at greater risk of HIV infection than any other group.

In sub-Saharan Africa, women becoming infected with HIV now outnumber men by 6 to 5. The National AIDS Control Program in Uganda reports that HIV is particularly high among young women.

"In the ages between 15 to 20 years, there are almost six times as many infected young women as there are young men," said Noerine Kaleeba, director of The AIDS Support Organization in Uganda. "This picture is emerging quite clearly in our counseling centers."

By 1993, more than 5 million women had been infected with HIV. The World Health Organization (WHO) estimates that by the year 2000, 13 million women will have been infected and 4 million will have died.

Biologically, women are more susceptible to HIV infection because sexual transmission of the virus is more efficient from men to women than from women to men. In addition, women are more likely to have untreated sexually transmitted diseases (STDs) that facilitate HIV transmission because women with STDs often have no symptoms.

But culture is the greatest obstacle to preventing AIDS among women, noted Evelyn Nyakoojo of Uganda's

Photo: WHO

Women's [illegible] in Mexico. Efforts to address the social [illegible] women's [illegible] to HIV [illegible]

Makerere University. "In our culture women must submit wholly," she said. "If women are to control AIDS, they must first have control over their bodies."

"We need to address the economic and sexual subordination of women," agreed Steven Kraus of WHO's Global Programme on AIDS. "We need to get these issues out in the forefront, because they are the real fuel of the fire of this epidemic."

Prevention or Development?

Given the limitations of current prevention options, some argue that AIDS programs targeting women will be ineffective without first improving women's economic and social status.

"Clearly both approaches are needed simultaneously," said Elizabeth Preble, director of the AIDS Control and Prevention (AIDSCAP) Project Technical Support Division. "Improving women's status is essential, but the benefits of these long-term efforts will likely arrive too late to prevent millions of women from becoming HIV-infected."

Helping women who have little economic or social power protect themselves against HIV is a difficult challenge, but "there is still a lot that can and must be done now," said Debrework Zewdie, deputy director of the AIDSCAP Africa regional office.

Awareness First

The first step is awareness, Dr. Zewdie said. "We have to get people to accept the fact that women are disproportionately affected by the epidemic."

It is particularly important for women to understand their own risk of infection, said Maxine Ankrah, senior advisor for AIDSCAP's Women's Initiative.

"In many countries, because women have never seen anybody with AIDS — never seen anybody die — they believe that they are okay, even when they know that their husbands are running around," Dr. Ankrah said. "They deny, they bury the possibility that they could become infected, and so they will do nothing to protect themselves."

Communication and Negotiation

Communication between men and women — and between parents and children — is the most important AIDS prevention measure, according to Wendy Roseberry, STD/HIV Strategy Coordinator for Africa at the World Bank. "We have to start talking about respect and love and equality, in addition to reproductive health, family planning and disease prevention," she said.

Studies from around the world suggest that such communication between men and women is rare. In many societies a "good" woman is defined as one who is ignorant about sex and passive in sexual interactions, explains Ellen Weiss of the International Center for Research on Women (ICRW). "Therefore women are reluctant to talk about sex for fear of being perceived as 'loose.'"

Communication between parents and children is also problematic. Parents often feel uncomfortable talking about sex with their children and fear that such discussions will encourage their children to become sexually active at an early age. But communication about sex can actually help delay sexual initiation and improve young people's ability to protect themselves from HIV.

"There is evidence to suggest that adolescent girls who have open communication with their parents, particularly their mothers, about sexual matters are less likely to be sexually active or become pregnant before marriage," Ms. Weiss said.

Parents who discuss sex with their children can also become role models, encouraging more open communication between partners in the next generation, she added.

Women Helping Women

Women can help each other learn how to talk to their husbands about sex and condom use, said Dr. Ankrah.

"We cannot expect women to act unilaterally until there are changes in social norms," she explained. "So the individual woman will remain subject to infection until she begins to come into community with other women."

Findings from ICRW's Women and AIDS Research Program reveal that women in a variety of countries and settings who participated in focus group discussions or group educational sessions were relieved that they could finally talk to someone about sexual concerns. These sessions enabled women to discuss the consequences of negotiating condom use or other HIV risk-reduction measures and to suggest ways to convince their partners to adopt such measures. They also allowed the women to practice negotiating skills in a non-threatening environment.

WHO

"We continue to pay in health costs and wasted economic potential for every generation of girls we fail to educate."

"What was particularly valuable about the discussions, the participants said, was the fact that women shared strategies that they themselves had used for initiating condom use and discussing HIV prevention with their partners," Ms. Weiss said.

A similar approach, involving role play and small group discussions with women from a low-income community, was used with some success in Zaire. In follow-up interviews with 60 participants, two-thirds of the women said they had begun a dialogue about HIV risk reduction with their partners. But more than half of those women said that their husbands believed there was no need to use condoms because they were not at risk of HIV.[1]

Involving Men

Such findings underscore the importance of targeting men and boys in programs that promote men's participation as equal partners in safer sex planning, Ms. Weiss said.

"The responsibility must be equally shared between men and women in terms of opening up about sexual issues and sexuality," Ms. Roseberry agreed. "Women have to talk to their partners, saying, 'I expect more from you.' And men have to challenge their egocentric position as the aggressive sexual male with several partners and little responsibility for reproduction or disease transmission."

Because of the value most societies place on children, promoting safer sex to prevent HIV transmission from mother to child may be an effective way to convince men of the need to change their behavior, Ms. Weiss noted. In studies in Guatemala and Zaire, women suggested that HIV prevention programs for men highlight the impact of AIDS on parents and children.[1]

Giving Women Control

Men must learn to take more responsibility for disease prevention, but women also need barrier prevention they can control and use, when necessary, without a partner's consent, Dr. Ankrah said.

"Barrier methods and methods that women can conceal should be promoted more aggressively," she said. "For example, the female condom should be promoted as a choice where women cannot succeed in getting their men to put on the male condom."

Studies in the United States and Latin America found that the female condom, a plastic vaginal pouch, was as effective in preventing conception as other barrier contraceptives. These results suggest that the device may also protect women against HIV and other STDs. Female condoms are not yet available for sale in developing countries, but a number of studies are assessing the acceptability of this method and its efficacy against STDs.

Research is also under way to develop microbicides that could be inserted in the vagina as a gel, foam, suppository or film to protect women from HIV and other STDs.

Improving STD Treatment

Another important option for protecting women from AIDS is to improve prevention, diagnosis and treatment of the sexually transmitted diseases that increase their susceptibility to HIV infection.

Most women with STD have no symptoms, so they do not seek treatment. Others are reluctant to seek treatment because of the stigma associated with STD clinics. When women do seek treatment, many clinics do not have the facilities, equipment or skilled staff needed to diagnose STDs in women.

"Very accurate tests for STDs are available," explained Dr. Judith Wasserheit, director of the Division of STD/HIV Prevention at the U.S. Center for Disease Control and Prevention. "The problem is that they are not sufficiently cheap or technologically simple or rapid enough to be useful in resource-poor settings, particularly in the developing world."

In such settings, STDs are usually diagnosed based on a clinical examination. Clinical diagnosis of STDs is much less accurate for women than for men, Dr. Wasserheit explained. Even when women are symptomatic, it is difficult to determine whether an STD is causing the symptom and if so, which STD it is.

"In women we have a particularly urgent need for cheap, rapid, simple

diagnostic tests, at least for screening purposes," she said.

In the meantime, Dr. Wasserheit added, STD services for asymptomatic women can be improved by using case management guidelines based on STD risk as well as signs and symptoms and by providing STD treatment at maternal and child health and family planning clinics. "The MCH and family planning constellation is a natural for providing these services in a less stigmatizing way," she said.

"Since men tend to have more sex partners and since clinical diagnosis in symptomatic men is pretty accurate," Dr. Wasserheit added, one of the most effective ways to prevent STDs in women is to diagnose and treat men.

Fundamental Change

Women need options for protecting themselves now, but efforts to address the social and economic factors that make women so susceptible to HIV must not be put off, Dr. Ankrah said.

"We said in 1981 that if you educate girls, they will have alternatives to dependence on men," she pointed out. "Just about an entire new generation has been born, yet we still say that educating girls is too long-term. Unless we begin the long-term things such as educating women and changing laws, women will remain vulnerable."

Fundamental social and economic change may seem too ambitious and expensive, but neglect will be far more costly, Dr. Ankrah added.

"We continue to pay in health costs and wasted economic potential for every generation of girls we fail to educate," she said. "Educating women is absolutely indispensable if we are to stop AIDS."

Other measures needed to improve women's status include legal reform to give women the right to inherit and own property and to enforce stronger penalties against rape and sexual abuse; increased employment opportunities and access to credit for women; and the adoption of "family-friendly" policies in mining and other industries to end the separation of workers from their families.

Policy makers must realize that AIDS is a development issue, Dr. Ankrah said.

"When we are dealing with this strictly as a health issue and looking toward the structures of health to make the change, we aren't moving fast enough," she said. "That is why the epidemic is outpacing us."

AIDS is such a threat to socioeconomic development that it may serve as a catalyst for long-needed structural change, noted Ms. Preble.

"The AIDS crisis may help provide the impetus necessary to mobilize women and force the kinds of political changes and social movement needed to achieve women's broader development goals," she said.

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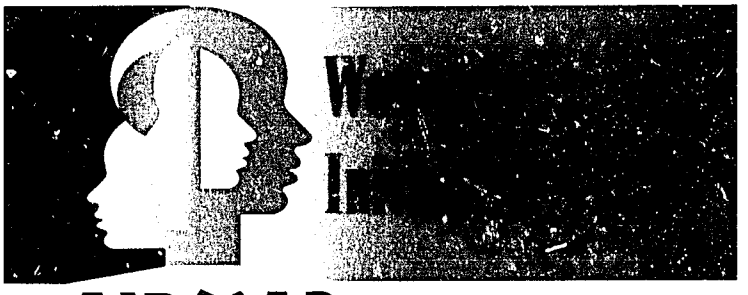

AIDSCAP

With support from USAID's Office of Women in Development and HIV-AIDS Division, AIDSCAP recently launched a program to strengthen HIV prevention efforts for women in developing countries. The Women's Initiative will integrate women's issues into current AIDSCAP-supported projects, sponsor new interventions and research with women, help women's organizations address HIV/AIDS, and provide a forum for information sharing, collaboration and advocacy.

Through the Women's Forum, a new AIDS*captions* feature, and other publications, AIDSCAP's Women's Initiative's will disseminate information about the impact of the epidemic on women and promising approaches to protecting women from HIV/AIDS. Proposals for articles are welcome and should be addressed to the editor.

Policy and HIV/AIDS Prevention: *Lessons Learned*

by Bill Rau

Until recently, the Brazilian government imposed a 15 percent import tax on condoms, pricing the product well out of reach of most people who need them. Policy makers had not intentionally set out to make condoms inaccessible; rather, the policy was based on an economic strategy that predated the HIV/AIDS epidemic.

[illegible] Myanmar, National NGO [illegible] grassroots [illegible] must work together to make AIDS prevention policies.

H. Page WHO

During 1993 and 1994, AIDS prevention activists launched an intensive information and advocacy campaign to convince policy makers that a supply of affordable condoms was crucial to slow the spread of HIV in Brazil. In April 1994, the tax was withdrawn.

The experience of AIDS activists in Brazil illustrates the crucial role of policies in HIV/AIDS prevention and the influence advocates can have on defining policies. The responses of governments, businesses and religious and nongovernmental organizations (NGOs) to the HIV/AIDS epidemic over the past decade have yielded important lessons about creating effective prevention policies. While there will be exceptions, the lessons learned outlined here are applicable in most countries encountering the HIV/AIDS epidemic. How each country develops its policy response, however, will reflect the political processes, power relations, resources and use of available information in that country.

Lesson 1:
Policy often lags behind the HIV/AIDS epidemic.

No single picture can describe the epidemiological, socioeconomic and political nature of the HIV virus. As the virus spreads through society, its touches new groups of people and affects them in different ways. But in every affected country, the epidemiological profile changes rapidly. As with other epidemics, HIV rushes ahead of policy, spreading faster than policy makers often realize and account for.

It is difficult to keep up with the epidemic because policy makers must work with information about HIV/AIDS that is out of date. For example, a 3 percent prevalence rate in a given population is likely to represent what existed months — and perhaps years — before publication of the data. The challenge for policy makers and advocates is to use the best available epidemiological, social and economic information to anticipate where the epidemic is going and what policy measures can be taken to reduce the rate of infection.

For the past several years, modelers have produced projections of the future course of both HIV infections and AIDS cases and deaths. These projections offer a tool for anticipating the dynamic character of the epidemic and allow policy makers to establish prevention programs that can alter the projections. In the Dominican Republic, Kenya and a number of other countries, impact projections have dramatically increased policy makers' awareness of the extent of the epidemic, stimulating both policy change and programmatic action.

Lesson 2:
Knowledge about HIV and AIDS among policy makers is often limited and inaccurate.

In country after country, policy makers do not have the most accurate, complete information about HIV/AIDS. In some cases, this is by choice: the information is available, but policy makers or their informants have decided that

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POLICIES MUST ADDRESS THE SOCIAL, CULTURAL AND ECONOMIC FACTORS THAT MAKE WOMEN VULNERABLE TO AIDS.

the information is unnecessary or is not to be believed.

Unfortunately, policy makers often believe and convey popular myths about the epidemic. For example, the myth that HIV is confined to select groups of people is in contrast to the reality that in most countries, HIV can be found across all socioeconomic, cultural, occupational and age groups. Another myth is that HIV infection is a result of immoral or antisocial behavior. The reality is that many women infected with HIV do not make choices about their risk behavior; it is decided for them by their spouses or partners.

A result of these and other myths is a culture of blaming vulnerable groups, such as commercial sex workers, other women forced into sale of sex for survival, and "foreigners." Myth making and blame contribute to a culture of denial that limits the willingness and ability of society as a whole to take a proactive stance against HIV/AIDS.

Lesson 3:
Women are facing the greatest impact from AIDS.

There is a common assumption that women are the main transmitters of HIV infection. This assumption overlooks the fact that women are more vulnerable than men to acquiring HIV from sexual union. Women are frequently prevented from negotiating safe sex with their partners, they have little control over the pre- or postmarital sexual behavior of their partners, and they are at greater risk of poverty and thus of having to exchange sex for survival.

There is ample scope for policies that address the social, cultural and economic factors that make women vulnerable to AIDS, such as rights of property inheritance and viable economic alternatives to sale of sex. Likewise, policies can help frame discussions between women and men about their conflicting and common needs and interests and promote efforts to correct the imbalance of power between the sexes. Initially, the single most effective measure is to ensure that women's needs are considered by involving women from all socioeconomic classes in setting policies and designing programs to prevent HIV/AIDS.

Lesson 4:
HIV/AIDS prevention efforts must compete with other priorities for limited resources.

This lesson is probably best known to policy makers, who regularly confront demands for new resources. Choices about the allocation of resources must be made: how do HIV prevention and AIDS care fit into national and organizational priorities?

Few countries have allocated substantial financial resources to HIV/AIDS prevention. Ironically, because of the failure to invest in prevention, the level of resources devoted to HIV/AIDS treatment and care is already substantial. Health staff are caring for a growing number of people with AIDS or AIDS-related illnesses; half and more of the beds in some African hospitals are filled with people with AIDS. Rising rates of tuberculosis associated with HIV infection and increased attention to other sexually transmitted diseases add to the costs of dealing with HIV/AIDS. These costs can only increase as the hundreds of thousands of HIV infected people acquire AIDS or related illnesses.

For the most part, policy makers have yet to address how their countries or organizations will absorb the financial costs of AIDS or to confront related issues such as equity of access to treatment, retraining of medical staff, and training of workers to replace those lost to AIDS. Barring a dramatic change in disease patterns resulting from prevention efforts, or policy choices that limit

Policies that offer security and stability, not fear and confusion, are essential for productive workforces.

access to health facilities for people with AIDS, the commitment of public and private resources will increase irrespective of existing spending priorities.

Studies of the impact of HIV/AIDS on the economy and financial health of a country or sector can be very valuable in motivating policy makers to commit resources to prevention. Projections of socioeconomic impact offer tangible examples of what could happen in the absence of an effective prevention strategy. In Honduras, for example, socioeconomic impact projections presented to the government stimulated extensive concern among policy makers, religious leaders and the media. As a result, a high-level HIV/AIDS advisory committee was formed, increased funding was directed to prevention, and religious groups assumed a more direct role in AIDS information dissemination.

Lesson 5:
Comparative examples can influence and guide policy formulation.

Because HIV/AIDS raises many new issues and questions, policy makers need examples of successful prevention interventions and effective policy and program responses from other countries or other parts of their own country. Policy makers are reluctant to experiment with untried efforts and readily look to the experiences of others to justify new efforts. This is particularly true with the HIV/AIDS epidemic, which involves sexuality, stigmatized and marginalized socioeconomic groups, and high costs.

Policy study tours between Indonesia and Thailand (see p. 24), workplace prevention case studies from Zimbabwe,[1] and international consultations for religious leaders such as the one held in Uganda in April 1994, are some examples of informed approaches to sharing experiences and concerns. In turn, ensuring that policy makers have access to examples and are encouraged to apply the lessons to their own situations remains a task for AIDS prevention advocates and those who influence policy.

Lesson 6:
Local prevention efforts too rarely inform the policy process.

NGOs, religious groups and grassroots associations tend to be best placed to begin the process of defining experiences and lessons. However, they need links to groups at the national level that can help facilitate analysis, strategizing and advocacy.

The AIDS Support Organization in Uganda (TASO) has been very influential in shaping local experiences to inform national and international policy makers about the contribution of counseling to behavior change. In many countries where HIV/AIDS has reached a critical stage, both local and national structures exist for furthering a policy agenda. Despite political and organizational constraints, in most cases it is possible to design effective strategies for policy education and advocacy.

Lesson 7:
Workplace prevention is neglected.

The workplace is a prime location for applying policies that support prevention and establishing programs to further prevention. However, most businesses have been slow to recognize the threat of HIV/AIDS to their workforce and to future productivity and profitability. Few businesses have official policies on HIV testing for employment, medical care for employees or absenteeism due to chronic illness. Many businesses have been willing to post HIV/AIDS prevention signs and perhaps stock condom dispensers, but few have created effective HIV/AIDS prevention information campaigns. Likewise, there has been little leadership from governments on appropriate policies for businesses and other workplaces. As a result, the private-sector response to AIDS in a country is often fragmented and occasionally contradictory.

There is great scope for using the unique features of the workplace to expand policy response to HIV/AIDS. For example, the experience of AIDS prevention programs in mines and commercial farms in Zimbabwe demonstrates that regular information-sharing programs for workers and managers can increase safer sexual behavior outside of work and enhance morale in the workplace.[1] Medical programs to treat sexually transmitted diseases will improve the health and longevity of workers. Policies that offer security and stability, not fear and confusion, are essential for productive workforces.

Conclusion

In many countries, policy makers' understanding of HIV/AIDS is evolving from general awareness to attention to specific policy issues. They are beginning to address legal and ethical issues, such as confidentiality for people who are HIV-positive and the economic needs of widows and orphans. In countries where the epidemic is at an earlier stage —particularly in Asia — policy makers have an opportunity to learn from the policy and program experiences of other nations. Perhaps the overriding policy lesson of the past decade is that the HIV/AIDS epidemic will not quickly or quietly go away.

References

1. Williams, Glen and Sunanda Ray. Work Against AIDS: Workplace-based AIDS Initiatives in Zimbabwe. Strategies for Hope Series no. 8. London: ACTIONAID in association with the African Medical Research Foundation.

Resources

Community Empowerment: A Participatory Training Manual on Community Project Development.

Office of International Training and Consultation, Northern Illinois University. Developed for community development trainers and practitioners, this manual presents both the rationale for participatory project development and a step-by-step process for its use in training workshops. The underlying theme of the manual is the need to empower community members to be partners in the process of community development. The manual is set up to enable community development practitioners, social workers, community leaders and volunteers to identify, plan, implement and evaluate small-scale development projects for communities. It includes sections on the major phases of the development process: project identification and planning, implementation and evaluation. Available for US $25.00 from PACT Publications, 777 United Nations Plaza, New York, NY 10017.

Guidelines for the Clinical Management of HIV Infection in Children.

World Health Organization-Global Programme on AIDS. Document # WHO/GPA/IDS/HCS/93.3. Available in English and French, this document presents recommended approaches for symptomatic diagnosis and treatment of HIV-related conditions at the local health center, district or referral level. The guidelines are intended to assist health-care staff in the diagnosis and clinical management of HIV-infected children and also in the assessment of resource needs for HIV/AIDS care and training. The format allows simple adaptation to local clinical and cultural circumstances where appropriate. Available free from the GPA Document Center, World Health Organization, 1211 Geneva 27, Switzerland.

Women and HIV/AIDS: An International Resource Book.

Reproductive Health Matters/ AHRTAG. Written from a woman's perspective, this book examines medical and social issues surrounding women and HIV/AIDS. It presents many of the shared experiences women have with the disease, such as the lack of power in sexual negotiations and the shortage of adequate preventive strategies and programs designed to meet women's need for protection. Topics include effects of HIV and AIDS on women's health, HIV risk factors and reduction, pregnancy, breastfeeding and motherhood, condom use, contraception and abortion, safer sex and relationships, and testing and counseling. Available for US $22.00 (US $3.75 for developing country nationals) from the AHRTAG Resource Centre, 1 London Bridge Street, London SE1 9SG, UK.

AIDS Home Care Handbook

World Health Organization/Global Programme on AIDS. Document # WHO/GPA/IDS/HCS/93.2. A guide for health care workers, social workers, religious people and counsellors, this handbook describes how people contract HIV, how it progresses to AIDS, ways to cope with AIDS and how to care for the dying at home. The first part of the book is a reference guide about common AIDS-related problems and possible causes, what can be done at home to alleviate these problems and when professional help should be sought. The book includes a list of print and video teaching resources and a selection of pictures for teaching individuals, families and communities to manage AIDS-related problems at home. Available for US $16.20, plus $3.00 for postage, from the GPA Document Center, World Health Organization, 1211 Geneva 27, Switzerland.

AIDS Prevention through Health Promotion: Facing Sensitive Issues.

World Health Organization. This book explores the reasons why efforts to educate and inform the public about HIV infection so often fail to alter attitudes or change the behavior of groups at risk. Concentrating on the need to understand how personal values, attitudes and feelings color reactions to health messages, the book presents eleven case studies illustrating how emotional factors influence the success of educational programs. The cases studies are presented to help health promotion planners address the complex emotional reactions to AIDS, anticipate their impact and design effective health messages. Available for US $14.40 from World Health Organization Publications, 1211 Geneva 27, Switzerland.

Women and HIV/AIDS: A Working Folder.

Colectivo Sol/AHRTAG. Available in Spanish, this folder is the first in a series of four information packets about different aspects of the HIV/ AIDS epidemic. The women and HIV/ AIDS folder includes a fact sheet, a bibliography of available articles, and five full-text articles on women and AIDS. The articles, written by medical doctors from Spain, Puerto Rico and Mexico, deal with heterosexual and perinatal transmission of HIV, condom use and AIDS treatment guidelines. The other three folders cover access to reliable information on antiretroviral drugs, access to STD treatment, and home care. Available free from Colectivo Sol, Apartado Postal 13-390, 03500 Mexico, D.F.