

changing faces

Trends in HIV and AIDS in Asia and opportunities to reverse them



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Front cover: In 2003, Queenie and two of her children were diagnosed HIV positive. The stigma she faced as a result was more damaging to her family than any effect of the virus. Her own mother told her to “go away and die somewhere else.” Greater understanding and involvement from authorities and communities is one of World Vision’s advocacy goals in India.

Left: Children take part in awareness raising in Thailand, World AIDS Day 2006



Above: Children from World Vision’s Manam Care Centre, Papua New Guinea, make messages for their caregivers. Many of these children are being raised by extended family for a variety of reasons including the effects of HIV and AIDS.

Acronyms

Though efforts have been made to avoid acronyms, the nature of government and health programs makes some unavoidable.

AIDS:	Acquired Immune Deficiency Syndrome
ART, ARV:	Anti-retroviral treatment
GFATM:	Global Fund for AIDS, Tuberculosis and Malaria
HIV:	Human Immunodeficiency Virus
IDUS:	Intravenous drug users
MSM:	Men who have sex with men
NCHADS:	National Center for HIV and AIDS, Dermatology and Sexually Transmitted Diseases (Cambodia)
NGO:	Non-government organisation
OVC:	Orphans and vulnerable children
PLWHA:	People living with HIV and AIDS
STI:	Sexually transmitted infection
UN:	United Nations
UNAIDS:	Joint United Nations Programme on HIV and AIDS
UNGASS:	United Nations General Assembly Special Session
VCT:	Voluntary counseling and testing

Background

Nearly thirty years after the first cases of HIV were diagnosed in Asia and the Pacific, the numbers of people living with HIV and AIDS in the region continues to climb, in some areas at an alarming percentage. According to the 2006 UNAIDS Epidemic Update, over 5 million people are now HIV positive in Asia, with nearly 1 million of those contracting the virus in the previous year.

A closer look at the faces of those living with HIV and AIDS reveals just how near the epidemic is to spiraling out of control in Asia and the Pacific. In Asia, 29% of people living with HIV and AIDS are women; in Oceania 47%. Groups traditionally considered at risk, such as sex workers and their clients, men who have sex with men and intravenous drug users, continue to contract the virus, but around a quarter of new infections are not in these groups.

One of the most tragic trends is that of mother-to-child transmission, especially in areas where testing facilities are limited or the virus heavily stigmatized. In Cambodia, one third of all new infections are in babies.

The effects of an HIV and AIDS pandemic have already been seen in sub-Saharan Africa, where very few families have not been affected by the death of breadwinners and primary carers. As HIV and AIDS infiltrates communities in the Asia-Pacific region, fears are justified that the same may happen here.

Yet these trends are reversible, the threats to livelihood, family and development avoidable. To face up to HIV and AIDS, action must be taken across all sectors of society, not just those considered high-risk.

The role of government

Many governments in the region already recognise their role in providing public health schemes to protect their citizens and economies. But they may not always be proactive in responding to trends or working alongside NGOs and community groups to effectively reach at-risk groups.

For instance, when Thailand's government acted to reduce HIV transmission among sex workers and their clients in the late 1990s, it became one of the few countries worldwide to reverse its HIV prevalence rate. However, nearly ten years later it has not acted similarly to protect other groups now at risk, such as young people and intravenous drug users.

Governments in the region still have the opportunity to consolidate policy and practice changes to address the pandemic. While there is no single recipe for success, government support of awareness and anti-stigma campaigns, coupled with improved testing facilities, treatment and drug availability, is called for in almost every country in the region.

The needs of children should be given priority in this response. Whether living with HIV and AIDS themselves, or living in hardship as a result of HIV and AIDS in their carers or community, children are affected the most by the epidemic. Reducing their vulnerability to the effects of HIV and AIDS is not only a rights-based issue, but also protects the next generation of parents, workers and leaders.

Right: Expectant mothers in Cambodia receive health advice to minimise the risks of mother-to-child transmission.

About this report

The research for this publication was commissioned by WorldVision as part of a quest for meaningful and accurate advocacy interventions at a national level. It contains no primary research; rather, it is a reference material that collects, cites and validates existing facts to reach recommendations on the way forward for governments.

The four countries selected for study in this report – Cambodia, India, Papua New Guinea, Thailand - are ideally suited to increasing government action on the issues of HIV and AIDS. All four have democratic governance structures open to dialogue and partnerships.

Three of them have already shown their commitment to combating the spread and impact of HIV and AIDS at national, provincial and community level. The fourth, Papua New Guinea, is struggling with various social challenges including HIV and AIDS, but has the fastest growing HIV prevalence in the region. Here, models of intervention that have worked elsewhere could be introduced to great effect.

In each country, a path of partnership can be shown between government, NGOs and UN agencies, helping to create new and lifesaving directions in policy and public health infrastructure. Attitudinal change has been evident, with governments committing budget and staff specifically for HIV-related health programs.

The similarities end there. Each country has a different set of challenges, of HIV infection trends and reduction strategies. This report aims to highlight opportunities for governments to address HIV and AIDS in their own unique context. It does this by giving examples of good practice and partnerships, as well as expanding on achievable goals which will lead to lasting change in reversing the prevalence and effects of HIV and AIDS.

Case studies from each country give expression to the human impact of HIV and AIDS, especially within families. Examples from WorldVision programmes and other NGO initiatives show theory in action. Between them, they illustrate that it is indeed possible to bridge gaps of ignorance, stigma and isolation and take a comprehensive approach to HIV intervention – government, community and NGO united towards the same vital goals.

Situational summary

Cambodia

After peaking at over 3%, HIV prevalence in Cambodia has subsided to a less alarming 0.9%*. Today, half of all new HIV infections occur to married women; one-third of all new HIV infections occur via mother-to-child transmission.

HIV and AIDS policy in Cambodia is well developed, with several government ministries rolling out a multi-sectoral response. People living with HIV and AIDS were protected by law in 2002 from discrimination and breaches of confidentiality. Cambodia has also won significant funding from the Global Fund for AIDS, Tuberculosis and Malaria. Two potential areas of advocacy are: (1) helping the government implement a policy to reduce the vulnerability of women and girls to HIV and AIDS; and (2) assisting the government in fixing an inadequate national health system.

* Latest NCHADS figures released July 2007 promote this figure.

India

India's 2006 estimate of nearly 6 million people living with HIV and AIDS has now been challenged; the real figure is now believed to be closer to 2.5 million. This still represents a significant health burden, with the effect on children and orphans of particular concern. The patterns of infection follow two very different geographical paths. In Northeast India, the spread of HIV and AIDS is fueled mainly, though not exclusively, by unsafe injecting practices of drug users, while in Southern India, it is driven by heterosexual transmission.

India has taken significant steps in improving HIV and AIDS policy and response. In 2002, the government issued a National AIDS Prevention and Control Policy. In 2003, the government began providing ART free of charge. India has been awarded with substantial monies from the GFATM. Three potential areas of advocacy are: (1) holding the government accountable to its commitment to developing interventions for orphans and other children affected by HIV and AIDS; (2) advocating for an improved and expanded government ART program; and (3) finding ways to address stigma, such as lobbying aggressively for an HIV Stigma Bill to be made into law.



Papua New Guinea

In Papua New Guinea, while accurate numbers are hard to come by, estimates pin the number of people living with HIV and AIDS at around 64 000, or 1.8% of the adult population (1% is considered epidemic level). Here, HIV and AIDS is transmitted almost exclusively by unsafe heterosexual sex, which is estimated to account for 84% of transmission; mother-to-child transmission accounts for the rest. Certain conditions make the epidemic extremely volatile in Papua New Guinea, including high rates of STIs; high rates of casual, multiple-partner sex; high rates of commercial sex; high rates of gendered violence; low rates of condom use; deteriorating health infrastructures; and an inadequate national response to the epidemic.

Recent policy developments include the passage of the 2003 HIV Prevention and Management Act, the formation of two parliamentary committees to advocate for HIV and AIDS policy, and a national strategic plan for HIV response from 2004 to 2008. Funding for HIV and AIDS work in Papua New Guinea comes primarily from AusAID and a GFATM Round 4 Grant. Three potential areas of advocacy are: (1) reducing sexual, physical, and structural violence against women; (2) reducing the vulnerability of children to HIV and AIDS and the impact of HIV and AIDS on OVC; and (3) encouraging local leaders to take ownership of the fight against HIV and AIDS.

Thailand

Thailand is considered a success story in reducing HIV and AIDS, with a current prevalence rate of around 1.4%. In 1991, the annual number of new HIV infections was 143 000; by 2003, it was 19 000. However, the main routes of HIV transmission have changed recently. While the remarkable success of the 100% Condom Program significantly curtailed transmission through unsafe sex industry behaviours, other avenues of HIV transmission have continued unabated. These avenues include sexual contact between HIV-positive men and their regular sex partners, unsafe injections among IDUs, and casual pre-marital or extra-marital unprotected sex among youth.

Thailand has taken formidable steps to develop and implement effective HIV and AIDS policy. However, the link between drug use and HIV has been consistently omitted from HIV policy, planning, and services, resulting in anachronously high rates of HIV among IDUs (estimated at around 50%). Declining high-level government commitment to HIV and AIDS response and declining budget allocation to HIV prevention services has given advocacy in Thailand an urgent edge. Two potential areas of advocacy in Thailand are: (1) holding the government responsible for its commitments to improving treatment and harm-reduction programs for IDUs; and (2) advocating for better nation-wide HIV prevention programs that reach out to youth.

Cambodia

Background

The HIV epidemic in Cambodia, first detected in 1991, was one of the most explosive in the region, rapidly climbing to a peak of over 3% prevalence in the general population in 1997.

The epidemic has only been stanchied through a concerted multi-sectoral effort involving government ministries, international and local NGOs, and funding agencies. Today, HIV prevalence in Cambodia has subsided to a less alarming 0.9%—yet still one of the highest prevalence rates in Asia.¹

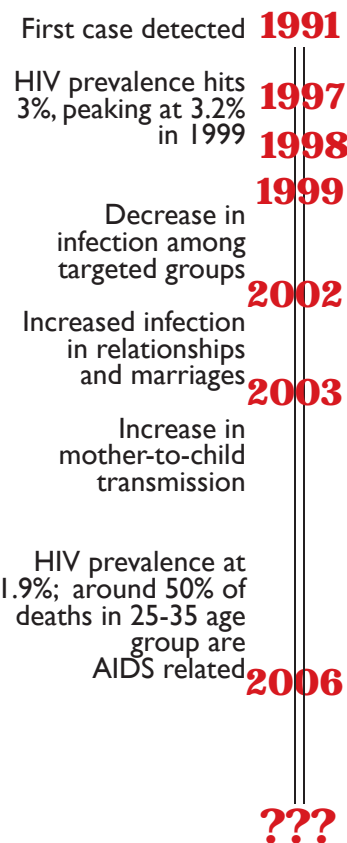
The impact of the epidemic on Cambodia is widening; it is estimated that currently over 50% of all deaths among men aged 25-35 and 46% of all deaths among women of the same age are HIV-related.¹ The highest prevalence rates are in the southeast and central provinces, and along the border with Thailand.

In the 1990s, unprotected heterosexual intercourse between commercial sex workers and their clients was identified as a major behavioral driver of the epidemic. After the Cambodian government enacted a 100% Condom Use Program, prevalence declined among brothel-based sex workers (from 43% in 1997 to 21% in 2003), indirect sex workers such as beer and bar girls (from 8% in 1997 to 12% in 2003) and male police officers (from 8% in 1997 to 3% in 2003).²

Today, unprotected heterosexual intercourse continues to represent the main route of HIV transmission, but it is the wives, girlfriends, and casual sex partners of already infected men who bear the greatest risk of contracting the virus. The National AIDS Authority of Cambodia reported in 2005 that the rates of consistent condom use by men with their sweethearts ranged between 40% and 55%; rates of condom use between husbands and wives are even lower.³

Half of all new HIV infections occur to married women; one-third of all new HIV infections occur via mother-to-child transmission.

Trends



Government response

NCHADS formed

100% Condom Use policy introduced

Prevention and Control Law passed

Broader target groups; improvements to supply and access of ART

Over 14 000 people, nearly half of them women, access ART

Greater attention to women's health, protection and empowerment to reduce vulnerability; Improve public health services for greater spread of ART and ante-natal care

Cambodia's response

In 1998, the Cambodian Ministry of Health combined its STI and HIV and AIDS programs to form the National Center for HIV and AIDS, Dermatology, and Sexually Transmitted Diseases (NCHADS), and piloted the 100% Condom Use Program in Sihanoukville. After evaluation of the pilot in 1999, Cambodia's prime minister approved a 100% Condom Use policy nationwide.

Cambodia's National Assembly subsequently gave some aspects of the Strategic Plan legal "teeth" in 2002, when it passed the Law on the Prevention and Control of HIV and AIDS. The Law provided guidelines for national HIV and AIDS awareness campaigns, epidemiological monitoring, and free primary health care for PLWHA. As well, the law protected the confidentiality of HIV and AIDS information and punished breaches of confidentiality with fines and imprisonment. All forms of discrimination against PLWHA (and their families) were prohibited.

1. NCHADS 2007, <http://www.nchads.org/pressrelease/28-06-07%20en.pdf>

2. World Bank 2004, <http://www1.worldbank.org/devoutreach/july04/article.asp?id=248>

3. WHO 2005 *Cambodia Summary Country Profile for HIV and AIDS Treatment Scale-Up*

Snapshot: Theara, aged 10

“When my parents were still alive, my brother and I were very happy. My parents took good care of us, fed us, bought us nice clothes, bathed us and played with us. My mother was a farmer while my father worked as a taxi driver. My brother and I spent most of our time with mother and grandmother.

One day in early 2004, my mother felt sick and we brought her to the hospital. The doctor diagnosed her as being HIV positive. Then my father, my brother and I decided to have our blood tested and we all received the same result. A few months later, my mother passed away.

After that, my brother and I followed my father everywhere in his taxi. In just a couple of months, my father’s health began to deteriorate, and he could no longer drive. When his health dropped to the point where he could no longer leave his bed, we brought him to the hospital. My grandmother never came to visit us. She began to hate us and said to me ‘If your father is dying don’t ever bring him to die at my house, go die somewhere else.’

My brother and I lived in the hospital with our father. We had no money to buy food. I remember meeting a sugar cane juice seller who felt sorry for me and gave me some juice. I brought the juice to my father and put a few drops in his mouth. A few days later, the doctor told me to get some medicine for him, but when I returned he had already passed away. It was just nine months after the death of my mother.

After the death of my father, my brother and I decided to come to my mother’s older sister’s house, hoping that she would accept us and let us stay. But when we arrived, she was not pleased. She did not allow her children to play or eat with us like before. At night she made us sleep outside under the tree without mosquito nets. It was dark and my brother and I were very frightened. My brother cried often. We were skinny, dirty and had itches all over our bodies. We were not allowed to use Auntie’s water for baths.

One day as my brother and I walked through our village, a shop owner asked me if I had any other relatives that could help us. I suddenly remembered another auntie, my father’s sister living in another province. I even remembered her telephone number. The shop owner lent me her phone and dialled the number for me. I heard my Auntie’s voice and told her that my parents died due to AIDS. My brother and I had no food to eat and no place to stay. I told her that we were skinny and starving and asked her to come and pick us up. I was very weak at the time but tried to speak as loudly as I could. She came to pick us up that same day.

Living with my Auntie’s family, my brother and I are well cared for. My Auntie works very hard. The income she gets is not really enough to raise all of us, but she takes as much care of us as her own children. She gives us baths and takes us to have health checkups at the hospital regularly. I really love her. If I could make one wish and have it come true, I would wish to have lots of money to help improve my Auntie’s living conditions and offer some peace in her life.

I would like to request all the older people that are married with children to please don’t bring AIDS home. That way your children won’t become orphans like me and my brother. Being orphans like us is very difficult. We have no security and no comfort in our lives.”



Key government groups

National Center for HIV and AIDS, Dermatology, and Sexually Transmitted Diseases (NCHADS):

► Formed in 1998 by the Cambodian Ministry of Health and pivotal in introductions of programs and policies including the Strategic Plan for HIV and AIDS and STI Prevention and Care 2001-2005

► Currently involved in implementation of the successor plan, the Strategic Plan for HIV and AIDS and STI Prevention and Care 2004-2007

► Main government liaison for HIV policy, leadership and coordination; lends support to provincial and operational district health managers; manages the supply chain of ARV drugs and HIV-related supplies.

National AIDS Authority:

► An interministerial body established in 1999 to launch and co-ordinate a response from non-health ministries

► Responsible for the National Strategic Plan for a Comprehensive and Multisectoral Response to HIV and AIDS 1999-2004, followed more recently by a successor plan for 2006 – 2010.

According to the law, HIV testing had to be voluntary, anonymous, and subject to pre- and post-test counseling. The law also prohibited HIV screening in connection with employment, education, freedom of residence and movement, and access to medical and other services.⁴

Two grants from the Global Fund in 2003 allowed Cambodia to extend existing programs to newly identified populations, provinces and target groups at risk, including military and police, to expand access to care interventions including ART, and to secure reliable and adequate drug supplies. Around three-quarters of the monies were administered through NGOs including World Vision, with the remainder delivered through the government.

In 2003, the Ministry of Health also launched a standardized Operational Framework for the Continuum of Care for People Living with HIV and AIDS. This defined a comprehensive package of HIV services to be provided at referral hospitals or within communities, as well as laying out an integrated approach to scaling up HIV treatment.

By establishing a clear framework for HIV and AIDS treatment and care, the Ministry of Health prepared itself for a rapid expansion in HIV treatment. In 2003, 2230 people were receiving ART; by March 2006, the number had grown to 14 310, 48% of whom were women.⁵

Given their role in developing and rebuilding Cambodian society, NGOs have had a good working relationship with the Cambodian government. This has been vital in the area of HIV and AIDS response; NGOs have carried out a major portion of the country's prevention and care activities since the early years of the epidemic.

Certainly, international donors and development agencies contribute the great majority of resources for fighting HIV and AIDS; in 2004, donor funding for HIV exceeded US\$37 million, whereas central government funding for HIV was US\$1 million.⁶

Still, the Cambodian government has been an active partner in responding to the epidemic. It has demonstrated a high-level commitment to addressing HIV and AIDS, maintained an exceptional sentinel and behavioral surveillance system, issued progressive policies and legislation, and showed a willingness to collaborate with NGOs.

This favorable environment for advocacy has been important to the relative success that Cambodia has enjoyed.

On the agenda

Women and HIV

According to the latest figures issued by the National AIDS Authority, women accounted for 75% of new HIV infections among adults in 2005. Married women alone accounted for 50% of them.⁷

These numbers underscore the fact that women are much more vulnerable to HIV and AIDS. The circumstances that generate vulnerability include: gender disparities in literacy and education; inequality in decision-making power; cultural acceptance of male promiscuity; and taboos on discussing sex or sexuality. Women have less access to information and little leverage in bargaining for safer sex; they often bear a double burden as both care providers and income earners.

These gender inequalities fuel sexual transmission of HIV and place women especially at risk. That condom use negotiation within marriage is socially unacceptable has certainly contributed to the large number of married women who are contracting HIV.

4. UNGASS 2005 *Monitoring the Declaration of Commitment January 2004 – December 2005*

5. Marseille, E, Garbus, L., 2003. *HIV and AIDS in Cambodia*

6. Speech by Dr. Hong Sun Huot, Chairman of the National AIDS Authority of Cambodia http://www.un.int/cambodia/pdf/Pointers_H.E._Hong_Sun_Huot.pdf

7. UNGASS 2005 *Monitoring the Declaration of Commitment January 2004 – December 2005*

Furthermore, legal will stops short of protecting women from sexual violence. “Cases of rape are often settled out of court while survivors themselves are often stigmatised. Violence or coercion is often used to force women into commercial sex work. ... Gang rape carried out by groups of men on park-based sex workers or those whom they perceive as ‘easy women’, is also a real danger.”⁸

It is clear that the epidemic will not be halted unless this gross imbalance is clearly confronted in HIV policy and strategy.

In 2003, the Cambodian government moved towards a gender-specific and gender-sensitive approach to HIV and AIDS response; the Ministry of Women’s and Veterans’ Affairs issued a Policy on Women, the Girl Child and STI/HIV and AIDS. The policy acknowledged that women were more vulnerable to HIV because of gender inequality.

It exhorted the need for: women’s empowerment to solve their problems; equal access to education, employment, and health services for women; safety from sexual and physical abuse; and men to recognize their responsibility for fueling the epidemic.

The policy also outlined actions to be taken by the Ministry of Women’s and Veteran’s Affairs, including: promoting greater access to treatment and prevention programs for women and girls; enforcing existing legislation that protect girls and women from abuse and discrimination; and promoting gender-specific poverty alleviation programs.

The policy has certainly been a welcome step in the right direction, but it leaves some doubt as to the capacity of the Ministry of Women’s and Veterans’ Affairs to accomplish its mission.

Specifically, the Ministry’s role has been limited to that of “a facilitator, a catalyst and an advocate for women.” The objectives of the policy mostly instruct the ministry to cooperate, promote, support, encourage, and assist.⁹

It seems that the gravity of the situation demands more drastic action—at higher as well as lower levels. Advocacy by NGOs will be necessary to turn the broadly conceived policy into grounded practice that will reduce the disproportionately high incidence of HIV in women.

Basic Healthcare Services

According to the National AIDS Authority, access to basic health and social welfare services is uneven in Cambodia. The rural poor, who live farthest from health centers and in areas with low service coverage, are especially disadvantaged.

Only one-third of the population has access to the minimum package of health services. Only one in ten births takes place in a health facility. Of the estimated 500 000 pregnant Cambodian women per year, less than half ever attend an antenatal clinic.

Furthermore, public facilities are often poorly funded, poorly staffed, and poorly stocked with essential medicines. As a result, a large and unregulated private sector has emerged, whose longer opening hours and convenient locations make private care a more attractive option.

Less than 20% of healthcare interactions in Cambodia occur through the public sector. Pharmacists and drug vendors are often sought out to provide medication without prior diagnosis.

Ministries rise to the challenge

In response to the National AIDS Authority’s multisectoral Strategy Plan in 1999, several ministries took significant action.

- ▶ *Ministry of Cults and Religions*: issued a Policy on Religious Response to the HIV and AIDS Epidemic in Cambodia, working to increase the participation of monks, achars and nuns in HIV and AIDS response. By 2003, 50 000 Buddhist monks had integrated HIV and AIDS issues in moral preaching nationwide.
- ▶ *Ministry of Social Affairs, Labour, and Youth Rehabilitation*: issued a Code of Practices Regarding HIV and AIDS in the Workplace.
- ▶ *Ministry of Education, Youth, and Sports*: revised school curriculum to incorporate reproductive health and HIV and AIDS information (although only a small fraction of the Cambodian population remains in school long enough to benefit from the new curriculum).
- ▶ *Ministry of Women’s and Veterans’ Affairs*: issued a Policy on Women, the Girl Child, STIs, HIV, and AIDS, which acknowledged the vulnerability of women through gender inequalities, and the need to address women’s capacities, their education, employment, health and safety, alongside HIV prevention programs.

8. UNGASS 2005 Monitoring the Declaration of Commitment January 2004 – December 2005

9. Policy on Women, the Girl Child, STIs, HIV, and AIDS, Ministry of Women’s and Veterans’ Affairs, 2003

In 2003, it was estimated that there were over 3700 “pharmacies” in the country, 75% of which were unlicensed. Many of the pharmacies carried and sold ARVs without appropriate advice or counseling.¹⁰

The unfortunate state of the public health system and the unregulated state of the private health sector have hindered the uptake and effectiveness of new HIV and AIDS services offered in Cambodia.

The expansion of mother-to-child prevention services, for example, has had only moderate effectiveness because so few mothers have access to or seek treatment from ante-natal clinics; even fewer give birth in a health facility.

Thus mother-to-child transmission has become a major factor in the epidemic, accounting for one-third of all new HIV infections in 2005.

Less dramatic, but equally worrisome, is the availability of ARVs from private, informal drug vendors. Studies have shown that over 70% of antibiotic therapies in Cambodia are inappropriately prescribed.

Steps must be taken to ensure that ARVs do not become similarly abused, in case strains of HIV develop resistance and become more difficult to treat.¹¹

Solution: Public healthcare provides mother-to-child protection



Through pre-natal care and medication, Reasmey has substantially lessened the risk of passing the HIV virus on to her new daughter.

“I hope that my baby will not have the same infection as me,” says Reasmey. “When Navy is 18 months old, she will get tested. Then we will see.”

The long-term aim of the PMCH project is to strengthen government health centres so that mothers at risk or infected with HIV have affordable access to appropriate treatment. The project has provided 45 health centres with equipment, technical support and training to government staff on women’s and maternal health.

World Vision’s Protecting Mothers and Children from HIV and AIDS project (PMCH) partners with the government’s National Maternal Child Health Centre and the National Centre for HIV and AIDS, Dermatology, and STDs (NCHADS) to provide pregnancy care for women.

One of them is Reasmey, in her mid-twenties, whose new baby girl Tum Navy is now 15 days old. While both mother and father are basking in the glow of parenthood, they face a long wait to find out their baby’s health status.

“I tested positive with HIV through the health centre’s doctor. I received care and support from the staff at the centre for about six months and delivered my baby at a hospital near here. I continue to receive advice and support from the centre and soon will join the care group in my village,” says Reasmey as she gently caresses her baby’s cheeks.

Staff at the centre provide information to women about nutrition, prenatal care, and HIV and AIDS prevention. Women are encouraged to take a free blood test so that preventative measures can be taken early to prevent the transmission of HIV from mother to child.

Because of early detection, baby Navy and her mother received a complete course of medication for prevention of transmission from mother to baby, treatment that reduces the risk by as much as 80%.

Cambodia statistics

Number of people living with HIV: 130 000

(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

Women aged 15 and over living with HIV: 59 000

(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

Children aged 0 to 14 living with HIV: 12 000

(Health Profile: Cambodia, USAID, 2005)

Number of AIDS orphans: 55 000

(Marseille, E, Garbus, L., HIV and AIDS in Cambodia, 2003)

Number of people needing ART: 35 000

(Cambodia Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO, 2005)

Number of people receiving ART: 14 310

(Dr. Hong Sun Huot, 2006)

Number of AIDS deaths in 2005: 16 000

(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

HIV and AIDS prevalence rate among adults aged 15 to 49: 1.9%

(Cambodia Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO, 2005)

HIV and AIDS prevalence rate among IDUs: 45%

(Monitoring the Declaration of Commitment Jan 2004 – Dec 2005, National AIDS Authority of Cambodia, 2005)

HIV and AIDS prevalence rate among MSM: 15%

(Monitoring the Declaration of Commitment Jan 2004 – Dec 2005, National AIDS Authority of Cambodia, 2005)

% with advanced HIV infection receiving anti-retroviral therapy: 36%

(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

% HIV-positive pregnant women receiving mother-to-child transmission treatment: 5%

(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

% new HIV infections in married women: 50%

(Monitoring the Declaration of Commitment Jan 2004 – Dec 2005, National AIDS Authority of Cambodia, 2005)

% new HIV infections in children via mother-to-child transmission: 33%

(Monitoring the Declaration of Commitment Jan 2004 – Dec 2005, National AIDS Authority of Cambodia, 2005)

India

Background

With over 1 billion people in India, it is enlightening to think of the country's HIV statistics in terms of numbers rather than percentages. UNAIDS estimates over 2.5 million people are living with HIV and AIDS in India.

Of the thirty-five states of India, six states—Andhra Pradesh, Tamil Nadu, Maharashtra, Karnataka, Manipur, and Nagaland—have generalized epidemics, where the prevalence rate among pregnant women in each of these districts is greater than 1%. These six states account for nearly 80% of all reported AIDS cases in the country.

Four of these—Andhra Pradesh, Tamil Nadu, Maharashtra, and Karnataka—are located in Southern India; in these states, heterosexual transmission accounts for more than 85% of the reported cases. The other two states of Manipur and Nagaland are located in Northeast India. In these states, injecting drug use is the main route of HIV transmission.

While the HIV and AIDS epidemic has affected these six states most forcefully, there is considerable concern in other states that the epidemic is spreading quickly from traditionally vulnerable groups to the general population.

The epidemic is also moving from urban epicenters outwards to the rural periphery. This trend is a consequence of low levels of awareness in rural areas, rising levels of unsafe sex among young people, and increasing migration to cities—mostly by young people—in search of employment opportunities.

Trends

First case detected (Chennai)

Safety of blood collection and transfusion improves

Most cases of HIV go untested and unreported

Emerging trends of transmission within families and children affected by HIV remains unaddressed

India's reported cases of HIV and AIDS are less than 5% of the estimated 2.5 million plus living with the virus

Government response

1986

1992

1999

2002

2003

2005

2006

???

NACO formed; NACP I introduced, emphasising awareness and blood safety

NACP II aims to change behaviour and work at state level

Prevention and Control Policy established

Commitment to providing free ART

Children are the subject of high-level discussion, resulting in the 'Delhi Commitment'

NACP II draws to close; planning for NACP III indicates awareness of children's vulnerability

Infrastructure commitment to care and support children living with or affected by HIV and AIDS; increased and more effective use of ART; addressing community attitudes that lead to stigma

The epidemic is expected to impact women and children in India with increasing virulence in the near future. In 2004, it was estimated that 39% of people living with HIV and AIDS were women. And while no official figures are available on orphans and vulnerable children, UNAIDS estimated in 2005 that more than 170 000 children under 15 years are living with HIV and AIDS.¹

Nationally, stigma is a large reason why only 100 000 of the estimated 2 500 000 people currently living with HIV and AIDS have been identified thus far. To place this in perspective, if every Indian person currently identified as HIV positive were placed on ART therapy, India would still be unable to meet the 355 000 target for the WHO "3 by 5" campaign.

1. *India Summary Country Profile for HIV and AIDS Treatment Scale-Up*, WHO, 2005

Key government groups

National AIDS Control Organization (NACO)

► Established in 1992 to design, promote and implement the strategies contained in the NACP plans.

► Currently at design phases of NACP III, to carry India's HIV and AIDS control strategies through to 2011 and safety, alongside HIV prevention programs.

Snapshot: Brahmaramba, aged 16, Southern India

“My father was a carpenter and my mother a daily labourer. They looked after my brother and me with a lot of love. I wanted to graduate and become a teacher. My father assured me that I could study as long as I wanted to. My grandfather came to live with us after my grandmother died.

Last February my father fell ill and was unable to go to work. He became thin and weak with fever. When it continued for a while, he was advised to go to the nearest town and do some tests. He was HIV positive. He did not share the results with me, but I saw the report and wept bitterly. I had been to an AIDS awareness programme in school and knew that it was spread through sexual contact, blood transfusions and mother to child.

Two weeks after my father’s test my mother was also asked to do the same test and was found HIV positive. This was during the vacation before my exams. I was busy doing all the housework and taking care of my father. I was also very disturbed and could not focus on my studies. My father died the day before my exams began.

My mother, who was in good health and supporting the family with her income, fell ill within a week and never recovered. Then there was no food, as no one was earning money. We spent days without food. For a week before her death my mother was bedridden. As we did not have money to admit her to hospital she was looked after at home.

I never expected my mother to die so fast. She died in the month of May, within two months of my father.

I was depressed. All day I would think about my brother and my future. I was worried about my studies and care and support for my brother. I worried a lot about whether my relatives would look after us or not, whether they would accept us in their family. I was scared that if they found out about how my parents died they may throw us from the community.

Some people in the community maintained distance from our family. People who were affectionate to me before would not come close to us. Neighbours did not come to our house or allow me into theirs.

I realized that my grandfather was too old to go out to work and the responsibility of providing for the family fell on me. I had failed two subjects in my exams and was only able to get a job in a tobacco grading unit, in a nearby village. I earned 810 rupees (US\$18) a month working from 8:30am to 6:00pm, 30 days a month. I felt very sorry about the situation because I had thought I would become a teacher.

I have already faced many problems in the past and I will face more in the future. I do not care any more who gets to know about my parents’ death. Now I am ready to talk to others about HIV and AIDS transmission and prevention. If we start talking then other children will not have to go through the same problems I faced.

I have started discussing this with my friends in the children’s club that I am a member of. It is called Karunamaya Children’s Club. It is group of 12 children who meet every month and discuss various issue related to children.

I keeping telling others that education is important. All children, especially girls, should know about HIV and AIDS.”



India's response

India's first documented case of HIV occurred in Chennai (then Madras) in 1986, but it was not until 1992 that India's national response truly began through the National AIDS Control Organization (NACO) and the rollout of the National AIDS Control Program Phase I (NACP I).

NACP I aimed to promote awareness, create surveillance and monitoring structures, and improve blood safety. NACP II, launched in 1999, represented a significant increase in scale and funding, and focused on changing behaviour.

In 2002, the Indian government established a comprehensive and rights-based National AIDS Prevention and Control Policy, which clearly encouraged voluntary testing and counseling over mandatory testing and guaranteed HIV-positive persons equal rights to education and employment.

In 2003, they made a commitment to begin providing free ART, formerly considered a financial impossibility. Since then, India has been awarded grants from the Global Fund to scale up services on mother-to-child transmission reduction, treatment for HIV-TB co-infection, and access to ART.

While performance indicators have stayed on schedule, large sums remain unused. Also, the 2002 policy makes little mention of women and children affected by HIV and AIDS. No mention at all is made of children orphaned by HIV.

In 2005, anticipating the end of the NACP II, the NACP III planning team began drafting a framework for HIV response from 2007 to 2011. At this critical juncture, hopes are high that the NACP III will bring India within striking distance of Millennium Development Goal Six: reversing the spread of the epidemic by 2015.

The environment for advocacy can, in fact, be described as promising. At this crucial point, continuation of committed and evidenced-based pressure is more important than ever.

On the agenda

Treatment, care, and support for orphans and vulnerable children affected by HIV and AIDS

While the Indian judiciary has extended limited protection from discrimination to people living with HIV and AIDS, newspapers consistently report heartbreaking stories of children who are expelled from schools and disowned by extended family because of their HIV-positive status.

According to Zama Coursen-Neff, the author of a Human Rights Watch report on the subject, "children affected by HIV and AIDS are being discriminated against in education and health services, denied care by orphanages, and pushed onto the streets and into the worst forms of child labor."²

Already by 2001, the World Health Organization estimated that the number of children orphaned by AIDS had reached 1.2 million. According to Dennis Broun, the head of UNAIDS in India, only 1 500 of the 50 000 children who need ART are currently receiving it.³

To address the deafening silence on OVC in the National AIDS Prevention and Control Policy, the Indian government brought several ministries, funding agencies, and NGOs (including World Vision) to a policy conference in March 2005.

The resulting "Delhi commitment" spelt out guidelines, funding commitments, resource deployments, and a framework for future work with children affected by HIV and AIDS.

Using the 'Delhi Commitment' as a reference point, many NGOs have increased their advocacy work by organizing more conferences to develop programmes, recommend policies, and create networks to benefit children affected by HIV and AIDS.

Some outcomes of these efforts are inspired; following the Joy 'n Joy consultation organized by the Positive Women's Network, the 53 children in attendance launched a network of their own called CAHA, or Children Affected by HIV and AIDS.⁴

Above right: Magic Bus party, Mumbai, a community celebration held by World Vision to bring some fun to the lives of children affected by HIV and AIDS.

2. "HIV children battle back to school," BBC News, 15 March 2004

3. "India has highest number of AIDS deaths, HIV cases: UNAIDS," The Indian Express, 13 June 2006

4. "India: HIV-infected children present their case," PlusNews, 26 June 2006



New policy on children

In July 2007, the Ministry of Health, Government of India, released its new Policy Framework for Children and AIDS. The framework was jointly prepared by the National AIDS Control Organization and the Ministry for Women and Child Development with support from UNICEF.

The policy adopts a rights-based approach, taking into account recent changes in the global understanding of the adverse impacts of HIV and AIDS on children and the best ways to address them. Under the framework, many ministries will now include social issues of HIV and AIDS under their portfolios.

The new framework also recognizes “the futility of trying to differentiate between children in distress and affirms the need for a universal approach in addressing the needs of all children subjected to social exclusion, neglect and abuse, including HIV/AIDS.”

Objectives of the framework are to:

- create a non-stigmatizing environment for children and young people
- identify HIV infected children and parents early and provide high quality treatment and support, to prolong and maintain high quality life
- ensure affected children are not excluded or differentially treated by service providers (both public and private)
- eliminate stigma and discrimination
- ensure that social protection measures are in place, to prevent and redress violation of their rights and entitlements.

Antiretroviral treatment

In June 2001, then Union Health Minister C.P.Thakur stated that the government could not provide subsidized antiretroviral treatment, only subsidized treatment of opportunistic infections.

But the following eighteen months saw a dramatic change in national and international attitudes toward making ART available and accessible to people living with HIV and AIDS. By the end of 2003, the government of India had pledged to begin providing ART free of charge in 2004.

While the initial target of 100 000 people on ART by the end of 2005 was postponed until 2007, it was clear that advocates and ministers were no longer debating “if” ART would be made available, but rather “when” and “to how many” ART would be available.

The shift in discourse was made possible largely by nearly US\$250 million from Global Fund grants to improve voluntary testing, mother-to-child transmission treatment and enhanced access to ART.

While changes in discourse and available funding bode well for NGOs offering direct services, there is no opportunity to be complacent about advocacy. For many living with HIV and AIDS, a government commitment to ART access that is delayed, deferred, or postponed is tantamount to no access at all.

NACO’s goal of treating 180 000 patients with ART by 2010 set a lower target than the WHO “3 by 5” initiative, which set the bar at 355 000 Indian recipients by 2005.

NACO’s goal is also at odds with the commitment of all UN Member States “to the goal of universal access to treatment by 2010 for all who need it.”⁶ In fact, the NACO goal is identical to that of the Global Fund grant, implying that NACO is relying solely on that funding source without trying to mobilize more resources.⁷

In addition, though no review of the Round 4 grant performance is yet available, it is probable that inefficiency is limiting efforts to make ART available to more people. Clearly, advocacy is necessary to accumulate the necessary political will and amass the appropriate technical expertise to widen the current bottleneck.

NGOs have already been making good headway in analyzing problems with ART treatment in India, which include the continued manufacture and supply of generic drugs, the lack of planning for second-line treatments or tailored ARV treatments (for instance children, or people coinfecting with liver conditions including hepatitis), and unequal access to ART.

An effective alliance

The India HIV and AIDS Alliance, established in 1999, is an exemplary model of combining direct service with effective advocacy to reach children. It is involved in three major programs; the Frontiers Prevention Project and the Avahan Project deliver STI treatment services to communities in Andhra Pradesh, while the Home and Community Based Care and Support Program meets the needs of children and families affected by HIV and AIDS in Delhi, Andhra Pradesh, and Tamil Nadu.

The Alliance also advocates on behalf of children affected by HIV and AIDS. In September 2004, it hosted a meeting between key NGOs in Delhi to raise, among other points, the fact that there was no national policy that addressed the special impact of HIV and AIDS on children. The meeting resulted in the formation of a working group that would meet quarterly and liaise with relevant government officials, encouraging discussions that would eventually lead to the “Delhi Commitment”.

In May 2006, the India HIV and AIDS Alliance hosted a National Workshop on Working with Children Living with HIV and AIDS, attended by representatives from NACO, the World Health Organization, UNICEF, UNAIDS, the Delhi State AIDS Control Society, and some 38 NGOs. The workshop generated a list of recommendations, some of which were addressed to the government and UN agencies, others of which were addressed to NGOs and donors.

The India HIV and AIDS Alliance is also drafting “Child-Centred Briefing Notes” which will focus on rights-based child-centred programming in the context of HIV and AIDS and the importance of children’s participation in the development, implementation, and evaluation of programmes and policies.

Support group represents minorities

- ▶ Created in 1997 as a support group, the Indian Network for People Living with HIV and AIDS (INP+) has grown into a national movement that combines advocacy and service. In Tamil Nadu, INP+ has combined prevention services with counseling and treatment in a gender sensitive, stigma-free environment. INP+ has also collaborated with the Social Welfare Association for Men to offer outreach services, behavior change communication, condom promotion, counseling, and care, in particular for men who have sex with men.
- ▶ INP+ is also active in advocating for stigma reduction, increased access to services, and greater involvement by PLWHA in shaping the national response to the epidemic. Advocacy activities include:
 - ▶ Positive Speakers Bureau (with branches in Chennai, Pune, Cochin, Imphal, and Bangalore) that aims to reduce stigma and discrimination by giving a human face to the epidemic;
 - ▶ Action-oriented research including two studies (A Needs Assessment Study of People Living with HIV and AIDS and Greater Involvement of People Living with HIV towards National Response)
 - ▶ Workshops to train government officials and development partners on how to address stigma and discrimination and how to include PLWHA in planning more successful programs.

This juncture between NACP II and NACP III represents an excellent opportunity to advocate for an improved and expanded government ART programme. The promise of a widespread, reliable, accessible ART programme will have the potential to increase voluntary testing, thus starting a virtuous cycle to combat the stigma that discourages people from seeking testing, care, and treatment.

Stigma

According to an ILO study that interviewed more than 120 women from Delhi, Maharashtra, Manipur, and Tamil Nadu, 74 per cent of the HIV-positive women faced discrimination and underwent hardships. Although the majority of women were infected by their husbands, they were blamed for the husband's death. In many cases, the woman was accused of causing her husband's illness, and either disowned or driven out by her in-laws.

The children of infected parents are also heavily discriminated against; they are taunted, abused and not allowed to interact with other children. Over 35% of the children in the ILO study were denied basic amenities and about 17% had to take up petty jobs to augment the family income.

People from already stigmatized, high risk groups, including sex workers and men who have contracted the disease through male-to-male sexual activity, may receive crass and sub-standard treatment at hospitals or be denied entry at all.

Despite an UNGASS commitment in 2001 to protect people living with HIV and AIDS from discrimination, India has almost no laws specifically protecting people living with HIV and AIDS from discrimination.

The only legal protection afforded people living with HIV and AIDS was granted by the Indian judiciary, which ruled in 1997 that PLWHA could not be denied recruitment in public employment merely on account of their HIV-positive status.

While the National AIDS Prevention and Control Policy provides that "the HIV-positive person should be guaranteed equal rights to education and employment as other members of the society," the national policy does not carry the force of the law.

To address this gap, the Ministry of Health and Family Welfare has drafted an HIV Stigma Bill that prohibits any discrimination by public or private entities against HIV-

positive persons. The bill will be proposed to Parliament in 2007 and merits heavy lobbying and support from all stake-holders.

The HIV Stigma Bill, if it becomes law, will open possibilities for litigation to be pursued by PLWHA who have experienced discrimination. Nevertheless, stigma and discrimination are particularly tenacious and insidious attitudes and will no doubt continue to affect the lives of PLWHA even if the bill is passed.

Such a bill cannot guarantee that an HIV-positive sex worker will not be stigmatized at an STD clinic or that

an HIV-positive widow will not be blamed for the death of her husband.

If more people are not identified as HIV-positive in the near future, expanding ART treatment will be a futile endeavor. As a steep barrier to prevention, care, and treatment, stigma needs to be vigorously addressed with multi-tiered advocacy that goes beyond lobbying for an anti-discrimination law.

Solution: Legal rights at local level



Manager of Mumbai Thane HIV and AIDS project, Heather Ferreira, helps families affected by HIV to have their rights recognised.

The living conditions for 10-year-old Vijay and his HIV positive mother are improving now, but not long ago they were sleeping every night on the verandah outside their own home, barred from entering by their in-laws.

Vijay's father passed away from HIV and AIDS four years ago, leaving Vijay and his mother to clear heavy debts. She works two jobs as a maid but, also HIV positive, she has often fallen sick.

"If Vijay was not there, I would not have survived," says his mother. Vijay has nursed her through bouts of illness, taken her to the hospital for treatment and helped her to understand her medication.

Vijay's father left his wife and son a small flat but his aunt and uncle moved in soon afterwards and took over the house. Since then Vijay and his mother have battled for shelter and the right to inherit the property, too poor to afford legal advice.

Hundreds of children are facing similar challenges to Vijay's. Cases of orphans on the verge of losing their parental house and imposters claiming ownership of assets belonging to the children's parents are common.

World Vision staff, who work with Vijay's community through their child-focussed Mumbai HIV and AIDS project, are already planning to bring in legal assistance to deal with Vijay's case. "There is a helpful group of lawyers prepared to take these cases, and we will see that they help this family," says project manager Heather Ferreira.

India statistics

- Number of people living with HIV: 2 500 000**
(Amendment to 2006 Report on the Global AIDS Epidemic, UNAIDS 2007)
- Number of reported PLWHA: 100 000**
(<http://www.jhsph.edu/publichealthnews/articles/2006/ramadoss.html>)
- Children aged 0 to 14 living with HIV: 170 000**
(India Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO 2005)
- Number of people needing antiretroviral therapy: 785 000**
(India Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO 2005)
- Number of people receiving free ART from designated government centres: 24 000**
(India Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO 2005)
- Number of people receiving free ART provided by intersectoral partners: 10 000**
(India Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO 2005)
- Total number of people receiving ART from public and private sources: 60 000**
(India Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO 2005)
- HIV and AIDS prevalence rate among adults aged 15 to 49: 0.34%**
(Amendment to 2006 Report on the Global AIDS Epidemic, UNAIDS 2007)
- % HIV+ pregnant women receiving mother-to-child transmission treatment: 1.6%**
(2006 Report on the Global AIDS Epidemic, UNAIDS)
- % men and women with advanced HIV infection receiving anti-retroviral therapy: 7.0%**
(2006 Report on the Global AIDS Epidemic, UNAIDS)
- % women, aged 15 to 24, who demonstrate knowledge of HIV prevention methods: 21%**
(India Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO 2005)
- % men, aged 15 to 24, who demonstrate knowledge of HIV prevention methods: 17%**
(India Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO 2005)
- % women, aged 15 to 24, who had sex with a casual partner in the past 12 months: 2.0%**
(2006 Report on the Global AIDS Epidemic, UNAIDS)
- % men, aged 15 to 24, who had sex with a casual partner in the past 12 months: 12.0%**
(2006 Report on the Global AIDS Epidemic, UNAIDS)
- % women, aged 15 to 24, who used a condom the last time they had sex with a casual partner: 51%**
(India Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO 2005)
- % men, aged 15 to 24, who used a condom the last time they had sex with a casual partner: 59%**
(India Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO 2005)
- % people living with HIV in rural areas with poor HIV and AIDS services: 58%**
(India Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO 2005)

Papua New Guinea

Background

Due to limited surveillance capacity, the current size of the epidemic in Papua New Guinea is notoriously difficult to pin down, with substantial differences in estimates; figures range from 25 000 at the low end of the scale to 100 000 at the high end. The most widely accepted figure—and the most recently reported by UNAIDS—appears to be 64 000.¹

Prevalence data from antenatal clinics are also scarce, but in 2003, pregnant women in Goroka had a 2% prevalence rate, 2.5% in Lae, and 1.4% in Port Moresby. More dramatically, HIV and AIDS has been the leading cause of mortality at Port Moresby General Hospital since 1999.² Today, a full 20% of patients at the hospital have HIV, and on average 14 patients die of AIDS every day.³

UNICEF has stated that knowledge of HIV and AIDS prevention has yet to make any inroads into rural areas, which have limited infrastructure and face significant logistical constraints in terms of transport and procurement systems.⁴ According to Banare Bun, chair of the Special Parliamentary Committee on HIV and AIDS, 85% of the rural population still lack accurate knowledge of HIV and AIDS prevention.⁵

Women are especially at risk of contracting the virus. Girls between 15 and 19 currently have the highest rate of infection in the country, four times that of boys in the same age group. According to UNICEF, the lack of open discussion about sexuality combined with high levels of sexual violence creates a noxious blend of gendered vulnerability that affects girls and women.⁶

Women have difficulty insisting that partners must use condoms, even if they suspect—with reason—that their partners have been unfaithful; a study has shown that 55% of Papua New Guinean men between 19 and 45 years have sex with more than one partner. Even commercial sex workers find condom use to be a difficult proposal; 70% of respondents in a survey of female sex workers in Port Moresby reported that they did not use a condom because clients paid more for unprotected sex.⁷

Trends

First case detected: remoteness, lack of funding and other priorities limit response

HIV and AIDS becomes the leading cause of death at Port Moresby General Hospital

Sex workers report they are paid more to have sex without a condom

HIV prevalence over 1%, or around 64,000 people; 50% are women

Government response

1987

1997

1998

2003

2004

2005

2006

???

National AIDS Council (NAC) established in partnership with NGOs and private sector

National Medium Term Plan issued

Discrimination addressed in HIV Prevention and Management Act

HIV highlighted as health priority; public awareness campaign launched

Multiple funding allows commitment to 2004 National Strategic Plan and education/mother-to-child transmission activities

First national HIV summit held in Port Moresby

Recognition and action on the links between sexual violence, gender imbalance and HIV infections; increase in children at school and alternative education methods, including HIV awareness, for those not at school

1. <http://www.unaids.org/en/MediaCentre/PressMaterials/FeatureStory/20060313-png.asp>

2. Cullen, T., "HIV and AIDS in Papua New Guinea: a reality check," *Pacific Journalism Review* 12(1) 2006

3. Kapi, L., "Alarm Bells over HIV and AIDS," *The National* 2004

4. http://www.unicef.org/infobycountry/papuang_30542.html

5. Cullen, T., "HIV and AIDS in Papua New Guinea: a reality check," *Pacific Journalism Review* 12(1) 2006

6. http://www.unicef.org/infobycountry/papuang_30542.html

7. Cullen, T., "HIV and AIDS in Papua New Guinea: a reality check," *Pacific Journalism Review* 12(1) 2006

Snapshot: David, 57, with his third wife Rose

“In 2002 I started to have diarrhea. At first I thought it was caused from the roadside food that I had eaten a few days before. However, the diarrhea continued to a stage where I began to lose weight. My wife at the time advised me to go for a medical checkup. I went for a blood test at the Port Moresby General Hospital, and was told that I was HIV positive.

When I went home from the hospital I did not tell anyone about the results for fear of being rejected. Finally I told my wife, who could not take the news and blamed me for infecting her also. It was even worse when I later told the rest of the family. Their reaction towards me was obvious – they were frightened of me.

In fact, they built a small hut in our backyard for me to live in. I was kept there and they would leave my food and water outside for fear of me passing the disease to them.

My girlfriend Rose suggested that I try taking herbal treatment to cure the disease. We had heard stories of other people getting healed by taking certain herbs in the country.

We tried different types, in liquid, leaves and from tree barks. This however did not show any improvement in me. Rose said I should try herbs from a different province because herbs differ in province to province. She said the ones in other province might be stronger and could heal me better than the ones sold in Port Moresby.

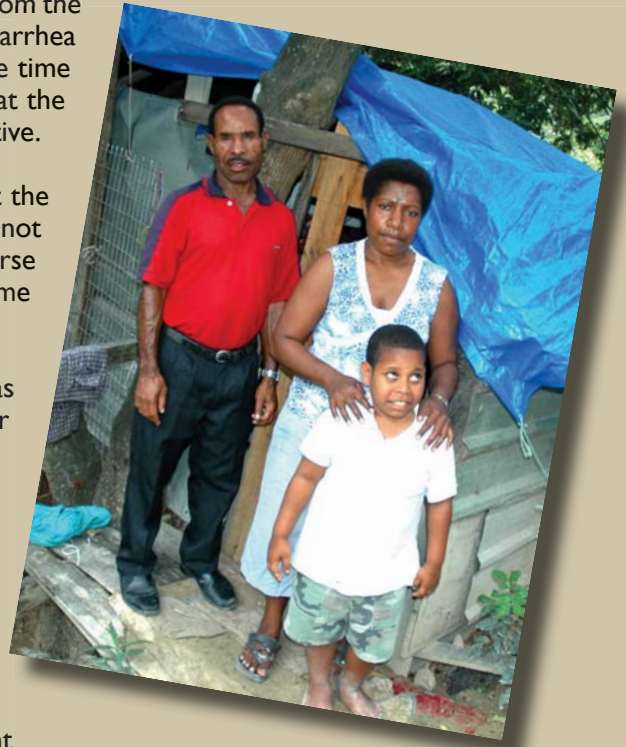
She paid for my plane ticket and I flew to Mt. Hagen, in the highlands of Papua New Guinea. There I visited almost all the places and people who sold herbs that claim to heal sicknesses. I even went as far as seeing people who were involved in sorcery.

After sometime there, I realized I'd spent a lot of money and my health was not showing any signs of improvement. I rang Rose and told her that it was no use and that I wanted to come home. I went to the hospital again, but they said there was nothing they could do. In other words, they were telling me that I was going to die.

I lost all hope. I went to the bank and withdrew K600 to pay for my funeral. I also divorced the wife who had thrown me out and married Rose instead. Rose was the only one who stood by me. She is much younger than me and she, too, is living with HIV and AIDS.

WorldVision helped us both to get onto anti-retrovirals. They talked about the importance of positive living – we were told to stop worrying and get on with life. The counselors told us that discrimination and rejection were the main causes of people dying quickly.

I am preparing to return home to the Southern Highlands, where I was born, to set up a small drop-in centre like the WorldVision one. I would like to provide awareness and counseling to the younger generation. They mustn't make the same mistakes that I made.”



Yet another trend that has unfortunate implications for the severity of the epidemic is the exceedingly high rates of sexually transmitted infections (STIs) in both high risk and low risk populations. As STIs cause biological vulnerabilities that HIV can exploit, such high rates of infection are likely to make HIV spread more rapidly through rural and sex worker populations.

Thus, while there is a lack of accurate information about the size of the epidemic, certain conditions make extremely high rates of HIV infection very likely.

These conditions include: high rates of STIs; high rates of casual, multiple-partner sex; high rates of commercial sex; high rates of gendered violence; low rates of condom use; deteriorating health infrastructures; and an inadequate national response to the epidemic.

Papua New Guinea's response

The first cases of HIV infection were reported in 1987. Ten years later, after HIV prevalence had increased steadily year after year, the Papua New Guinea government established its National AIDS Council (NAC), which included representatives from the government, NGOs, faith-based organizations, and the private sector.

In 1998 the Council issued the Australian-funded National Medium Term Plan (1998-2002, but more recently extended to 2006), which prioritized behavior change communication programs, services for high-risk populations, and improved management of sexually transmitted infections.

In 2003, the HIV Prevention and Management Act was passed. The Act outlaws discrimination and stigmatization of people living with HIV and AIDS, makes acts of deliberate transmission a criminal offence and provides guidelines for voluntary testing and counseling, confidentiality of medical records and legal avenues of redress for civil and criminal infringements.

2004 saw HIV highlighted as one of four main objectives in the Health Sector Strategic Plan (2004-2006) issued by the Papua New Guinea Department of Health. More importantly, the NAC issued the National Strategic Plan on HIV and AIDS 2004-2008, which laid out a framework for the national response to HIV. The National Strategic Plan was not accompanied by a budget and financial plan, however.

Key government groups

National AIDS Council (NAC)

- ▶ The coordinating body for national response, with a wide range of programs and activities
- ▶ One of the NAC's major achievements was to establish provincial AIDS committees, although a number of them have since stopped operating due to political instability and other factors.
- ▶ Other activities have included media campaigns, condom promotion, educational drama groups, and guidelines for workplace HIV policies, which have since been implemented within the mining sector, logging sector, police and correctional services, and the PNG Defence Force.

Parliamentary Special Committee

- ▶ Established in 2004 to advocate for an improved governmental response to HIV and AIDS
- ▶ Grew out of an earlier Parliamentary Advocacy group composed of members of parliament and government ministers, working in consultation with UNAIDS

Consequently, there was no clear way forward for implementing the strategies outlined in the Plan.⁸ The budget allocation for HIV and AIDS in 2004 remained the same as it was in 2003.

Lastly, 2004 marked the start of a controversial HIV awareness campaign sponsored by AusAID and the NAC, featuring somewhat vulgar slogans on billboards and commercials which aimed to raise HIV and AIDS awareness amongst the general public.

In 2005, greater funds were made available, through a budget hike by the Papua New Guinea government, assistance from China, and finally a Global Fund Round 4 grant to roll out a five-year plan.

The targets were: HIV and AIDS education in all schools; PMTC services available to all mothers who are HIV-positive; post-exposure prophylaxis for all health care workers who have had occupational exposure to HIV; at least one VCT centre in each of Papua New Guinea's 89 districts; thirty ART facilities providing treatment to 1500 PLWHA; and five youth centers that will make peer education available to 40% of Papua New Guinea's population.⁹

Also in June 2005, the UN resident coordinator hosted a Donor Partner Coordination Meeting for HIV and AIDS to synchronize strategies and priorities and to decrease reduplication of efforts.

On 3 March 2006, the first National HIV Summit was held in Port Moresby, where Papua New Guinea's Prime Minister reaffirmed a three-fold government budget increase (though the majority of yearly funding is still provided by AUSAid) and announced a restructure of the NAC to bring it more power and visibility.

Nonetheless, Papua New Guinea's attitude to the rising toll has been criticized over several years. Facing chronic development and governance challenges, political will for changes in attitude and behaviour on HIV and AIDS is lacking or underprioritized.

For instance, though the 2003 HIV Prevention and Management Act specifically states that HIV and AIDS awareness materials, condoms, and lubricant cannot be considered obscene, police continue to harass sex workers, outreach workers, and students for possessing condoms.

The "HIV and AIDS Stakeholder Mapping in Papua New Guinea," released by UNAIDS, AusAID, and the NAC in September 2004, stated: "Of specific concern is the lack of response within the health sector, despite grim warnings of the impact of the epidemic on the capacity of the health system to cope with an increasing number of cases."¹⁰

On the agenda

Women and HIV

The 2006 UNAIDS report cites the high incidence of rape, sexual aggression, and other forms of violence against women as major factors in the explosive growth of the epidemic.

Furthermore, the National AIDS Council has acknowledged in the National Strategic Plan on HIV and AIDS 2004-2008 that the epidemic is enabled by "patterns of male sexual behavior including a high incidence of rape, line-ups or pack rape, sexual assault, and weak law enforcement."¹¹

It is laudable that the link between gendered violence and escalated risk for HIV has been enshrined in Papua New Guinea's national policy.

Now, NGOs must advocate for widespread recognition of the gendered double jeopardy that women face followed by widespread action from all sectors of society—including the national government, the provincial governments, and the private sector—to reduce the violence that is inflicted on women.

Children and HIV

Prevention efforts among children are complicated by a low literacy rate; only 76% of school age children receive primary education. The gender disparity is large; in primary schools, there are 80 girls for every 100 boys. In secondary school, the disparity gets larger; there are only 65 girls for every 100 boys.¹²

This significantly reduces the impact of a school-based education program, which will reach only a fraction of the youth in the country.

To address this, the NAC has proposed using Global Fund monies to build five youth-friendly centers to generate safe spaces for peer education; whether the centers will be accessible to 40% of the population (the target of the proposal) remains to be seen.

As elsewhere, children affected by HIV and AIDS are particularly vulnerable to exploitation. Orphaned by HIV and AIDS and cared for by extended family members, children are at risk of domestic slavery or sexual abuse.

UNICEF predicts that the situation for AIDS orphans and HIV positive children in Papua New Guinea will continue to worsen in the years ahead.¹³

To date there has been no policy, legislation or government plan specific to children's needs. Recognition of children's vulnerability is the first important step, followed by a concerted societal mobilization to reduce the risks they face.

9. GFATM Summary of Grant Proposal for Grant PNG-405-G02-H

10. *HIV and AIDS Stakeholder Mapping in Papua New Guinea*, UNAIDS, AusAID, and NAC, 2004

11. "Making Their Own Rules," Human Rights Watch, 17(8), September 2005

12. "Health Profile: Papua New Guinea," USAID, April 2005

The cultural landscape

Dr. Ninkama Moiya, Director of the NAC Secretariat, has said: "Getting the message [across to people] is not a problem but it is changing attitudes and behavior that is an issue.... We can say and do all we want but if people at the individual level can't respond positively to prevent HIV, all we've done will go for nothing."¹⁴

The statement reflects the difficulties that behavior change communication programs have encountered in Papua New Guinea. The concern over behavior change is underscored by the fact that social and behavioral research is one of the seven key components of Papua New Guinea's National Strategic Plan on HIV and AIDS 2004-2008.

Certainly, no shortage of problems arises from the fact that Papua New Guinea is host to more than 700 languages. In this fragmented national context, it appears that no simple, universal template for prevention and awareness programming will ever suffice, and that individual programs will have to be sensitive to context, innovative in method, and flexible in response.

To this end, the role of provincial AIDS committees in meeting the needs of linguistically and culturally diverse constituents cannot be underestimated. Provincial leaders must be convinced to take ownership of local responses to HIV and AIDS.

Solution: Youth leadership challenges culture of violence

Don Ole, former gang leader, Joyce Bay, Papua New Guinea

"When I was younger, I was not a very well educated person and I was involved in lots of what is called 'high-risk' behaviour. That is, crime and lots of illegal things like that. I led a team to go for breaking and entering and stealing vehicles.

That's why a majority of my community respect me – like the boys in Joyce Bay. When anything had to be done with the youth in the community, people came to me.

That's why I was asked to help with HIV education. I ended up a team leader.

"Personally I am changed. I went for training in HIV and AIDS and now I understand it. I feel as if I have been given a task to do, to give example to others.

"Now we have about 500 young people who have become involved in sports and getting rid of risky behaviour. I introduced the sport leaders to planning sex and other ideas to change their behaviour. Me and my peers are involved – so the community has changed. We have plenty of committees and leaders and programmes – not car thieves.

"Now I am a positive role model and that is how my peers recognize me. As a leader I have to support my community."



Joyce Bay's HIV awareness campaign is addressing the needs of young people, many of whom are uneducated and unemployed. Youth groups and clubs give them knowledge on self-worth alongside HIV prevention.

Papua New Guinea statistics

Number of people living with HIV : 64 000
(UNAIDS 2006)

Number of reported PLWHA: 12 341
(PNG Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO, 2005)

Adults aged 15 and over living with HIV: 57 000
(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

Women aged 15 and over living with HIV: 34 000
(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

Children aged 0 to 14 living with HIV: 11 000
(Gerewa, M., 2005, "11 000 kids have AIDS," Post Courier, 26 January, 2005)

Number of AIDS orphans: 9 400
(Gerewa, M., 2005, "11 000 kids have AIDS," Post Courier, 26 January, 2005)

Number of people needing ART: 2 000
(PNG Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO, 2005)

Number of people receiving free antiretroviral therapy: 320
(PNG Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO, 2005)

Number of AIDS deaths in 2005: 3 300
(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

HIV and AIDS prevalence rate among adults aged 15 to 49: 1.8%
(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

% reported PLWHA who are women: 50%
(PNG Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO, 2005)

% reported PLWHA who are adults: 93.1%
(PNG Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO, 2005)

% people with advanced HIV infection receiving anti-retroviral therapy: 15.0%
(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

% HIV cases attributed to heterosexual transmission: 84%
(PNG Summary Country Profile for HIV/AIDS Treatment Scale-Up, WHO, 2005)

% rural residents who lack accurate knowledge of HIV and AIDS prevention: 85%
(Cullen, T., "HIV and AIDS in Papua New Guinea: a reality check," Pacific Journalism Review, 12(1), 2006)

Thailand

Background

Thailand has been applauded as one of a handful of countries to have reversed a serious HIV and AIDS epidemic. Yet the 580 000 Thais currently estimated to be HIV positive serve as a reminder that success is relative; Thailand's 1.4% HIV prevalence rate still stands as one of the highest in Asia.¹

The potential for a resurgent epidemic has not yet subsided. Unless Thailand continues to fight the epidemic on new fronts, it risks negating the hard-won achievements of years past.

While HIV was widely and rapidly transmitted by unsafe commercial sex during the 1990s, the remarkable success of the 100% Condom Program significantly curtailed this mode of transmission.

However, other avenues of HIV transmission have continued unabated. These avenues include sexual contact between HIV-positive men and their regular sex partners, unsafe injections among intravenous drug users, and casual pre-marital or extra-marital unprotected sex among youth.

The link between drug use and HIV has been consistently omitted from HIV policy, planning, and services. Given that less than 1% of Thai drug users receive any HIV prevention services and that needle exchange programmes are rare throughout Thailand, it is no surprise that between 50 000 and 125 000 IDUs (or around 50%) are now HIV-positive.

There is also concern that the 100% Condom Program may be waning in effectiveness, due to changes in culture. While fewer men are having sex with commercial sex workers, more sex work is now done "indirectly" in settings that are difficult to regulate, such as bars, clubs, restaurants, and hotels.

Furthermore, the increase in foreign commercial sex workers introduces a population that is more difficult for authorities to identify, educate, counsel, and treat.

Lastly, sexually transmitted infections (STI) among youth increased by 30% in 2004—a menacing harbinger of increased HIV prevalence among youth in the next few years.

Trends

First cases reported

1984

Explosion in reported cases especially in sex workers (50% in 1991), drug users and the military

1988

Reported condom use in brothels at 90%

1991

1994

1999

HIV prevalence increases in male-to-male community; in drug users remains at 50%

2003

Sexual activity and STIs in young people on the rise

2006

???

Government response

NCAPA begins interventions including 100% Condom Policy and widespread publicity campaigns

Most hospitals use AZT to reduce mother-to-child transmission

"War on drugs" targets users as well as traffickers; government HIV funding slashed

Services, facilities and recognition of the rights of drug users vulnerable to HIV and AIDS; renewal of campaigns and interventions targeting young people

The epidemic is undergoing geographic changes as well. Nationwide, HIV prevalence among pregnant women has been decreasing over the past several years. But data from the South has shown that HIV prevalence is, in fact, increasing in the region. Between 2000 and 2002, HIV prevalence among pregnant women in the Lower South doubled from 1% to 2%, and exceeded 3.5% in the provinces of Nakhon Sri Thammarat and Phuket.²

Thailand's response

Though AIDS was first reported in Thailand in 1984, 1988 marked the first major wave of the epidemic; within a single year, estimated HIV prevalence among IDUs shot up from nil to 40%. A second wave exploded among sex workers at about the same time, infecting up to 44% of sex workers in regions of northern Thailand. This bred the idea that HIV was a disease that afflicted only a few individuals in high-risk groups.

Snapshot: Lewadee Prachumwat, 35, living with HIV and AIDS in Ranong



“I consider myself fortunate in so many ways. I can think of many painful experiences but it is useless to dwell on them. I still have so many reasons to live.

My mother died when I was 11, leaving us in the care of our father who drank heavily and would bring his drinking friends home every day. When I was 14, I left home and went to Bangkok in search of a paid job.

I loved hair dressing and doing make up for others. I couldn't go to hairdressing classes because I did not have a government identification card, so I watched from a distance to learn how it was done. Eventually I applied for a job and got it, and I thought it was a good beginning for me.

But I ended up in some bad company, going out at night and gambling. I met my first husband then. He physically abused me and tricked me into spending all the money I was earning. I escaped from that with the support of Krilati, who became my second husband.

One day I had a severe headache after eating squid. I was dizzy and weak. My face and eyes got so swollen I had to go

home from work. I went to a doctor who said there was nothing wrong with me.

But I felt there was more to it than just an ordinary ailment. I suspected my first husband could have HIV. He had been on drugs, and I was fearful I'd been infected.

I went to a government clinic and was tested. I fainted when the doctor told me I was HIV positive. What could be more frightening? I didn't tell anyone – I was scared and ashamed.

I kept working and tried to save as much money as I could. When my health started to fail, I decided to go back to my home town... I never told Krilati where I was going. I just left him, thinking it was unfair to drag him with me in my misery. I lost weight, and gradually I lost my eyesight.

To my amazement, neighbours did not shun me. They knew why I was sick, yet they accepted me, with open arms. My brother became my guide and strength, making sure I took my medicine on time and taking me for checkups. I gained weight and a little sight. I found a job cleaning seafood in a processing shop.

Then Krilati came to find me and told me he wanted to be with me as I was. I never expected I would get so much love and support. I thought having HIV would be the end of everything for me. He gave me courage when I needed it most. I am fortunate beyond measure to have him in my life.

To others with HIV-AIDS, I say, do not conceal your condition. How can you find support if you hide yourself? How can other people help when they do now know your true situation? You can never be free if you are in hiding. You can never be a lesson to others. Accept the truth and come out. There are good people who can understand and help. And love and support from families can move mountains.”

Key government groups

National Committee on AIDS Prevention and Alleviation (NCAPA)

- ▶ Originally under the Ministry of Health, but moved in 1991 to the Office of the Prime Minister. Chaired by then Prime Minister Anand Panyarchun until 1999
- ▶ Prioritized HIV and AIDS ahead of law enforcement by working with commercial sex establishments on the “100% Condom Policy”
- ▶ Implemented three National Plans with measurable success but more recently disempowered by reduced funding and a general attitude that the battle has been won.

Thus, early government responses to the epidemic were limited to a short term HIV and AIDS plan (1989-1991) that focused on education and surveillance, and a policy to screen donated blood for HIV. However, by 1991, the gravity of the situation demanded intervention. New HIV infections totaled 140 000 per year. Prevalence topped 50% among sex workers and 3.5% among military recruits.

Moving the national HIV and AIDS response team from the Ministry of Health to the Office of the Prime Minister allowed it to take inspirational leaps in policy, including: implementing a National Plan for Prevention and Alleviation of the AIDS Problem (1992-1996); assigning each government Ministry a role in the HIV and AIDS response; creating provincial and regional AIDS committees; increasing the budget for HIV and AIDS; repealing the policy of mandatory reporting of AIDS patients; and launching a public information campaign via radio, television, and schools.

Perhaps the most important and effective step was the creation of the “100% Condom Program,” which aimed to enforce universal condom use in all commercial sex establishments. Although prostitution was illegal in Thailand, the government took pragmatic steps to work with brothel owners to enforce 100% condom use in all commercial sex establishments.

The program provided free distribution of condoms; better STI treatment; mandatory monthly STI screenings for sex workers; and a campaign to discourage men from visiting brothels. 19 From 1991 to 1994, the number of government STI clinics grew from 85 to 474.³ Reported

condom use in commercial sex establishments increased from 14% in 1989 to 90% in 1994.⁴

In 1997, interviews with owners of sex establishments in 24 provinces found that 90% had been visited by health workers, sometimes as often as once a month.⁵

The second National Plan for Prevention and Alleviation of the AIDS Problem (1997-2001) extended previous programs and added others, such as ante-natal services. By 1999, the drug zidovudine (AZT) was being used in most hospitals in Thailand to reduce mother-to-child transmission of HIV.

The third National Plan for Prevention and Alleviation of the AIDS Problem (2002-2006) set three targets: (1) reduce adult HIV prevalence to less than 1% by 2006; (2) provide access to care and support for at least 80% of PLWHA; and (3) shift ownership of prevention and alleviation programs to local administrations and community organizations.

The need to extend HIV treatment and prevention services to IDUs was omitted in all three National Plans, and this lack of consideration confirmed early in 2003, when a “war on drugs” gave local authorities and police free reign to deal in a “ruthless” and “severe” manner with persons charged with drug offenses. The first three months of the crackdown resulted in 2 275 extrajudicial killings.⁶

In contrast to the inclusion of commercial sex workers—who, like IDUs, were technically breaking the law—into programs for HIV prevention and treatment, IDUs continued to be neglected and, in the case of the crackdown, actively suppressed.

In 2003, Thailand was awarded two Global Fund grants, used to strengthen the existing framework of prevention and treatment, to extend ART services from four pilot projects to all 76 provinces of Thailand; and to scale up HIV prevention and STI treatment services for 500 000 migrant workers from Myanmar, Cambodia, and Laos. The Global Fund also provided funds to the Raks Thai Foundation for a five-year proposal to make reproductive health services and condom promotion programs more accessible to migrant workers.

There has been disturbing evidence that a lack of government commitment is allowing a resurgence in the HIV epidemic. In 2003, while the influx of foreign funding reduced the number of AIDS deaths sharply, government funding fell to one-third of what it had been in 1997.

3. Hanenberg, R., and Rojanapithayakorn, W., 1996. “Prevention as Policy: How Thailand Reduced STD and HIV Transmission,” *Family Health International*

4. <http://www.who.int/inf-news/aids1.htm>

5. Thailand’s Response to HIV and AIDS: Progress and Challenges, UNDP, 2004

6. http://hrw.org/english/docs/2004/07/13/thaila9053_txt.htm

7. Cummings-Bruce, N., “Thailand faces new AIDS threat,” *International Herald Tribune* 2005

The HIV prevalence among MSM has been increasing, as well as the HIV prevalence of the general population in areas of Southern Thailand. The HIV prevalence rate among IDUs has remained at an atrocious 50%.⁷ According to UNAIDS Thailand, public awareness campaigns have all but disappeared. Police have been recently treating the possession of a condom as evidence of selling sex—a practice prohibited by law.⁸ Furthermore, nothing yet has been done by the government to address the rampant HIV prevalence levels among IDUs.

On the agenda

Services for injecting drug users

Prevalence rates among IDUs have remained at very high levels—40% to 50%—long after prevalence rates in nearly all other populations have decreased. Despite the fact that IDUs in Thailand number only 250 000 (Thailand's entire population exceeds 64 million), Human Rights Watch estimated that IDUs accounted for 30% of new HIV infections in 2005.

The injustice of the situation is clear, and so is the danger; it would be foolhardy to presume that the epidemic will stay neatly confined to this sub-population. To continue ignoring the issue is to invite an HIV resurgence in the coming years.

Government policy regarding drug users has not so much been ignoring them as criminalizing them. The 2003 “war on drugs” functioned to drive drug use further

underground. Studies have shown that imprisoned drug users continue injecting in prison, often sharing needles and syringes with other prisoners.

Whether in prison or in hiding, IDUs in such circumstances are not likely to seek or receive prevention education, let alone treatment for HIV. The end results of the war on drugs are disastrous for IDUs as well as their sexual partners.

As of 2005, almost no HIV and AIDS services were being offered to IDUs. Methadone maintenance and needle exchange programs were scarcely available. Only one out of every hundred drug users was receiving any HIV prevention services. Few drug users had access to ART. In fact, drug users were not eligible for ART until after the Thai Drug Users' Network was formed in 2002 and advocated the Ministry of Public Health for their inclusion. Furthermore, IDUs continued to be left out of the government's HIV and AIDS response, including applications to the Global Fund.

In 2004, the Thai Drug Users' Network collaborated with the Raks Thai Foundation to win an independent Global Fund grant to scale-up a peer-driven network and to establish facilities for harm reduction.

The Thai government has pledged to improve both HIV prevention services for IDUs and the availability of human drug treatment programs, but these promises have yet to materialize. It will be up to the Thai Drug Users' Network, in collaboration with NGOs and civil society, to hold the government to its promises, and then assist in carrying them out.

Drug users demand their rights

The Thai Drug Users' Network represents a remarkable case of successful advocacy at the national and international level.

Drug use had long represented a “gap” in Thailand's otherwise outstanding HIV and AIDS policy. After seeing so many of their peers succumb to AIDS, a few drug users formed the Thai Drug Users' Network in 2002 to begin documenting their lack of access to HIV prevention and AIDS treatment services.

In April 2003, members of the Network organized a peaceful protest during a presentation by the Thai minister of health at a meeting of the International Harm Reduction Association. Protestors stood with signs that read “Clean needles saves lives” and “50% of Thai drug users = HIV+”. The action brought international attention to the recent anti-drug crackdown and to the absence of government attention to HIV and AIDS among drug users.

Afterwards, officials of the Ministry of Public Health and the Office of Narcotics Control agreed to meet with the Thai Drug Users' Network. Following this and subsequent meetings, the eligibility criteria for ART was changed to allow drug users to receive ARV treatment.

In spite of some collaboration with policy-makers, the Thai Drug Users' Network was unable to persuade the Thai government to include HIV and AIDS services for drug users in the proposals it submitted to the Global Fund.

Taking advocacy to a higher level, the Thai Drug Users' Network submitted a separate application to the Global Fund and won a grant to continue its advocacy as well as to expand services for drug users.

8. http://www.un.or.th/unaidsth/five_priority.php#

Prevention of youth transmission

According to former minister and current Senator Mechai Viravaidya, public education was creative, enlightened, and persuasive from the years 1991 to 2000. But from 2000 onward, after the government's HIV and AIDS budget was slashed following the Asian Financial Crisis, "public education has been in a state of suspended animation."⁹

With the virtual disappearance of prevention campaigns for six years, a cohort of adolescents grew into adulthood without the AIDS awareness and prevention messages that pervaded the media only years before. Of young people 15 to 24 years old, 80% feel that they are in no danger of being infected.¹⁰ Only 20% of sexually active young people report using condoms regularly.¹¹

Misconceptions about HIV transmission are common; nearly 20% of young people surveyed believed that HIV and AIDS could be transmitted by hugging or kissing.¹² Most ominous of all, surveillance data from 2004 found that STI among youth increased by 30% in 2004.¹³

In 2003, prevention programs accounted for 8% of the total HIV and AIDS budget. In 1997 the budget for prevention programs was 11% of the total HIV and AIDS budget. While the current administration's initiative to scale-up ART is admirable, it seems as if the expansion is coming at the cost of prevention.

Implementing universal ART does nothing to halt the spread of HIV if it is not accompanied by prevention efforts. Without public education, HIV will continue to spread, eventually making universal treatment far more expensive and difficult for a nation to achieve.

Solution: Life skills for young people



An education session on the dangers of syringes for young people in northern Thailand.

With networks and programmes already working on education, leadership and rights awareness for children in disadvantaged communities, World Vision is well placed in Thailand to share messages of HIV and AIDS among young people.

An annual sports competition, for instance, has become a forum for discussions on teenage health issues, including sexual activity and drug use. After a home town selection process, followed by district finals, children congregate from all over Thailand to compete for the Supanimit World Vision Cup.

Here they have opportunities to learn about HIV and AIDS, ask questions and discuss the community and peer pressures they face. They are encouraged to take up HIV and AIDS awareness as a personal campaign when they return to their communities.

In 2006, the finals were held in Chiang Mai. Most of the participants were aged around 12, still young enough to be excited by trips to the flower show and local zoo, but already vulnerable to the pressures of adolescence. In between playoffs, a series of short workshops taught them about the links between drug use and HIV infection, as well as the importance of safe sexual behaviour.

Winners of the girls' volleyball were the team from Phayao in Northern Thailand, and the boys' soccer from Songkhla in the south. Both areas have been ravaged by HIV and AIDS, and in Thailand's south, prevalence is still on the rise.

For the sake of these young people and their peers, the Supanimit Cup may have come just in time.

9. <http://www.abc.net.au/ra/asiapac/programs/s1152229.htm>

10. Opinion Poll on HIV and AIDS in Thailand, Research Institute of Bangkok University, UNDP, 2004
<http://www.undp.or.th/docs/OpinionPollAIDS.pdf>

11, 12. *Thailand's Response to HIV and AIDS: Progress and Challenges*, UNDP, 2004

13. Tang, A., "AIDS believed on the rise again in Thailand," *Associated Press*, 2005

<http://www.sfgate.com/cgi-bin/article.cgi?f=/n/a/2005/10/03/international/i065014D99.DTL&type=health>

Thailand statistics

Number of people living with HIV: 580 000

(2006 Report on the Global AIDS Epidemic, UNAIDS)

Adults aged 15 and over living with HIV: 560 000

(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

Women aged 15 and over living with HIV: 220 000

(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

Children aged 0 to 14 living with HIV: 16 000

(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

Number of people needing ART in 2004: 100 000

(Thailand's Response to HIV/AIDS: Progress and Challenges, UNDP, 2004)

Number of people receiving free antiretroviral therapy in 2004: 50 752

(Follow up to the Declaration of Commitment on HIV/AIDS, UNGASS, 2006)

Number of AIDS deaths in 2005: 21 000

(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

HIV and AIDS prevalence rate among adults aged 15 to 49: 1.4%

(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

HIV and AIDS prevalence rate among IDUs: 50%

(Thailand's Response to HIV/AIDS: Progress and Challenges, UNDP, 2004)

HIV and AIDS prevalence rate among MSM: 24%

(“Thailand faces new AIDS threat,” International Herald Tribune, 2005)

% people with advanced HIV infection receiving anti-retroviral therapy: 60.0%

(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

% HIV-positive pregnant women receiving treatment to reduce mother-to-child transmission: 30.6%

(2006 Report on the Global AIDS Epidemic, UNAIDS 2006)

% HIV cases attributed to heterosexual transmission: 80%

(Health Profile: Thailand, USAID, 2005)

% youth who are being reached by adequate HIV and AIDS prevention services: 5%

(Thailand's Response to HIV/AIDS: Progress and Challenges, UNDP, 2004)

Recommendations for change

The HIV/AIDS pandemic is spreading rapidly in parts of Asia and is an urgent matter for millions. Gaps in policy and practice demand response from civil society which promotes positive change for all especially children. Advocacy linked to and integrated with programs is a powerful approach which has increased international commitment. It is also effective to build momentum with local authorities and address attitudes and behaviors arising from stigma.

In 2006 public health specialist Dr Douglas Shaw prepared a review for World Vision of HIV and AIDS advocacy approaches. The following summary of his recommendations gives useful, encouraging recommendations for future advocacy planning on the issue of HIV and AIDS in the Asia-Pacific region.

Below: A community rally to raise awareness of gender violence in rural Cambodia. With gender inequality one of the contributing factors to the spread of HIV and AIDS, integrated advocacy campaigns can have multiple benefits.



What is advocacy?

World Vision defines advocacy as: “a project, programme or programmatic approach which seeks to address the structural and systemic causes of poverty by changing policies, systems, practices and attitudes that perpetuate inequality and deny human rights. Advocacy is a ministry of influence using persuasion, dialogue and reason to obtain change. To be successful in advocacy we must work at two complimentary levels: policy influence and citizen empowerment.”

World Vision supports approaches which promote empowerment as a central tenet, with the development of alternatives to the current, predominantly western, advocacy model, which will move policy analysis closer to the actual programs. Ideally, models will be child focused with health, education and livelihoods as the key themes around which advocacy will be built.

Reliable high quality research is foundational for strong advocacy work and this will involve World Vision in active participation in coalitions and partnerships, including relevant faith-based coalitions. Advocacy models will be adapted for various contexts including those in stable democracies, politically constrained countries and fragile states.

Advocacy, status and respect in Asia-Pacific cultures

One relevant and interesting issue for further consideration is the respect accorded to persons of different status in Asian and Pacific (and many other) cultures and the importance of strong personal relationships.

The World Vision Foundation of Thailand has demonstrated success in advocacy at multiple levels, with the advocate selected on the basis of the required status and respect level. In this example, World Vision senior managers advocate at the national government level. project managers and coordinators advocate at the provincial and district levels, while World Vision field staff advocate at the community level. This reaches two levels of advocacy where World Vision seeks to operate: citizen empowerment and policy in practice.

Child-centered rights approach for HIV advocacy

The United Nations has published a General Comment on HIV/AIDS and the rights of the child, based around the Convention of the Rights of the Child (CRC) . Of direct relevance to this review of HIV and AIDS advocacy are the following points:

Article 2: the right to non-discrimination.

Discrimination can lead to children being denied access to information, education and health or social care services, especially for girls.

Article 3: the best interests of the child.

All policies and programs for prevention, care and support of HIV among children must consider the best interests of the child with strategies adapted to children's rights and needs.

Article 12: the right to express views and have them taken into account.

The participation of children in HIV prevention, care and support planning, implementing, monitoring and evaluation is strongly endorsed with specific mention of peer education.

Article 17: the right to access information and material aimed at the promotion of the social, spiritual and moral well-being, physical and mental health of children.

Article 24 (f): the right to preventive health care, sex education and family planning education and services

Stigma and Discrimination

One consistent finding in relation to advocacy for HIV and AIDS in Cambodia, India, Papua New Guinea and Thailand was the importance of addressing stigma and discrimination. A recent study by Ogden and Nyblade in 2005, in Ethiopia, Tanzania, Viet Nam and Zambia, described stigma as “a process of devaluation” of people either living with, or associated with, HIV and AIDS.

Here, one key finding was that HIV and AIDS stigma and discrimination was “remarkably consistent” across the four countries studied despite the very different contexts.

A detailed analysis of the results indicated that in all four study locations a process of fear related to unlikely casual modes of transmission, combined with fear-based public messages and underlying moral judgments, led to a division between “them” and “us”. People living with HIV tended to be placed on a continuum from innocence (children) to guilt (sex workers and injecting drug users). Stigma was found to be greater towards women than men, perhaps because women are expected to uphold the moral traditions of society.

Four broad types of stigma were found in all four countries, although with varied specific expression:

- ▶ physical stigma: isolation and violence
- ▶ social stigma: isolation, voyeurism, loss of identity and role
- ▶ verbal stigma: gossip, taunting, experience of blame and shame, labeling and use of derogatory words
- ▶ institutional stigma: loss of livelihood and housing and differential treatment in school, health care, public spaces and in the media.

The consequences for individuals with HIV infection were: loss of marriage and child-bearing as life options; loss of livelihood; poor care in the health sector; withdrawal of care-giving in the home; and internalized or “self-stigma”, with effects on mental health including loss of hope, feeling worthless, having no future, anxiety and depression.

Programming guidance of direct relevance for advocacy includes:

- ▶ Focus on the most vulnerable children and communities, not only children orphaned by AIDS to minimize stigma and discrimination
- ▶ Involve children and young people as active participants in the response
- ▶ Give particular attention to the roles of boys and girls, men and women, and address gender discrimination, with efforts to encourage men to assume greater responsibility for child-rearing, providing care for those who are ill, and in daily household tasks
- ▶ Strengthen partnerships and mobilize collaborative action.

Tips for successful advocacy:

- ▶ Patience – advocacy takes time
- ▶ Understand the context
- ▶ Build strong personal relationships – which also takes time and effort
- ▶ Build strong partnerships and networks – with the active involvement of all members
- ▶ Identify the appropriate advocate for the task ahead, culturally and/or hierarchically
- ▶ Link advocacy efforts directly to other activities (eg. behaviour change communication and advocacy to reduce stigma and discrimination)
- ▶ Connect grass-roots programmes with national/international advocacy initiatives
- ▶ Organize advocacy initiatives to address local causes of problems already identified by development programmes
- ▶ Identify the issue(s) and assess how important they are – prioritise and order actions
- ▶ Identify the gatekeepers
- ▶ Monitor progress, evaluate, document and share among the NGO community
- ▶ Community mobilisation/participation as an important component of effective advocacy
- ▶ Intentionally include advocacy aims in project design including capacity building on advocacy approaches with program staff and partners.
- ▶ Ensure support, understanding and commitment on advocacy from internal management and human resources

World Vision's international campaign for orphans and vulnerable children calls for the following:

- ▶ Implementation of the 2001 HIV and AIDS UNGASS Declaration of Commitments for children orphaned and made vulnerable by HIV and AIDS
- ▶ Raise \$15 billion globally per year for OVC, based on proportional giving from all developed and developing countries and focused on strengthening family and community care for OVC
- ▶ Eliminate local school and health fees, and associated costs for vulnerable children
- ▶ Provide access to treatments (both drugs for opportunistic infections and ARVs) for parents to delay orphaning and extend the parent-child relationship
- ▶ Provide access to treatments for children with HIV
- ▶ Drop the debt for newly indebted countries with significant numbers of orphans

World Vision maintains that attention to the following areas are mandatory to an effective response:

1. Expanding and strengthening care for OVC

- ▶ Every country with a substantial number of orphans and vulnerable children has a fully resourced and implemented OVC policy and action plan based on the international OVC framework, and
- ▶ Not less than 10% of HIV and AIDS funding (by governments of north and south, bilateral and multilateral donors) is allocated to OVC care and support,

2. Reduction of gender-based vulnerability to HIV

- ▶ By 2010, all national governments in countries where World Vision operates are working with civil society partners to protect child rights and equip all girls and boys with life skills that enable them to reduce their own and others' gender-based vulnerability to HIV transmission,

3. Continuum of care and treatment

- ▶ By 2010, all national governments in countries where World Vision operates have developed and are implementing rights-based policies and action plans enabling effective universal access to a continuum of care and treatment to help all girls, boys, women, and men living with HIV and AIDS to experience life in all its fullness.

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