



*Socioeconomic Impacts of and Resource Requirements for HIV and AIDS*



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A mother and her son harvest vegetables grown using traditional methods. ©2005 Kyaw Winn.

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Socioeconomic Impacts of  
and Resource Requirements for  
**HIVandAIDS**

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## FOREWORD



**T**he ASEAN Heads of State and Government met in a Special Session during the 12th ASEAN Summit in Cebu, Philippines, on 13 January 2007, to review and renew Member Countries' Commitments on HIV and AIDS. They agreed to "Prioritise and lead the mainstreaming and alignment of HIV policies and programmes with our national development and poverty reduction plans and strategies to involve multi-sectoral responses in harmonised approaches, address the gender dimension of the epidemic, and ensure that all stakeholders at national and local levels are actively and effectively involved."

To follow up on this commitment, policymakers, programme planners, and implementers should be provided with the required analytical tools and timely information in order to make sense of the magnitude and extent of the problem, the dynamics of different socioeconomic factors involved, the interactions of various stakeholders or groups impacted by the problem, and the alternatives or options available for feasible solutions now and in the long term. A similar policy concern was expressed by the United Nations General Assembly Special Session on HIV and AIDS (UNGASS, June 2006) when it called for "costed, inclusive, sustainable, credible, and evidence-based national HIV/AIDS plans that are funded and implemented with transparency, accountability, and effectiveness."

It is for these reasons that the ASEAN Secretariat and the ASEAN Task Force on AIDS (ATFOA), together with the United States Agency for International Development (USAID) under the USAID Cooperation with ASEAN on the implementation of the Operational Framework for ASEAN Work Programme on HIV/AIDS 2002–2005 (AWP II), initiated a series of workshops and country-level discussions on the socioeconomic impact of and future resource requirements for HIV and AIDS, using tools and internationally recognised approaches (specifically, the National AIDS Spending Assessment and the Resource Needs Model developed by Constella Futures, a USAID implementing agency).



The country reports emanating from these research and dialogue activities in Cambodia, Indonesia, Lao PDR, Malaysia, Philippines, Thailand, and Viet Nam are presented in this book. The reports help shed light on the economic effects of HIV and AIDS in low-prevalence countries such as the ASEAN Member Countries, with the view of spurring efforts in addressing the pandemic before it reaches socially destabilising proportions as in the affected countries. The data presented here address several inter-related concerns for policymakers and stakeholder groups, specifically:

- 1) The socioeconomic impact of HIV and AIDS in countries with low-prevalence and concentrated epidemics;
- 2) The cost of implementing HIV and AIDS interventions in the ASEAN Member Countries; and
- 3) The important implications for action to mitigate the socioeconomic impact of HIV and AIDS.

The book comes at an opportune time. ASEAN Member Countries will review the work that needs to be done in stopping the spread of HIV and AIDS given the pledges that the ASEAN Leaders have made in the ASEAN Commitments on HIV and AIDS and the Operational Work Plan for the Third ASEAN Work Programme on HIV and AIDS for 2007–2010 (AWP III), which they also adopted at the Cebu Summit on 13 January 2007. In doing so, the ASEAN Leaders also called on “Dialogue Partners, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Secretariat and its co-sponsors, other UN organisations, international partners, civil society organisations and the private sector in realising our commitment to scale up effective responses to HIV and AIDS.”

I would like to congratulate and thank the ATFOA, USAID, and Constella Futures for this outstanding endeavour. I would also like to acknowledge the following individuals who were instrumental in developing their respective country reports:

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Indonesia: Dr. Rosmini Day, Dr. Dicky Budiman, Mr. Chandra Widya Yudha, M. Taswin Munier, Dr. Nyoman Kandun, and Mr. Berton Suar.

Lao PDR: H.E. Mr. Sayakane Sisouvong, Dr. Chansy Phimphachanh, Dr. Keophouvanh Douangphachanh, Dr. Michael Hahn, and Ms. Sengaloun Inmixai.

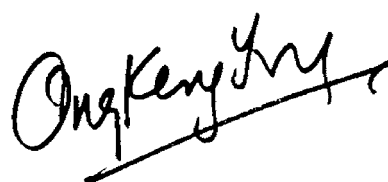
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It is our hope that all involved in the fight against the spread of HIV in ASEAN and elsewhere in the world will find this publication useful.



Ong Keng Yong  
Secretary-General of ASEAN

## ABBREVIATIONS

ADB	Asian Development Bank	DILG	Department of Interior and Local Government
ADB-JFPR	Asian Development Bank – Japan Fund for Poverty Reduction	DOH	Department of Health
AIDS	acquired immune deficiency syndrome	EU	European Union
AMTP	AIDS Medium Term Plan	FHI	Family Health International
ART	antiretroviral therapy	GDP	gross domestic product
ARV	antiretroviral	GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
ATFOA	ASEAN Task Force on AIDS	GTZ	German Agency for Technical Cooperation
AusAID	Australian Agency for International Development	HBC	home-based care
BCC	behaviour change and communication	HF-SW	high-frequency sex worker
BKKBN	National Family Planning Coordination Board	HIV	human immunodeficiency virus
BNN	National Narcotics Bureau	HSS	HIV sentinel surveillance
BSS	Behavioural Surveillance Survey	IDR	Indonesian rupiah
CBC	complete blood count	IDU	injecting drug user
CBO	community-based organisation	IEC	information, education, and communication
CCC	comprehensive community care	JICA	Japan International Cooperation Agency
CDC & EH	Communicable Disease Control and Environmental Health	LF-SW	low-frequency sex worker
CEMSHAD	Center for Multidisciplinary Studies on Health and Development	LFT	liver function test
CHAS	Centre for HIV/AIDS/STI (Lao PDR)	LGU	local government unit
CHASPPAR	Control of HIV/AIDS/STD Partnership Project in Asia Region	M&E	monitoring and evaluation
CHD	Centre for Health Development	MAC	Malaysian AIDS Council
CHE	current health expenditure	MDG	Millennium Development Goal
CSMBS	Civil Servants' Medical Benefit Scheme	MOH	Ministry of Health
CST	Care, Support, and Treatment (programme)	MSM	men who have sex with men
DALY	disability-adjusted life year	MTPDP	Medium Term Philippine Development Plan
		NAA	National AIDS Accounts (Thailand)
		NAA	National AIDS Authority (Cambodia)



NAC	National AIDS Commission	SW	sex worker
NAP	National AIDS Programme	TB	tuberculosis
NASPCP	National AIDS/STD Prevention and Control Programme	TRIPS	Trade-Related aspects of Intellectual Property Rights
NCCA	National Committee for the Control of AIDS	UNAIDS	Joint United Nations Programme on HIV/AIDS
NCHADS	National Centre for HIV/AIDS, Dermatology, and STDs	UNDP	United Nations Development Programme
NEC	National Epidemiology Centre	UNFPA	United Nations Population Fund
NGO	nongovernmental organisation	UNGASS	United Nations General Assembly Special Session
NGPES	National Growth Poverty Eradication Strategy	UNICEF	United Nations Children's Fund
NIHE	National Institute of Hygiene and Epidemiology	UNODC	United Nations Office on Drugs and Crime
NSEP	Needle and Syringe Exchange Programme	UP	universal precaution
NSP	National Strategic Plan	USAID	United States Agency for International Development
OFW	overseas Filipino worker	VAAC	Viet Nam Administration of HIV/AIDS Control
OI	opportunistic infection	VCCT	voluntary confidential counselling and testing
OI Tx	opportunistic infection treatment	VCT	voluntary counselling and testing
OVC	orphans and vulnerable children	VND	Vietnamese dong
PDR	People's Democratic Republic	WHO	World Health Organization
PEP	post-exposure prophylaxis		
PHP	Philippine peso		
PLHA	person living with HIV or AIDS		
PMTCT	prevention of mother-to-child transmission		
PNAC	Philippine National AIDS Council		
PSI	Population Services International		
QOL	quality of life		
SSS	Social Security Scheme		
STD	sexually transmitted disease		
STI	sexually transmitted infection		



# I. OVERVIEW



The Assessment of the Socioeconomic Impact of HIV and AIDS is the second activity under the USAID Cooperation with ASEAN through the Operational Framework for the ASEAN Work Programme on HIV/AIDS (2002–2005). The work programme identifies the need to understand the socioeconomic impact of HIV and AIDS on the region in order to inform advocacy for increased political commitment and leadership and, thus, increased financial, human, and institutional resources for HIV and AIDS.

In October 2005, at a workshop in the Philippines, participants from ASEAN Member Countries were given the necessary skills and tools—including resource planning tools—to assess the impact of HIV and AIDS in their countries. Following the workshop, seven ASEAN Member Countries prepared country reports on the socioeconomic impacts of and future resource requirements for HIV and AIDS at the country level, using tools and internationally recognised standards (e.g., the National AIDS Spending Assessment and Resource Needs Model). A Regional Symposium was held in April 2006 to share country results and deliberate the implications of these findings.

This overview addresses several key questions:

- Why is it important to know the impacts of HIV and AIDS in low-prevalence countries and how significant are the impacts?
- What can be done and what will it cost?
- What are the important implications for action?

### WHY IS IT IMPORTANT TO KNOW THE IMPACTS OF HIV AND AIDS IN LOW-PREVALENCE COUNTRIES AND HOW SIGNIFICANT ARE THE IMPACTS?

Asia accounts for about half of the world's population. Table 1-1 shows the HIV prevalence and number of people living with HIV in the ten ASEAN Member Countries.<sup>1</sup>

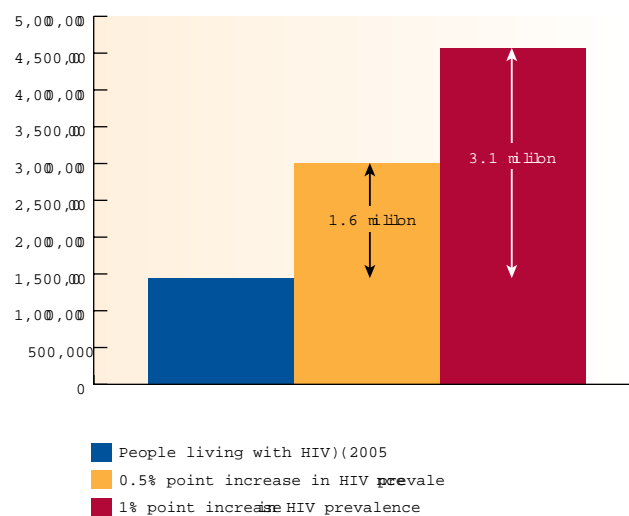
Little is known about the economic impact of HIV and AIDS in low-prevalence countries. A key driver of the impact is

Table 1-1-HIV Prevalence (2006)

	Adult HIV Prevalence (2006)	Number of HIV+ Adults (2006)
Brunei Darussalam	<0.1%	<100
Cambodia	1.6%	130,000
Indonesia	0.1%	170,000
Lao PDR	0.1%	8,200
Malaysia	0.5%	67,000
Myanmar	1.3%	35,000
Philippines	<0.1%	12,000
Singapore	0.3%	5,500
Thailand	14%	560,000
Viet Nam	0.5%	25,000
	0.4% (median)	1,552,700 (total)

Source: UNAIDS, 2006.

Figure 11. Impact of an increase in HIV prevalence in the ASEAN Member Countries



Source: UNAIDS, 2006, and author's calculation.

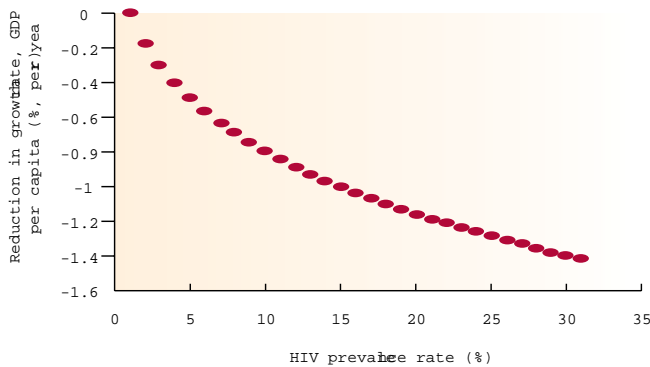
the size of the population in the region; a 1 percentage point increase in HIV prevalence will increase the number of people living with HIV by 3.1 million. Even a smaller increase of 0.5 to 0.9 percentage points will result in 1.6 million more HIV-positive people (see Figure 1-1). For this reason, even at a low average prevalence in the ASEAN Member Countries, large numbers of people are living with or affected by HIV.

<sup>1</sup> At the Regional Symposium held in April 2006, it was agreed that seven of the ten ASEAN Member Countries would proceed with this first report. The countries are Cambodia, Indonesia, Lao People's Democratic Republic (PDR), Malaysia, Philippines, Thailand, and Viet Nam.

For example, Viet Nam, with an adult prevalence of 0.5 percent, has 250,000 people living with HIV; this is more than in Swaziland, where 220,000 people are living with HIV, but adult prevalence is 33.4 percent (UNAIDS, 2006).

The impact on national gross domestic product (GDP) is likely to be modest in the countries in the region. Figure 1-2 summarises the findings from a World Bank study showing the relationship between HIV prevalence on the horizontal axis and per capita GDP growth on the vertical axis. At HIV prevalence of less than 2 percent, as is the case for ASEAN Member Countries, GDP loss is likely to be modest. Furthermore, ASEAN Member Countries' economies are growing well in excess of the global mean; and, therefore, the impact on GDP growth is not likely to be the most important economic effect of HIV and AIDS.

Figure 12.  
Impact of HIV on Economic Growth



Source: R. Banel (2000) Economic Analysis of HIV/AIDS, ADF2000 Background paper, World Bank

Table 1-2 shows selected development indicators associated with low, concentrated, and generalised epidemics. The impact on development indicators is mixed. The first set of indicators showing impacts at the national level indicate a small impact associated with low and concentrated epidemics. However, in certain subnational areas in the ASEAN Member Countries, the impact on particular indicators is comparable to that of generalised epidemics—these subnational impacts are largely driven by the concentrations of high-risk behaviour in some subnational locations;

Table 1-2.  
Impact on Development Indicators at National and Subnational Levels

Indicator	Unit	Type of Epidemic		
		Low	Concentrated	Generalized
<b>National level</b>				
HIV prevalence	%	9	9	
Mortality rate	/100	9	9	
Annual growth rate	%	9	9	
Life expectancy	years	9	9	
Disability adjusted life years	years	9	9	
HIV-positive population	number			
AIDS-related deaths	number			
<b>Subnational level</b>				
HIV prevalence	%			
Mortality rate	/100	9	9	
Annual growth rate	%			
Life expectancy	years			
Disability adjusted life years	years	9	9	
HIV-positive population	number			
AIDS-related deaths	number			

Source: Rhucharoenpornpanich, 2004 in UNAIDS/ADB, 2004. Magnitude of the impact is indicated by size of symbol (small orange)

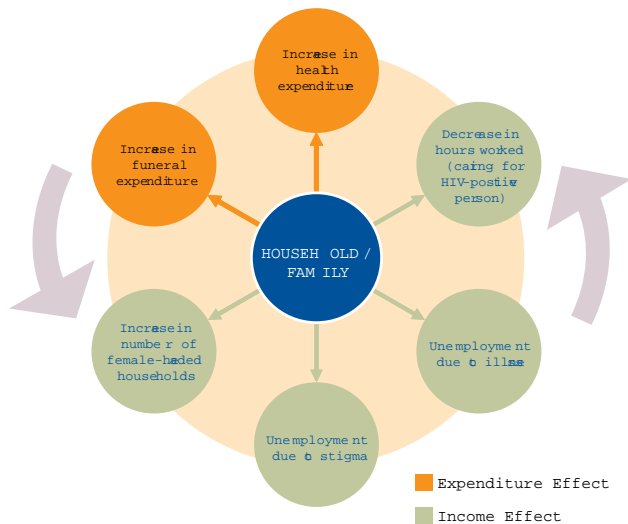
examples include Chiang Mai in Thailand, Siem Reap in Cambodia, and Ho Chi Minh City in Viet Nam (Rhucharoenpornpanich, 2004 in UNAIDS/ADB, 2004).

HIV and AIDS have a profound impact on households. This impact was previously neglected in economic analyses that focussed mainly on HIV and AIDS impacts on economic growth. A phenomenon called the “medical poverty trap” provides a useful conceptual framework to assess the household effects of HIV and AIDS (see Figure 1-3). The effects can be divided into income and expenditure effects. Households with a person living with HIV or AIDS (PLHA) are faced with HIV- or AIDS-related expenditures (e.g., healthcare and funeral costs) and income effects (e.g., loss of income from a PLHA and reduced working hours by a caregiver, most of whom are females) (Martin, 2004a and b; UNDP, 2005).

Households with a PLHA experience a combination of income and expenditure effects at a time when they are least able to handle them. Healthcare costs and costs of antiretroviral treatment (ART) are major drivers of costs to households. Countries in the region already spend high levels of household expenditure on healthcare; for example, in Viet Nam, a third of households spend more than 5 percent of their income on healthcare (Wagstaff and Doorslaer, 2003).

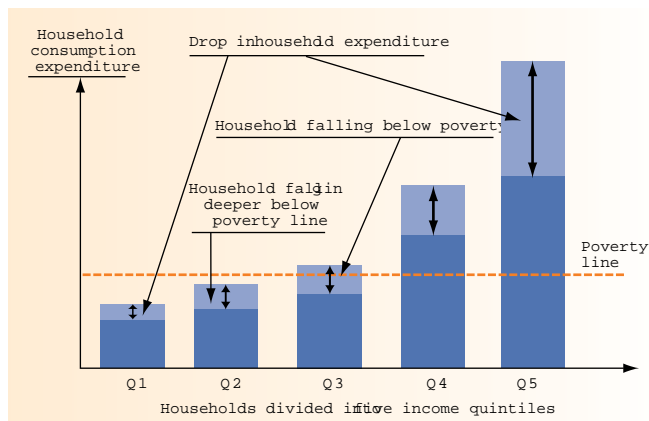


Figure 13. Medical Expenditure



Sources: Martin, 2004a and b.

Figure 14. Conceptual Framework for Assessing the Impact of AIDS on Poverty



Sources: Martin, 2004a and b.

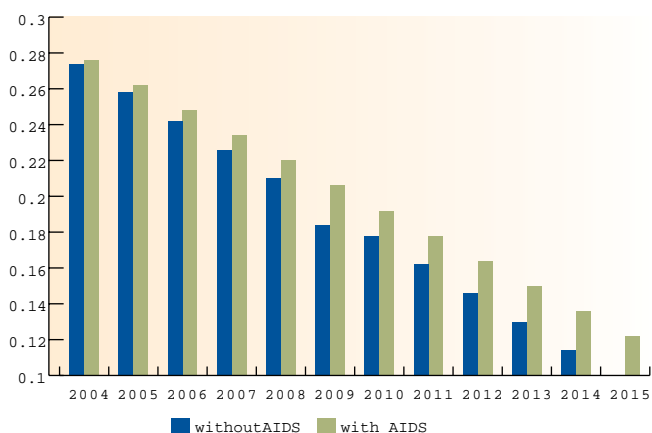
AIDS has magnified the links among health, poverty, and development. Health is important in its own right, but it is also an asset. This is especially true for the poor. Ill health limits the already constrained asset base of poor households and can have devastating impacts. Furthermore, HIV, in particular, can be even more devastating because family support and community-based coping mechanisms may not be available due to HIV-related stigma and discrimination.

The diagram in Figure 1-4 shows the conceptual framework used to assess the impact of AIDS on household vulnerability and poverty. On the vertical axis is household consumption expenditure. All households with a PLHA were divided into income quintiles, with quintile one being the poorest 20 percent of the population and quintile five being the wealthiest 20 percent. Relative to the poverty line, some households are either poor or non-poor. The impact of AIDS-related income and expenditure effects (see Figure 1-3) is fewer resources to spend on household consumption expenditures such as food, education, and healthcare for other family members. This situation may cause some households to fall below the poverty line or deeper into poverty.

According to the United Nations Millennium Project, the ASEAN Member Countries are on track to meet the first Millennium Development Goal (MDG), which is to halve the number of people living in poverty by 2010 (UN Millennium Project, 2005). How may HIV and AIDS impact these poverty reduction achievements? This question is particularly pertinent, because AIDS is directly linked to some of the most common concerns of the poor cited in participatory poverty assessments conducted by the World Bank: poor health, life events such as death, or a drug-using family member (World Bank, 1999).

Figure 1-5 shows the example of deterministic simulation modelling that was done for Viet Nam based on the analytical framework identified in Figure 1-4. Between 1993 and 1998 the poverty rate in Viet Nam decreased at an average annual rate of 4.2 percentage points (World Bank/Poverty Working Group, 2000). Between 1998 and 2002 poverty reduction continued but slowed slightly to 1.6 percentage points annually (World Bank/Poverty Working Group, 2002). It is projected that HIV and AIDS may potentially slow down poverty reduction efforts between 2004 and 2015 by close to a tenth of the rate of poverty reduction in the most recent years (as illustrated in Figure 1-5).

**Figure 15.**  
Projected Poverty Reduction Achievements  
with and without AEs in Viet Nam



Sources: Marth, 2004a; UNDP, 2005; UNAIDS/ADB, 2004.

largely from being clients of SWs (which includes brothel-based sex work as well as other more informal transactional sex work such as street-based and karaoke-based sex work) or from injecting drug use. These populations are linked behaviourally, and an epidemic in one sub-population will not remain confined to that risk group. Table 1-3 summarises the epidemiological information from the country reports. HIV prevalence among most-at-risk groups is high in many countries. For example, prevalence among IDUs in Viet Nam is 72.2 percent; prevalence among SWs in Cambodia is 28.8 percent; and the number of PLHAs in Thailand is 560,000.

Because these most at-risk groups are marginalised and highly stigmatised, prevention responses have had varied success in the ASEAN Member Countries. However, Thailand and Cambodia have had remarkable successes and are recognised as global leaders in the fight against HIV and AIDS.

## WHAT CAN BE DONE AND WHAT WILL IT COST?

As the country reports suggest, there is a growing body of knowledge about Asian HIV epidemics. HIV is concentrated among most-at-risk groups such as sex workers (SWs) and their clients, injecting drug users (IDUs), and men who have sex with men (MSM). In several of the countries, migrants are also an at-risk group, but the elevated risk among migrants in many instances is

There is an urgent need to accelerate implementation of focussed prevention programmes for the following groups: IDUs, SWs and their clients, and MSM. Furthermore, the focus of the programmes must be based on evidence and not political motivations. The acceleration will require tough decisionmaking, but it is the only way to turn the HIV epidemics around in Asia. The Thailand experience has also highlighted the importance of continued commitment to prevention efforts, especially when access to ART is being scaled up.

**Table 1-3** Summary of Epidemiology Indicators

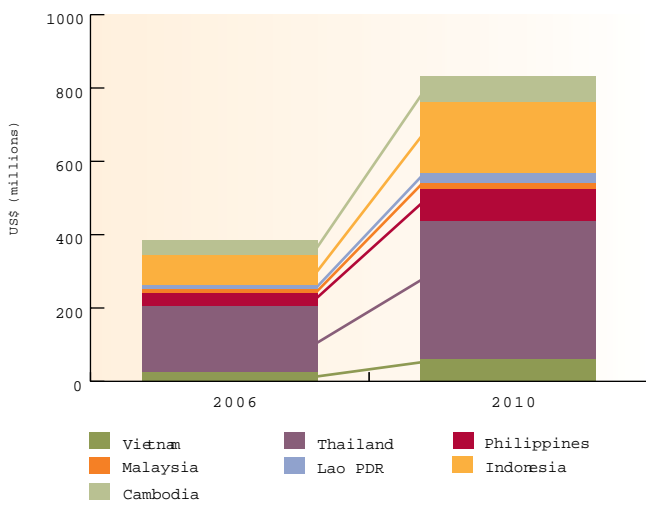
	Cambodia	Indonesia	Lao PDR	Malaysia	Philippines	Thailand	Viet Nam
Population (2006)	14,071,000	22,781,000	5,921,000	2,347,000	83,034,000	64,233,000	84,238,000
Gross national income per capita (2006)	US\$320	US\$1,140	US\$390	US\$4,650	US\$1,100	US\$2,490	US\$550
<b>HIV prevalence</b>							
Adults (2006)	1.60%	0.10%	0.10%	0.50%	<0.1%	14.0%	0.50%
Direct sex workers	28.80%	31.2%		51-7.6%	n/a	73.6%	11.50%
Injecting drug users*	n/a	16%		13.3-25.6%	n/a	41.2%	72.25%
Men who have sex with men*	n/a	0.90%		1.23-3.6%	n/a	2%	5.80%
Adults living with HIV (2006)	130,000	170,000	820	67,000	2,000	560,000	250,000
Women living with HIV (2006)	59,000	29,000	4,000	17,000	3400	220,000	84,000
New HIV infections*	7,300		1,520	n/a	n/a	18,172	n/a
AIDS-related deaths (2006)	16,000	5,500	40	4,000	4,000	2,000	3,000

Sources: Country reports included in this publication.

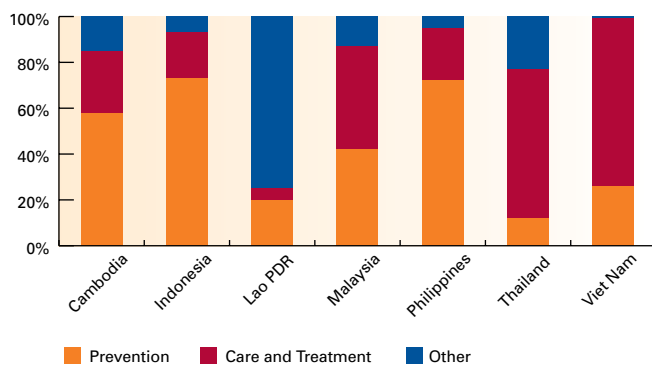
\* Various years

The estimated resource requirement in 2006 for the seven countries is US\$385 million, increasing to US\$832 million in 2010 (see Figure 1-6). The largest share of the requirement is for Thailand, followed by Indonesia. Care and treatment and prevention account for 46 percent and 37 percent of the resources, respectively (see Figure 1-7). It is important to note that in Thailand and Viet Nam, the majority of national resources for HIV and AIDS is allocated to care and treatment.

**Figure 1-6.**  
Estimated Resource Needs



**Figure 1-7.**  
Breakdown of Estimated Resource Needs, 2006–2010



How does this resource requirement compare with what is currently spent on HIV in the ASEAN Member Countries? The total expenditure of HIV and AIDS in 2004 in the seven countries was US\$204.4 million, with Thailand accounting for the largest share (60%) (see Table 1-4).

**Table 1-4.**  
Expenditure on HIV and AIDS, 2004

AIDS Expenditure (2004)	US\$ (millions)	Share (%)
Cambodia	\$29.2	14.3%
Indonesia	\$8.5	4.2%
Lao PDR	\$5.0	2.4%
Malaysia	\$10.5	5.1%
Philippines	\$2.9	1.4%
Thailand	\$122.9	60.1%
Viet Nam	\$25.4	12.4%
<b>Total</b>	<b>\$204.4</b>	<b>100%</b>

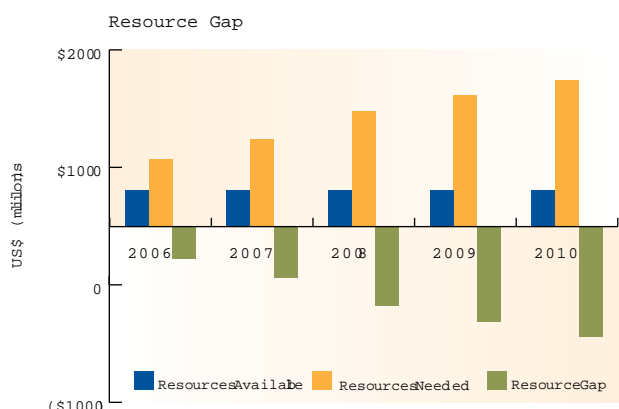
Source: Country reports included in this publication.

Figure 1-8 shows the resource gap analysis based on current resource availability. Information on future commitments was not available for all the countries. For this reason, the future resource requirements were compared with current HIV and AIDS spending for comparability between countries. If resource availability were to remain at the levels for 2005, only one quarter (25%) of the projected resource requirements will be met in 2010.

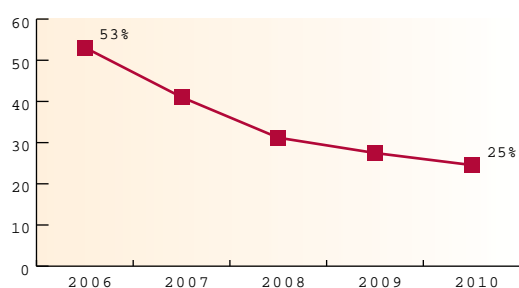
Thus, there is a need for substantial resource mobilisation. However, given the magnitude of the resource gap, the question to consider is: What if only part of the resource gap can be filled? Priorities will then need to be identified based on the following:

- Epidemic trends and the sources of the largest numbers of new infections;
- Effectiveness of interventions (for example, as revealed through the Goals Model Impact Matrix, which is a collation of the evidence from a large body of epidemiology impact literature);
- Cost-effectiveness and cost analysis; and
- Scenario modelling to highlight the cost and impact of various combinations of interventions.

Figure 18. Resource Gap Analysis



Percent of Resource Met



## WHAT ARE THE IMPORTANT IMPLICATIONS FOR ACTION?

The studies in the accompanying country reports have identified a variety of social and economic consequences of HIV and AIDS, which make a strong case for increased government commitment in preventing HIV. Furthermore, they make an even stronger case for a multisectoral response and the formal incorporation of HIV and AIDS initiatives in governments' efforts to reduce poverty and prepare socioeconomic and development plans. Within this context, the consequences of HIV and AIDS, which increase households' vulnerability to poverty, need to be fully acknowledged in poverty assessments in the region. By assessing determinants of the impact of HIV and AIDS in the ASEAN Member Countries, as well as what it will cost to respond, the work in this report, led by the ASEAN

Secretariat, will inform and motivate proactive action.

Healthcare costs are a major driver of HIV- and AIDS-related household expenditures and increased vulnerability to poverty. Subsidisation of healthcare costs will be important for impact mitigation. The analysis using the aforementioned conceptual framework suggests that it does not only matter how many people get access to ART (as is the motivation expressed in many initiatives to improve access to ART), but also who gets access. Subsidisation of ART by national governments, donor partners, or international bodies should be appropriately directed at those groups most in need.

Effective resource mobilisation requires quantification of resource requirements. In many countries, this assessment represents the first time that national resource requirements have been estimated in any systematic manner. The country-led process that resulted in these estimates needs to feed into national debates and dialogues with ministries of planning and finance in order to mobilise the necessary resources required to avert the impacts described. While data gaps remain, decisionmaking cannot wait for complete information. While data collection processes are being improved in individual countries, decisionmaking can be informed by available data and collated information and experiences from all the region's countries.

Some of the assessment's key conclusions are:

- The potential for further HIV spread in the region remains large and real, especially given the large percentage of most-at-risk groups that are not yet receiving HIV prevention services. Asian epidemics may be curbed by focussing prevention efforts on most-at-risk populations in order to minimise the 'bridging' of the epidemic into the rest of the population. Resources should be allocated to accelerate the implementation of focussed prevention programmes for IDUs; SWs and their clients; and MSM.
- Healthcare costs have a major impact on households and make them more vulnerable to poverty. Subsidisation of healthcare costs and drugs for ART will be important for mitigating impact on the household.
- Who gets access to ART matters as much as how many people get access. Targeted subsidisation of access to

treatment should be a key consideration.

- The importance of HIV as a factor that increases households' vulnerability to poverty must be acknowledged by including HIV and AIDS issues and activities in poverty assessments and development plans and in the governments' efforts to reduce poverty.
- Political will and effective leadership from donors and governments are crucial. Donors have major roles to play in easing the burden on low-income countries in the region and the very poor in middle- and high-income countries.
- Substantial resources need to be mobilised. Where resource gaps remain, tough choices have to be made based on epidemiological and cost-effectiveness evidence. Data and analyses can help policymakers see the implications of different resource allocation scenarios

and facilitate the decisionmaking process.

The window of opportunity for action for ASEAN governments is steadily closing and bold leadership and action are essential now. It is hoped that the information from this report will inform the focussed and priority actions needed to ensure the maximum use of resources mobilised for the HIV and AIDS response.

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## II. CAMBODIA

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**C**ambodia is among the countries most affected by the HIV epidemic in Asia. The National Centre for HIV/AIDS, Dermatology, and STDs (NCHADS) estimates that 123,100 adults in Cambodia were living with HIV in 2003 (NCHADS, 2003). In 2005, the national HIV prevalence was estimated at 1.9 percent (NCHADS, 2005).

Although transmission of HIV has decreased in recent years, the country still has the highest prevalence in Southeast Asia. The epidemic is fueled by SWs and their clients, as well as MSM, individuals engaging in unprotected sex, and IDUs sharing contaminated needles and syringes. Mobile and migrant populations are also at increased risk of infection and an increasing proportion of infections are transmitted between couples and from mothers to infants.

This report presents empirical findings regarding (1) the socioeconomic impact of HIV and AIDS in Cambodia; (2) the National AIDS Spending Assessment from 2000–2004;



A woman in Cambodia holds her healthy infant.

## COUNTRY PROFILE

Population (2006): 14,071,000<sup>a</sup>  
 Gross national income (2004): US\$320 per capita<sup>b</sup>  
 Adult HIV prevalence (2006): 1.6%<sup>a</sup>  
 Percent HIV prevalence among most-at-risk groups:  
     Direct female sex workers (2002): 28.8%<sup>d</sup>  
     Indirect female sex workers (2002): 14.8%<sup>d</sup>  
 Adults living with HIV (2006): 130,000<sup>a</sup>  
 Women (15–49) living with HIV (2006): 59,000<sup>a</sup>  
 New HIV infections (2002): 7,300<sup>d</sup>  
 AIDS-related deaths (2006): 16,000<sup>a</sup>

Sources: <sup>a</sup>UNAIDS, 2006; <sup>b</sup>World Bank, 2005; <sup>c</sup>NCHADS, 2005; <sup>d</sup>NCHADS website

(3) a summary of the country’s strategic plan for a scaled-up response to HIV and AIDS; (4) an estimate of the resources required for HIV and AIDS programmes in the near future; and (5) a summary of key policy issues and next steps for mitigating the socioeconomic impact of the epidemic.

## SOCIOECONOMIC IMPACT OF HIV AND AIDS

**A**lthough Cambodia has made great strides in curbing the course of the epidemic, the country will continue to feel the social and economic effects of a large population living with HIV. An HIV-related illness in a household places a burden on the entire household unit—a safety net that has already been weakened, in many instances, by genocide, civil war, poverty, and famine. Studies show that the economic impact of the epidemic varies across socioeconomic levels, with poorer households bearing a proportionately higher cost of illness and death of family members (Basu et al., 1997).

Little is known about the macroeconomic impact of HIV and AIDS in Cambodia—on economic development, poverty, and security—but estimates show that the impact is significant. Sectoral impact studies are part of the second national strategic plan. According to a study by the Asian

Development Bank (ADB) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), poverty reduction in Cambodia will be slowed by up to 60 percent between 2003 and 2015 if prevention, care, and treatment efforts continue to be as inadequate as at present (ADB and UNAIDS, 2004).

More information about the effects of HIV and AIDS on the household is available in Cambodia, especially as it relates to orphans and vulnerable children. One of the Royal Government of Cambodia's four priorities for promoting the rights and well-being of children is addressing the needs of those affected by HIV.<sup>1</sup> Studies from Cambodia show that households with members living with HIV often have fewer resources to cover children's school fees, uniforms, school supplies, healthcare, clothing, and other basic necessities.

The study of a Cambodian home-based care network in 2000 found that 40 percent of children in households affected by HIV had to go without basic necessities such as food and



A girl sells crabs at a market in Sianoukville, Cambodia.

clothing; 30 percent had to take on additional caretaking and household responsibilities; and 21 percent had to start working to support the household (KHANA, 2000).

Another study (2004), looking at the social and economic impact of HIV and AIDS on households conducted in Cambodia, found that households with one or more adults living with HIV have a lower income, lower non-health expenditures, higher health expenditures, and fewer household assets than neighbouring unaffected households.<sup>2</sup> The study confirmed that being HIV positive is a significant factor contributing to a loss of household income. It also showed that in coping with illness, HIV-positive guardians are more likely to reduce non-health expenditures, borrow money, and sell assets to pay for their health-related expenditures, demonstrating the increased economic burden and opportunity costs on children and adolescents living in the affected households (POLICY Project, 2004).

The same study in Cambodia found that children in households affected by HIV are more likely to experience hunger than non-affected households in the same geographic area, suggesting that there may be a need to ration food supply to pay for medical care. Children and adolescents in HIV-affected households were more likely to work for money and take on additional responsibilities in the household; school enrollment levels were found to be lower among the HIV-affected households. The researchers also used a quality of life (QOL) index to identify whether or not the physical and emotional needs of the children and adolescents were being satisfied, and findings indicate that the QOL of children in HIV-affected households is significantly lower than in non-affected households. Together, these findings confirm that the HIV-related illness of an adult guardian places a burden on children and adolescents that may limit their normal development and diminish their social and economic well-being.

## NATIONAL AIDS SPENDING

Figure 2-1 shows the budgeted and actual expenditure available for HIV and AIDS in Cambodia between 2001 and 2004. In 2001, \$16.2 million was available for HIV and AIDS, increasing to \$42.6 million in 2004. However, in 2001, only \$9.3 million was spent, leaving an estimated \$6.9

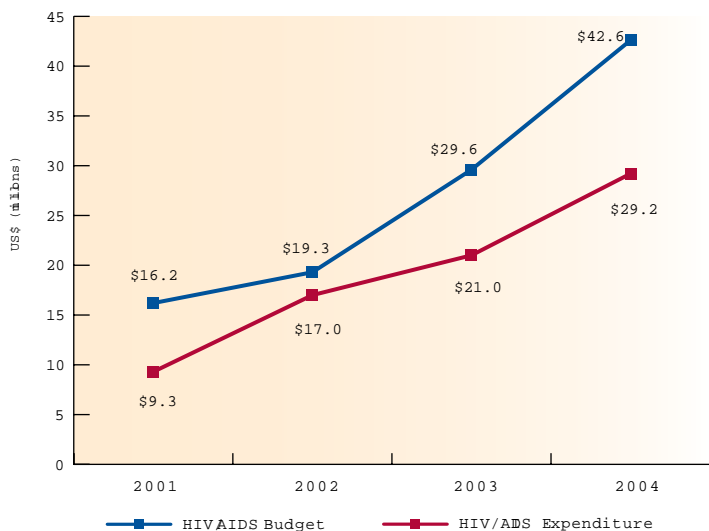
<sup>1</sup> This statement was made by the Cambodian government on June 1, 2004, International Children's Day, and is in line with the country's goals outlined in several declarations—the 2000 United Nations Millennium Declaration and Millennium Development Goals, the 2002 United Nations General Assembly Special Session on Children, the Bali Consensus of the 2003 East Asia and Pacific Ministerial Consultation on Children—and several of the government's national policies, plans, and strategies.

<sup>2</sup> The study used a case-comparison design in which the case population was self-selected and the comparison group was the nearest neighbouring household.



million unspent—a variance of 43 percent. The variance (in percentage terms) was less in subsequent years, decreasing to 12 percent in 2002. In absolute terms, the largest difference between budgeted and actual spending was in 2004 when \$29.2 million (69%) of the budgeted \$42.6 million was spent.

Figure 2-1 Available sources for HIV and AIDS



Sources: NCHADS, 2005; Godwin, 2005; and POLICY Project 2009.

## NATIONAL STRATEGIC PLAN ON HIV/AIDS/STI 2006–2010

The overall goals of the Second National Strategic Plan (NSP-II) are to reduce new infections of HIV; provide care and support to people living with and affected by HIV; and alleviate the socioeconomic and human impact of HIV on the individual, family, and community. To achieve these goals, the NSP-II includes seven strategies and associated HIV and AIDS interventions for implementation during 2006–2010. These strategies are

- Increased coverage of effective prevention interventions;
- Increased coverage of effective care, support, and treatment; voluntary confidential counselling and testing (VCCT); and prevention of mother-to-child transmission (PMTCT);
- Increased coverage of effective impact mitigation interventions;

- Increased capacity of government and civil society to respond to HIV and AIDS;
- A supportive legal and policy environment to respond to HIV and AIDS;
- Increased availability of information for decisionmaking—collected during research, surveillance, and monitoring and evaluation; and
- Increased, sustainable, and equitably allocated resources for the national response.

A description of each strategy follows.

### Strategy 1: Prevention

The risk of an epidemic resurgence remains because of high-risk sexual behaviour; therefore, continued emphasis is needed on HIV prevention among commercial and casual sex networks and “bridge populations” such as mobile men, garment factory workers, MSM, and drug users. Transmission among lower risk groups is projected to represent an increased proportion of new infections, even though the absolute number of infections among these groups is decreasing. Thus, the strategic plan outlines activities to prevent the increasing proportion of infections by increasing access to health services (PMTCT, management of sexually transmitted infections (STIs), blood safety, and condom distribution), and involving the educational system, the arts, and the media.



A billboard in Cambodia promotes condoms for the prevention of STIs. Cambodia has the highest rate of HIV-positive persons in Southeast Asia.

## Strategy 2: Care and Treatment

According to the strategic plan, VCCT needs to be scaled up, as the majority of people living with HIV are not aware of their sero-status and do not access the corresponding care and support. The Continuum of Care will be broadened to include more services—notably ART—and expanded to reach more people infected and affected by HIV.



Providers at a community health centre in Cambodia counsel waiting room clients on family planning and reproductive health. Providers were trained by the Reproductive and Child Health Alliance (RACHA) as part of RACHA's IUD campaign, Cambodia.

## Strategy 3: Impact Mitigation

Impact mitigation efforts aimed at individuals, including people living with HIV or AIDS, orphans and vulnerable children, widows, and families affected by HIV will be scaled up between 2006 and 2010. The activities outlined in the plan will also assess and address the broader impact on communities and sectors.

## Strategy 4: Coordination and Implementation Capacity

This strategy holds line ministries and local governments accountable for translating HIV and AIDS policies and strategies into activities and allocating resources for implementation. In the event that policies or strategies are not in place, the emphasis will be on assessing the impact

of HIV and AIDS and on strategic planning. Special attention is placed on the local government at operational district and commune levels to coordinate and implement HIV and AIDS activities. Civil society organisations—including the private sector, the media, faith-based organisations, and community groups—will be supported to engage in the response.

## Strategy 5: Legal and Policy Environment

Further steps to fostering a more supportive public policy and legal environment will be taken at several levels. The national strategic development plan will include HIV as a crosscutting concern. An enabling policy environment will support the implementation of the Law on the Prevention and Control of HIV/AIDS and other relevant legislation through education, the training of law enforcement personnel, and the development and reform of further legislation.

## Strategy 6: Information Gathering, Research, Surveillance, and Monitoring and Evaluation

The surveillance system will remain the backbone of the national multisectoral monitoring and evaluation system, and the tracking of additional core indicators from other sectors will complement this system. Annual progress reports will be produced and annual joint reviews will be undertaken to assess progress and adjust the NSP-II strategies. Research efforts will be better coordinated, documented, and disseminated so that more programme planners and policymakers can benefit from the information.

## Strategy 7: Resource Mobilisation and Funding Arrangements

A costing exercise has been done to assess the financial resources required to respond to HIV and AIDS and will inform resource mobilisation. Mechanisms will be designed to overcome non-financial barriers, such as human resources, in order to increase absorptive capacity.

## ESTIMATED RESOURCE NEEDS FOR HIV/AIDS/STI PREVENTION

In Cambodia, the National AIDS Authority (NAA) led an extensive data collation process to estimate the resource requirements of HIV-related interventions proposed in the strategic plan. Stakeholders used HIV and



AIDS expenditure information collected by donors and implementing agencies such as the POLICY Project and the NAA in 2005, reports produced for the review of Cambodia's First National Strategic Plan, and other strategic documents. Estimates prepared by NCHADS, the primary implementing agency for HIV-related care and treatment, informed the cost of care and treatment interventions. Several data consultation meetings were conducted to verify the data inputs entered into the model.

### Total Resource Requirement

Figures 2-2 and 2-3 show the resource requirements for implementing all the strategies. The total required is estimated to be approximately US\$42.4 million in 2006 and US\$70.7 million in 2010. Strategy 1 constitutes 46 percent of the total in 2010; Strategy 2 constitutes 39 percent; and Strategy 3 constitutes 11 percent. Prevention (including VCCT and PMTCT) accounts for the largest share, as shown in Figure 2-3. The total required for prevention is estimated to be US\$25.2 million in 2006 and US\$41.0 million in 2010.

### Strategy 1: Prevention

Figure 2-4 shows the resources required for the interventions included under Strategy 1. Resource needs for prevention increase from approximately US\$21.3 million in 2006 to

US\$ 32.3 million in 2010. However, as some prevention interventions (VCCT and PMTCT) are captured under Strategy 2, this graph does not reflect the total amount required for prevention interventions.

Figure 23. Total Resource Required

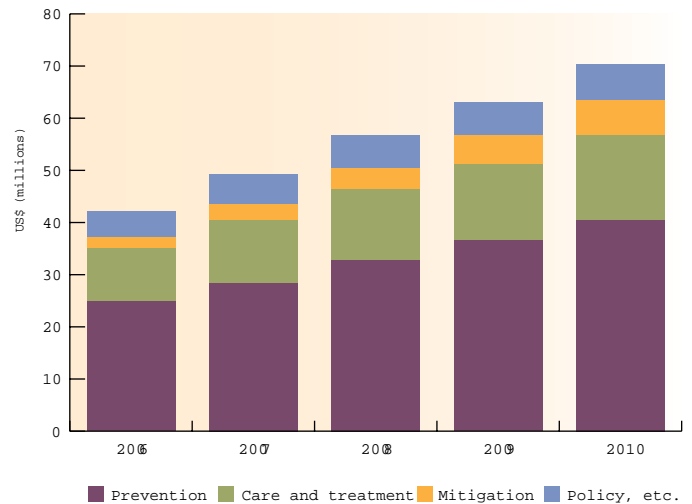


Figure 24. Resource Required for Strategy 1

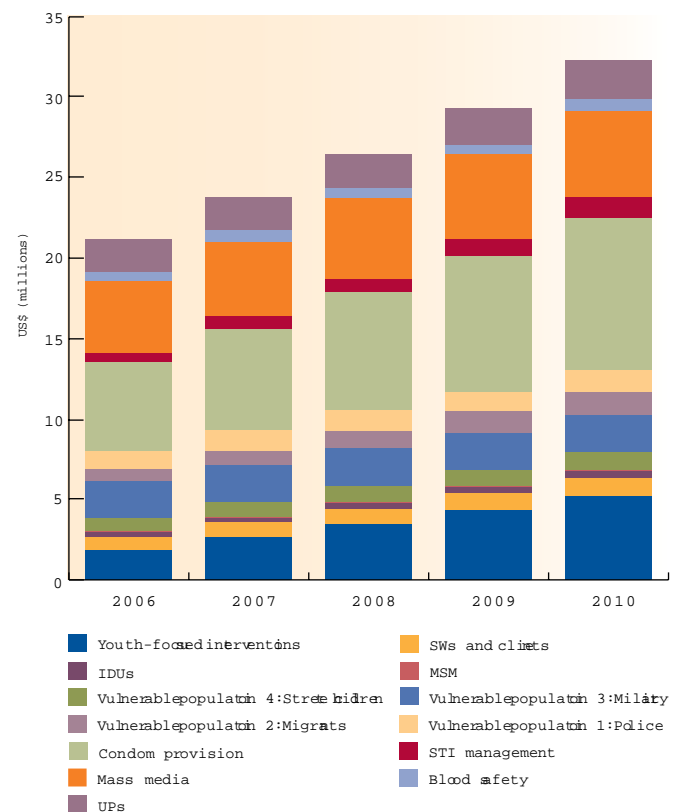
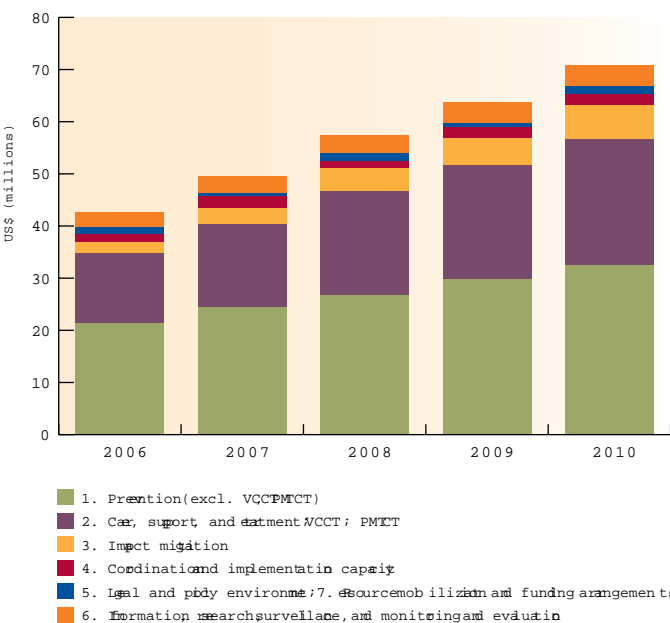


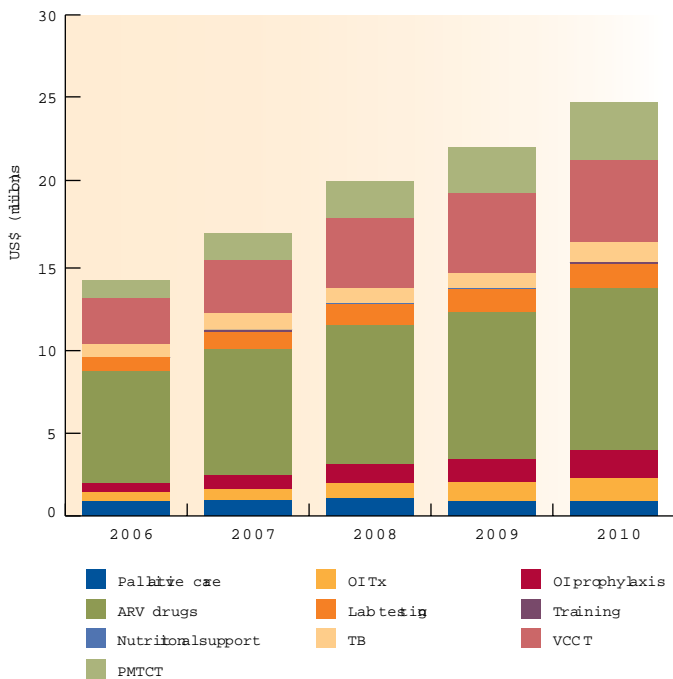
Figure 22. Total Resources Required by Strategy



## Strategy 2: Care and Treatment

The estimated resource requirement for Strategy 2 in 2006 is US\$14.1 million and is projected to increase to US\$24.8 million in 2010 (see Figure 2-5).

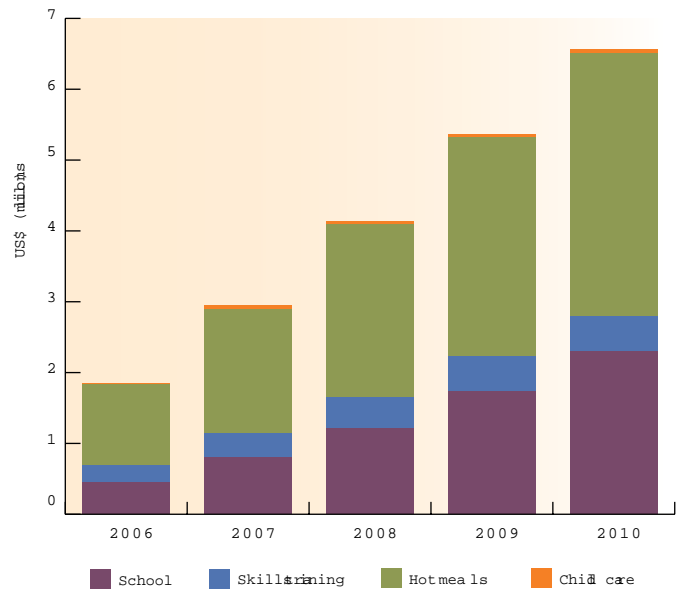
Figure 25. Resource Required for Strategy 2



## Strategy 3: Impact Mitigation

Figure 2-6 shows that in 2006, the total resource requirement for impact mitigation will be US\$1.9 million, increasing to US\$6.6 million in 2010. Assistance for school fees and other school-related expenses and food constitutes the largest portion of the total required resources.

Figure 26. Resource Required for Strategy 3



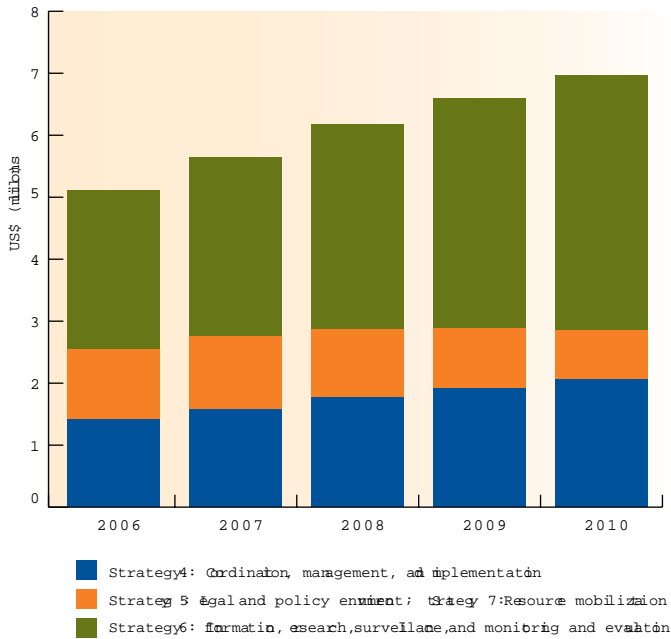
## Strategies 4-7

The activities captured in these strategies are typically hard to estimate because they do not lend themselves to the basic approach used in the Resource Needs Model, which uses three key variables (population size, coverage, and unit costs). The approach used here instead is to estimate the resources needed for these activities as a percentage of the direct programme resources. In the AIDS expenditure analysis done using 2004 data, the percentages allocated to these categories were used to calibrate the percentages to be assigned to each category. Table 2-1 shows the estimated resource needs for strategies 4-7, as a percentage of prevention resources in 2006 and 2010. These estimations total US\$5.1 million in 2006 and US\$7.0 million in 2010.

Table 2-1. Shares of Resources Needed for Strategies 4-7

	2006	2010	
Legal and policy environment	4.7%	20%	Strategy 5, 7
Management, administration, and coordination	57%	5.0%	Strategy 4
Research	5.0%	50%	Strategy 6
Monitoring and evaluation	5.0%	50%	
Resources needed (US\$ millions)	\$5.1	\$7.0	

Figure 27. Resource Required for Strategies 4-7



While the categories used in the model do not perfectly coincide with Strategies 4–7, the last column in Table 2-1 provides a sense of the distribution of resource requirements by strategy, which is further illustrated in Figure 2-7.

### KEY POLICY ISSUES AND NEXT STEPS FOR MITIGATION

The future response to HIV and AIDS as it is outlined in the strategic plan is consistent with international best practice. However, the lack of infrastructure remains a barrier to successful implementation, and as a result, efforts should be made to identify priorities. Some recommendations follow.

Maintain past gains in prevention and increase coverage of other prevention activities. Continued emphasis is needed on HIV prevention among commercial and casual sex networks and “bridge populations”—such as mobile men, garment factory workers, MSM, and drug users—as outlined in the strategic plan. The next level of priority should be focussed on prevention of secondary transmission, as the wives and monogamous partners of the most-at-risk individuals will represent an increased proportion of new infections in the future. Prevention activities should also include PMTCT, STI management, blood safety, and condom distribution.

Direct HIV and AIDS resources to improvements in healthcare infrastructure to achieve the care and treatment targets. Although Cambodia has had early successes in increasing access to ART, continued access will be a challenge because of weak healthcare infrastructure and human resource capacity. Only a small percentage of resources allocated to the HIV and AIDS response in Cambodia has been used to improve healthcare infrastructure. Future efforts to improve the national programme should be linked with a health sector reform programme.

Strengthen coordination and implementation capacity among multisectoral groups. As outlined in the strategic plan, successful implementation of an expanded response will include participation by a multisectoral group, including civil society organisations, the private sector, the media, the arts, and faith-based organisations.

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## III. INDONESIA

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Since the first case of AIDS was identified in 1987 in Indonesia, the number of infected individuals has increased each year, reaching 6,000 reported HIV and AIDS cases by 2005 (CEMSHAD, 2005).

During the last 18 years, HIV prevalence in Indonesia has gone through three stages: in the first six years, the prevalence rate slowly increased, but since then, it has gone from steadily increasing to finally accelerating in the last 4–5 years. The Indonesian Red Cross reported that four in every 100,000 donors tested in 1998/1999 were HIV positive. By the year 2000, a significant increase in HIV prevalence was found among SWs in Jakarta (3.36%), Tanjung Balai karimun of Riau province (8.38%), and Merauke of Papua (26.5%). In the same year, HIV infections were already being reported in all of Indonesia's provinces.

## COUNTRY PROFILE

Population (2006): 222,781,000<sup>a</sup>

Gross national income (2004): US\$1,140 per capita<sup>b</sup>

HIV prevalence (2006): 0.1%<sup>a</sup>

Percent HIV prevalence among most-at-risk groups:

Sex workers: 3–12%<sup>c</sup>

Injecting drug users outside urban areas: 16%

Men who have sex with men: n/a

Adults of living with HIV (2006): 170,000<sup>a</sup>

Number of new infections: n/a

AIDS-related deaths (2006): 5,500<sup>a</sup>

Sources: <sup>a</sup>UNAIDS, 2006; <sup>b</sup>World Bank, 2005; <sup>c</sup>CDC&EH, MOH, 2004

In 2003, the reported number of PLHAs in Indonesia was 3,647 (2,559 with HIV and 1,088 with AIDS). Of this number, 4.1 percent was 15–19 years old and 25.5 percent was 20–24 years old, implying that a large portion of PLHAs are teenagers and young adults. It is common knowledge that the reported number of HIV and AIDS cases is only the tip of the iceberg. The number of unreported or undetected HIV and AIDS cases is far greater than the known figures.

The Ministry of Health (MOH) estimated that, in 2005, between 90,000 and 130,000 people were living with HIV in Indonesia (UNAIDS and WHO, 2004). This calculation was based on the available sentinel surveillance and behavioural surveillance data. The 2006 UNAIDS report estimates 170,000 people living with HIV in 2006 (UNAIDS, 2006). However, an Australian Agency for International Development (AusAID)-funded HIV epidemiological modelling and impact study estimated the figure to be 250,000 people in 2005 (AusAID, 2006). The Australian study projected that if the response to the epidemic is not scaled up substantially, the figure would reach 1.95 million in 2025. Due to different epidemic patterns and modes of transmission, estimates of HIV prevalence in Papua are generally discussed separately from other provinces. In this modelling and impact projection, the majority of cases would be found in Papua. A comprehensive HIV and AIDS response could result in a best-case intervention scenario, where the number of HIV infections would stay under 400,000 in provinces other than Papua and below 80,000 in Papua (CEMSHAD, 2005).

There has been no systematic tracking of the epidemic in Indonesia, and according to available information, the MOH suggests that the modes of transmission have changed throughout the course of the epidemic. Initially, most HIV infections were contracted through homosexual and heterosexual contact. Then followed a stage where the share of infections from heterosexual contact steadily declined, while the number of infections from homosexual contact increased. In recent years, the share of the latter also declined and a sharp and consistent increase has occurred among IDUs. During the last six years, IDUs have contributed to the majority of the new HIV infections in Indonesia. In the Jakarta Drug Addict Hospital, HIV prevalence among IDUs increased threefold between 1999 and 2003—from 19 to 48 percent (CEMSHAD, 2005 and UNAIDS and WHO, 2004).

In addition to IDUs, other most-at-risk groups include prisoners, SWs, and transgender SWs known as waria. Among inmates in Jakarta's Cipinang prison, 25 percent were HIV positive in 2003 (UNAIDS, 2004). HIV prevalence varies widely among the more than 200,000 female SWs in Indonesia, ranging from a rare occurrence to as high as 8–17 percent. Among waria in Jakarta, HIV prevalence increased

from 0.3 percent in 1995 to nearly 22 percent in 2002. According to UNAIDS, there is “strong evidence that various sexual and injecting drug user networks in Indonesia overlap significantly, thus creating an ideal environment for HIV to spread” (UNAIDS and WHO, 2004). There are important gaps in the epidemiologic picture and therefore a systematic analysis is needed.

## CURRENT STATUS OF PREVENTION AND INTERVENTION EFFORTS

The Research and Development Board of the MOH led the initial response to HIV and AIDS by establishing a working group on HIV and AIDS as early as 1985 (PW/NAC, 2003); its duties include monitoring the development and collection of epidemiological information on HIV and AIDS. By 1989, the working group included other ministries and nongovernmental organisations (NGOs) as their members; although the other ministries proved not to be actively involved. After realising that HIV is not merely a health problem, the government established the National AIDS Commission (NAC) in 1994. This multisectoral coordinating body is led by the Coordinating Minister of People’s Welfare. The NAC formulated the National Strategy of HIV/AIDS Prevention and Control in 1995, and it was implemented by government ministries and agencies, as well as NGOs with support from international agencies such as the World Health Organization (WHO), the United Nations Development Programme (UNDP), UNAIDS, and the United Nations Children’s Fund (UNICEF). Following its implementation, NAC offices were established in the provinces and focussed their activities on interventions for most-at-risk groups such as SWs,<sup>1</sup> MSM, and transgender. Some of the initial endeavours were HIV surveillance among targeted groups, blood screening conducted by the Indonesian Red Cross, the upgrading of equipment in provincial hospital laboratories, and the education and training of paramedics on HIV and AIDS.

A new national strategy was adopted in 2003 in response to the majority of new infections being among IDUs. This change was also due to the new decentralised governance system in which more power is given to the local governments. The revised strategy suggested that prevention efforts should be integrated with the Care, Support, and Treatment (CST)

programme, including the provision of ART. The focus is not only on SWs and MSM but also IDUs. Based on their local conditions, the respective local governments are allowed to make adjustments in implementing the new strategy.

## SOCIOECONOMIC IMPACT OF HIV AND AIDS

The most productive age group of 20–29 years old has the highest HIV prevalence rate and constitutes more than 80 percent of the reported HIV and AIDS cases in Indonesia. This suggests that the potential exists for direct and indirect effects on economic development. The economic effects could include the declining of labour productivity, an increase in the mortality rate among the productive age group, and an increase in poverty. The social effects are linked to an increase in the number of orphans. Orphans experience a loss of care and support from both their family members and the community. PLHAs experience stigma and discrimination by family members and the community and in the workplace.



A farmer leads oxen through a flooded field in Indonesia.

According to the AusAID modelling and impact study, the overall effects of AIDS-related mortality on the Indonesian economy in the best-case intervention scenario, will be limited, except in Papua (AusAID, 2006). Under both the baseline and best-case intervention scenario, Papua would experience particularly devastating effects on the workforce, which is largely working in the agricultural sector. It is estimated that one third of deaths would be among adult women.

<sup>1</sup> Sex workers include female SWs (HIV prevalence of 3%); male SWs (4.5% prevalence); and transgender SWs (12% prevalence).

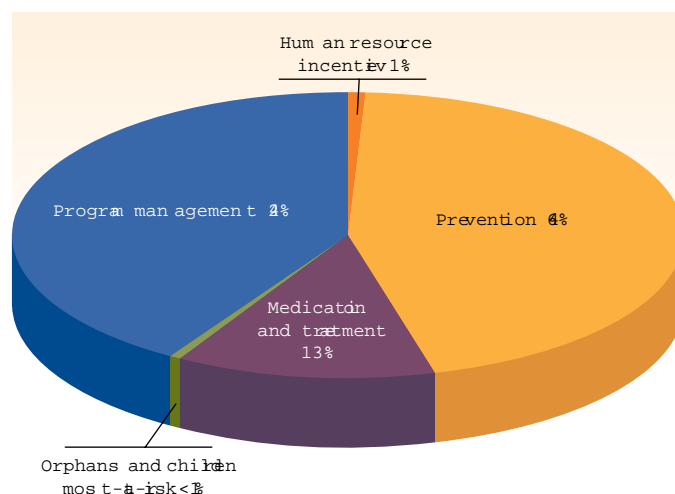
Although increasing care and treatment costs and the rising demands on the health sector could be considered systemic, greater social and economic effects would be felt at the household level—related to the costs of HIV testing, care and support of PLHAs, and treatment.

## NATIONAL AIDS SPENDING

In 2004, the central government allocated IDR87 billion (US\$8.5 million) to implement HIV and AIDS interventions. Table 3-1 shows a breakdown of the total allocation. The MOH was allocated the largest share (85.3% of the total).

Figure 3-1 illustrates the central government's 2004 budget allocation by type of activity. It is implementing intervention programmes in three main areas: prevention (45.6%), programme management (41.5%), and care and treatment (12.7%).

Figure 3-1 Budget Allocation by Type of Activity 2004



million, respectively). Between 2004 and 2005, the budget increased by 40 percent to US\$13 million in 2005 (US\$11.4 million from the central government and US\$1.6 million from the local government).

## NATIONAL STRATEGIC PLAN

The National Strategy for HIV/AIDS Prevention and Control was initially formulated and implemented in 1994; the increase in HIV prevalence, the change in the mode of transmission since 1995, and decentralisation policies led to its revision in 2003. The objectives of the strategy are to (1) prevent HIV transmission; (2) minimise the number of infected people and the social and economic effects of HIV and AIDS countrywide; and (3) coordinate and administer all HIV and AIDS prevention and control efforts.

The strategy is also reflected in the country's sixth development plan, which includes the following components: (1) communication, information, and education; (2) prevention; (3) testing and counselling; (4) care, support, and treatment; (5) research and study; (6) monitoring and evaluation; (7) education and training; (8) international cooperation; (9) programme management; and (10) laws and regulations. To ensure that they are implemented, the relevant institutions are expected to monitor and evaluate the efforts on an ongoing basis.

Table 3-1 Budget Allocation for HIV/AIDS Intervention, 2004

Department	Amount (US\$)
Ministry of Health	7257702
Ministry of National Education	76,32
Coordinating Minister of People's Welfare	10,837
Department of Transmigration and Labor Force	12,25
Department Social Affairs	96,48
Department of Religion	96,40
Department of Communication	91,24
Department Internal Affairs	3,102
National Narcotics Board (BNN)	87,336
Department of Defense	2,72
State Minister of Women Empowerment	21,55
National Family Planning Coordinating Board (BKKBN)	6,195
<b>Total</b>	<b>8507,510</b>

Source: Central Committee on the Control and UNAIDS Indonesia, 2004.

Funds allocated in other categories suggested by UNAIDS for national HIV and AIDS spending assessments have not been included in the budget for two reasons: some interventions or activities are not yet being implemented or they are already included under existing intervention categories.

Indonesia is scaling up its response to fight the epidemic. The central and local government funds allocated for HIV and AIDS increased in 2003 and 2004 (US\$6.3 million and US\$9.3



An Indonesian truck driver shows his support for condom use.

There are eight basic principles underlying HIV and AIDS prevention and control efforts in Indonesia:

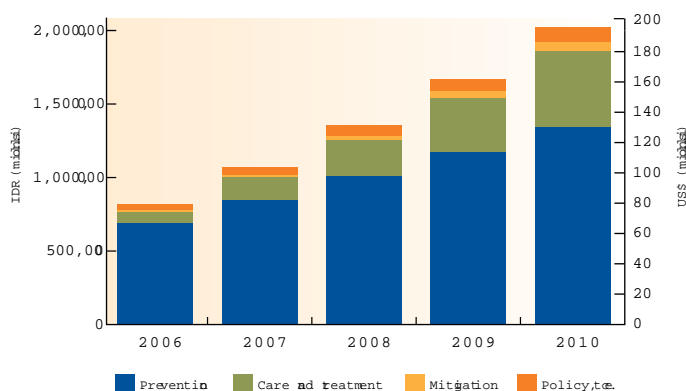
- 1) Efforts should become the responsibility of all people living in Indonesia. The community has the most important role, while the government is obliged to provide guidance, advice, and a supportive environment.
- 2) Efforts should reflect Indonesia's religious and cultural values.
- 3) Activities should defend and strengthen the unity and welfare of the family and the community social support system.
- 4) Education and mentoring activities should be undertaken to grow healthy attitudes, inhibit any chances of HIV transmission, and change high-risk behaviour;
- 5) Every person has the right and access to correct information for protecting themselves and others from HIV infection.
- 6) All testing and medical services provided should avoid any discrimination and biased attitudes toward PLHAs.
- 7) Every test to diagnose HIV should be initiated with appropriate counselling on HIV and should require consent from the patient. The test result should be kept confidential.
- 8) The current laws and regulations must be supportive and in line with the national strategies for HIV and AIDS prevention and control efforts at all government levels.

## ESTIMATED RESOURCE NEEDS FOR HIV/AIDS/STI PROGRAMMES

The interventions that constitute the HIV and AIDS response can be divided into (1) prevention; (2) care and treatment; (3) mitigation; and (4) policy, advocacy, administration, and monitoring and evaluation (M&E). The total estimated resource requirement in 2006 is IDR824 billion (US\$79.9 million), increasing to IDR2,007 billion (US\$194.7 million) in 2010. This is substantially higher than the IDR87 billion (US\$8.5 million) allocated by the central government in 2004.

Figure 3-2 shows the breakdown of the resource needs across the four categories. Prevention activities constitute 73 percent of the total, while care and treatment, mitigation, and policy and management constitute 20 percent, 3 percent, and 5 percent, respectively.

Figure 32.  
Total Resource Required for  
HIV/AIDS/STI Programs



The funding required for each type of prevention intervention is shown in Figure 3-3. Workplace, MSM, and blood safety interventions require the largest amount of resources. Figure 3-4 shows the resources required for care and treatment; ART requires the largest share, followed by Laboratory for ART and the treatment of opportunistic infections (OIs).

Figure 33.

Resources Required for Prevention Interventions

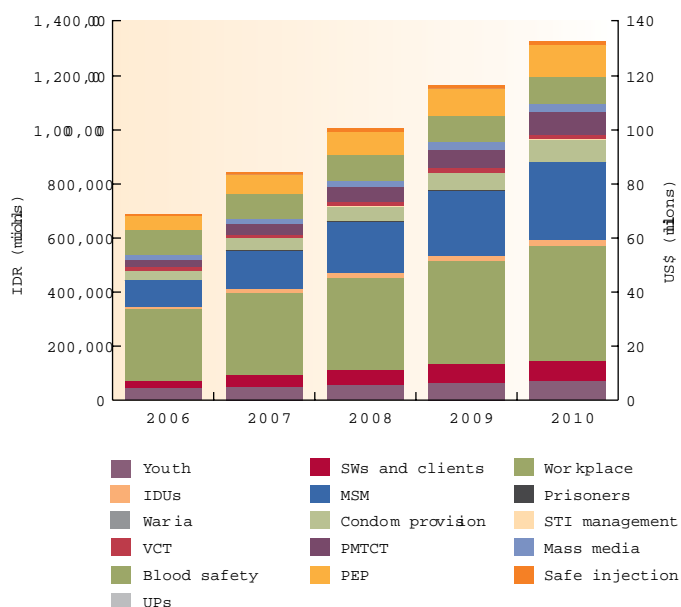
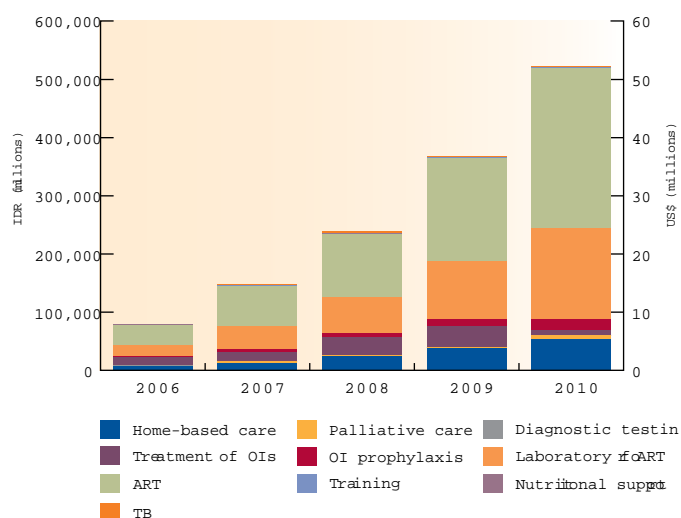


Figure 34.

Resources Required for Care and Treatment



## KEY POLICIES AND NEXT STEPS

Indonesia faces considerable constraints and challenges in preventing the spread of HIV. The low-prevalence situation contributed to a lack of public awareness of the problem. For many people, the perception is that HIV is a problem experienced by SWs and not the whole community. Undercover sex work is prevalent and condom use is low. There is still resistance among Indonesians to the idea that Indonesia, a religious country, will be affected by HIV. Misunderstanding and moralistic judgment are also evident in the attitudes of health workers. PLHAs often face stigma and discrimination. The new policy on decentralisation confounded the situation as many local governments do not have a full understanding of the HIV and AIDS situation, yet the power to allocate resources is now in their hands.

A strategic plan that includes prevention, care, support, and treatment run by both the government and NGOs has been in place since the beginning of the epidemic, but the spread of HIV continues unabated. Government officials and decisionmakers at all levels need to recognise that HIV is not just a health issue but also a socioeconomic concern that can reverse all the developmental gains achieved to date.

The Coordinating Ministry of People's Welfare and the NAC have identified the following key policy issues:

- Coverage of most-at-risk groups is insufficient. For example, less than 10 percent of the people who are at risk are reached by the prevention programme; few have access to voluntary counselling and testing (VCT) (18% of IDUs and 14% of SWs), and a small number of people have adequate knowledge about HIV and AIDS.
- High-risk behaviour is still widespread, the number of people using condoms is still low, and needle sharing is high.
- Life-skills training is not widely accessible to youth in cities in Eastern Indonesia or in small cities in Java.
- Discrimination against PLHAs in the community and workplace is widely prevalent.





Village women attend a community meeting in Java, Indonesia.

The MOH, with the assistance of international donors, will aim to implement the following programmes planned for the coming years:

- The facilitation of comprehensive training for the CST programme and VCT in all provinces (the CST programme currently covers 106 hospitals, and 75 of these are appointed as referral hospitals to provide ART: In 2006, ART will be given to as many as 5,500 patients—the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) will fund ART for 3,000 patients, and the government will fund ART for 2,500 patients);
- Promotion and prevention programmes (including seminars and workshops) for children and youth to avoid high-risk behaviour such as engaging in premarital sexual intercourse, unsafe sex, and injection drug use; and
- HIV prevention programmes directed at IDUs and the Methadone Maintenance Programme in four hospitals in Jakarta.

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## IV. LAO PEOPLE'S DEMOCRATIC REPUBLIC

### ACKNOWLEDGEMENTS

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**L**ao People's Democratic Republic (PDR) is classified by UNAIDS as a low-prevalence country, with an estimated prevalence of 0.06 percent. The first HIV and AIDS cases were diagnosed in 1990 and 1992, respectively. By June 2005, 1,636 HIV-positive cases, 946 AIDS cases, and 584 deaths had been reported (CHAS, 2005). Two-thirds of all cases are in just two regions of the country: Savannakhet and Vientiane Capital.

In the absence of effective prevention measures, potential risk factors may result in an increase in HIV infection among most-at-risk groups. The nature of sex work in the country has centered on entertainment establishments such as small beer shops, karaoke bars, and discos. The Behavioural Surveillance Survey (BSS) indicates that a majority of female workers in these establishments are available for sex work—if only on an occasional basis (FHI, 2002). Their number of partners is low and the turnover of SWs is high, resulting in an overall low risk of contracting HIV.

## COUNTRY PROFILE

Population (2006): 5,924,000<sup>a</sup>

Gross national income (2004): US\$390 per capita<sup>b</sup>

Adult HIV prevalence (2006): 0.1%<sup>a</sup>

Adults living with HIV (2006): 8,200<sup>c</sup>

Women living with HIV (2006): <1,000<sup>a</sup>

Number of new infections (2003): 1,520<sup>c</sup>

AIDS-related deaths (2006): <402<sup>c</sup>

Sources: <sup>a</sup>UNAIDS, 2006; <sup>b</sup>World Bank, 2005; <sup>c</sup>CHAS and UNAIDS, 2006

Lao PDR has experienced rapid economic development and the establishment of new infrastructure, such as highways, which are contributing to urbanisation. These developments have led to increased mobility of the population as new employment opportunities (e.g., construction, mining, and seasonal farming) become more accessible. These industries attract migrant workers both within and across Lao PDR's borders with Cambodia, Thailand, and Myanmar—countries with significant HIV epidemics. Population groups vulnerable to contracting HIV include migrant populations, as well as

SWs and their clients, drug users, MSM, and youth with high-risk behaviour. Some development projects in the country include programmes for HIV prevention and the reduction of trafficking and drug abuse, but many of these most-at-risk groups still do not have access to these programmes.

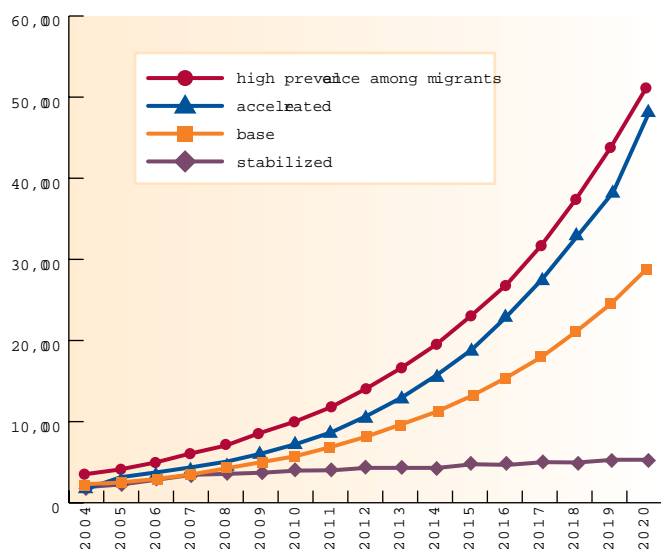
While there is little information about injecting drug use in Laos, the recent collection of site-specific information has identified established IDU activity, including among some service women. This highlights the need for a comprehensive assessment of drug-using behaviour. In addition, recent MSM studies in other countries in the region found high rates of HIV among this population, which indicates the need for a similar study in Laos.

Aside from the increasing prevalence among most-at-risk groups, a number of factors fuel the HIV epidemic: low levels of HIV and AIDS awareness; limited access to comprehensive health services; the low socioeconomic status of women; and high levels of poverty. The Human Development Index Ranking for Lao PDR is 135, and the country is considered the poorest in Southeast Asia, with an annual per capita income of \$330 (UNDP, 2003). Thirty-nine percent of the population was living below the poverty line in 2003. These factors suggest that prevalence could increase. Figure 4-1 illustrates scenarios that could occur under the following assumptions:

- Base: The epidemic develops further but without a significant increase in high-risk behaviour for SWs or their clients. The response continues at present levels. The number of PLHAs will reach almost 30,000 by 2020.
- Accelerated: The epidemic accelerates, for example through increased injecting drug use or other increased high-risk behaviour. The response continues at present levels. The number of PLHAs reaches almost 50,000 in 2020.
- High HIV-prevalence among migrants: This assumes HIV prevalence among labour migrants was 2–4 percent in 2004. If high-risk behaviour continues among labour migrants and the response continues at present levels, the number of PLHAs will reach more than 50,000 by 2020. Note that the epidemiologic picture in Laos is

<sup>1</sup> Service women are defined as women who work in a small drink shop, nightclub, or guesthouse and have direct contact with patrons. In addition to serving food or beer, some service women sell sex.

Figure 4-1 People Living with HIV in Lao PDR



largely incomplete. The knowledge about Asian epidemics suggest that HIV is likely concentrated among female SWs, MSM, and IDUs; and while there is unconfirmed information about HIV among migrant workers, a more systematic analysis is needed.

- **Stabilised:** The epidemic stabilises around 0.09 percent due to an expanded response related to prevention and care. Under this scenario, the number of PLHAs reaches 5,420 by 2020.

The above scenarios show that an expanded response would prevent a number of infections, save thousands of lives, and save the country's economy millions of dollars each year.

To effectively respond to the HIV epidemic, the government requires strategic information about the epidemiological situation. The first national epidemiological surveillance was conducted in 2001 by the Centre of HIV/AIDS/STI (CHAS), in collaboration with FHI, UNDP, WHO, CHASPPAR, and the EU's STI Project. The second round of surveillance was repeated in collaboration with FHI, WHO, GTZ, GFATM, UNODC, ADB-JFPR, UNDP, and PSI. However, there is no effective government-sponsored epidemiological and behavioural surveillance system in place.

The following review presents empirical findings regarding (1) the socioeconomic impact of HIV and AIDS in Lao PDR;

- (2) the National AIDS Spending Assessment from 2000–2004;
- (3) a summary of the country's strategic plan for a scaled-up response to HIV and AIDS;
- (4) an estimate of the resources required for HIV and AIDS programmes in the near future;
- and (5) a summary of key policy issues and next steps for mitigating the socioeconomic impact of HIV and AIDS.

## SOCIOECONOMIC IMPACT OF HIV AND AIDS

**A**lthough the prevalence of HIV remains low, the country is faced with many risk factors that could lead to increased HIV transmission in the near future if appropriate prevention measures are not taken. A key motivation for conducting impact assessments in low-prevalence countries is to inform the implementation of effective prevention activities (UNFPA, 2003).

Even though Lao PDR is a low-prevalence country, early measures should be taken to prevent the spread of the epidemic. HIV not only affects health but also many aspects of society and development. In recognising this, the government and donors have included HIV as a component of the country's National Growth Poverty Eradication Strategy (NGPES).

To date, there have not been any country-specific studies on the impact of HIV and AIDS in Lao PDR. Additional analysis to quantify the economic and social impact of HIV and AIDS is considered a priority in the national strategic plan. Estimates show that an expanded response would, by 2015, prevent between 10,000 and 20,000 infections (CHAS and UNAIDS, 2005). Increased and targeted prevention and care efforts would not only save thousands of lives but would also prevent already strained households from falling into poverty, or deeper poverty, due to HIV and AIDS expenditures.

## NATIONAL AIDS SPENDING

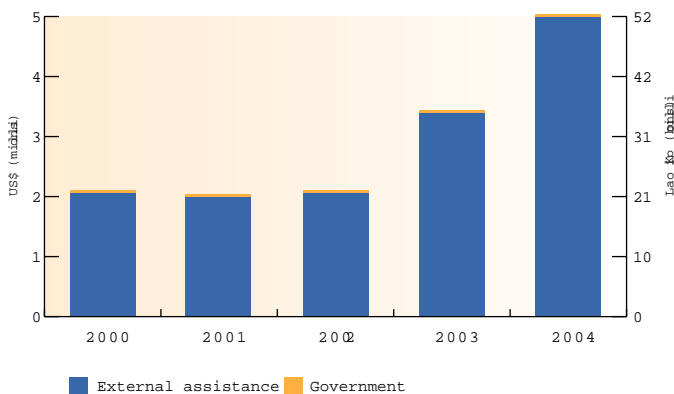
**I**n response to the global spread of HIV, the government of Lao PDR established the National Committee for the Control of AIDS (NCCA) at the end of 1988, and this committee was restructured in 2003 to promote a more multisectoral response to HIV and AIDS.<sup>2</sup> The purpose of this multisectoral response is to mainstream responses to

<sup>2</sup> The NCCA is chaired by the Minister of Health and vice-chaired by the Vice Minister of Information and Culture and the Vice Minister of Education. Representatives from various ministries and other organisations serve as committee members. Each province has set up a Provincial Committee for the Control of AIDS chaired by the governor or vice governor. At the district level, there are District Committees for the Control of AIDS chaired by district governors or vice governors.

HIV and AIDS into socioeconomic development planning. It is the responsibility of the NCCA to conduct the National AIDS Spending Assessment.

The National AIDS Spending Assessment provides a situation analysis on the government’s HIV and AIDS expenditures by different institutions during the last five years (2000–2004). The cumulative HIV and AIDS expenditure during this period was estimated at the local currency (Lao Kip) 148.62 billion (US\$14.85 million). The expenditure trend has increased steadily every year from 22 billion Kip (US\$2.1 million) in 2000 to 52 billion Kip (US\$5.0 million) in 2004. There were two sources of national HIV and AIDS spending: the government and donors. The amount of resources from the government has remained stable, while the amount from donors has increased by 134 percent during a five-year period. Government spending constituted only 0.5 percent of the total in 2004 (see Figure 4-2).

Figure 42. National HIV and AIDS Expenditure by Source



Expenditure on HIV and AIDS by households is not reported in this summary but should be considered as a large burden on households. Although out-of-pocket HIV and AIDS expenditures are difficult to capture, Laotians’ expenditures on healthcare are estimated at an average of 2 percent of total household consumption, and for households with a PLHA, this percentage is likely to come close to 5 percent, which is the international benchmark for assessing the affordability of healthcare costs.

Figure 43. HIV and AIDS Expenditure by Activity, 2000–2004

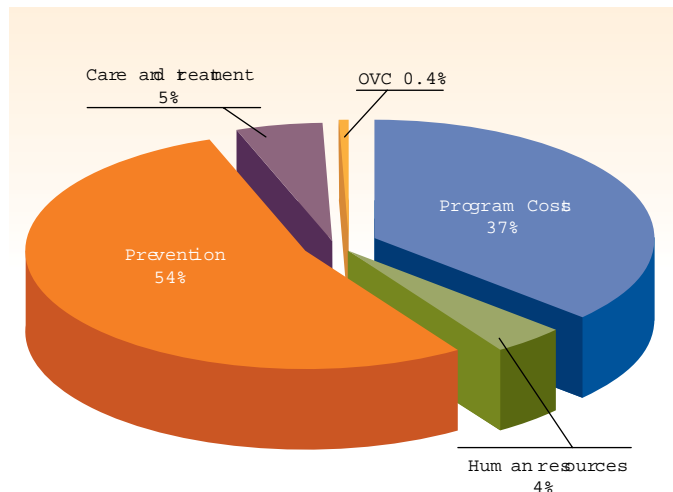


Figure 4-3 shows the breakdown of cumulative expenditures from 2000–2004 by activity. Fifty-four percent of the expenditures covered prevention-related activities and 37 percent covered programme costs. Care and treatment expenditures constituted 5 percent of the total; human resources constituted 4 percent; and orphans and vulnerable children (OVC) constituted 0.4 percent.

The majority of expenditures on prevention-related activities funded condom social marketing (28.7%); in- and out-of-school youth programmes (11.2%); blood safety (11.2%); improved STI services (9%); and mass media campaigns (5.9%). Funding for HIV and AIDS programmes was used for management and training and also the management of the logistics and supply system. A more detailed analysis of national HIV and AIDS spending is included in the Appendix.

## NATIONAL STRATEGIC PLAN ON HIV/AIDS/STI 2006–2010

The National Programme on HIV/AIDS/STI 2002–2005 presented the strategy and the action plan separately. The new National Strategy and Action Plan (2006–2010) combines them to ensure coherence and practical linkages between strategies and actions. The National Strategic Plan 2006–2010 is based primarily on reviews of the 2002–2005 plan and the second round of behavioural and sero-surveillance (October 2004). The priorities are as follows:

- 1) Reaching full coverage of targeted and comprehensive interventions in priority provinces/districts in a phased approach;
- 2) Establishing an enabling environment for an expanded response at all levels;
- 3) Increasing data availability to monitor both the epidemic and the response (strategic information);
- 4) Building the capacity of implementing partners at all levels; and
- 5) Effectively managing, coordinating, and monitoring the expanded response.

### Coverage

The national strategy defines a reach of 90 percent for prevention activities as full coverage.<sup>3</sup> More importantly, since the quality of interventions plays a crucial role in behaviour change, “essential elements” of the plan are defined to ensure that the desired impact is achieved. For example, the plan takes into consideration that STI treatment for SWs without condom provision and behaviour change interventions will have little impact.

To maximise the use of limited resources and to ensure the coverage needed to have an effect on the epidemic, the first phase of the expanded response occurred in provinces and districts that were found to be vulnerable.<sup>4</sup> The most vulnerable provinces and districts were selected to scale up interventions in the first two years. Programmes in other selected provinces and districts will be targeted at a later stage. In the remaining seven provinces and 95 districts, a minimum package of awareness-raising activities (including mass media campaigns), integration of HIV and AIDS efforts into other ongoing programmes, and condom social marketing will be provided (see Figure 4-4).

### Services

The national strategy includes a balance of prevention and care activities in the selected priority provinces and districts. The strategy defines vulnerable groups as those people whose lifestyles, social or professional situation, and behaviour make them most vulnerable to HIV. Although numerous groups and communities in Lao PDR can be classified as “vulnerable” due to the high level of poverty in the country, the vulnerable groups identified as a possible

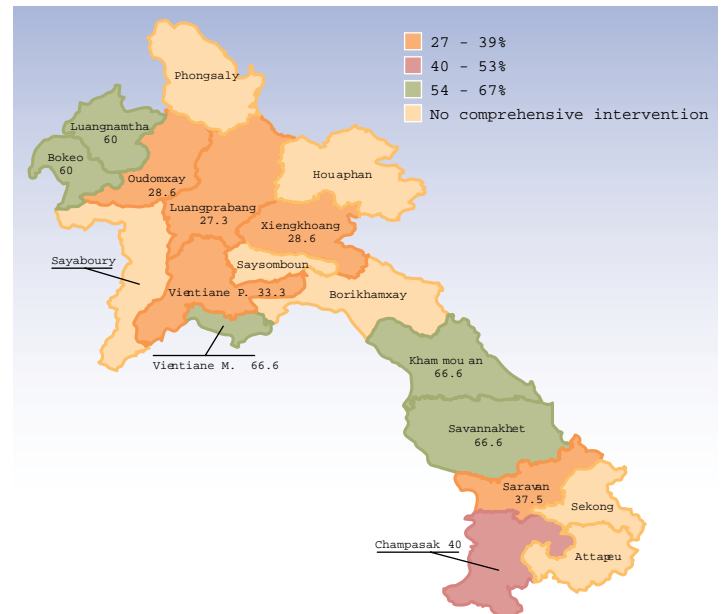
nucleus for a generalised epidemic (because of their size, HIV sero-prevalence and multiple linkages to the rest of the population) are SWs and their clients; mobile populations; drug users; MSM; and youth with high-risk behaviour.

The provision of VCT and essential care and support services, including ART, is also included in the strategic plan.

### Enabling Environment

The strategy promotes commitment, leadership, the establishment of an enabling environment at all levels of the government, and the local ownership of planning and implementation. The plan highlights activities that will improve the participation and understanding of decisionmakers and communities in addressing vulnerable groups. Local ownership of the strategic plan will ensure the broad-based commitment necessary for successful implementation. Evidence-based information will be used to foster the necessary supportive political and local environments and to provide, if needed, the legal framework for action.

Figure 4-4. Percentage of Districts that Will Be Covered by Comprehensive Interventions



<sup>3</sup> “Reach” is the number of people reached with an intervention but does not imply that all people reached will change their behaviour. To achieve behaviour change in 60 to 70 percent of people, a 90 percent reach is assumed to be necessary.

<sup>4</sup> A vulnerability assessment was conducted based on the main determinants of the epidemic (heterosexual transmission primarily through SWs and their clients and mobile groups), and the following criteria: population density, HIV prevalence, proximity to communication routes and infrastructure projects, the number of entertainment sites per location, and the degree of mobility of the population.



## Increased Data Availability

The strategy outlines activities that will ensure increased data availability for monitoring the epidemic and the response. There is a need for gathering high-quality strategic information through coordinated and targeted research, improved second generation surveillance, improved data analysis and dissemination, and the establishment of an HIV and AIDS response database. A national monitoring and evaluation framework will further facilitate the assessment of progress and constraints.

## Capacity Building

Strengthening the implementation capacity of the government and NGOs is a priority area in the new strategy. To expand the number of implementing partners and improve quality and coverage, the strategy outlines the need for financial resources for technical assistance, training activities, and the exchange of knowledge and experience.

## Management, Coordination, and Monitoring

The challenge of future management and implementation structures will be to

- Support and strengthen the leading role of the government and the MOH, as the technical line ministry, in facilitating the formulation of policies and strategies; monitoring and evaluation, including quality assurance; epidemiology and surveillance; the involvement of other government structures (e.g., other line ministries); and coordination;
- Provide flexible, accountable, and results-oriented management of a larger programme at national and subnational levels;
- Establish new partnerships at all levels to fight the epidemic;
- Support the decentralisation and integration of activities at the community level;
- Increase responsiveness; and
- Provide the basis for sustainability through the involvement of the private sector and civil society.

Shifting from individually funded “projects” to a “programme”; from outputs to results orientation; from donor interest to national priorities; from the capacity

building of central structures to the strengthening of implementation capacity; and from a health sector response to a multisectoral approach will require time and resources. This is, however, the precondition for an effective and efficient national response to HIV and AIDS.

## RESOURCE NEEDS FOR HIV/AIDS/STI PROGRAMMES

The action plan contains a number of interventions under the following categories: prevention, care and treatment, mitigation, and policy and management. The cumulative estimated funding required between 2006 and 2010 is 928 billion Kip (US\$89.4 million) (see Figure 4-5). This is substantially higher than the level of expenditure recorded in the National AIDS Spending Assessment (52 billion Kip/ US\$4.99 million).

Figure 4-5. Total Resources Required for HIV/AIDS/STI Programmes

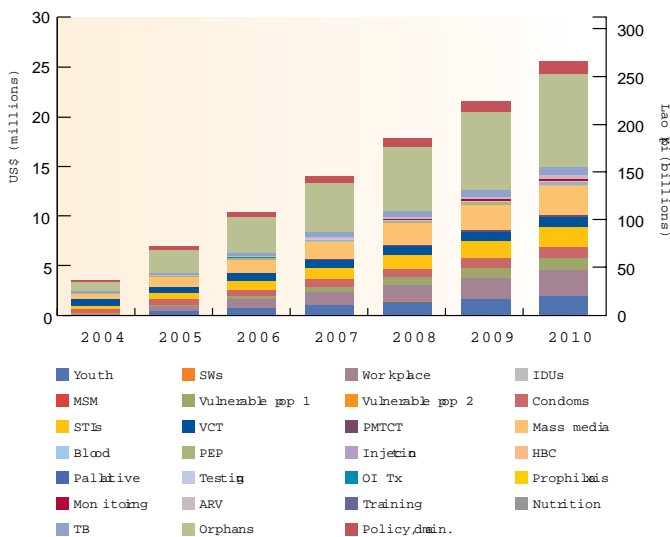


Figure 4-6 shows the distribution of resources across the following funding categories: prevention; care and treatment; mitigation; and policy, administration, M&E, and research. Prevention activities constitute 53 percent of the estimated cumulative resources required between 2006 and 2010, while mitigation and care and treatment activities constitute

Figure 4-6. Total Resources Required by Funding Category

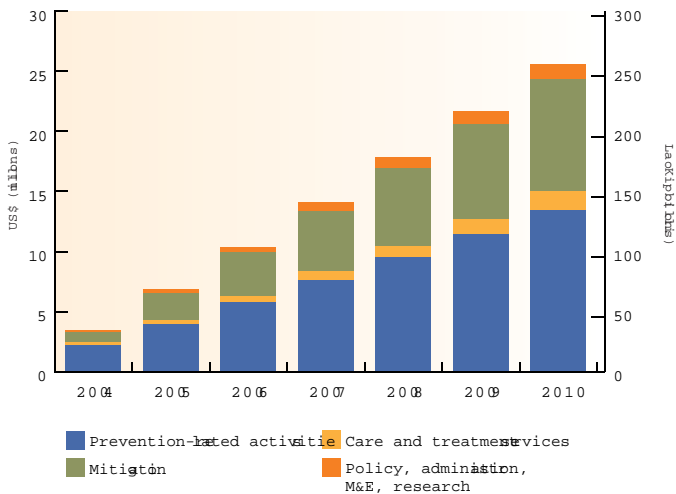
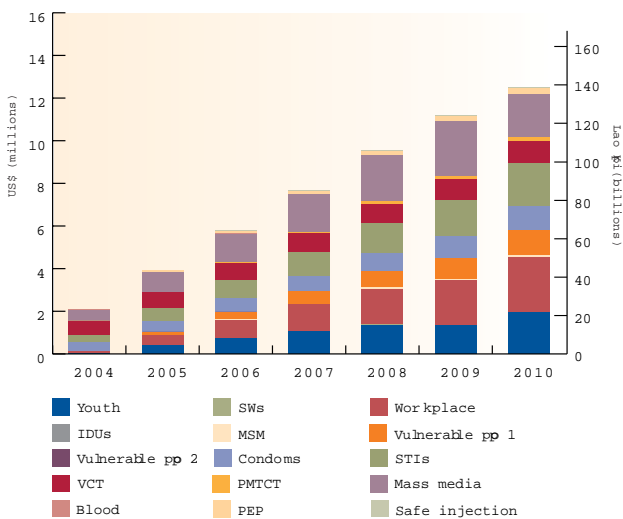


Figure 4-7. Resources Required for Prevention Services



36 percent and 6 percent, respectively. Policy, administration, M&E, and research together constitute less than 5 percent of the total amount of resources required.

Prevention-related services and the funding required for them are shown in Figure 4-7. The three services requiring the largest amount of resources between 2006 and 2010 are the mass media (23%), workplace interventions (18%), STIs (15%).

Figure 4-8. Resources Required for Care and Treatment

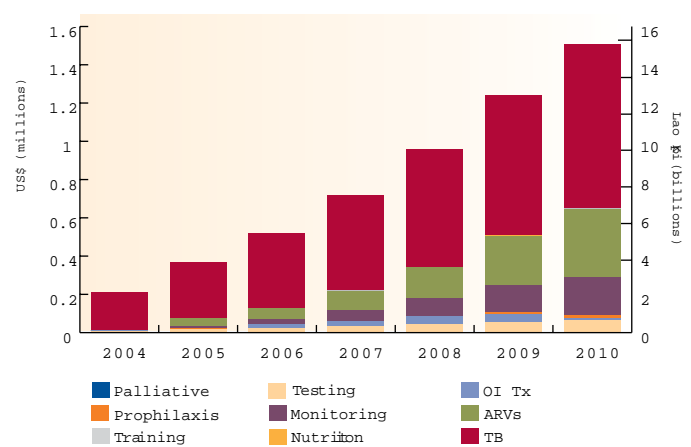


Figure 4-8 shows the total resources required for care and treatment by intervention; interventions for tuberculosis (TB), antiretrovirals (ARVs), and monitoring constitute the largest share of care and treatment costs (at 63%, 19%, and 11%, respectively) between 2006 and 2010.

## KEY POLICY ISSUES AND NEXT STEPS FOR MITIGATION

The strategic plan and national action plan are technically consistent with international best practice. Given the limited financial resources available in Lao PDR, it may not be possible to implement all activities in the plan. Therefore, eight recommendations for priority areas that should be addressed in the response include:

Increase coverage of prevention activities for most-at-risk populations. If the HIV epidemic expands in Lao PDR, it will most likely be driven by transmission among most-at-risk groups. Given that the epidemic is concentrated in urban and border areas, the priority should be on “hot spot” provinces, with an emphasis on reducing high-risk behaviour.

Improve advocacy to increase government commitment. Currently, government financial commitment is low, as reflected in the low percentage of HIV and AIDS spending



coming from the government. The reality is that Lao PDR faces several more urgent health problems compared with AIDS, such as malaria. The continuing low prevalence of HIV may have given rise to a level of complacency among leaders. More effective advocacy is needed to emphasise (a) that low HIV prevalence does not mean that the threat of an epidemic is low and (b) that prevention will go a long way to curbing the course of an epidemic.

Advocacy efforts and information campaigns need to be based on credible information and a thorough understanding of the dynamics of Asian HIV epidemics. If prevalence increases, Lao PDR is likely to experience a situation similar to that of its neighbours, with a concentration of the epidemic within high-risk groups such as mobile populations, service women and their clients, IDUs, and possibly MSM and uniformed forces. However, there is no evidence to indicate that the country faces the threat of a generalised epidemic in the medium term and advocacy messages should convey this information.

Link planning and policy development to the implementation of programmes. The national strategy and the national policy, although important, are broad documents that set overall directions. An operational policy does not exist to guide the implementation of programmes. The size of the country, its limited resources, and low HIV prevalence mean that it would be unwise to put significant resources into developing a comprehensive range of detailed operational policies. However, some operational guidelines are needed to guide effective programme implementation.

Strengthen surveillance and research. Implementing an effective government-sponsored epidemiological and behavioural surveillance system will ensure that strategic information is available to guide the government's response to HIV and AIDS, rather than depending on international agencies for this information.

Build capacity at all levels. One of the challenges affecting all development work in Lao PDR is the lack of infrastructure and human resources and financial capacity, especially outside Vientiane, Luang Prabang, and Savannakhet. A viable national HIV and AIDS programme will require capacity

building at all levels. For example, delivering community-based care services will require training, infrastructure, and financial resources. VCT services, although expanding throughout the country, need to be more accessible.

Formalise a multisectoral response. The national strategy emphasises the issue of multisectoral coordination. The level of key agencies' commitment to responding to HIV and AIDS must be addressed through advocacy and leadership development. The clear mandates, functions, and duties of various agencies should be clearly defined and mechanisms for cooperation among agencies established. These issues need to be addressed at the national and provincial levels. Given the concentration of the epidemic in several provinces, priority should initially be given to these provinces.

The vulnerability of mobile populations is a good example of where multisectoral collaboration among organisations—such as the MOH, the Ministry of Transport, provincial authorities, and the private sector—is needed to ensure effective interventions. For example, the government could assist with the implementation of the 1999 ASEAN Chiang Rai Meeting Recommendation, which called on governments to adopt a common policy on integrating infrastructure development with HIV-prevention programmes.

Increase government financial commitment to HIV and AIDS. Implementing the activities in the strategic plan will require a substantial amount of resources. Currently, the government is dependent on external assistance for almost all its HIV and AIDS resources. Given the large gap in resources between those outlined in the National AIDS Spending Assessment and the estimated resources required, it is crucial that the government increase funding for national HIV and AIDS programmes.

Apply lessons of success from countries in the region. Although Lao PDR's HIV prevalence is low, it is important to expand the current response to mitigate the impact; there is still a window of opportunity for curbing an epidemic. The country can learn from countries in the Mekong region, which have been the most successful countries globally in intervening at an early stage of the HIV epidemic.

## APPENDIX:

### National HIV and AIDS Expenditures, 2000-2004

Essential Indicators	Year				
	2000	2001	2002	2003	2004
Total population	5218,000	5,220,000	5366,000	5,440,000	5514,000
Number of new HIV and AIDS cases	162	192	187	170	258
Estimated number of PLHAs	1,010	1360	1740	2140	2600
Nominal GDP at current price (Kip millions)	3,669,485	15,701,809	18,400,978	22,511,415	26,590,131
<b>HIV and AIDS Expenditures</b>					
Total amount (Kip millions)	16,832	8,296	23,174	37,877	52,441
Total amount (US\$)	2145,065	2,020,83	2145,786	3,507,39	4994,365
Per capita total population (US\$)	0.411	0.388	0.3999	0.647	0.9058
Per capita PLHA (US\$)	2124	1,517	1,233	1,639	1,921
As percent of GDP	0.1%	0.2%	0.2%	0.2%	0.2%
Health expenditure (Kip millions)	NY	26,171	650,26	815,27	1300,94
As percent of total health expenditure		69.9%	35.6%	46.5%	40.3%
Exchange rate (Kip per US\$)	7,84	880	10,800	10800	10500
<b>Profile of HIV and AIDS Expenditures</b>					
<b>By financing source:</b>					
Public	1.2%	12%	1.2%	07%	0.5%
Nonpublic	0%	0%	0%	0%	0%
External	98.8%	98.8%	98.8%	99.3%	99.8%
<b>By financing agent:</b>					
Public	31.2%	19.4%	24.2%	25.8%	29.8%
Nonpublic	0%	0%	0%	0%	0%
External	69.0%	80.6%	75.8%	73.1%	70.0%
<b>By functions:</b>					
Prevention	55.0%	56.1%	50.5%	53.0%	55.3%
Treatment and care	1.0%	3.3%	4.9%	6.9%	5.1%
Mitigation (OVC)	0.1%	0.4%	0.5%	0.4%	0.4%
Management, coordination logistics and supplies, human resources	44.0%	40.2%	44.1%	39.7%	39.3%

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## V. MALAYSIA

### ACKNOWLEDGEMENTS

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There were a cumulative total of 70,559 HIV and AIDS cases reported in Malaysia by the end of 2005 (Department of Public Health, 2006). For the last five years, the number of new HIV cases has been averaging 6,000 to 6,900 per year. Since the disease emerged in 1986, the prevalence of HIV has remained consistently driven by IDUs, who are predominantly young males ages 20–39 years old among the Malay ethnic group. While the highest HIV prevalence rate persists among IDUs, increasing trends are being observed among other groups. For example, heterosexual transmission accounted for 4.9 percent of reported HIV infections in 1990 and 19.8 percent in 2004. Similarly, the proportion of women infected with HIV increased from 1.2 percent to 10.8 percent of the total number of reported HIV and AIDS cases from 1990 to 2004. The challenges facing Malaysia are, therefore, not only related to HIV prevention but also to the treatment, care, and support of those infected with and affected by HIV.

## COUNTRY PROFILE

Population (2006): 25,347,000<sup>a</sup>

Gross national income (2004): US\$4,650 per capita<sup>b</sup>

Adult HIV prevalence (2003): 0.5%<sup>a</sup>

HIV prevalence among most-at-risk groups:

Sex workers (2003): 5.1–7.6%<sup>c</sup>

Injecting drug users (2003): 13.3–25.6%<sup>c</sup>

Men who have sex with men (2003): 1.2–3.6%<sup>c</sup>

Adults living with HIV (2003): 67,000<sup>a,c</sup>

Women living with HIV (2006): 17,00<sup>a</sup>

New HIV infections: n/a

AIDS-related deaths (2006): 4,000<sup>a</sup>

Sources: <sup>a</sup>UNAIDS, 2006; <sup>b</sup>World Bank, 2005; <sup>c</sup>Department of Public Health and WHO, 2004.

Malaysia responded promptly to the first detected cases of HIV in 1986. The national response is a collaborative effort among government and civil society, with strong support from international agencies. Malaysia has demonstrated a commitment to responding to HIV and AIDS as a signatory

to the Millennium Declaration on the MDGs (2000), the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS (2001), and the ASEAN Declaration on HIV/AIDS (2001).

The government has taken a lead role in policymaking and programme implementation. A National AIDS Task Force comprising representatives from public agencies and NGOs was set up in 1985 in response to the international concern over the HIV epidemic, and the first Plan of Action was formulated in 1988. Thereafter, an Interministerial Cabinet Committee on AIDS was formed in 1992<sup>1</sup> and the National AIDS Task Force was replaced in 1993 with the National Coordinating Committee on HIV/AIDS and the National Technical Committee on HIV/AIDS. The committees are chaired by the Secretary-General and Director-General of the MOH, respectively. State coordinating committees responsible for the implementation and coordination of state-level HIV and AIDS prevention and control activities were set up in all 14 states. The first National Strategy Plan (NSP) was adopted in 1998, and the fourth plan was drafted in 2005 (NSP 2006–2010).

The government has launched nationwide prevention campaigns and integrated HIV and AIDS information into the secondary school curriculum. Civil society and the private sector have contributed significantly to the national HIV and AIDS response through service provision and fundraising. In 1992, the Malaysian AIDS Council (MAC) was formed to coordinate the HIV and AIDS activities of various community-based organisations (CBOs) and NGOs, reflecting a close partnership of the government and civil society in responding to HIV and AIDS. NGOs and CBOs spearheaded actions on issues deemed sensitive for government action—notably, providing prevention, care, and support services including information, education, and communication campaigns on HIV and AIDS and condom promotion aimed at PLHAs (most of whom are drug users, SWs, MSM, and foreign workers). Civil society and the government were also proponents in promoting human rights vis-à-vis HIV and AIDS.

Malaysia strongly advocates for a multisectoral response to the HIV epidemic. The newly revised National Strategic Plan on HIV/AIDS 2006–2010 provides a stronger leadership

<sup>1</sup> Attendees included either the ministers or their representatives from the ministries of education; youth and sports; national unity and social development; culture, art, and tourism; home affairs; rural development; and the Prime Minister's Department for Islamic Affairs.

framework in line with the second “Three Ones” principle. The revised plan proposes the formation of a Cabinet Committee on HIV/AIDS, chaired by the Deputy Prime Minister; a National Advisory Committee on AIDS, chaired by the Minister of Health; and a Technical Committee on AIDS, chaired by the Director-General of Health. Both the advisory and technical committees will include government and civil society representatives. With this high level of commitment and leadership, Malaysian stakeholders will jointly work to reverse the epidemic through the following actions:

- Minimise the socioeconomic effect of the epidemic;
- Reduce the vulnerability of people most at risk of HIV infection;
- Achieve agreed targets for the prevention of HIV infection;
- Ensure that care and support are available to people infected with and affected by HIV;
- Provide affordable and accessible preventive, diagnostic, and curative commodities; and
- Mobilise adequate financial and human resources.

## HIV AND AIDS IN MALAYSIA

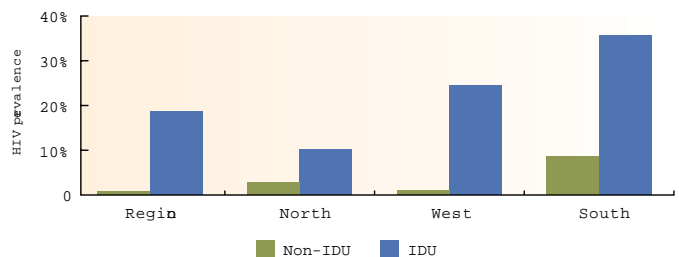
The Malaysian government initiated its national efforts to combat the epidemic of HIV in 1985. Systematic HIV surveillance was started in the country in 1987 and was further strengthened in 1998 by introducing the Plan of Action for Prevention and Control of HIV in Malaysia and introducing the Prevention and Control of Infectious Diseases Act in 1998 (Act 342). In addition to the passive HIV surveillance (case-reporting system for HIV), active HIV surveillance through HIV sentinel surveillance (HSS) was established in 1994. HIV behavioural surveillance in Malaysia was initiated in 2003 (Department of Public Health, 2004).

The latest statistics show that the total cumulative number of reported HIV infections in Malaysia reached 70,559 cases by the end of 2005, with 8,955 AIDS cases and 6,665 AIDS-related deaths (Department of Public Health, 2006).

## EPIDEMIOLOGY

Most-at-risk groups: Reported HIV transmission in Malaysia indicates that transmission by infection through the sharing of needles among IDUs is the main driver of the epidemic (75.7% of reported HIV and AIDS cases). This is followed by sexual transmission through heterosexual (12.9%) and homo/bisexual contact (1.0%). Only 0.7 percent and 0.05 percent of reported HIV infections are attributed to vertical transmission and blood transfusion, respectively (Department of Public Health, 2003). Not all drug users are at equal risk. The distinction between IDUs and non-IDUs is important because there is considerable variation in HIV prevalence between the two groups, as Figure 5-1 illustrates (Department of Public Health, 2004).

Figure 5-1.  
HIV Prevalence Among IDUs and Non-IDUs in Peninsular Malaysia 1998



Source: Department of Public Health, 2004.

Ethnicity: The majority of reported cases (72.7%) are among Malays, followed by Chinese (15.1%), Indians (8.4%), and foreigners (2.8%). Nearly 80 percent (79.4%) of the reported HIV and AIDS cases are within the age group of 20–39 years old, mainly among young drug users who are also sexually active. The trend of reported HIV and AIDS cases from 1986–2003 shows an increasing number of cases each year; there were three peaks noted in 1992, 1996, and 2002 (Department of Public Health, 2003).

Location: Reported HIV infections by state show that Selangor has reported the highest number of HIV infections in 2003 (16.6%), followed by Johor (15.1%). This distribution may be a reflection of where the infections were diagnosed (mostly by drug rehabilitation centres and prisons and not by



residence). The pattern of distribution of AIDS cases by state generally follows that of registered drug users. Kuala Lumpur and Kelantan had reported the highest number of AIDS cases in 2002 and 2003 (429 and 249 cases, respectively), followed by Johor (237 AIDS cases) (Department of Public Health, 2003). Figure 5-1 gives further insight into the regional variation in HIV prevalence, showing that among IDUs, HIV prevalence is highest in the western and southern provinces.

**Women:** The number of HIV infections among women has increased from 9 (1.2% of the total) in 1990 to 673 (10% of the total) in 2003, while during the same period, the number of AIDS cases among women increased from 0 to 137. The number of detected HIV infections among women increased after 1998, when routine HIV screening among pregnant mothers was implemented through a prevention of mother-to-child transmission programme at public health clinics. In 2003, Kuala Lumpur reported the highest number of HIV cases among women (117), followed by Kelantan (106), Johor (81), and Selangor (72). The majority of the reported cases among women were among housewives (44.0%), followed by industrial workers (6.9%), SWs (4.7%), the working class in the private sector (4.7%), government servants (3.3%), and students (1.6%) (Department of Public Health, 2003).

**Occupation groups:** In 2002, out of 6,756 HIV and AIDS cases with known last occupations, 50.2 percent were part-time workers or didn't specify their job; 19.8 percent were unemployed; 16.9 percent were industrial or private workers; 3.9 percent were housewives; and 3.5 percent and 3.1 percent were fishermen and long distance drivers, respectively. SWs represented only 0.6 percent because there were no proper screening activities targeting this group in 2003 (Department of Public Health, 2003).

It is widely acknowledged that case-reporting systems under-report HIV prevalence. The MOH, with the support of the WHO, holds a biennial national consensus meeting on the HIV and AIDS situation in Malaysia. The most recent consensus estimates were produced for 2003, using the Workbook method as prescribed by the UNAIDS Reference Group on Estimates, Models, and Projections. The national HIV-prevalence rate in 2003 was estimated at 0.4 percent

and the number of people living with HIV was 52,329. HIV prevalence among IDUs is between 13.3 and 25.6 percent. Other most-at-risk groups were MSM and SWs and their clients (Department of Public Health and WHO, 2004).

### HIV and AIDS National Response

The MAC is participatory and multisectoral in nature, including PLHAs; various government ministries (e.g., education, human resources, youth and sports, and immigration); and civil society partners.

An HSS programme was piloted in 1993 and scaled up throughout the country in 1994, covering women attending the antenatal clinics and new patients diagnosed with STIs or TB. By 2002, there were 62 HIV-screening centres, with at least one centre per state. HIV screening is conducted among most-at-risk groups (e.g., IDUs and prisoners injecting drugs) and lower-risk groups (e.g., pregnant women attending antenatal clinics and blood donors). For some groups, HIV testing is voluntarily (e.g., all inmates in drug rehabilitation centres and prisons, SWs, TB and STI patients, and antenatal women attending government clinics), while testing for several other groups is compulsory (e.g., blood donors and migrant foreign workers).

A behavioural surveillance survey (BSS) of HIV and AIDS began in July 2003. BSS in Malaysia is conducted among IDUs and SWs and started in five states: Wilayah Persekutuan, Johor Baharu, Penang, Kota Bharu, and Kuching. Data collection through BSS was implemented in February 2004, and officials expect to have more information regarding risk behaviours of HIV infection in subsequent years. In addition to the routine HIV and AIDS case-reporting and HIV-screening programmes, various programmes or organisations conducted prevalence surveys; for example, in 1999/2000, the Division of Disease Control of the MOH conducted a prevalence and behavioural survey of STIs among 208 SWs and 1,070 mothers attending antenatal clinics in Kuala Lumpur (Department of Public Health, 2004).

The transmission of HIV is closely related to human behaviour and practice. Continuous HIV and AIDS health education is a major part of HIV prevention; several promotional activities and

AIDS campaigns are being implemented and health education materials are being produced. The current MOH programmes are described below. In addition to these programmes, the MOH initiated two pilot programmes in 2005: (1) a clean needles and syringes and condoms programme implemented by MAC and (2) a methadone substitution therapy programme.

#### Prevention of Mother-to-Child Transmission

The coverage of HIV screening among antenatal pregnant women in government clinics in all states was high, ranging from 77.4 percent to 100 percent in 2002, with all states showing increases in coverage. Antenatal screening coverage generally reached 96.5 percent of the attending pregnant women, and found HIV prevalence among this group to be only 0.047 percent.

#### Voluntary HIV Counselling and Testing

VCT is a key component of HIV prevention and care programmes. Widespread access to VCT may lead to greater openness about HIV and AIDS, with a reduction in stigma and discrimination. Within care programmes, HIV-positive VCT clients can be referred to relevant care and support services. VCT services, therefore, provide an entry point for HIV care and support services and other services such as supportive counselling, treatment of OIs and prophylaxis, and ART. For those who require hospitalisation or have AIDS symptoms, they will be referred to the nearest hospital for further care (Department of Public Health, 2003).

The number of VCT clients has increased substantially since the programme was scaled up to 380 clinics nationwide. In 2003, the number of clients screened was 5,234—of which 1.3 percent was confirmed HIV positive. Most of the clients were males and Malays; the Chinese and Indians represented only 8.4 percent and 6.5 percent of clients, respectively, with no HIV cases detected among these two groups.

#### HIV Care Management at Primary Healthcare Clinics

Since the programme's implementation in 2000, the number of clients attending these clinics has increased annually. Throughout 2003, there were 6,629 clients attending and treated at 208 clinics compared with 5,807 clients in 120 clinics in 2002.

#### Screening in Prisons and Drug Rehabilitation Centres

The MOH, the Prison Department, and the National Drug Centres Agency jointly implement an HIV-screening programme, along with other preventive programmes. These programmes have been strengthened with the increased supply of rapid test kits. Screening is done on admission after six months and pre-release. Out of 12,808 individuals screened in 2003 in rehabilitation centres, 16.3 percent were diagnosed HIV positive, whereas 6.8 percent of individuals screened in prisons were diagnosed HIV positive.

Not all drug users are IDUs. A study the National Drug Centres Agency carried out in 1998 among drug users in 16 drug rehabilitation centres revealed that 67 percent of drug users were IDUs. About 80 percent of IDUs' HIV infections are estimated to be transmitted by sharing a needle during injecting; the rest are attributed to sexual contact.

#### HIV Screening among Tuberculosis Patients

TB patients have been routinely screened for HIV infection since 1990. The detected HIV cases among TB patients has been increasing, reaching 6.5 percent in 2003.

#### HIV Screening of Donated Blood

Compulsory screening of all donated blood in government blood centres started in 1987 and was extended to all teaching hospitals in 2003. Out of 432,316 donations screened for HIV antibodies, 0.03 percent tested positive (Department of Public Health, 2003).

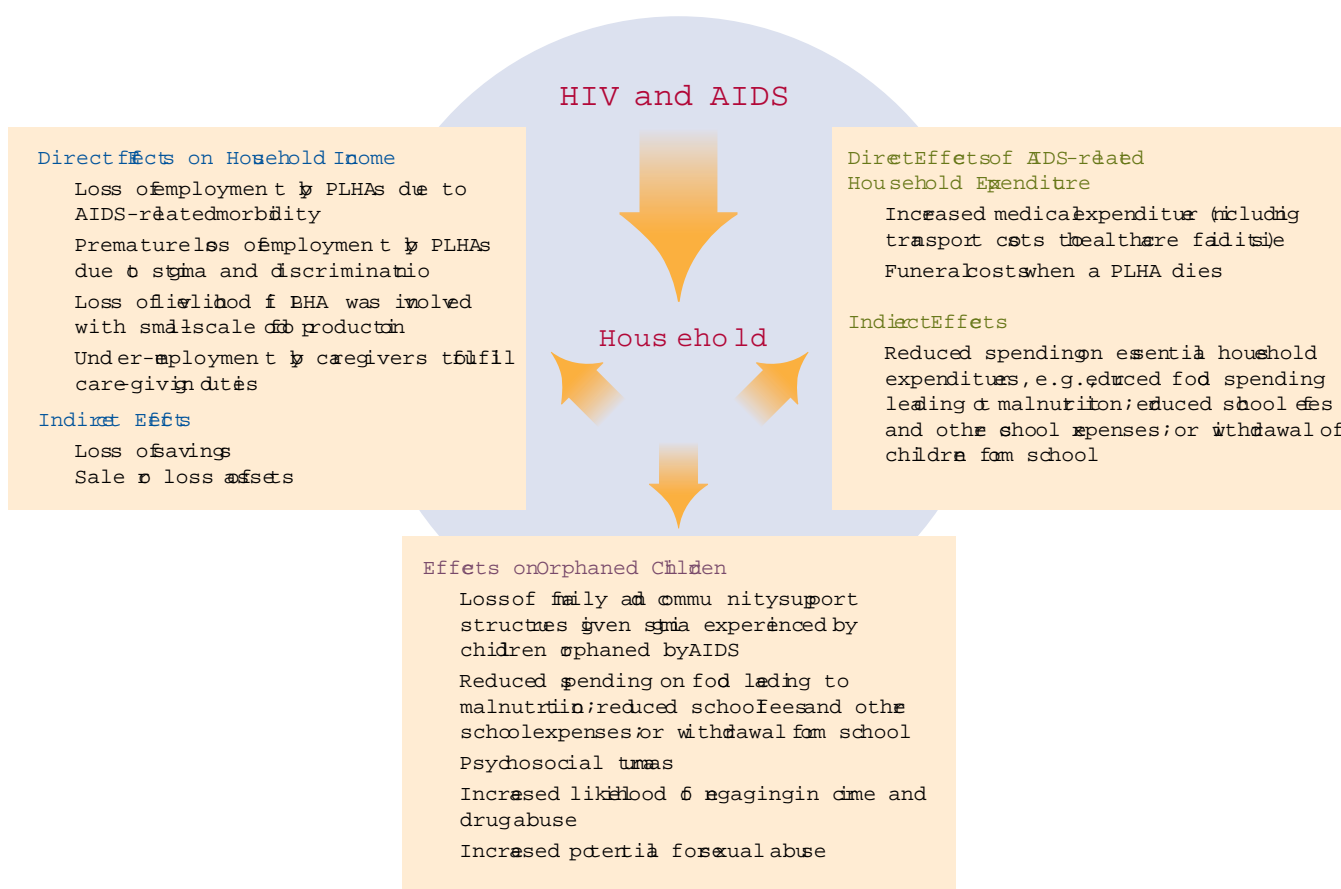
## SOCIOECONOMIC IMPACT OF HIV AND AIDS

In many countries, the HIV epidemic is now having a large-scale impact on the economy and society. HIV thus becomes an issue for macroeconomic analysis, and policies to prevent the spread of HIV have direct implications for key economic indicators, such as economic growth and income per capita, and for economic development more generally (Haacker, 2004). The economic burden of living with HIV is far greater than its direct medical costs. Patients, as well as family members and friends who provide care, incur costs that may not be covered by the government or

insurers. Similarly, costs are not limited to hospitalisation, physician visits, and prescription medications; they also include other costs related to lost wages, informal care and support services, housing subsidies, and productivity loss.

Figure 5-2 summarises the key factors that determine the socioeconomic impact of HIV and AIDS. So far, no study has been conducted in Malaysia on the socioeconomic impact of HIV and AIDS. However, a three-year study on this issue has been planned with a local university (see Appendix).

Figure 5-2 Factors Determining the Socioeconomic Impact of HIV and AIDS



## APPENDIX:

### Study to Assess the Socioeconomic Impact of HIV and AIDS in Malaysia

#### STUDY OBJECTIVES

##### General Objective

To assess the socioeconomic impact of HIV and AIDS in Malaysia

##### Specific Objectives

- 1) To describe the socio-demographic characteristics of HIV and AIDS cases
- 2) To study the use of healthcare services by people living with HIV and AIDS patients
- 3) To estimate providers' healthcare costs in addressing the needs of people living with HIV and AIDS patients
- 4) To measure the direct healthcare costs of HIV and AIDS on households
- 5) To estimate the loss of productivity of PLHAs and their family members
- 6) To identify the socio-demographic factors that may influence the direct and indirect healthcare costs of HIV and AIDS
- 7) To identify the social effect of HIV and AIDS on number of orphans, education level, dependency ratio, and living standards
- 8) To develop and recommend a suitable model for assessing the economic effect of other issues of this magnitude in Malaysia

#### METHODOLOGY

This study is divided into three main components:

##### 1) Hospital cost analysis

An hospital cost analysis will be carried out to obtain the providers' costs in addressing the needs of people living with HIV and AIDS patients. A macro- and micro-costing approach will be used.

##### 2) Household survey

An assessment of the HIV and AIDS impact on the household will include:

- The household costs in caring for HIV-positive members;
- Productivity loss, household income changes, and debts;
- Impact of age, sex, partnership stability, sexual orientation, and history of drug use on household costs of care and productivity loss due to HIV or AIDS; and
- Dependency ratio and education.

##### 3) Expert group discussion

Substantial changes in the field of HIV treatment have occurred in the last few years, prompting a revision of the guidelines for antiretroviral treatment of HIV-positive adults. Physicians and other supportive staff who provide HIV care should be updated on the necessary care for HIV and AIDS cases—when to start ART, what drugs to start with, when to change drug regimens, and what drug regimens to switch to after therapy fails. In this particular study, a panel of experts will discuss the clinical pathway of managing HIV and AIDS cases according to the latest information and their typical clinical practices. Pre-hospital, hospital, and post-hospital care and the related costs for each will also be discussed.

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## VI. PHILIPPINES

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PHOTO CREDITS

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The HIV and AIDS situation in the Philippines is described as hidden and growing. According to the HIV/AIDS Registry of the National Epidemiology Centre (NEC) of the Department of Health (DOH), the total number of HIV sero-positive reported cases between 1984 and 2005 was 2,373. As in other countries, the number of HIV infections is generally under-reported; UNAIDS estimated the number of people living with HIV in 2006 at 12,000 (UNAIDS, 2006). Despite the increasing number of HIV infections, the prevalence rate remains consistently below 0.1 percent (UNAIDS, 2006).

The low prevalence rate can be attributed to the following factors: male circumcision, which is associated with reduced prevalence of infection; a culture of sexual conservatism; a low level of sexual networking among clients of sex workers; no land borders and a relatively low number of foreign tourists; and low (but increasing) levels of injecting drug use (USAID, 2005).

## COUNTRY PROFILE

Population (2006): 83,054,000<sup>a</sup>

Gross national income (2004): US\$1,100 per capita<sup>b</sup>

Adult HIV prevalence (2006): <0.1%<sup>a</sup>

HIV prevalence among most-at-risk groups:

Sex workers: n/a

Injecting drug users: n/a

Men who have sex with men: n/a

Adults living with HIV (2006): 12,000<sup>a</sup>

Women as percent of HIV+ adults (2006): 28%<sup>a</sup>

New HIV infections: n/a

AIDS-related deaths (2006): <1,000<sup>a</sup>

Sources: <sup>a</sup>UNAIDS, 2006; <sup>b</sup>World Bank, 2005

Generally, the policies and programmes implemented in the country have been in line with the Philippine AIDS Prevention and Control Act of 1998 (Republic Act 8504) and the Third Medium Term Plan (MTP III) on AIDS 2000–2004. The AIDS Prevention and Control Act institutionalised the Philippine National AIDS Council (PNAC), which includes 17 government agencies and nine selected NGOs. In response to the challenges posed by the epidemic and within the framework provided by these policies, government agencies and NGOs implement various prevention and control interventions. Condom social marketing and related mass media interventions are implemented by local government units (LGUs) and NGOs, for example, DKT-Philippines.

The purpose of this report is to summarise the key findings on the socioeconomic impact of HIV and AIDS in the Philippines, summarise the level of HIV and AIDS spending, and estimate the resources needed to comprehensively respond to HIV and AIDS in the Philippines.

## SOCIOECONOMIC IMPACT OF HIV AND AIDS

For many years, the Philippines has been able to describe its HIV prevalence as “low and slow.” While this is the third decade of the global HIV pandemic, the adult HIV-prevalence rate in the Philippines is still less than 0.1 percent (UNAIDS, 2006). This is low compared with many countries in the region (for example, Thailand, with a prevalence rate of 1.5 percent and Cambodia, with a prevalence rate of 1.9%).

However, this low rate should not be a reason for complacency. Motivated by the increasing number of HIV-positive cases, as well as risk factors that suggest the potential for a rapid increase in infections, the PNAC now speaks of a “hidden and growing” HIV epidemic in the Philippines. The risk factors are the high prevalence of STIs; low, incorrect, and inconsistent condom use; a relatively young sexually active population; increasing injecting drug use, coupled with the sharing of injecting equipment; and, lastly, widespread misconceptions about HIV and AIDS.



Officers, members, and supporters of the Baguio City AIDS Watch Council (BCAWC) light candles around a ribbon made of red roses remembering those who are suffering and dead from AIDS. The May 16, 2005, Baguio AIDS Candle Light Memorial had the theme “Turning Remembrance Into Action” and was held at the Peoples Park in Baguio City, Philippines.

## Key Factors Influencing the Socioeconomic Impact of HIV and AIDS

Even with the current low-prevalence rates of HIV, the costs of caring for people living with HIV are already becoming a burden on the over-stretched healthcare system. The lowest cost for ARV drugs, used to slow down the course of HIV infection, is US\$468 (PHP 24,000) per patient, per year—which the Philippine government was able to subsidise for its first year of implementation. There are also other HIV-related costs; for example, as more overseas workers contract HIV, there could be wide-reaching implications on the Philippine economy given that it is so dependent on dollar remittances.

The highest HIV prevalence rates were found in prime-aged and economically active adults (ages 20–49 years old) (DOH, 2000). This age distribution may be associated with impacts on the local labour force, such as an increase in absenteeism, exacerbating underemployment, and unemployment. Given the low HIV prevalence, it is unlikely that these effects will be reflected in reduced macroeconomic performance.



A crowd of students at a high school listening to popular singer Lea Salonga. Ms. Salonga performed and spoke about sexual responsibility to some 50,000 students during her tour of schools. The tours culminated in mini-concerts, students’ essays, and art contests.

The impact of HIV and AIDS in the Philippines is more likely to be felt at the microeconomic and household level. A family with a member living with HIV or AIDS suffers increased financial, social, and psychological effects—in the form of medical costs (medicines and care), debt (as a result of depleted savings and possible job loss), the disruption of other important activities (e.g., a child’s education), and funeral costs should the person living with AIDS pass away.

More than just a medical or public health issue, HIV is a development issue. Its future trajectory—whether kept low and slow or growing rapidly—will greatly affect Philippine society. Conversely, the state of the country’s development will affect the course of HIV. For example, with a small budget available for health, HIV and AIDS information and education campaigns are being neglected, which could put many Filipinos at risk of HIV infection.

The most important effect at the national level is likely to be felt in the health sector. The present brain-drain of health professionals, especially of doctors and nurses, has affected the way the health system cares for people living with HIV. Many hospitals are losing their older, more experienced healthcare providers. This is particularly a problem for HIV and AIDS treatment and care, which is already a field avoided by many health professionals because of stigma.

## NATIONAL HIV AND AIDS SPENDING

Data on HIV and AIDS spending were provided by NGOs, agencies/donor institutions, and LGUs; and collected from the General Appropriations Act (Department of Budget and Management, 2002), the National Expenditure Programme publication of the Department of Budget and Management (Department of Budget and Management, 2004), and published NGO project progress reports.

Data were not available to assess all the sources of HIV and AIDS spending. For example, regarding the expenditures of public health facilities, only the spending of San Lazaro Hospital and the Research Institute for Tropical Medicine was calculated because these two hospitals are considered the major providers of treatment services and there were limited data available on other health facilities. The expenditures of provincial and local hospitals, including social hygiene clinics for STI management and other prevention activities, are not captured in this report. In addition, the expenditure on ART is not included, as it is usually borne by the patient. HIV and AIDS expenditures were analysed according to sources of financing, implementing agency, and type of intervention.

### Financing HIV and AIDS

Total HIV and AIDS spending over the last five years (2000–2004) is estimated at PHP1.4 billion (US\$26.1 million) (see Figure 6-1). Spending peaked in 2001 at PHP493.9 million (US\$9.6 million), mainly because of the large donor contributions—from the Japan International Cooperation Agency (JICA) and from USAID early in the response effort. Since 2001, total spending on HIV and AIDS has been decreasing, while the number of HIV and AIDS cases has been increasing.

The government-financed spending on HIV and AIDS as a share of total HIV and AIDS spending in the last five years has been relatively small (15.6% in 2000, 6.5% in 2001, and 21% in 2004) because the Philippines has experienced fiscal constraints that have resulted in limited budget appropriations. This happened across all DOH programmes

due to restructuring. A large share of the total spending, therefore, came from external sources (84% in 2000, 85% in 2002, and 79% in 2004) (see Figure 6-2).

Public sector sources include national government agencies and LGUs. National government resources come mainly from the DOH's National AIDS/STD Prevention and Control Programme (NASPCP) and its Centres for Health Development (CHDs), the PNAC, the Department of Education, the Department of Labour and Employment's Occupational Health and Safety Centre, among others. External sources of financing come from USAID, JICA, UNAIDS, the United Nations Population Fund, the German Development Bank (Kreditanstalt für Wiederaufbau or KfW), among others.

Figure 61. Total HIV and AIDS Spending

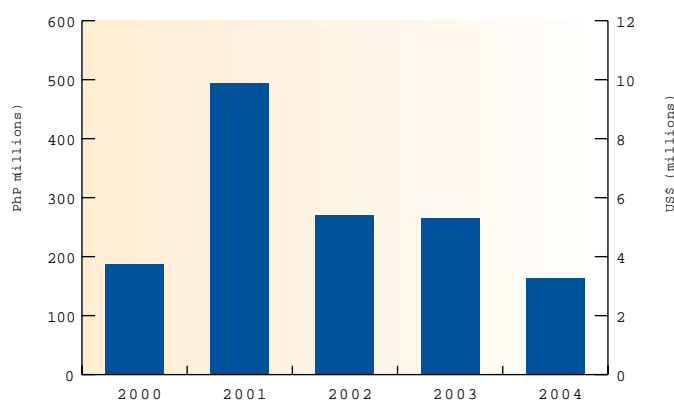
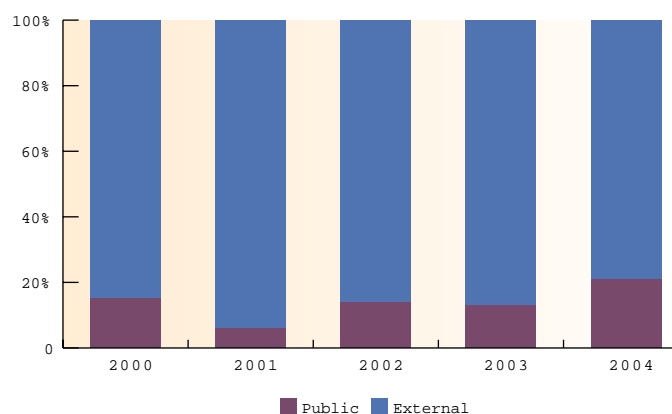


Figure 62. Share of Total HIV and AIDS Spending by Source



## Implementing Agencies

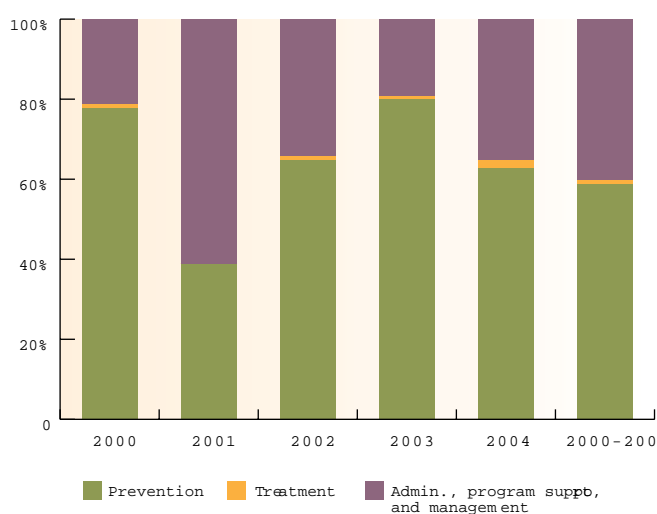
Since 2002, more than half of the total spending has been implemented by the private sector or NGOs (71% in 2002, 79% in 2003, and 57% in 2004). In the Philippines, NGOs are highly effective in carrying out HIV prevention and control activities. This affirms the importance of the NGO community in delivering critical services that are best provided by institutions from the community or grassroots level and the government's recognition of the need for public-private sector collaboration in areas for which NGOs have the comparative advantage.

## Type of HIV and AIDS Programme Spending

Resources were spent mostly on prevention activities (77.7% in 2000, 65.5% in 2002, and 62.3% in 2004) (see Figure 6-3). With the low prevalence of HIV in the country, efforts were concentrated on keeping the rate of transmission low. Prevention programmes in the country include information, education, and communication (IEC) campaigns; condom social marketing; counselling and testing; STI case management; among others. Prevention accounted for 59.5 percent of the cumulative resources between 2000 and 2004.

Although the share of spending for treatment is low, it has been increasing since 2002 (0.9% in 2002 and 2.4% in 2004). These services are limited to laboratory tests, prophylaxis for OIs,<sup>1</sup>

Figure 63. Distribution of Spending by Type



## STRATEGIC PLAN FOR A SCALED-UP RESPONSE TO HIV AND AIDS

The Philippine response to HIV and AIDS, summarised in Table 6-1, is embodied in the Fourth AIDS Medium Term Plan (AMTP IV) (2005–2010) implemented by the PNAC (see Appendix). Although the reported cases are relatively low, the disease is deemed “hidden and growing,” and the conditions for HIV to “take off” are present. For this reason, the plan emphasises the improvement and expansion of preventive interventions. Critical prevention activities should be directed at highly vulnerable groups—SWs and their clients, MSM, IDUs, and in particular, overseas Filipino workers (OFWs).

Treatment, care, and support services for people living with or affected by HIV and/or AIDS must likewise be improved. The mechanisms for acquiring less expensive ART must be carefully examined and institutionalised. Management systems in support of the delivery of HIV and AIDS information and prevention services should be strengthened.

The AMTP IV will pursue the following key strategies:

- Strategy 1: Scaling-up and quality improvement of preventive interventions for identified highly vulnerable groups (SWs and their clients, IDUs, MSM, and OFWs)
- Strategy 2: Strengthening of institutional and community-based preventive interventions
- Strategy 3: Scaling-up and quality improvement of treatment, care, and support services for people living with or affected by HIV and/or AIDS
- Strategy 4: Integration of stigma reduction measures in the delivery of prevention, treatment, care, and support services and in the design of management systems
- Strategy 5: Strengthening and institutionalisation of management systems in support of the delivery of HIV and AIDS information and preventive services

<sup>1</sup> Efforts to provide low-cost ARVs began under the administration of Secretary Manuel M. Dayrit. Presently, under Secretary Francisco T. Duque III, ART is provided for free.

Table 61.  
Timeline of HIV and AIDS-related Events and Activities

1984	First HIV infection reported in the Philippines
1988	Establishment of the NASPCP and HIV/AIDS Registry
1988-1990	USAID supports projects for the strengthening of laboratories and communications programmes
1988-1993	First AMTP is developed and implemented as a guide in formulating national strategies and interventions needed given the HIV and AIDS situation
1992	Establishment of the PNAC, a multi-sectoral advisory committee responsible for HIV and AIDS policies by virtue of Executive Order 39 by the President of the Republic of the Philippines
1993-1999	Second AMTP is developed and implemented
1993-2003	USAID pilots AIDS Surveillance and Education Project in 10 Philippine cities
1994	Establishment of Pinoy PIs Association, the first organization of PWAs in the Philippines
1995	JICA supports creation of a central SIMIV/AIDS reference laboratory
1995	First Filipino movie with HIV theme: The Dolzura Cortez Story
1995	Bahay Lingap (a halfway home of symptomatic Filipino LHAs) inaugurated
1996	BSS Conducted
1996	Creation of HIV/AIDS Core Teams
1997	The Philippines hosts the 4th International Congress on AIDS in Asia and the Pacific
1997	Another Filipino movie with HIV theme: The Sara Jane Salazar Story
1997	Formal establishment of the ST/AIDS Cooperative Central Laboratory Development of the fourth AMTP
1997	Proclamation 88 as National AIDS Prevention and Control Year for the Republic of the Philippines. President Fidel V. Ramos was the first president to do so, which facilitated the passage of the AIDS law
1998	Enactment of Republic Act 840 or the Philippines AIDS Prevention and Control Act of 1998; law that balances human rights and public safety
2000-2004	Third AMTP is developed and implemented  Local AIDS councils are created in some cities  The institutionalisation of LGU and NGO budgetary allocations for HIV and AIDS activities is also enacted
2001	The UNGASS Declaration of Commitment on HIV/AIDS (the declaration details strategies to address all broad areas in the battle against HIV and AIDS, with clear targets and timelines)
2004	UNAIDS adopts the "Three Ones," calling on each country to adopt a common action framework, a national AIDS coordinating authority, and a country monitoring and evaluation plan
2004	NDHS included HIV and AIDS
2004	Round 3 Proposal for GATM approved, providing external resources to scale up the local response
2004	First MTV AIDS Music Summit in the Philippines
2005	Creation of the Medium Term Philippine Development Plan (MTPDP)
2005	The government procures ARVs as a essential commodity



## Resources Required for HIV and AIDS Programmes

Since 2001, the total spending on HIV and AIDS has been decreasing despite the increasing number of cases. Based on the AMTP IV, about PHP275 million (US\$5.4 million) is needed to implement the major strategies and activities in 2005 and 2006. However, based on the spending assessment for the past five years, the government spends only about PHP34 million (US\$0.663 million) every year (domestic resources). This illustrates the need for more resources in view of the huge financing gap. The resource requirement based on the AMTP was arrived at by estimating the HIV and AIDS budgetary allocations from donor agencies. As such, it is not the "ideal resource requirement," since it only reflects the resources committed by donor agencies and not based on a systematic model that takes into account all pertinent factors.

Figure 6-4 shows the estimated resource needs for prevention, care and treatment; mitigation; and policy, advocacy, administration, and research activities. The funding estimates are for a comprehensive response to the epidemic, with programmes covering about 60 percent of the target population. One of the key limitations of this analysis is the lack of accurate unit cost data. In several instances, unit cost data were taken from estimates in the region. This limitation needs to be addressed in the future. Based on the Resource Needs Model, about PHP15.9 billion (US\$284.0 million) is needed for 2006–2010 to finance prevention activities (PHP11.5 billion/US\$205.5 million); care and treatment services (PHP 3.6 billion/US\$64.0 million); mitigation (PHP53.1 million/US\$0.9 million); and policy, advocacy, administration, and research activities (PHP757.8 million/US\$13.4 million).

About 72 percent of the total resource requirement will be for prevention activities, including activities for priority populations (such as youth, SWs and their clients, IDUs, MSM, and migrant workers); service delivery (condom provision, STI management, VCT, PMTCT, mass media campaigns); and healthcare (blood safety, PEP, safe injection, and UPS) (see Figure 6-5).

About 23 percent will be for care and treatment services, including home-based care, palliative care, diagnostic testing, treatment of TB and other OIs, ART, nutritional support, training, laboratory support for ART, and OI prophylaxis.

Figure 64. Resources Required for HIV and AIDS

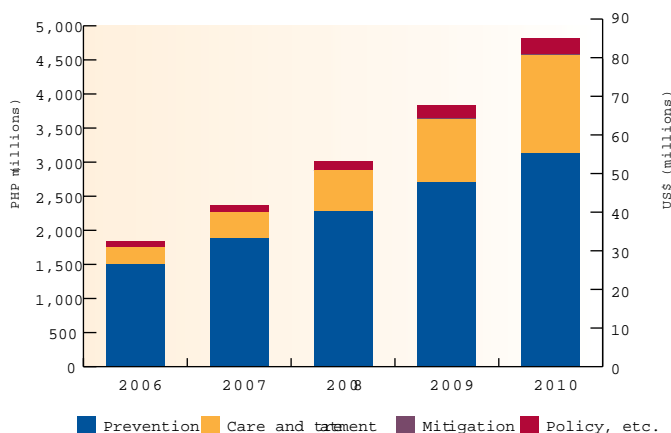
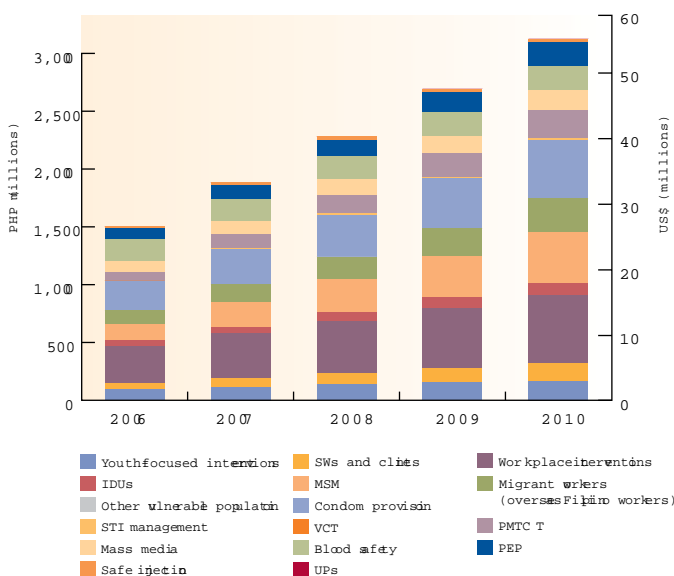


Figure 65. Resources Required for Prevention Interventions



Mitigation activities focussed on orphan care constitute about 12.8 percent of the total investment requirement. Meanwhile, about 4.8 percent of the requirement is for policy, advocacy, administration, and research.

Data provided in this analysis emphasise the need for a substantial increase in resources to prevent and control the spread of HIV. Moreover, based on the National AIDS Spending Assessment, the government provided only about PHP33 million (US\$594,000) in 2004 out of the total spending of about PHP156.9 million (US\$2.8 million), largely coming from external sources. Hence, all stakeholders will have to generate resources to meet the investment requirements. The donor/international community can be tapped. Another potential source is the LGUs, although, like the national government, their investment is also subject to fiscal constraints.

## KEY POLICY ISSUES AND NEXT STEPS TO ADDRESS ISSUES

Mobilising resources for the HIV and AIDS response is a critical challenge facing the Philippines. A key strategy for ensuring the sustainability of the effort is to engage the local government to invest in the local response. Resources are needed to improve and expand preventive interventions. Critical prevention activities should be directed at highly vulnerable groups—SWs and their clients, MSM, and other emergent highly vulnerable groups identified by the government.

Institutional (workplace, school-based) and community-based interventions must be strengthened. Notably, the large size

of particular population groups, such as workers and youth (in-school and out-of-school), requires substantial amounts of resources to cover essential outreach and information services. Advocacy and IEC activities aimed at encouraging the use of VCT must be implemented.

Treatment, care, and support services for people living with or affected by HIV or AIDS must likewise be improved. The mechanisms for acquiring less expensive ART must be carefully examined and institutionalised. Management systems in support of the delivery of HIV and AIDS information and preventive services should be strengthened.

More important, resources from the public sector must be used effectively and efficiently, given the financial constraints. Best practice methods in other countries must be examined for possible adoption or replication in the Philippines. Given the volatility in the level of resources, the proper mix of interventions must be carefully studied so that limited resources are optimally utilised.

Lastly, a data collection system should be institutionalised so that HIV and AIDS expenditures (among other indicators) can be regularly monitored and programmes and projects designed more effectively and efficiently. The development of a monitoring and evaluation system and the institutionalisation of data collection on AIDS expenditures are in progress. It is essential to harmonise the type of financial data to be collected and analysed, standardise definitions, determine the type of healthcare functions to include, and ensure the compliance of annual reporting of all stakeholders to ensure consistency with the Country Response Information System, as this has been adopted for HIV and AIDS monitoring.

## APPENDIX:

### Fourth AIDS Medium Term Plan, 2005–2010<sup>2</sup>

#### Guiding Principles

The formulation of the AMTP IV was guided by the following principles:

1. The formulation and implementation of socioeconomic development policies and programmes should consider the effects of HIV and AIDS. Responses to STIs, HIV, and AIDS should be integrated into national and local development plans. Resources should be equitably allocated, taking into consideration the needs of different populations.
2. Multisectoral involvement is essential to the planning, execution, and monitoring of the national and local responses to HIV and AIDS. People should be empowered to prevent further HIV and STI transmission in all environments.
3. Treatment, care, and support services for people living with and affected by HIV and/or AIDS should be integrated into existing health and social services.
4. The dignity and rights of people living with and affected by HIV and/or AIDS and that of healthcare providers must, at all times, be promoted and respected.
5. Significant efforts should be made to ensure the genuine and meaningful involvement of people living with and affected by HIV and/or AIDS at all levels of policymaking, project design, implementation, monitoring and evaluation.
6. HIV interventions should be voluntary, provide high-quality information, and be guaranteed with utmost confidentiality.
7. Efforts should continually improve HIV-related programmes and adopt gender-responsive and rights-based approaches.

#### Policy Directions

The AMTP IV for 2005–2010 shall

1. Be geared toward preventing the spread of HIV and reducing its effects on individuals, families, and communities.
2. Ensure that measures and programmes are responsive to the identified needs of concerned sectors, individuals, and groups.
3. Give priority to HIV-positive and -affected people as well as to existing and emergent highly vulnerable groups, especially those not covered in the AMTP III, which include OFWs, youth, and HIV-positive and affected children.
4. Improve the quality of the design and implementation of STI, HIV, and AIDS interventions. Systems to monitor and measure the quality of every intervention must be established.
5. Scale up and expand effective intervention measures, with ample resource support.
6. Ensure integration and harmony of purpose for new and ongoing HIV and AIDS projects and programmes to avoid overlaps.
7. Include mechanisms to ensure a protected level of funding to support its goals and objectives.
8. Build on existing structures and systems for the implementation, coordination, and monitoring and evaluation of the AMTP IV—particularly those provided by the Local Government Code.
9. Be aligned with the vision, goals, and purposes of the MTPDP, the MDGs, the UNGASS Declaration of Commitment on HIV/AIDS, the ASEAN Joint Ministerial Statement, and other international commitments that are considered relevant to the country.

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<sup>2</sup> This appendix only includes excerpts from the Fourth AIDS Medium Term Plan (AMTP IV) for 2005–2010. To access the full plan, visit <http://www.doh.gov.ph/pnacwebsite/>.

The AMTP IV shall take into consideration the different population groups and sectors in launching the national response to HIV and AIDS in the next six years. It will continue to focus interventions on: (a) SWs, both registered and non-registered, and their clients, (b) IDUs, and (c) MSM. Equal consideration will be provided to PLHAs and those affected by AIDS. Providing HIV-prevention information and services will continue among the workforce, in-school youth, and the groups at lower risk for HIV. The AMTP IV will give ample attention to emerging population groups becoming more vulnerable to STIs and HIV—the OFWs, young adults, and children.

Considering that everyone is susceptible to HIV but differs markedly in their degree of vulnerability to the infection, women, men, youth, children, and the workforce must all be made aware of their own vulnerability to HIV infection.

### Operational Strategies

For the Philippines, epidemiological studies have identified most-at-risk behaviours and vulnerability factors that facilitate the transmission of HIV, such as unprotected sex as frequently practiced by MSM and SWs and their clients; and the use of infected needles among IDUs. Specific population groups, such as OFWs, are also identified as being vulnerable to contracting HIV because of the socioeconomic and occupational contexts they are in. Though the country lacks solid data on the number of highly vulnerable populations, studies show an increased prevalence of unprotected sex among them, and some occupational groups are emerging as more vulnerable than others.

Improving the quality of prevention interventions among most-at-risk groups and expanding coverage would contribute significantly to halting the spread of HIV. There is an urgent need to assess existing interventions in terms of their responsiveness and quality. Due attention will be given to

the promotion of the 100% Condom Use Programme, while behaviour change communication activities will be integrated into every prevention effort. The Harm Reduction Programme will be expanded to other areas where the number of IDUs is increasing. Aside from strengthening existing health facilities as providers of STI, HIV, and AIDS information and services, efforts will be undertaken to widen the outreach network that will proactively reach and serve the vulnerable groups. This will require intensive mobilisation and the organisation of the target groups as well as the capacity building of outreach workers and other stakeholders.

The criteria and process for identifying most-at-risk areas will be refined and reapplied. The AMTP IV aims to cover all 43 identified areas, phasing coverage from 2005 to 2010. Partnerships among the local governments and NGOs will be strongly advocated while the establishment of local AIDS councils will be fully encouraged. Resources will be mobilised to support local responses in the identified most-at-risk areas. Particular attention will be devoted to enhancing existing programmes for OFWs, while establishing new measures to facilitate their access to services abroad.

The PNAC, with the support of its secretariat, shall serve as the overall coordinator in the execution of the AMTP IV. Member agencies shall carry out their respective mandates. The existing committee structure will be reviewed and modified given the emerging needs for focussed interventions. An organisational planning meeting will be held at the start of every year to translate the AMTP IV into an annual operational plan, where the focus of responsibility for each major activity will be identified and agreed on by the whole body. A subnational coordination task force will be established and equipped to strengthen coordination at the local level and to facilitate the flow of information, technical assistance, and resources.

## Policy

Policies and guidelines that will direct the implementation of the AMTP IV will be formulated at the national level with due consultation among various stakeholders, including those involved in implementing local programmes. Each member agency of PNAC has its own policy concerns, and each one is, therefore, expected to develop their respective policies and guidelines following a consultative process. Issuance and adequate dissemination of these guidelines shall also follow the formal route of the agency concerned. All policies and guidelines developed shall be subject to review by the PNAC. The LGUs are also expected to formulate ordinances that support HIV and AIDS prevention, treatment, care, and support in their respective localities. They are to adopt or localise national policies and guidelines as appropriate to their respective situations and needs. Both the national government and LGUs are expected to enforce them.

## Technical Assistance

The concerned agencies and partner NGOs shall provide training and other forms of technical assistance needed at the local level. The PNAC secretariat will facilitate the infusion (NGO to NGO, NGO to LGU, LGU to NGO, LGU to other donors, and NGO to other donors) and wider application of appropriate technology by coordinating with those who have the expertise and those who need them. It will establish a directory of resource persons at various levels who will be tapped to address the training requirements of stakeholders. PNAC will ensure the training is of high quality by creating and disseminating standards and reviewing the training modules of institution-based programmes. Should there be a need to mobilise experts from the international community, the PNAC shall take the lead in mobilising them.

## Advocacy

The AMTP IV requires the design of an overall advocacy plan to harmonise advocacy efforts, purposes, and messages and direct them at specific groups or audiences. It is incumbent on PNAC to undertake this initiative in consultation with concerned stakeholders at all levels. Local stakeholders have been conducting their respective advocacy efforts and shall continue to do so but will be guided by a national advocacy plan.

## Information, Education, and Communication

The PNAC shall endeavour to make an inventory of IEC efforts with support from the local government, NGOs, the donor community, and other stakeholders and will undertake an assessment of their effectiveness. It shall strengthen the existing communication plan and ensure that each concerned member agency implements and monitors the communication activities as designed and planned. The local stakeholders shall reflect this overall plan in implementing IEC strategies and interventions in their localities. Each member agency of PNAC has been mandated to undertake HIV- and AIDS-related IEC activities for the various risk groups they are to reach and serve. These mandates should be articulated to their regional or local counterparts to ensure wider coverage and reach.

## Treatment, Care, and Support

The provision of responsive treatment, care, and support for those people living with or affected by HIV and/or AIDS requires the coordinated efforts of all concerned, including hospitals, LGUs, national agencies, NGOs, and other concerned institutions and community groups. The DOH, in consultation with key stakeholders, shall take the lead in reviewing and strengthening the referral system to ensure continuity of care. The Department of Social Welfare and Development, together with its partner NGOs, will be responsible for establishing community and home-based care systems. Policies and guidelines for treatment, care, and support shall be reviewed and updated at the national level. PNAC shall ensure that these are appropriately disseminated to all concerned.

## Logistics

The procurement and acquisition of necessary treatment drugs and other medicines will not be cost-efficient and effective if they are done by LGUs and NGOs on an individual basis. The DOH is tasked to coordinate procurement and shall establish a procurement and distribution mechanism to facilitate the easy access and availment of these supplies by those concerned. At the local level, LGUs shall take the primary responsibility for procuring drugs, supplies, and reagents for their social hygiene clinics.

## Surveillance and Research

The DOH shall be mainly responsible for providing technical assistance to LGUs in establishing their surveillance systems, which the LGUs shall be responsible for operating and maintaining. Surveillance data will follow the routine flow from the LGUs and hospitals to the DOH-CHD and DOH-national level. The DOH shall be responsible for disseminating reports to all concerned. The PNAC shall review and update the research agenda for the next six years, which shall serve as a guide in the review and approval of future research studies. Local stakeholders are encouraged to undertake their own research on concerns applicable to their area.

## Resource Mobilisation

Given the huge amount of resources to implement the AMTP IV, the PNAC Chair with support from the secretariat, shall spearhead the mobilisation of resources. The PNAC must also take an active stance in coordinating and mobilising donor assistance to further increase resources and ensure they are appropriately used. It shall establish a mechanism by which the technical expertise of donor agencies, NGOs, and concerned national agencies can be transferred and expanded to other areas needing technical support. Furthermore, the PNAC shall document various mechanisms and initiatives to promote the sustainability of programmes and interventions for HIV and AIDS prevention, treatment, care, and support. As to the wealth of non-fiscal resources that the country has accumulated in implementing a national response, the need to maximise their value will be addressed by the establishment of a dynamic resource centre that will act as a central repository of training modules; research studies; IEC templates and materials; and information on agencies, organisations, and individuals with expertise in these areas. With the timely matching of needs and present resources, the mobilisation of these resources is facilitated.

## Monitoring and Evaluation

The implementation of the AMTP IV will be monitored and evaluated using the set of indicators as defined and established by the Ad Hoc Committee on Monitoring and Evaluation. Specific targets for each indicator will be established once the baseline data is collected, which is a priority activity for the first year of AMTP IV implementation.

As designed, M&E will be operationalised through the various agencies as part of their mandates. Each database will generate information that will be centrally collected by the PNAC through its Secretariat. The PNAC, in turn, will be responsible for consolidating and disseminating this information on a regular basis. Information from the LGUs will be coursed through the Department of Interior and Local Government (DILG). NGOs at the local and national levels will be linked to the M&E system through an NGO data clearinghouse.

The M&E system calls for various methodologies in collecting data, including population-based surveys, programme monitoring, surveillance, special surveys, and routine reporting.

The PNAC, with DILG taking the lead, will organise monitoring teams to make the necessary visits to local areas implementing their respective responses to HIV and AIDS. A midterm evaluation will be conducted to determine the progress of implementation and the potential results of activities and other inputs.

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## VII. THAILAND

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PHOTO CREDITS

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Since the inception of Thailand's National AIDS Control Programme (NACP) in 1987, the government has emphasised a multisectoral national response to HIV and AIDS, with major achievements in prevention, treatment, care, and social support. However, despite aggressive actions to stem transmission, the HIV epidemic in Thailand continues to grow. The government's recent effort to move toward universal access to ART has significant short- and long-term financial implications and impacts on the national HIV and AIDS response.

This report presents empirical findings regarding (1) the socioeconomic impact of HIV and AIDS in Thailand; (2) the results of the National AIDS Accounts (NAA) study; (3) a summary of the country's strategic plan for a scaled-up response to HIV and AIDS; (4) an estimate of the resources required for HIV and AIDS programmes in the near future; and (5) a summary of key policy issues and next steps for mitigating the socioeconomic impact of the HIV epidemic.

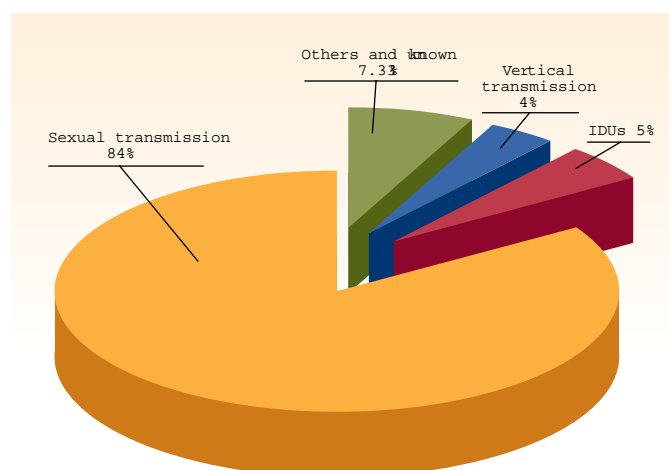
## EPIDEMIOLOGY

The first case of AIDS in Thailand was reported in September 1984. While early cases were generally confined to homosexual males, the virus subsequently spread to IDUs and SWs and their clients. The epidemic has now become generalised in the population, with heterosexual transmission accounting for the highest proportion of cases.

Of the AIDS cases reported to date, sexual transmission accounts for the highest proportion of cases (84%), followed by injecting drug use (5%) and perinatal transmission (4%) (see Figure 7-1).

By 2005, a cumulative number of 287,202 AIDS cases had been reported to the Bureau of Epidemiology, Ministry of Public Health.

Figure 7-1. Distribution of Reported AIDS Cases in Thailand, September 1984–December 2004



## COUNTRY PROFILE

Population (2005): 64,233,000<sup>a</sup>

Gross national income (2004): US\$2490 per capita<sup>b</sup>

Adult HIV Prevalence (2005): 1.4% (0.7%–2.1%)

HIV prevalence among most-at-risk groups:

Sex workers: 7.36%

Injecting drug users: 41.2%

Men having sex with men: 28% (Bangkok)

Adults living with HIV (2005): 560,000

Women as a percentage of HIV+ adults (2005): 39%<sup>a</sup>

New HIV infections in 2005: 18,172<sup>c</sup>

AIDS-related deaths (2005): 21,000<sup>a</sup>

Sources: <sup>a</sup>UNAIDS, 2006; <sup>b</sup>World Bank, 2005; <sup>c</sup>Ministry of Public Health, 2002

## HIV PREVALENCE

In 2004, HIV prevalence among pregnant women was 1.04 percent. The highest (median) prevalence was among IDUs (41.2%) followed by female direct SWs (7.36%), male STI clients (5.0%), female indirect SWs (4.0%), and blood donors (0.24%). HIV prevalence in military conscripts at the national level decreased from 4 percent in 1993 to 0.5 percent in 2002. It is evident that the strong national response has resulted in a large decline in new infections. The prevalence rate among IDUs, however, continues to be one of the major challenges to Thailand's efforts to control HIV, illustrated by an increase from 39 percent in 1989 to 51 percent in 1999 and only a slight decrease from 50 percent in 2001 to 41.67 percent in 2002. Although data on MSM in Thailand are incomplete, increased infections among this at-risk group pose another challenge for the Thai government: In Bangkok, HIV prevalence among MSM increased from 17 percent in 2003 to 28 percent in 2005 (UNAIDS, 2006).

## SOCIOECONOMIC IMPACT OF HIV AND AIDS

The greatest impact of HIV and AIDS, in terms of human and social costs, is felt at the household level. However, there is increasing evidence and recognition of the macro-level effects in Thailand.

### Household Impact

Several studies in Thailand have indicated that AIDS has placed a significant economic burden on the household both directly and indirectly (UNDP, 2004). These studies look at costs associated with care and treatment for people living with AIDS and the impact of AIDS on employment and productivity. A study conducted by Pitayanon (1997) found that the direct cost of AIDS-related illnesses, as measured by healthcare costs, travel costs, and funeral costs, is of similar magnitude as non-AIDS-related illnesses because of the short duration relative to other chronic diseases (see Table 7-1). The total direct cost of AIDS-related illness and death was 64,355 Baht (US\$1,608.87) compared with 70,258 Baht (US\$1,756.45) for other chronic illnesses (Pitayanon et al., 1997).

However, indirect costs due to AIDS-related illnesses are higher than non-AIDS illnesses. Indirect costs include income lost and income forgone due to illness and premature death. The total economic burden of AIDS, both direct and indirect, is about 62 percent higher than it is for non-AIDS chronic illnesses. AIDS-related illnesses create a greater burden on the economy because those who die from AIDS-related causes are much younger than those who die from other illnesses, thereby resulting in greater loss of productivity.

Another study conducted in rural Thailand by Kongsin (2002) found that households in which a member is living with AIDS use the following coping strategies: decrease household consumption, reallocate labour by withdrawing children from school, dis-save, and depend on the extended family system or the community for support. The income of some households decreased by as much as 70 percent over a six-month period, while total income per capita and total consumption per capita decreased by 68.4 percent and 43.5 percent, respectively. To maintain consumption levels, the primary coping strategy used by households was to delve into their savings. When savings were spent, households

Table 7-1.  
Comparison of HIV and AIDS and non-HIV and AIDS Direct and Indirect Costs

	HIV/AIDS	Non HIV/AIDS
<b>Direct costs (Baht)</b>		
Medical treatment	2,344	22,075
Travel expense	1,571	1332
Funeral expense	38,440	46,850
<b>Total direct cost</b>	<b>41,355</b>	<b>70,258</b>
<b>Indirect costs (Baht)</b>		
Income loss of care provider	254	1,944
Income loss of the deceased		
Regular job (per month)	3875	3681
(per year)	46,500	44,172
Regular supplementary job (per month)	6,050	4,655
(per year)	72,600	55,860
Income foregone of the deceased (*)		
Regular job	71,800	50,500
Regular supplementary job	1,18,750	70,530
<b>Total indirect cost</b>		
Without supplementary job	71,834	55,244
With supplementary job	119,291	70,350
<b>Total direct and indirect costs (Baht)</b>		
Without supplementary job	<b>71,665</b>	<b>62,270</b>
With supplementary job	<b>125,646</b>	<b>77,552</b>

Source: Pitayanon et al., 1997.

resorted to borrowing. Households incurred per capita loans of 28.4 percent and per capita debt of 118 percent relative to total household income per capita. The study illustrates how coping strategies used by households affected by HIV and/or AIDS have a negative impact on household welfare. The high level of dis-saving and significant percentage of income devoted to healthcare expenditure indicates that HIV and/or AIDS could push households into poverty.

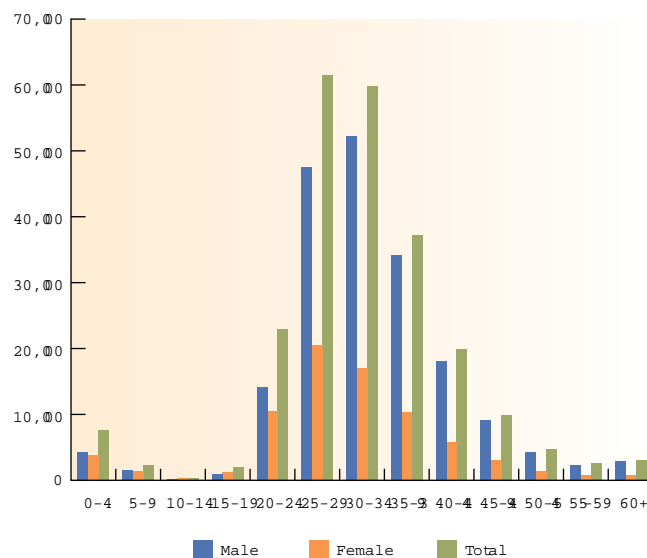
### Macroeconomic Impact

It is difficult to measure all aspects of economic impact at the national level due to the complexity of the impact. Among many impacts, AIDS-related illnesses may reduce productivity of workers; increase absenteeism, and/or result in loss of workers and loss of tacit knowledge. AIDS also increases the cost of medical care and treatment, increases demand for training and recruitment, increases insurance coverage, and increases funeral costs. At the market level, AIDS-related deaths reduce the size of the labour pool and suppliers. Thus, measuring impacts at the national level can be done on some aspects where information is available (UNDP, 2004).

The HIV epidemic affects adults in their most productive years. In 2006, there were 560,000 adults living with HIV in Thailand (UNAIDS, 2006). More than 27 percent of people living with AIDS in 2005 were between 25 and 29 years old; 25 percent were between 30 and 34 years old; 16 percent were between 35 and 39 years old; 10 percent were between 20 and 24 years old; and 8 percent were between 40 and 44 years old (see Figure 7-2). In 2000, over 90 percent of all new AIDS-related deaths were in the 20–44 age range—the most productive segment of the labour force. The ratio of AIDS cases among males to females is approximately 2.8 to 1 (see Figure 7-2).

Estimates made by the Bureau of the Census suggested that life expectancy in Thailand is 2–3 years less than it would have been in the absence of AIDS. In the northern region of Thailand, which is the most severely hit by HIV, life expectancy of children under four has dropped by 10 years for boys and 5 years for girls.

Figure 7.2. Distribution of Reported AIDS Cases by Age Group of Diagnosis in Thailand, September 1984–April 2005



AIDS-related deaths are grossly under-reported, therefore making it difficult to measure wages lost due to AIDS-related illness. However, an annual estimation of new HIV cases, new AIDS cases, and new AIDS-related deaths was derived from the study by Rumakom (2002) (Rumakom, 2002). A follow-on study in 2004 found that wage loss due to HIV infection and AIDS-related illness and death increased from 26,722 million Baht (US\$668.05 million) in 1996 to 40,521 million Baht (US\$1013.025 million) in 2000 (UNDP, 2004).

The macro-level information on AIDS morbidity and estimation in terms of disability-adjusted life years (DALYs) was estimated by the Bureau of Health Policy and Planning. After adjusting for under-reporting, the bureau estimated (Ministry of Public Health, 2002) that the total number of DALYs for AIDS was 1.3 million years lost (14% of total DALYs) and ranked first of the top 10 disease category in 1999.

## Impact of Treatment on Macroeconomic Expenditures

Over the next few years, several factors may affect the costs of treating HIV cases in Thailand. First, if universal coverage by the '30 Baht scheme' continues to be a government policy priority, the total number of cases under treatment may gradually increase to about 100,000 people. Second, it is possible that an increasing proportion of second-line and even third-line ARVs may be required. These are significantly more expensive than first-line drugs. Third, it is unknown how long the GFATM will support ART. If it phases out, then the Thai government would need to replace that funding. Together, these factors could significantly increase current costs to the government. A study currently underway indicates that costs could rise much higher, perhaps more than 10 times higher, if prevention fails to contain the epidemic to a minority of the population.

## The Impact of HIV and AIDS on Children

The results of the "Global Orphans Study for Thailand" showed that, in 1998, there were approximately 35,000 children under the age of 15 who had already lost their mothers to AIDS-related causes and another 57,000 whose mothers were living with AIDS. A more recent estimate, in 2000, revealed that 298,000 children under the age of 15 have been orphaned by AIDS.

Children living in households affected by HIV and/or AIDS in Thailand are often faced with fewer educational opportunities, especially when family members are at the advanced stages of AIDS-related illness. Family members have to reallocate their time to either take care of the ill members or mobilise their children to work to compensate for the lost income (Kongsin, 2002).

In addition to those children living in households affected by HIV and/or AIDS, there are approximately 1,200 children who are infected with HIV each year due to mother-to-child transmission. A recent study found that 20 percent of these children died during their first or second year of life and that the majority will suffer a chronic HIV illness and will require ongoing medical management for their health, as well as counselling and support.

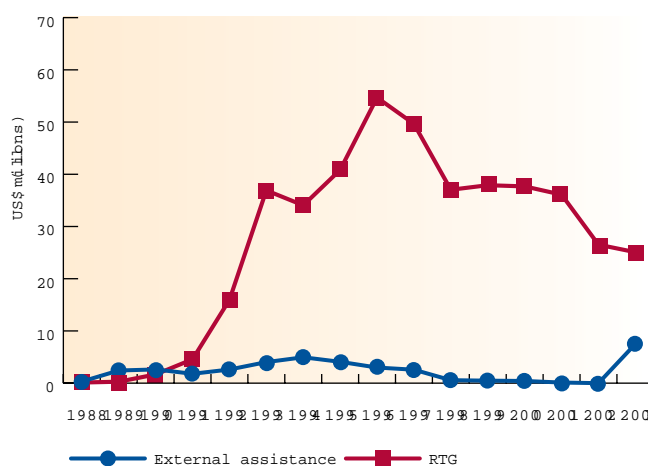
## NATIONAL AIDS SPENDING

### Financing the HIV and AIDS Budget

In the early years of the epidemic, the HIV prevention and control programme in Thailand was supported by international organisations, notably the WHO through the Global Programme on AIDS, the UNDP, the EU, USAID, JICA, GTZ, and others. In 1988, HIV and AIDS expenditure in Thailand (from the government budget and external assistance) was 17.1 million Baht (US\$0.68 million)—of which 73 percent came from international assistance. International assistance increased to 90 percent in 1989. Then, in the early 90s, the Thai government resumed its financial backing of the programme. Support from the Thai government increased from 4.6 million Baht (US\$0.18 million) in 1988 to 182.66 million Baht (US\$7.17 million) in 1991 and 2,187.54 million Baht (US\$86.33 million) in 1996. As the public budget increased, donor resources were phased out to 10 percent and 5 percent in 1993 and 1996, respectively (see Figure 7-3).

According to the NAA, 60 percent of HIV and AIDS funding in 2003 came from the Thai government and 21 percent came from households. Donor resources, including from the GFATM, accounted for 13.5 percent of the spending.

Figure 7-3.  
Government Budget and External Assistance on HIV/AIDS Program 1988-2003





### HIV and AIDS Expenditures by Category

Thailand's NAA revealed that total HIV and AIDS expenditure was 4,479.16 million Baht for the year 2003. Health expenditures made up 90 percent of total HIV and AIDS expenditure, healthcare related expenditures made up 8 percent, and non-health expenditures made up 2 percent (see Table 7-2). The ART programme made up the largest share of the resources (45.6%), followed by outpatient treatment of OIs (23.1%) and inpatient care for OIs (9.6%).

### HIV and AIDS Expenditures by Healthcare Function

Table 7-3 from the NAA shows that total expenditures increased from US\$78.2 million in 2000 to US\$107.9 million in 2003. In 2003, two items, ART (45.6%) and OI treatment (32.8%) account for the major share of total current spending on HIV. Spending on these two items increased from 67.9 percent in 2000 to 78.4 percent in 2003 as a result of the increase in ART spending (from 19.3% to 45.6%) and the reduction trend in OI treatment expenditure (from 48.6% to 32.8%). This indicates a trade-off between spending on ART and the reduction of OI treatment expenditure, i.e., cost savings from the treatment of OI.

In 2003, the third largest item (though small) is PMTCT (3.1% of the total), followed by IEC (3.2%), and blood safety (2%).

### Total HIV and AIDS Expenditure and Total Health Expenditure

The NAA found that spending on HIV and AIDS was US\$113 per person living with HIV or AIDS in 2000 and increased to US\$179 in 2003—a 58 percent nominal increase. However, if HIV and AIDS expenditure was divided by total population, in 2000, Thailand spent US\$1.3 per capita and this increased to US\$1.7 per capita in 2003. When compared with current health expenditure (CHE) in 2003, HIV and AIDS spending was 2.24 percent of CHE—an increase from 2 percent in 2000.



A display of HIV and AIDS education and prevention materials.



Table 7-2.

National AIDS Accounts 2003 million Baht current year price

FUNCTIONS OF HEALTH CARE	Public	CSM BS	SSS	Household	Donors	Total	Percent
I. Current Health Expenditure	2,563.95	127.53	104.04	952.42	287.68	4,035.61	90.10
Inpatient care for OI	368.33	24.86	24.86	14.34	-	428.39	9.65
Day care services	-	-	-	-	-	-	-
CCC at home	-	-	-	-	-	-	-
STI treatment	17.79	1.21	6.66	31.88	-	55.54	1.28
Outpatient care for OI	893.30	59.49	59.49	22.54	-	1,034.82	23.10
ART programme	864.73	41.97	13.02	868.21	252.71	2,049.66	45.56
Long-term care	-	-	-	-	-	-	-
PMTCT	140.13	-	-	-	-	140.13	3.13
VCT	38.32	-	-	0.42	-	38.74	0.86
Blood safety	84.32	-	-	-	-	84.32	1.88
AIDS education and life skills	41.25	-	-	-	3.97	45.22	1.07
Safer sex practices	27.17	-	-	15.02	-	42.19	0.94
IDU harm reduction	73.40	-	-	-	-	73.40	1.64
Detoxification	63.80	-	-	-	-	63.80	1.42
Prevention	9.60	-	-	-	-	9.60	0.21
Surveillance	15.21	-	-	-	-	15.21	0.34
Sero-surveillance	12.93	-	-	-	-	12.93	0.29
Behavioural surveillance	2.28	-	-	-	-	2.28	0.05
Programme administration	-	-	-	-	-	-	-
II. Health Related Expenditure	39.01	-	-	-	38.89	77.90	1.87
Education and training	-	-	-	-	65.89	65.89	1.47
Research and development	39.01	-	-	-	33.00	72.01	1.67
III. Memorandum Items (non-health expenditure)	85.66	-	-	-	-	85.66	1.91
Mitigation impact	80.66	-	-	-	-	80.66	1.80
Social research	5.00	-	-	-	-	5.00	0.11
GRAND TOTAL	2,688.61	127.53	104.04	952.42	606.57	4,479.16	100.00
Percent	60.02	2.85	2.32	21.26	13.54	100.00	

**Table 7-3.**  
**Profile of HIV and AIDS Expenditure by Major Functions 2000-2003, as a percent of total expenditure**

Major Functions	2000	2001	2002	2003
OITreatment (OP andIP)	48.6	45.1	37.8	32.8
STI treatment	1.9	1.8	1.6	1.3
ART	19.3	23.1	2.8	45.6
PMTCT	67	95	3.3	3.1
VCT	0.9	0.8	0.6	0.9
Blood safety	2.7	2.4	2.2	1.9
Condom	1.6	1.0	1.8	0.9
IDU-detoxification and rehab	3.2	1.1	1.6	1.6
Surveillance	0.6	0.5	0.4	0.3
IEC	6.0	3.7	0.8	3.2
Research and development	4.3	6.1	3.3	6.6
Mitigating impact	2.7	2.5	2.2	1.8
Program administration	1.4	2.2	1.2	0.0
Total(%)	100.0	100.0	100.0	100.0
Total current expenditure, million Baht	3,141.5	3,447.8	3,781.1	4,479.2
Total current expenditure, million US\$	78.2	77.5	87.9	107.9
Exchange rate, Baht per US\$	40.2	44.5	43.0	41.5

## NATIONAL PLAN FOR THE PREVENTION AND ALLEVIATION OF HIV/AIDS, 2002–2006

The main objective of the 2002–2006 strategic plan is to develop the capability of people, family, and communities to prevent and alleviate HIV and AIDS problems. The activities aim to develop the infrastructure and human resources to ensure that PLHAs can access health and education services.

### Strategy 1: Developing the potential of individuals, families, communities, and the broader social environment to prevent and alleviate HIV and AIDS problems.

First Picture of Success: Individuals, families, and communities are aware of their responsibilities and work together in a sustained manner to prevent and alleviate HIV and AIDS problems.

Actions:

1. Build awareness through the promotion of knowledge, the fostering of a sense of duty, and sustained HIV and AIDS prevention and alleviation work.
2. Individuals, families, and communities work together in a sustained effort to prevent and alleviate HIV and AIDS problems.
3. Develop educational curricula, activities, and schemes to improve formal and informal education for people of all age groups at all levels of the society.

Second Picture of Success: Individuals, families, and communities accept and live normally together with individuals living with HIV or AIDS.

Actions:

1. Encourage families and communities to accept and live normally together with individuals who have HIV or AIDS.
2. Support the establishment of funds to assist people living with or affected by HIV and/or AIDS.
3. Support community activities that include or involve people living with HIV or AIDS, the members of their families, and others affected by HIV or AIDS.

Third Picture of Success: Aspects of the environment that have a bearing upon the lifestyles of people in society are developed to facilitate prevention and alleviation of HIV and AIDS problems.

Actions:

1. Develop a structure of the economy that will reduce most-at-risk behavior that can result in HIV transmission.
2. Support Thai society by having religion play a central role in the lives of individuals, families, and the community.
3. Give local entertainment establishments and related individuals an important part in the implementation of activities to prevent the spread of HIV in communities.

## Strategy 2: Establishment of health and social welfare services for the prevention and alleviation of HIV and AIDS problems.

### Actions:

1. Develop counselling and mental health services.
2. Improve the quality and efficiency of medical services for people living with HIV or AIDS to assure equal access and proper treatment for all patients.
3. Develop a system of social and economic services to help improve quality of life and reach the long-term goal of self-sufficiency.
4. Promote and support mechanisms for protecting the rights of the general public, including people living with HIV or AIDS and their families.
5. Develop the healthcare system to facilitate the prevention and alleviation of HIV and AIDS problems for the general public and special target groups.

## Strategy 3: Development of knowledge and research for the prevention and alleviation of HIV and AIDS problems.

### Actions:

1. Promote and support the monitoring of the HIV and AIDS situation and the development of projections that can be used to determine HIV and AIDS prevention and alleviation policies at local and national levels.
2. Support the establishment of a work unit with expertise in research administration to determine the direction and standard of HIV and AIDS prevention- and alleviation-related research and evaluate the results of the National Plan for the Prevention of HIV/AIDS 2002–2006.
3. Support ongoing learning to strengthen capabilities to prevent and alleviate HIV and AIDS problems.
4. Support the establishment of research and development into HIV and AIDS prevention and treatment with the potential to yield results that can be appropriately applied under existing social and economic conditions. At the same time, promote investment, support the development of industrial production, and encourage the protection of human and intellectual property rights.

## Strategy 4: Fostering of international cooperation for the prevention and alleviation of HIV and AIDS problems.

### Actions:

1. Coordinate the use of foreign resources to assure that the maximum benefit is derived, in accordance with methods stipulated in the National Plan for the Prevention and Alleviation of HIV/AIDS 2002–2006.
2. Strengthen cooperation with various countries, particularly those bordering Thailand, to address the issue of cross-border labour; and protect the rights of people living with HIV and AIDS.
3. Support the international exchange of technology evaluations and scientific knowledge to prevent and alleviate HIV and AIDS problems.

## Strategy 5: Development of a holistic programme management system to integrate the tasks of HIV and AIDS prevention and alleviation.

### Actions:

1. Foster serious coordinated planning and multilateral implementation efforts to ensure that the work of preventing and alleviating the problems of HIV and AIDS in Thailand is efficiently undertaken.
2. Promote the distribution of resources and decisionmaking authority and develop multilateral checks and balances to ensure that the administration of organisations at the regional and community levels is transparent.
3. Develop mechanisms for the modification of plans to ensure systematic and efficient implementation in accordance with the plan's strategies.
4. Develop systems and mechanisms (with clear criteria for monitoring and evaluation), which can be used as tools for efficient project planning and administration.

## ESTIMATED RESOURCE NEEDS

### STI/HIV Prevention

Effective prevention programmes such as the 100% Condom Programme, PMTCT, STI screening and treatment, universal HIV screening in blood services, and universal precautions in healthcare services have contributed to a decrease in the incidence of HIV. To further reduce incidence, prevention activities need to focus on the most vulnerable groups: MSM, IDUs, female SWs (high frequency and low frequency) and their clients, and youth. The resources required for prevention are allocated to target groups (see Figure 7-4) and interventions (see Figure 7-5). The exchange rate for the figures is 1 US\$ = 40 Baht.

**MSM.** From 2003 to 2005, HIV prevalence among MSM in Bangkok increased from 17 to 28 percent (UNAIDS, 2006). Interventions directed at MSM target three subgroups: male SWs; non-SWs; and hidden MSM (MSM who may not identify themselves as MSM). Three main interventions for all the subgroups relate to condom provision, outreach, and STI treatment. In 2006 and 2010, the estimated costs of reaching MSM was 53.5 million Baht (US\$1.34 million) and 137 million Baht (US\$3.4 million), respectively. The percentage of hidden MSM is approximately 15 percent of the total MSM population.

**IDUs.** HIV prevalence among IDUs has been high since the start of the epidemic. A new scheme of activities aimed to reduce the sharing of needles and maintain treatment has been revised and expanded. The two main activities for this population relate to drug substitution and condom provision. In 2006 and 2010, an estimated 39 million Baht (US\$.97 million) and 67 million Baht (US\$1.7 million), respectively, will be needed to implement these activities (see IDUs in Figure 7-4). The government does not support needle and syringe exchange programmes (NSEPs) or clean needle programmes. However, there are pilot sites for NSEPs in Bangkok that are supported by an NGO.

**Female SWs and their clients.** Although the 100% Condom Programme is still in effect all over Thailand and condoms are provided free of charge to SWs who need them, the need for rapid expansion of HIV prevention activities to reach both

direct and indirect SWs is increasingly important. The pattern of sex work has shifted toward a more indirect type of service and more freelance SWs have been observed during recent years. The interventions and activities for HIV prevention among this group must be adapted to the new situation. The estimated costs required for female SWs are divided into two categories according to the frequency of sexual acts. Activities for direct SWs (high-frequency) (HF-SW)

Figure 74. Resources Required for Prevention, by Target Groups

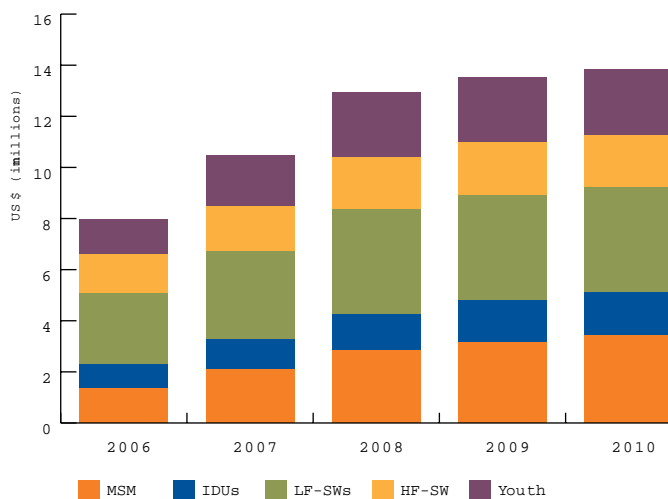
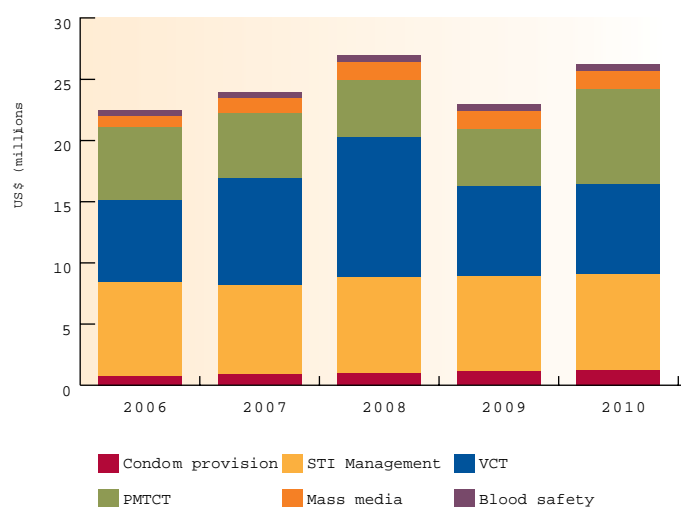


Figure 75. Resources Required for Prevention by Intervention





Three field coordinators use a flip chart to educate members of a brothel about HIV and AIDS in Chiang Rai, Thailand.

and indirect SWs (low-frequency) (LF-SW) are the same and consist of two main interventions related to condom provision and outreach. In 2006 and 2010, the estimated costs for reaching direct SWs are 60 million Baht (US\$1.5 million) and 82 million Baht (US\$2.1 million), respectively; the estimated costs of reaching indirect SWs are higher at 111 million Baht (US\$2.8 million) and 164 million Baht (US\$4.1 million).

Youth as a cross-cutting population. There is evidence to suggest that young people are at increased risk of HIV infection. Many studies conducted in recent years indicate that the age at first sex is earlier than it was in the past. There is a higher frequency of young people having sex with their friends and partners, without using a condom. In addition, reports of STIs among young people have also increased during the past few years. All of this information indicates an urgent need to prevent HIV transmission among youth. Thus, the estimated costs of implementing prevention activities for youth (training teachers; providing peer counselling for in-school youth and out-of-school youth) are 55.6 million Baht (US\$1.4 million) in 2006 and 103 million Baht (US\$2.6 million) in 2010.

It is well known that discordant couples are also at risk of contracting HIV. Many partners of people living with HIV do

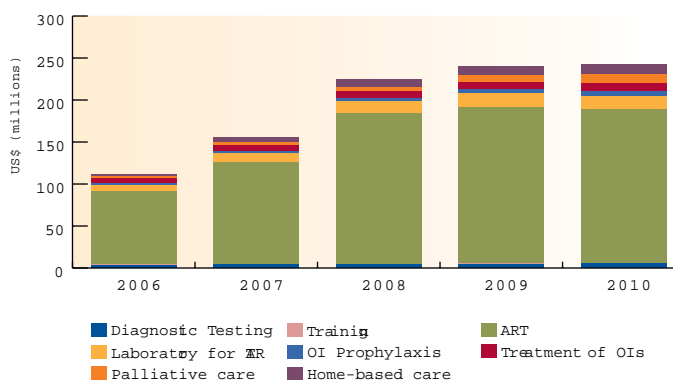
not even know their status. Thailand plans to expand VCT services and provide condoms for all HIV-positive individuals. According to the resource needs exercise, the estimated cost of VCT activities is 268 million Baht (US\$6.7 million) in 2006, increasing to 295 million Baht (US\$7.4 million) in 2010 (see Figure 7-5). STI management increases slightly from 307 million Baht (US\$7.67 million) to 311 million Baht (US\$7.77 million) between 2006 and 2010; condom provision costs 30 million Baht (US\$750,000) in 2006 and 50 million Baht (US\$1.3 million) by 2010. The costs of mass media are estimated at 34 million Baht (US\$851,000) in 2006 and 58 million Baht (US\$1.5 million) by 2010.

### Care and Treatment

The ARV programme in Thailand began in 2001, and by 2006 there were 508,300 people living with HIV who needed treatment, including 17,000 new cases (Ministry of Public Health, 2002). Universal access to comprehensive and high-quality treatment services will be available by the end of 2010. The strategic plan outlines activities to meet the goal of universal access. For example, one of the key activities is increasing VCT, as not all HIV-positive people know their status. Access to VCT is crucial in terms of strengthening the prevention programme and early care and support for those in need.

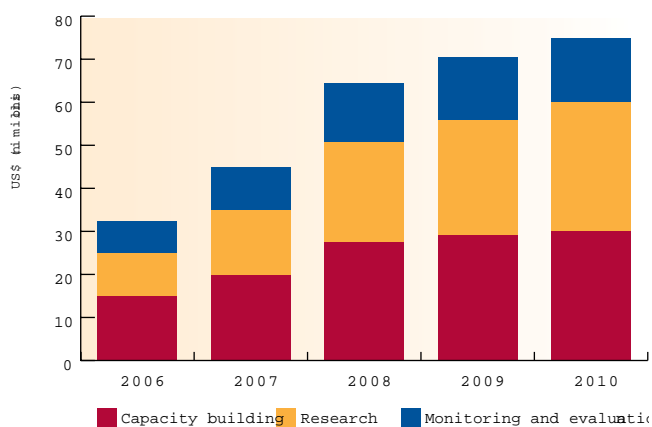
In 2006, the ARV programme was included in the national health insurance scheme. Figure 7-6 shows that the cost of care and treatment increases quickly from 2006 to 2008 due to the number of patients that can access treatment and the cost of second-line regimens. Until recently, the ARV programme has provided the first-line ARV regimen to Thai people. The increasing demand of the second-line regimen has grown year by year. The estimation consists of several factors: cost for toxicity therapy (complication), ARV-TB treatment, and the first- and second-line regimens. ART has the highest cost under care and treatment: in 2006 and 2010, the estimated costs for ART are 3.5 billion Baht (US\$87.7 million) and 7.3 billion Baht (US\$182 million), respectively. The second largest cost is for laboratory services, as the government provides the following tests: CD4, viral load, drug resistance testing, and basic screening tests (CBC, LFT, etc.). The estimated costs for

Figure 7-6.  
Resources Required for Care and Treatment



Laboratory for ART in 2006 and 2010 are 283 million Baht (US\$7.1 million) and 643 million Baht (US\$16.1 million), respectively. Finally, the combined cost for OI treatment and prophylaxis increases from 318 million Baht (US\$8.0 million) in 2006 to 615 million Baht (US\$15.4 million) in 2010. HIV diagnostic testing increases from 136 million Baht (US\$3.4 million) to 219 million Baht (US\$5.5 million) between 2006 and 2010. The cost of both home-based care and palliative care increases fourfold over the five-year period because the number of HIV-positive people needing care increases rapidly. The combined cost of home-based and palliative care increases from 218 million Baht (US\$5.4 million) in 2006 to 873 million Baht (US\$21.8 million) in 2010.

Figure 7-7.  
Resources Required for an Enabling Policy Environment: Capacity Building, Research, and M&E



### Policy and Administration

The total estimated cost for policy and administration increases from 1.3 billion Baht (US\$32.4 million) in 2006 to 3 billion Baht (US\$75 million) in 2010 (see Figure 7-7). These activities include the costs of capacity building, research, and monitoring and evaluation. Implementation of the National AIDS Prevention and Alleviation Plan 2002–2006 has been challenged by a drastic change in national financial planning and management in Thailand in that it has been shifted from a vertical to an integrated programme.

### Mitigation

The Thai government has committed to providing ART for HIV-positive children and scholarships for 13,000 children orphaned by AIDS. The cost of mitigation and orphan support was calculated based on the following: cost per primary student, cost per secondary student, and cost of economic support. Figure 7-8 shows that the estimated costs for mitigating the impact of HIV and AIDS among orphans increases from 280 million Baht (US\$7.0 million) in 2006 to 700 million Baht (US\$17.5 million) in 2010.

Figure 7-8.  
Resources Required for Mitigation/Orphan Support

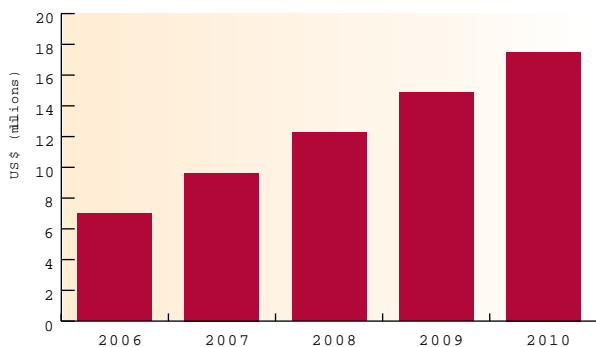


Figure 7-9. Total Resource Required

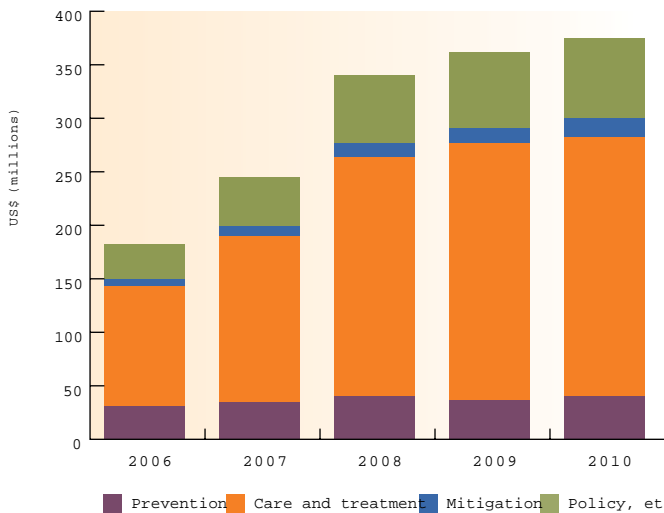
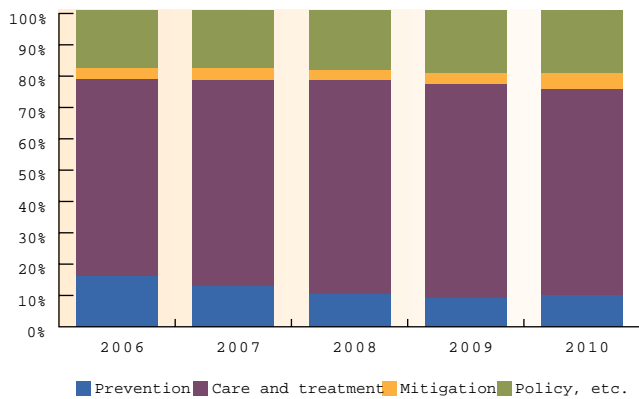


Figure 7-10. Share of Total Resources Required



### Total Resource Requirement

The total cost for all interventions, including prevention, care and treatment, mitigation, and policy is estimated at 7.3 billion Baht (US\$182 million) in 2006 and 15 billion Baht (US\$375 million) in 2010. Costs of prevention, mitigation, and policy increase slightly over the five-year period, while the cost of care and treatment increases dramatically (see Figures 7-9 and 7-10). However, the proportion of each cost category is relatively stable.

### Gap Analysis

To illustrate the gap between resource needs and resource availability over the next five years, the NAA was used to project the expected government expenditure (assuming the

trend from historical spending continues) and compare it with the level of resources needed.

**Prevention.** Resource availability for prevention between 2006 and 2010 is based on the NAA 2000–2004, assuming an average annual increase in resources of approximately 19 percent between 2004 and 2010. According to this assumption, the level of resources needed will exceed the resources available until 2008, but thereafter, the level of resources available would exceed the resources needed (see Figure 7-11).

**Care and treatment.** The gap for care and treatment resources is widest in 2008 (US\$3.7 billion) and decreases slightly by 2010 (see Figure 7-12). Rapidly increasing care and treatment costs is an unavoidable situation. Therefore, the government needs to focus its efforts on interventions such as monitoring at service delivery points in the community, reducing ARV and OI drug prices, and collaborating with networks of people living with HIV to ensure early care and treatment.

The overall resource gap stems mainly from the costs of care and treatment. According to this analysis, only between 58 percent and 74 percent of resources required between 2008 and 2010 will be attained (see Figure 7-13).

Figure 7-11. Gap Between Prevention Resources Needed and Resources Available

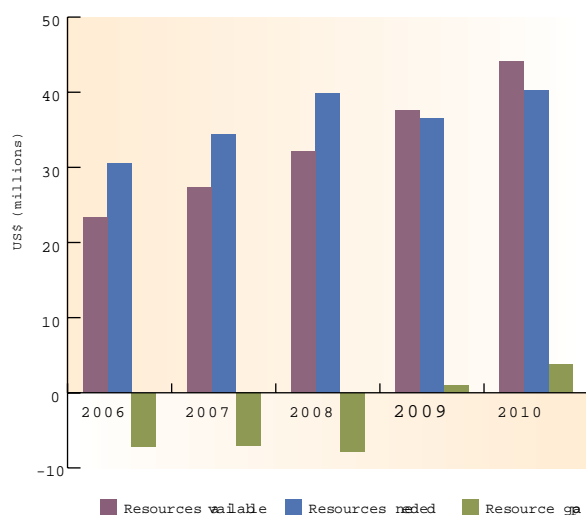




Figure 7-12.  
Gap Between Care and Treatment Resources Needed and Resources Available

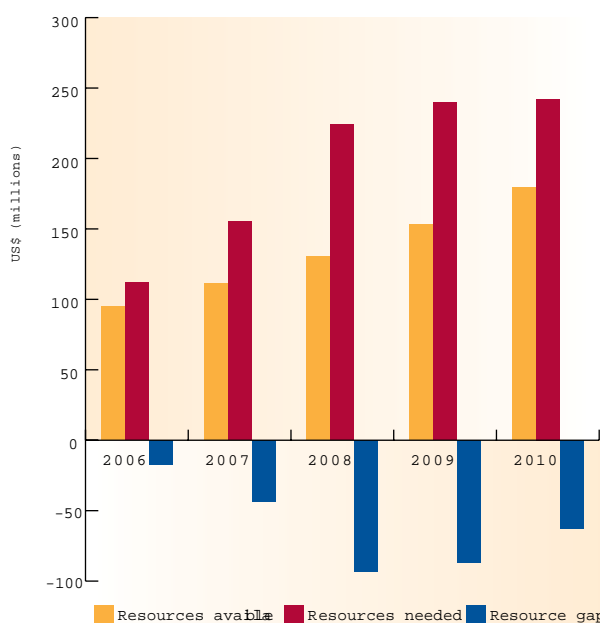
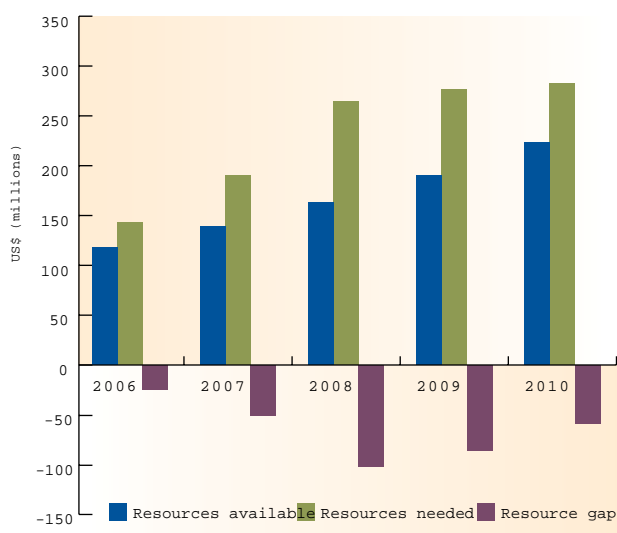


Figure 7-13.  
Gap Between Overall Resources Needed and Resources Available



## KEY POLICY ISSUES AND NEXT STEPS FOR MITIGATION

As shown in this analysis, much effort is being made to mitigate the impact of HIV and AIDS. However, a number of challenges remain. There is still a gap between the resources available and the resources required, thereby emphasising the importance of mobilising resources from all sources and allocating resources efficiently and effectively. Scarce national resources should be optimised by allocating to interventions that are proven to be cost-effective. The NAA in Thailand has provided invaluable information on resource tracking and will facilitate decisionmaking on future spending for the HIV and AIDS programme.

Currently, prevention programmes in Thailand consume only a small fraction of the resources targeted for HIV and AIDS (US\$10 million out of US\$80 million) and financial allocations under the 30 Baht scheme are sometimes diverted into hospital treatment costs. These costs need to be included in budget line items, especially for most-at-risk groups, such as IDUs and MSM, whose behaviour is driving the epidemic.

With an increasing number of people gaining access to ART, it is extremely important that international trade negotiations on TRIPS and other agreements that impinge on the future cost of second-line and third-line ARVs be conducted with great care. Despite implementation of universal coverage, the NAA analysis showed that households still shoulder a significant proportion of expenditure on ART. Many HIV-positive people who began ART several years ago and who are now taking second- or third-line regimens have not been adequately covered by the national ART programme. Efforts need to be made to ensure funding is available to guarantee HIV-positive people continued access to treatment.

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## VIII. VIET NAM

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PHOTO CREDITS

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**D**uring the 1990s, the HIV epidemic spread quickly in Viet Nam. As of September 2005, Viet Nam had recorded 100,791 people living with HIV, although the estimates of the Viet Nam Administration of HIV/AIDS Control (VAAC) put the figure between 200,000 and 250,000. Major factors contributing to the epidemic include a thriving commercial sex industry in which condom use is not the norm and SWs are not reached by prevention programmes; frequent population migration; injecting drug use and needle sharing; substantial sexual links among IDUs and communities that have limited risk otherwise; limited public discussion of HIV and AIDS; and pervasive stigma.

The HIV epidemic in Viet Nam is in the concentrated epidemic stage. HIV has spread rapidly in specific most-at-risk groups, particularly among IDUs, SWs, and MSM; however, it is not yet well established in the rest of the population. It is important to note that the current status of the epidemic does not mean that it is compartmentalised or restricted to these groups. Links between most-at-risk groups and the rest of the population will determine the future course of the epidemic.

HIV and AIDS effects social and economic development at many levels: individual, household, community, business,

governmental, and macroeconomic. When a family member develops AIDS-related illnesses, his or her family faces increased expenditures for care and often must sell household assets. Other family members may need to stay home from school or work to provide care. When a family member dies from AIDS-related causes, the resulting loss of income can push a non-poor family into poverty. Children often suffer the most when a parent dies from AIDS-related causes. They lose the care and support of a parent and may be withdrawn from school. The loss of educational opportunities can permanently hinder future employment prospects.

The health sector is affected by the growing HIV epidemic in several ways. There is an increased demand for health services—to provide care and treatment for those who are infected and to support prevention efforts. Health sector expenditures related to HIV and AIDS care and prevention are likely to increase 20-fold in the next 10 years. The additional expenditure and attention to HIV and AIDS may reduce the resources available for other health priorities.

Substantial macroeconomic changes could occur if the epidemic becomes much worse. Deaths of productive workers and increased costs of healthcare, recruitment, and training can seriously erode profits and reduce international competitiveness. However, these effects may not be substantial if the epidemic can be controlled.

There is a clear need for urgent action, including the following:

- A comprehensive programme of HIV prevention interventions based on best practices from the region;
- The provision of care and treatment for PLHAs;
- Mobilisation of human and financial resources via a coordinated multisectoral response;
- Increased community participation by vulnerable groups and people affected by HIV or AIDS in the policy and programme dialogue crucial for the design of high-quality, user-friendly services; and
- An in-depth assessment of the social and economic effects of HIV and AIDS to inform the preparation of national development plans and poverty reduction strategies.

## COUNTRY PROFILE

Population (2006): 84,238,000<sup>a</sup>

Gross national income (2004): US\$540 per capita<sup>b</sup>

HIV prevalence (2006): 0.5%<sup>a</sup>

HIV prevalence among most-at-risk groups:

Sex workers in urban areas: 11.5%

Injecting drug users in urban areas: 72.25%

Men who have sex with men in urban areas: 5.8%

Number of adults living with HIV(2006): 250,000<sup>a</sup>

Number of women living with HIV(2006): 84,000<sup>a</sup>

New HIV infections: n/a

AIDS-related deaths (2006): 13,000<sup>a</sup>

Sources: <sup>a</sup>UNAIDS, 2006; <sup>b</sup>World Bank, 2005

## SOCIOECONOMIC IMPACT OF HIV AND AIDS

### HIV and AIDS Situation

In Viet Nam, after the first HIV-positive person was detected in 1990, the HIV epidemic has gradually spread throughout all 64 provinces. According to the VAAC, by September 2005, a cumulative total of 100,800 cases of HIV infection had been reported across the country. In addition, 16,464 AIDS cases had been reported—of which 9,540 had resulted in death. It is estimated that the number of AIDS cases will reach 31,000 by 2010. Quang Ninh province, Hai Phong province, Ho Chi Minh City, Ba Ria-Vung Tau province, An Giang province, and Ha Noi are reported to have the highest prevalence rates.

The majority of HIV-positive people in Viet Nam are also IDUs; the prevalence rate among this group rose from 9.4 percent in 1996 to 27.7 percent in 2003. Rates of HIV infection via sexual transmission are increasing. Among SWs, rates of HIV infection rose from negligible in 1994 to 7.81 percent in 2001 (UNAIDS and WHO, 2004). Among pregnant women, HIV prevalence rose from .02 percent in 1997 to 0.5 percent in 2001. HIV infections have been found in many groups, spreading to peasants, students, army conscripts, and state employees.

### Impact of HIV and AIDS

A study conducted in 2005 showed that the total healthcare expenditure for a household with a person living with HIV or AIDS was 13 times higher than the average household healthcare expenditure in Viet Nam. Seventy-five percent of PLHAs interviewed required the assistance of caregivers for roughly five hours a day. Twenty-four percent of all caregivers reported having to give up their job and 36.2 percent experienced a significant monthly income reduction. Two-thirds of households with a PLHA that died reported having difficulty with paying for basic services such as food, education, healthcare, electricity, and transport. The most common form of coping is borrowing money, followed by reducing food and healthcare consumption (UNDP, 2005).

HIV and AIDS also puts pressure on the healthcare sector, especially the public sector. The preventive health system is dealing with various diseases and the difficult task of HIV prevention and control. Hospital-based care and treatment for HIV or AIDS is limited. The primary constraint is funding.

The advent of HIV has negatively impacted the poverty reduction efforts of Viet Nam. The UNDP reports that a large share of households with a PLHA will fall below the poverty line. As a result, HIV and AIDS reverses economic gains made by some households and drives the poor deeper into poverty. Simulations indicate that in 2004, 126,000 people either became newly poor or were driven deeper into poverty as a result of HIV and AIDS. Rising HIV prevalence over the next decade could increase this number to half a million by 2015 (UNDP, 2005).

## NATIONAL AIDS SPENDING

From the beginning of the epidemic, the government has allocated the following funding to the HIV and AIDS programme:

- 1990–1993: US\$0.7 million (VND 11.1 billion) for 4 years
- 1994: US\$2.5 million (VND 40 billion)
- 1995–1999: US\$2.8 to 3.5 million (VND 45–55 billion) per year
- 2000–2003: US\$3.8 million (VND 60 billion) per year
- 2004: US\$5 million (VND 80 billion) per year

These funds were allocated to more than 15 different operations in many ministries and provinces. Besides the State budget allocations, a number of provinces and municipalities have provided supplementary local budget allocations to the programme, including Ho Chi Minh City, Ha Noi, and Hai Phong. Nevertheless, many provinces have not yet made any contributions to the HIV and AIDS prevention and control programme in their localities (Government of Viet Nam, 2004).

The largest increase in HIV and AIDS spending between 2002 and 2004 can be attributed to donor funding, which, during this period, totaled US\$16.4 million (VND 259.3 billion). This amount accounted for 44.9 percent of the total HIV and AIDS expenditure in Viet Nam. Donor-funded HIV and AIDS expenditure increased from US\$15,000 (VND 0.2 billion) in 2000 to US\$8.1 million (VND 128 billion) in 2004. The largest annual increase (61.5%) was in 2004 (VAAC, 2005).

Household expenditure on HIV and AIDS is not reported here because the data is unavailable. However, the largest proportion of total health spending in Viet Nam is borne by households, suggesting that household spending on HIV and AIDS is substantial.

The total HIV and AIDS expenditure in Viet Nam from 2000 to 2004 was US\$36.5 million (VND 579.3 billion). As Table 8-1 shows, total expenditure in 2000 was US\$3.8 million (VND 60.2 billion) and increased to US\$13.1 million (VND 208 billion) in 2004. HIV and AIDS spending in Viet Nam on average during this period, as a share of total health expenditure, ranged from 3 percent to 5 percent (VAAC, 2005).

## NATIONAL STRATEGIC PLAN FOR A SCALED-UP RESPONSE TO HIV AND AIDS

Since the detection of the first case of HIV in 1990, Viet Nam has formulated and implemented the 1993–1996 and 1996–2000 medium-term plans for HIV prevention and control. In March 2004, the Prime Minister approved the first National Strategy on HIV/AIDS Prevention and Control up to 2010, with a Vision to 2020. The strategy promotes a multisectoral response to HIV and AIDS and mobilisation of the whole society. It puts forth the direction, priorities, and programmes for HIV prevention and control for 2004–2010, with a vision to 2020.

The Central Party Committee issued a Directive on HIV prevention and control in March 1995. In May 1995, the Standing Committee of the IXth National Assembly adopted the Ordinance on HIV/AIDS Prevention and Control, which has served as a legal basis for the related activities. The National Assembly has paid special attention to HIV and AIDS prevention and control: the Standing Committee received HIV and AIDS reports and the Committee for Social Affairs

Table 8-1 HIV and AIDS Funding by Source

Year	2000		2001		2002		2003		2004		2005	
	US\$ million	%	US\$ million	%	US\$ million	%	US\$ million	%	US\$ million	%	US\$ million	%
Government	3.8	99.7	3.8	92.6	3.8	48.4	3.8	49.1	5.0	38.5	5.5	34.4
International NGOs, bilateral donors, and United Nations agencies	0.03	0.3	0.3	7.4	4.0	51.6	3.9	50.9	8.1	61.5	10.6	65.6
Total	3,798,017		4,088,328		7,823,344		7716,088		13,128,028		16,108,000	

Source: Internal NAC report to the government in November 2005.



organised meetings at the central and regional levels to discuss related policies and the strengthening of the National Assembly's function in supervising HIV prevention and control programmes in previous years. The participation of the community, socio-political organisations, and religious organisations has been increasing. While there are policies that allow for a comprehensive response to HIV and AIDS, the real challenge that remains is implementation of the National Strategy on HIV/AIDS Prevention and Control up to 2010, with a Vision to 2020, and its nine action plans.

### Behaviour Change Communication (BCC) (Action Plan 1)

Efforts aimed at only individuals will not achieve behaviour change and must be complemented by campaigns to achieve social and community change. Prevention campaigns should include messages to increase knowledge and awareness of the modes of HIV transmission with messages to reduce most-at-risk behaviour. The goals are to

- Make full use of existing communication channels to disseminate knowledge on HIV prevention and control to the population, particularly most-at-risk groups;
- Organise large-scale communication campaigns nationwide at least twice a year and integrate education and communication on the prevention of HIV transmission into major political, economic, cultural, and social events;
- Build individual skills in HIV and AIDS prevention and care and use appropriate approaches to reach specific groups for communication and mobilisation, paying more attention to face-to-face and small group communication and peer education; and
- Raise the quality and quantity of communication material and messages—focus on content that leads to behaviour change suitable to each target group.

### Interventions Targeting High-risk Groups (Action Plan 2)

Harm reduction interventions are considered key elements of HIV prevention activities in Viet Nam, where about 70 percent of HIV-positive people are IDUs (including SWs using injection drugs) (NIHE, 2005).

To ensure uniform direction and implementation, the programme should begin by amending and supplementing legal documents related to intervention activities for risk reduction and the prevention of HIV transmission. Comprehensive risk-reduction interventions should include HIV and AIDS education; life skills training; 100 percent condom use programmes; drug substitution programmes; and VCT in high-prevalence areas with large numbers of IDUs and SWs.

Peer education and outreach programmes have been implemented in Viet Nam since 1994. However, only minimal services for IDUs are currently available, and 95 percent of IDUs relapse after rehabilitation. The programmes should be expanded among most-at-risk groups such as IDUs and SWs—both inside and outside rehabilitation centres—to reduce needle sharing and promote proper use of condoms for sexual intercourse.

VCT is critical as a motivational behaviour change tool and as an entry point to support services and early medical care for OIs; ART; preventive therapy for TB; and prevention/treatment for STIs. The literature suggests that VCT is more effective at reducing most-at-risk behaviour than IEC efforts alone (Coates et al., 1997). Although more than one million blood samples were tested for HIV between 2000 and 2004, VCT services need to be marketed, and training in counselling is needed. It is important that referral systems be established for appropriate palliative and curative services.

### Care, Support, and Treatment (Action Plans 3, 5)

With a current estimate of about 200,000 PLHAs, the number of PLHAs in Viet Nam is projected to increase in the near future, necessitating an increase in available high-quality care and treatment. Providing care and treatment for PLHAs adds years of economic productivity that, in turn, supports and protects the families of PLHAs (MacNeil and Anderson, 1998).

The Viet Nam medical system is facing serious challenges at the national and provincial levels in gearing up for the treatment of an increased number of PLHAs. An evaluation

of the Viet Nam national AIDS programme highlighted a lack of infrastructure, equipment for the diagnosis of opportunistic diseases and follow-up treatment, medicine for specific treatment, and staff training. Community- and home-based models of care need to be systematically designed and implemented, and minimal care packages need to be produced and distributed. It will be equally important to establish partnerships among public health and medical authorities, PLHAs, NGOs, and communities to provide an adequate range of care and treatment services on a large scale. Greater attention must be given to ways that care and prevention activities can be integrated to increase the effectiveness and efficiency of interventions. Linking care and prevention activities seems particularly relevant in programmes involving children, adolescents, and women.

### Surveillance and M&E and STI Management (Action Plans 4, 7)

Action Plan 4 will address the need to coordinate HIV, STI, and behavioural surveillance. Early warning systems need to be integrated to identify emerging risks and prevention needs. Data on the cost-effectiveness of interventions, which currently are not collected, are critical to the strategic allocation of resources. Situation analysis and monitoring of the type and severity of individual, household, and sector problems caused by HIV are also essential to planning and implementing effective interventions.

Action Plan 7 will also help to integrate STI services into health systems—such as primary healthcare, maternal and child health, family planning, and other appropriate services—to increase coverage among sexually active adults and SWs. Given that the contraction of HIV is more likely to occur among individuals who have other STIs, reducing STI transmission, particularly among SWs and their clients, is an effective way to help contain the spread of HIV in Viet Nam.

### PMTCT (Action Plan 6)

Action Plan 6 is intended to promote PMTCT programmes; safe sexual behaviour, especially for women of reproductive age; HIV testing before marriage; and HIV counselling before delivery. The action plan includes the provision of treatment



A newborn child sleeps next to his mother at the Tinh Gia District Health Centre in Viet Nam.

to prevent mother-to-child transmission during labour and delivery and ensures adequate treatment and drugs to address the OIs of HIV-positive children.

### Blood Safety, Capacity Building and International Cooperation, Occupational Post-Exposure Prophylaxis, and Safe Injection and Universal Precautions (Action Plans 8, 9, and Others)

To ensure the safety of blood transfusion, joint efforts of the Red Cross Society, the Youth Union, and other entities dealing with blood transfusion must be mobilised to consistently maintain a source of safe blood donors and encourage people with a low risk of infection to voluntarily donate blood. This action plan is intended to promptly provide high-quality bioproducts for blood screening to ensure 100 percent of blood units and blood products are screened for HIV before transfusion.

Figure 8-1. Resources Required by Action Plan

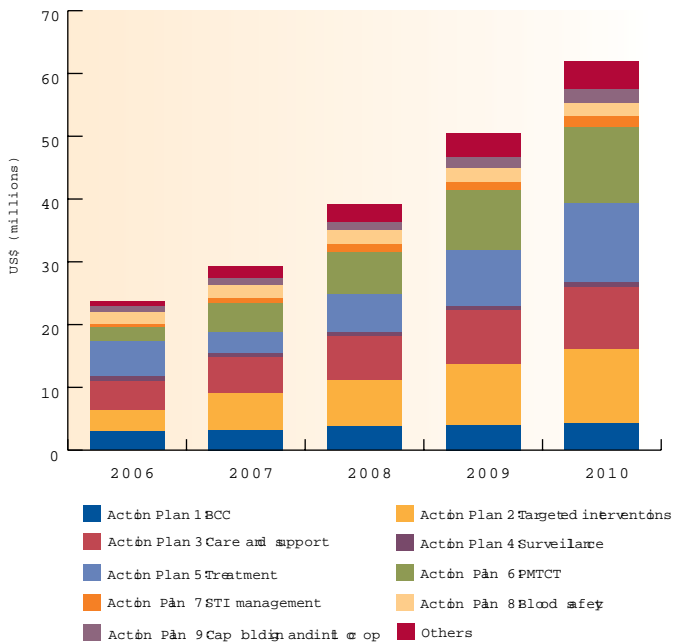
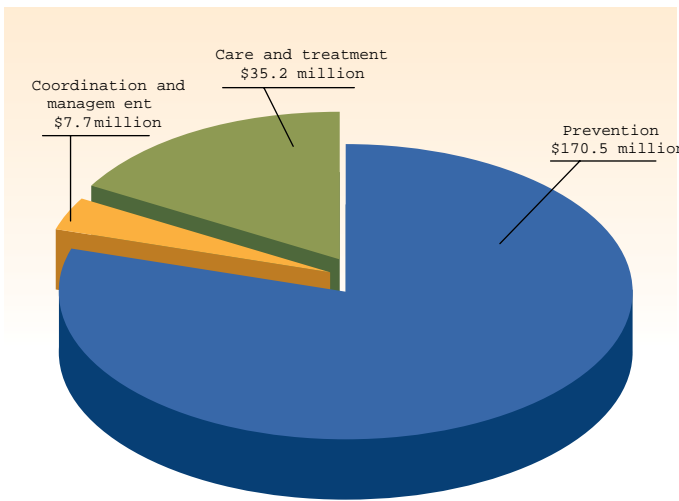


Figure 8-2. Resources Required by Intervention Category 2006–2010 US\$



The prevention of HIV transmission among medical and social service workers can be improved by expanded dissemination of information on universal precautions and the prompt provision of ARV prophylaxis for healthcare workers exposed

to HIV infection. This action plan will supply sterilisation and disinfection equipment for medical establishments, especially those at district and commune levels, and ensure that all private medical establishments have sufficient equipment and supplies for sterilisation in their hospitals.

### RESOURCE NEEDS FOR HIV AND AIDS PROGRAMMES

The Resource Needs Model was adapted to determine the funds required to implement the National Strategy on HIV/AIDS Prevention and Control in Viet Nam up to 2010, with a Vision to 2020. The interventions captured in the model were organised under the nine action plans of the strategy discussed in the previous section. Data inputs used in the model have been verified with national institutions, including the National Institute for Hygiene and Epidemiology and VAAC. The resource requirements for each action plan are summarised below by type of intervention (also see the Appendix).

#### Total Resources Required

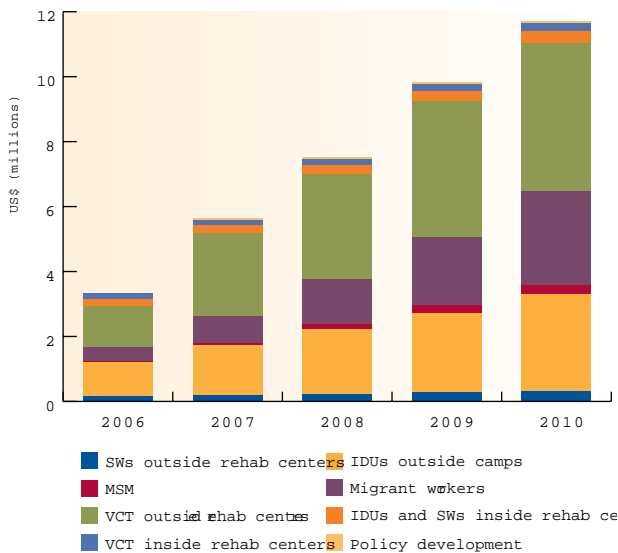
Figures 8-1 and 8-2 show the total resource requirement to implement the components of the national strategy from 2006–2010. It is estimated that in 2006, US\$24.0 million (VND 380.2 billion) will be required. The projected requirement for 2010 is US\$61.8 million (VND 978.7 billion). As illustrated in Figure 8-1, the largest amounts of resources are required for Action Plan 2: Interventions Targeting High-risk Groups and Action Plan 5: Treatment (each are 18 percent of the total). Two other action plans that require substantial resources are Action Plan 3: Care and Support and Action Plan 6: PMTCT (each are 17 percent of the total).

Figure 8-2 shows the total resource requirement broken down by prevention, care and treatment, and coordination and management. Prevention is the largest component of the plan by far, requiring US\$170.5 million from 2006–2010.

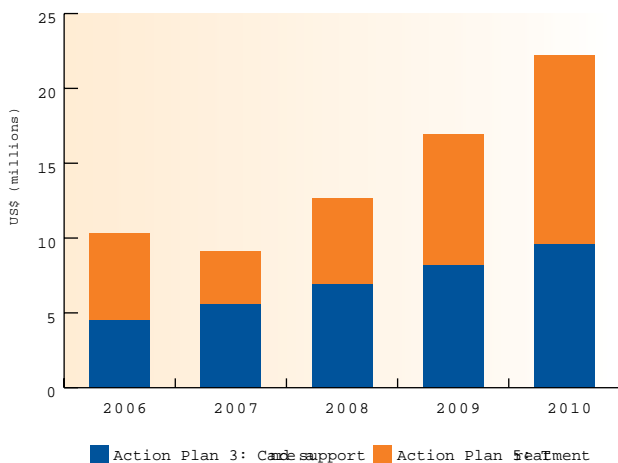
#### Resource Requirements for Action Plan 1: Behaviour Change Communication

This action plan contains advocacy, activities to improve the policy environment, training, and mass media activities. It

**Figure 83. Resources Required for Action Plan 2**



**Figure 84. Resources Required for Action Plans 3 and 5**



aims to reach policymakers and lower risk groups to create a supportive environment for HIV and AIDS interventions. To implement the plan, US\$3.2 million (VND 50.0 billion) will be needed in 2006, and to reach the established targets, this amount must increase to US\$4.6 million (VND 73.4 billion) in 2010. During 2006–2010, about 10 percent of the total

estimated resource requirement for the strategy is needed for this plan's activities.

### Resource Requirements for Action Plan 2: Interventions Targeting Most-at-risk Groups

Action Plan 2 includes peer education and outreach programmes directed at SWs, IDUs, MSM, and migrant workers; as well as condom provision, VCT, peer education and VCT programmes targeting SWs and IDUs in rehabilitation centres, and the development of an enabling policy and legal environment.

As shown in Figure 8-3, to implement the action plan, it is estimated that US\$3.3 million (VND 52.9 billion) will be required in 2006, increasing to US\$11.6 million (VND 183.5 billion) in 2010. Based on the present assumptions about coverage and target population size, the largest share of resources will be consumed by VCT programmes targeting most-at-risk groups such as IDUs and SWs; the programmes will use 42 percent of the resources in 2006 and will continue to require the largest share through 2010—when their share will be 41 percent. During 2006–2010, peer education directed at IDUs will consume, on average, more than a fourth of resources required for Action Plan 2 (32% in 2006 and 25% in 2010). On average, interventions targeting migrant workers will consume about 18 percent.

### Resource Requirements for Action Plan 3 and 5: Care, Support, and Treatment

Action Plan 3 and Action Plan 5 focus on improving access to the treatment of OIs and ART. Care and support centres have been identified as the ideal method of expanding care and support to PLHAs in Viet Nam. A combination of out-patient care and prevention services are available at the centres. Only the costs of out-patient services at these centres are considered here (out-patient services are also delivered to PLHAs at provincial general hospitals).

Figure 8-4 shows the resources required for care and support, the prophylaxis of OIs, and ART. It is estimated that in 2006, US\$4.6 million (VND 73.3 billion) is needed for out-patient care and support and OI prophylaxis services delivered at the various out-patients sites, increasing to

US\$9.6 million (VND 152.7 billion) in 2010. The cost of ART will be US\$5.7 million (VND 90.6 billion) in 2006 and US\$12.6 million (VND 200.2 billion) in 2010. In 2006 and 2010, these plans will use 31 percent and 36 percent, respectively, of the total resources required.

### Resource Requirements for Action Plan 4 and 7: Surveillance and M&E and STIs Management

Action Plan 4 consists of HIV and behaviour surveillance and monitoring and evaluation activities, while Action Plan 7 includes STI management. The total resource requirement for these activities is estimated to be US\$731,000 (VND 11.6 billion) in 2006 and US\$888,000 (VND 14.1 billion) in 2010. The smallest share of the total is taken up by Action Plan 7: 1.9 percent of the total resource required in 2006 (US\$450,000 or VND 7.1 billion) and 2.7 percent of the resources required in 2010 (US\$1.1 million or VND 26.2 billion).

### Resource Requirements for Action Plan 6: PMTCT

As stated in Action Plan 6, the goal is to increase coverage of HIV-positive pregnant women with PMTCT services to 70 percent in 2006 and to 83 percent in 2010. Based on this target, the resource requirement for Action Plan 6 was estimated to be US\$2.0 million (VND 31.6 billion) in 2006 and US\$11.9 million (VND 188.6 billion) in 2010. The largest portion of resources will be required for counselling and testing. Although the PMTCT package (VCT, PMTCT, and infant formula) has a low unit cost (US\$11 per person), the plan's intention is to test all pregnant women for HIV.

### Resource Requirements for Action Plan 8, 9, and Others: Blood Safety, Capacity Building and International Cooperation, Occupational Post-Exposure Prophylaxis, and Safe Injection and Universal Precautions

Figure 8-5 shows the total resource requirement for Action Plans 8, 9, and others to be US\$2.0 million, US\$0.9 million, and US\$1.1 million (VND 32.1 billion, VND 14.4 billion, and VND 16.7 billion) in 2006 for each of the action plans, respectively. These amounts are projected to increase to US\$2.1 million, US\$2.1 million, and US\$4.6 million (VND

Figure 85. Resources Required for Action Plans 8, 9, and Others

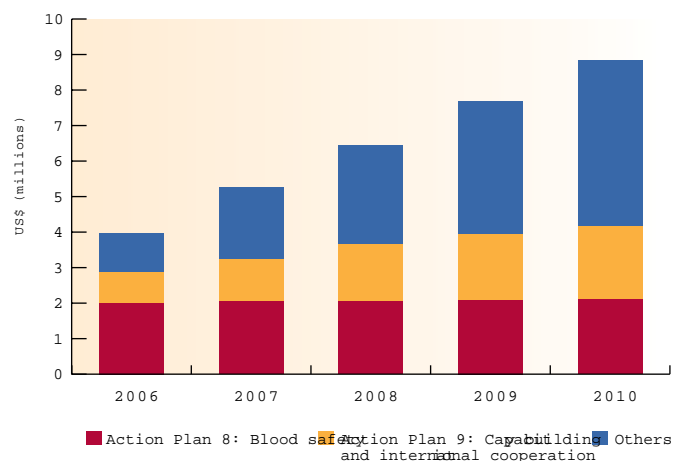
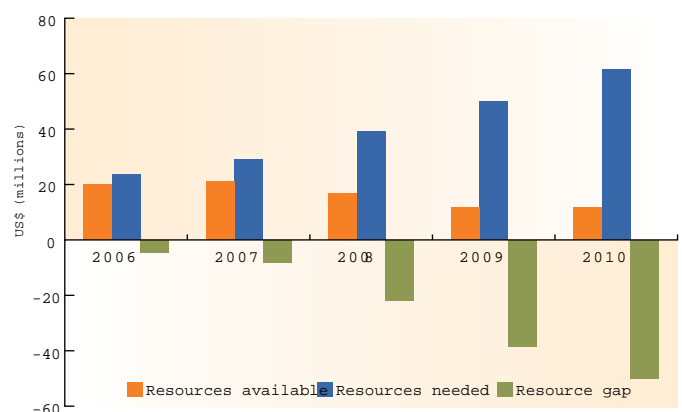


Figure 86. Resource Gap Analysis



33.6 billion, VND 32.8 billion, and VND 73.6 billion) by 2010, respectively.

### Resource Gap Analysis

The availability of resources, including government and international resources committed for 2006–2010, was calculated. Based on this calculation and the aforementioned estimated requirements, Figure 8-6 shows the projected resource gap through 2010. If no additional resources become available, the estimated needs will not be met in 2006, leaving a shortfall of US\$4.2 million (VND 65.9 billion). In 2010, the resource gap will be US\$49.7 million (VND 787.8 billion)—equal to 80 percent of the total resource needs.

## KEY POLICY ISSUES AND NEXT STEPS TO ADDRESS ISSUES

**W**ith the attention of the Communist Party, National Assembly, and government—combined with the great efforts made by other national and local government entities, community organisations, and localities—HIV prevention and control activities have been fully carried out through IEC campaigns on the prevention and control of HIV transmission resulting from drug injection and prostitution; and through technical activities such as epidemiological surveillance, blood transfusion safety, treatment, and PMTCT. However, the HIV epidemic still poses a serious danger. Therefore, it is necessary to have policies and commitments from national and subnational leaders and the community.

Viet Nam is under the leadership of the Communist Party so its role is important in the leadership and direction of HIV prevention and control activities. The Party committees shall regularly supervise, encourage, examine, and direct HIV prevention and control activities and include these activities as priorities within the socioeconomic development strategy. The Party shall promulgate directives guiding the activities. The Party congresses should discuss the related issues and include these issues in their official documents, resolutions, and socioeconomic development strategies.

Strengthening the National Assembly and People's Councils' examination and supervision of HIV prevention and control efforts is also a critical issue. The National Assembly should increase its direction of the development of laws and budget allocations for HIV prevention and control tasks. The People's Councils should issue resolutions on HIV prevention and control. HIV prevention and control activities must be institutionalised in local socioeconomic development programmes.

The government should guide HIV prevention and control activities, considering this work part of its annual socioeconomic development tasks; direct the ministries, ministerial-level agencies, agencies associated with the government, and the People's Committees to actively

implement HIV prevention and control measures; and hold periodic meetings to listen to updated reports on HIV in order to inform future action.

The government should also integrate HIV prevention and control programmes into hunger elimination and poverty alleviation programmes, giving priority to deep-lying, remote, or otherwise hard to reach areas. Furthermore, the government and the People's Committees should ensure the appropriate budgets, human resources, and material resources to effectively implement HIV prevention and control activities.

Multisectoral coordination should be strengthened by the implementation of a comprehensive and multisectoral HIV prevention and control programme, giving special importance to effectively integrating it into the drug and prostitution prevention and control programmes in order to prevent HIV transmission and mobilise the participation of all organisations and individuals. It will also be important to strengthen the government's guidance and implementation of multisectoral activities in HIV prevention and control.

It is also crucial to encourage religious, social, charity, and NGOs and community groups, including HIV-positive people and their families, to participate in HIV prevention and control efforts. The active and innovative participation of the community in planning and implementing activities and identifying HIV as a community issue will help to control the epidemic.

Necessary next steps also include amending and supplementing the Ordinance on HIV/AIDS Prevention and Control and legal documents on criminal, civil, and labour issues that are directly related to HIV and AIDS. These should be reviewed regularly and a system should be established for the timely revision or cancellation of regulations and legal documents that are no longer appropriate. Other next steps include supplementing or promulgating new documents on HIV-related issues that are not yet governed by law or not relevant. Law provision must aim to provide opportunities for people at risk of HIV infection to access services that help maintain or change behaviours to protect them from HIV transmission. To ensure these opportunities, current

HIV-related laws should be considered from the anti-stigma and anti-discrimination viewpoints to create equality for people who have or are at risk of contracting HIV.

It is also important to (1) promulgate appropriate regimes and policies for the staff engaged in HIV prevention and control activities and for people living with or affected by HIV and/or AIDS; (2) ensure gender equitable policies and policies designed to address the needs of each target group, particularly children living with or affected by HIV and/or AIDS; and (3) enhance the capacity of different levels and sectors of government to develop policies and plans based on the role and strengths of each branch.

Resource mobilisation and planning the optimal investment of human and financial resources in containing the early stages of the epidemic and, thereby, working toward solving the long-term economic problems posed by HIV and AIDS, will be the best protection against the exhaustion of health resources as the epidemic progresses. Mobilisation in an environment of scarce fiscal resources must be augmented by a coordinated multisectoral response. The hypothesis is that knowledge of what works best from the fields of public health, medical care, care of orphans, child-rearing, education, and so forth can be distilled through strategic planning

that gathers and focusses limited resources on combined programmes of interventions. Although the Administration of HIV/AIDS Prevention and Control of the MOH has been quick to assume responsibility for HIV prevention and control and a network of AIDS authorities has been established from the national to the local level, a tremendous disparity remains in resource availability among provinces and levels of government. In some provinces where HIV is an acute issue amid an environment of strong leadership, the local AIDS committees are strong and effective (e.g., Ha Noi and Ho Chi Minh City) and coordinate a broad range of activities in cooperation with government, community organisations, and international NGOs. In other provinces, the lack of financial and human resources translates programmatically into a particularly low capacity to undertake prevention and awareness activities, training, and care and support for PLHAs. A greater degree of support should be provided at the provincial level to strengthen the capacity of committees and bureaus in the near future. In 2004, Viet Nam's per capita state budget for HIV prevention and control was about US\$0.31—a small amount in comparison with per capita expenditures of between US\$0.60 and US\$1.60 in Thailand. Increased government investment and more effective use of large-scale international assistance are needed.



## APPENDIX:

Total Resource Requirement by Action Plan, 2006-2010

Year	2006	2007	2008	2009	2010
Total	\$23,985,452	\$29,422,955	\$39,146,435	\$50,245,754	\$61,750,599
Action Plan 1: BCC	\$3,153,202	\$3,528,210	\$3,893,218	\$4,263,225	\$4,633,234
Action Plan 2: Hazard reduction	\$3,334,709	\$5,600,700	\$7,444,048	\$9,735,505	\$11,576,776
Action Plan 3: Flood support	\$4,625,688	\$5,708,066	\$6,904,454	\$8,214,537	\$9,634,040
Action Plan 4: Surveillance	\$70,952	\$767,499	\$805,874	\$846,168	\$888,176
Action Plan 5: Settlement	\$7,715,223	\$3,445,300	\$5,753,645	\$8,795,669	\$12,630,762
Action Plan 6: HMT	\$1,995,535	\$4,381,270	\$6,827,325	\$9,334,300	\$11,899,859
Action Plan 7: STI management	\$450,000	\$750,106	\$1,050,296	\$1,350,570	\$1,650,929
Action Plan 8: Child safety	\$2,022,377	\$2,047,928	\$2,073,134	\$2,098,119	\$2,122,820
Action Plan 9: Capacity building and international cooperation	\$96,000	\$1,277,000	\$1,534,000	\$1,891,500	\$2,070,000
Others	\$1,051,476	\$1,920,565	\$2,809,241	\$3,717,131	\$4,643,700

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