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# **Thailand: Addressing HIV/AIDS— Proven Solutions and New Problems**

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## **Executive Summary**

The East Asia and Pacific region of the World Bank has an estimated 2.3 million adults and children living with HIV/AIDS, out of the global total of 42 million. In such a large and diverse area, the HIV/AIDS epidemic is as varied as the countries—from 12 fishermen with HIV in Tuvalu, with potentially devastating consequences for the country's fishing-based economy, to an estimated 1 million people infected in China at the end of 2002, with profound implications for the health system there. HIV threatens progress towards achieving the Millennium Development Goals and related poverty targets in the region and around the world. Although the situation varies greatly from country to country and even among provinces within countries, the situation is urgent.

Thailand has acted decisively in the face of this challenge, leading the way in prevention programs, mobilizing civil society and building political commitment. At the beginning of the AIDS epidemic, the initial standard public health approach did not discover many cases, leaving Thai officials with the perception that HIV affected only marginal groups. In 1989 HIV testing of injecting drug users revealed the explosive spread of infection. By 1992, 31 percent of commercial sex workers were HIV-positive, and there were signs of HIV spreading to the heterosexual population. Thailand implemented good serological surveillance of the general population, sentinel surveillance of groups whose member practice high-risk behavior, and surveillance of risky behavior. The national response to the crisis was strong, swift, and comprehensive, thanks to strong political commitment from the King and Prime Minister.

Strong leadership provided high-level support for HIV-prevention programs among commercial sex workers and their clients. AIDS policy was run from the Prime Minister's Office. A massive public information campaign emphasizing prevention, behavior change, and condom use was launched. Private initiatives, focusing on education and prevention in the workplace, complemented the government efforts. A 100 percent condom program to promote universal and consistent use of condoms in commercial sex was adopted nationwide, including regular screening for sexually transmitted diseases (STDS) and free condoms. Public spending on AIDS prevention and control increased greatly from 1987 to 1997, when it totaled \$82 million a year. The result: a profound decline in high-risk behavior, reducing new cases of HIV and eventually decreasing the level of HIV in the population. (HIV prevalence in 21-year-old army conscripts declined nationally from 4 percent in 1993 to 1.9 percent in 1999.)

Around the world the international AIDS community is scaling up interventions that have been tried in other countries or in a randomized controlled trial. Both Thailand and Cambodia have excelled in systematically launching local pilot projects, including 100 percent condom programs and treatment or home-care programs, before applying them nationally. In addition, Thailand has encouraged large international research projects that measured HIV incidence, and participated in the first large-scale trial of an HIV/AIDS vaccine.

A regional approach is needed to address external catalysts such as migration and mobility, which have a complex impact on the spread of HIV/AIDS. There are also regional networks trafficking in women and illicit drugs. These regional factors create the preconditions of high-risk behavior, behavior that can ignite an HIV/AIDS epidemic. International assistance has also played and will continue to play a major role in local responses in countries throughout the region.

A major reminder from each of the countries experiencing the epidemic is that inaction can be more costly than action. This need for action is illustrated in the Millennium Development Goal (MDG) of reducing HIV prevalence in persons aged 15-24 by 25 percent by 2010. If countries are not successful in achieving this goal, other MDGs could also be compromised. Similarly, AIDS can destroy human capital and can weaken mechanisms that generate human capital formation. Through this long-term process, the disease could lead to severe economic consequences. For example, some studies show that in Thailand farm output and income fell between 52 and 67 percent in households affected by AIDS.

In order to lessen the economic and social costs of HIV—and continue the fight against poverty—we must learn from the lessons of countries already deeply involved in the struggle:

- Political commitment is imperative to tackle and mobilize resources around difficult social issues, such as sexual behavior and commercial sex work.
- Institutional innovation within governments, the health system, social services, and other sectors must be encouraged.
- Systematic learning and experimentation, based on strong pilot tests and evaluation, can enhance national programming.
- Interactions with external catalysts, including international donor assistance, must be managed well.

“Government reluctance to address AIDS has something to do with sex.” That’s the view of Mechai Viravaidya, founder of Thailand’s Population and Community Development Association. He has successfully put AIDS and condoms in the public eye and kept them there using humor and flair. Mechai says, “Humor has kept the issue alive. And in areas where there is possible embarrassment, it has helped tremendously.”

The way these and other lessons are adopted and adapted within the East Asian region will determine the future of the epidemic and the social and economic landscape of Asian society. As Jemal ud-din Kassum, the regional vice president for the East Asia and Pacific Region at the World Bank, says: “Political leaders and the public have to acknowledge that it’s a problem. Then they have to move swiftly and deeply on prevention for all risk groups, build capacity, and address health system issues. They also need to prepare for treatment and support. And in doing all of this, we need to continue to keep the focus on achieving results.”

## Implementation Process

The initial response to the epidemic in Thailand<sup>1</sup>, identified in 1984, was muted. The government believed that the epidemic would remain concentrated in groups practicing high-risk behaviors, particularly intravenous drug users and men who have sex with men. This view changed in 1989, when the first national epidemiological surveillance found that 44 percent of sex workers in the northern province of Chiang Mai were infected with HIV, leading first to increasing rates of HIV infection among their male clients and then among the general population. At this point, (1991) its national response—strong, swift, and comprehensive—addressed the situation.

### **Moving from standard approaches to national sentinel surveillance for monitoring key risk groups**

Before 1989 Thai government policy on HIV/AIDS control followed a standard public health approach, emphasizing case reporting of AIDS through the medical system.<sup>2</sup> The standard reporting system did not discover many cases: in the five years after the first case was reported, only 43 AIDS cases and 145 cases of AIDS-related complex were reported to the Ministry of Public Health's AIDS Control Unit.<sup>3</sup> Small surveys of HIV seroprevalence in Bangkok through 1987 failed to detect the rapid spread of HIV, and there was limited information on high-risk groups. AIDS was thought of largely as a foreigners' disease, supported by the fact that the first cases were among gay men returning from abroad. The government initially downplayed the significance of the epidemic to the general population, doing nothing to correct the perception that AIDS was likely to affect marginal groups such as men who have sex with men, male sex workers, and injecting drug users.

In 1989, the government saw the importance of a comprehensive surveillance system and adequate treatment of sexually transmitted infections. Supported by more than a decade of technical cooperation with the U.S. Centers for Disease Control and Prevention, Thailand had good serological surveillance of the general population, sentinel surveillance of groups whose members practice high-risk behavior, and surveillance of risky behavior. This surveillance identified some of the key sources of the spread of the disease and monitored the effectiveness of public health interventions. And this public health infrastructure enabled commercial sex workers to receive regular check-ups for sexually transmitted infections—infections that can increase the chance of contracting and transmitting HIV. At that time there was little public education by the government.

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<sup>1</sup> This section has been abridged from the Thailand Social Monitor (World Bank. 2000. *Thailand Social Monitor: Thailand's Response to AIDS: Building on Success, Confronting the Future*. Bangkok.).

<sup>2</sup> Phoolcharoen, Wiput, Kumnuan Ungchusak, Werarit Sittitai, and Tim Brown. 1998. "Thailand: Lessons learned from a strong national response to HIV/AIDS." Bangkok: AIDS Division, Communicable Disease Control Department, Ministry of Public Health. June.

<sup>3</sup> Ibid.

### **HIV prevalence numbers transform the perception of threat as minor to real and broad**

In 1989 HIV testing was introduced into government methadone treatment centers for heroin addicts.<sup>4</sup> At the same time, a short term AIDS plan was developed by the Communicable Disease Control Department of the Ministry of Public Health, supported by the World Health Organization (WHO). The explosive spread of HIV infection among injecting drug users that year prompted both the Royal Thai Army and the Ministry of Public Health to launch HIV surveillance of specific groups. Small samples were tested from sentinel high-risk groups – injecting drug users, male patients at clinics for sexually transmitted infections, blood donors, pregnant women, prisoners, and brothel-based, indirect, and male sex workers. By 1990 the testing was expanded to all 73 provinces, but government public education was still missing.

The implementation of the national sentinel surveillance system and the public dissemination of results made it difficult to deny the reality of the disease and helped initiate the change in social norms necessary to change behavior. The findings that the HIV infection already had a foothold transformed the perception of the disease to one that posed a threat to the entire population.<sup>5</sup> Public availability of survey results by the NGO Sector helped introduce an expanded AIDS policy. But many factors impeded transparency like the concerns of deterring tourism, immigration restrictions on people carrying HIV, and mandatory reporting of the information of all HIV/AIDS patients to the government.

### **Top leaders make prevention and control a top priority**

Although many pieces of the puzzle were beginning to come together by the early 90s, this issue was not given priority at the national level – a key to longer-term sustainability for such initiatives – until January 1991. At this time, under the short, transitional government of Prime Minister Anand Panyarachun (1991–92), AIDS prevention and control became a national priority at the highest level, emphasizing progressive policies to encourage safer behavior.

Thailand’s response was based on a political commitment to tackle difficult social issues, such as sexual behavior and commercial sex work. The government, in particular the prime minister, made HIV/AIDS prevention a priority and focused on decreasing high-risk behavior. The prime minister chaired an official multisectoral National AIDS Prevention and Control Committee, signaling political commitment at the highest level and introducing formal participation of NGOs in the policymaking process. Four developments catalyzed political support for confronting HIV/AIDS.

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<sup>4</sup> Ibid; Weigner, Burce G., Khanchit Limpakarnjanarat, Kumnuan Ungchusak, Sombat Thanprasertusk, Kachit Choopanya, Suphak Vanichseni, Thongchai Uneklabh, Prasert Thongcharoen and Chantapong Wasi. 1991. “The epidemiology of HIV infection and AIDS in Thailand.” *AIDS* 5(suppl 2): S71-S85.

<sup>5</sup> Porapakkham, Yaowarat, Somjai Pramarnpol, Suparatra Athichhoddhi and Richard Bernhard. 1996. “The evolution of HIV/AIDS Policy in Thailand: 1984-1994.” *AIDSCAP Policy Working Paper Series, WP5*. Family Health International/AIDSCAP/USAID. Project 936-5972.31-4692046.

- AIDS policy was put under the Office of the Prime Minister, and the prime minister chaired the multisectoral National AIDS Prevention and Control Committee. The Minister of Public Health became deputy chair. This signaled high-level political commitment and opened up dialogue with nongovernmental organizations (NGOs) and other groups.
- At the same time, a public information campaign was launched with high-level political support from the Prime Minister's fellow cabinet minister, Mechai Viravaidya, previously a nationally known political figure with experience in family planning campaigns and strong ties to NGOs.
- The 100 percent condom program was introduced, encouraging public health officials to work together with law enforcement.
- A variety of repressive policies were repealed, such as the mandatory reporting of the names and addresses of people with HIV.

### **Massive information campaign gets AIDS in the public eye**

Mechai Viravaidya led a massive public information campaign. Mandatory half-minute TV and radio AIDS education spots emphasized prevention, behavior change, and condom use, presenting AIDS not just as a health problem, but as a social problem. All radio and TV stations were required to play these announcements during every hour of broadcast. The Ministry of Education launched peer education programs among students, greatly raising their level of awareness. Government efforts were complemented by private initiatives, culminating in the Thailand Business Coalition on AIDS, formed in 1993 to promote HIV/AIDS education and prevention in the workplace. Together, this information built a solid foundation of prevention messages on which other elements of the campaign were built. Most government officials were given short courses on HIV/AIDS.

### **Prevention at the core of the response—The 100 percent condom program**

In 1989, a new approach – later to be called the 100 percent condom program – was implemented in the Ratchaburi province. In collaboration with local authorities, public health officers, sex establishment owners, and sex workers, the program required that all establishments and sex workers in the province would use condoms in every sex act. Soon after implementation, rates of sexually transmitted diseases decreased significantly. And by late 1991 other provinces decided to create similar programs – with similar outcomes. At the same time, the Faculty of Medicine at Khon Kaen University and the Thai Red Cross were piloting similar programs in Khon Kaen, Bangkok and Pattaya.<sup>6</sup>

As these early efforts were producing significant results, the Thai government decided to take this initiative to an even higher level. In 1992 a 100 percent condom program was adopted

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<sup>6</sup> UNAIDS, Thailand MOH. 2000. Evaluation of the 100 percent Condom Programme in Thailand. Geneva.

nationwide to promote universal and consistent use of condoms in commercial sex.<sup>7</sup> Prostitution remained illegal. But instead of attempting to suppress commercial sex, the authorities took a pragmatic approach of encouraging condom use. Sex workers were screened weekly or biweekly for STDs, treated, and provided with free condoms.<sup>8</sup>

The program required cooperation between public health officials, brothel owners, local police officials, and sex workers. Widespread implementation ensured that sex establishments that enforced condom use would not lose business to those that did not. Mechanisms to monitor compliance already existed: Thailand had an extensive network of STD treatment clinics and a public health service list of sex establishments. Compliance was monitored by tracing STD patients back to the brothels where they were infected.

### **Public spending increases**

Between 1991 and 1997 the Thai government greatly increased its spending on AIDS prevention and control. Total AIDS spending by government and donors rose from \$684,000 in 1989, mostly financed by WHO, to \$10.1 million in 1991, with almost three-fourths financed by the Thai Government. By 1997 total spending from the AIDS control budget had reached \$82 million a year, with 96 percent financed by the government. Private business and the civil society sector contributed another \$80 million in 1991.<sup>9</sup>

## **Impact Analysis**

The way in which the national government, local communities and people practicing high risk behaviors responded to the crisis appears to have led to a reduction in demand for commercial sex, a significant increase in condom use in commercial sex in brothels, a decrease in sexually transmitted infections, and ultimately a decrease in new HIV infections. Condom use in brothels rose from about 14 percent to more than 90 percent between 1988 and 1992 (figure 1). The number of men visiting sex workers also declined. Between 1990 and 1993, the percent of men reporting any premarital and extramarital sex dropped from 28 percent to 15 percent, and the percent visiting sex workers dropped from 22 percent to 10 percent. HIV prevalence among 21-year-old army conscripts, which had risen to 4 percent in 1993, began a steady decline to 1.56 percent by 1999. The decline was even more profound in the North, where it dropped from 12

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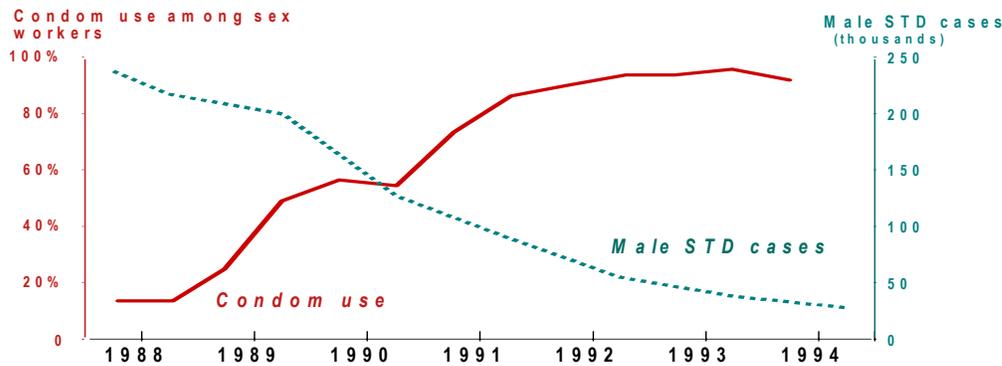
<sup>7</sup> Rojanapithayakorn, Wiawat and Robert Hanenberg. 1996. "The 100 percent condom program in Thailand." *AIDS* 10(1): 1-7.

<sup>8</sup> Chitwarakorn, Anupong, Werasit Sittitrai, Tim Brown and Doris Mugrditchian. 1998. "Sexually transmitted diseases in Thailand", Chapter 20 of Tim Brown, ed., *Sexually Transmitted Diseases in Asia and the Pacific*. Melbourne: Venerology Publishing Inc.; Chamrathirong, Aphichat, Varachai Thongthai, Wathinee Boonchalaksi, Philip Guest, Churnrurtai Kanchanachitra, and Anchalee Varangrat. 1999. "The success of the 100 percent condom promotion programme." Institute for Population and Social Research, Mahidol University.

<sup>9</sup> Viravaidya, Mechai, Stasia A. Obremsky and Charles Myers. 1993. "The economic impact of AID on Thailand." Chapter 2 of D.E. Bloom and J.W. Lyons, eds. *Economic implication of AIDS in Asia*. New Delhi: United Nations Development Program.

percent to less than 2 percent. Sexually transmitted infections among men also declined dramatically (see figure 1).

**Figure 1. Rising condom use and declining sexually transmitted infections, 1988–94<sup>10</sup>**



### Big behavior changes and better outcomes

- *Condom use up.* Condom use in brothels rose from about 14 percent in 1988 to more than 90 percent in 1992. And high condom use was maintained: a 1997 survey of nearly 2,000 sex workers in 24 provinces found that 97 percent of sex workers always used condoms with casual customers and 93 percent always used them with regular customers.<sup>11</sup>
- *Commercial sex down.* Between 1990 and 1993, the share of men reporting any premarital or extramarital sex dropped from 28 percent to 15 percent, those visiting sex workers dropped from 22 percent to 10 percent, and the share consistently using condoms in commercial sex rose from 36 percent to 71 percent.<sup>12</sup> The decline among 21-year-old army conscripts was also pronounced.

By the end of 2003, the number of new infections was reduced to 17,000 cases, significantly lower than the estimated 200,000 new cases at the end of 1991.

<sup>10</sup> Rojanapithayakorn, Wiwat and Robert Hanenberg. 1996. “The 100 percent condom program in Thailand.” *AIDS* 10(1): 1-7.

<sup>11</sup> Chamrathirong, Aphichat, Varachai Thongthai, Wathinee Boonchalaksi, Philip Guest, Churnrurtai Kanchanachitra, and Anchalee Varangrat. 1999. “The success of the 100 percent condom promotion program I Thailand: Survey results of the evaluation of the 100 percent condom promotion program.” Institute for Population and Social Research, Mahidol University.

<sup>12</sup> Phoolcharoen, Wiput, Kumnuan Ungchusak, Weraset Sittitrai, and Tim Brown. 1998. “Thailand: Lessons learned from a strong national response to HIV/AIDS.” Bangkok: AIDS Division, Communicable Disease Control Department, Ministry of Public Health. June.

## Driving Factors

Thailand – as well as other countries in the region – have committed to reducing the impact of the epidemic. Countries throughout the region have experimented with and piloted approaches that were drawn from regional and global innovations and were largely driven by a few key factors.

### Commitment and Political Economy for Change

Political commitment is difficult to mobilize for HIV/AIDS for two reasons: (a) because HIV is asymptomatic and therefore 'invisible' to policymakers when it is spreading the fastest and there are few AIDS cases; and (b) because it spreads in high-risk groups like injecting drug users and sex workers.

Surveillance of HIV behavior has been and should continue to be used to raise political commitment within this context. In Thailand, it was surveillance of HIV (in high-risk groups), coupled with behavioral studies, that showed a high percentage of commercial sex use. This made it impossible to deny the epidemic in Thailand and launched the government response: to raise condom use in commercial sex. Surveillance of HIV and behavior has also been key in Cambodia to demonstrate the vulnerability of the population (because of the behaviors) and to justify prevention in high-risk groups, which is politically difficult. Unfortunately, though, countries often only monitor HIV in pregnant women, a low-risk group, helping them to continue denying the epidemic. In such countries, change in policy could possibly heighten political commitment.

Surveillance is also important in a country like the Philippines, even though the epidemic is classified as low level. Currently, the sample sizes for surveillance are smaller than optimal for detecting changes in the general population, especially given the relatively high levels of certain sexually transmitted infections.

Communications are also necessary for building political understanding and commitment across a broad sectoral spectrum (health, education, transport) and for increasing public support for HIV/AIDS prevention programs. Understanding of not only *what* people think, but *why*, is critical to ensuring that communication aimed at achieving political commitment, raising awareness and changing attitudes and behaviors is focused and resonates with critical audiences. As noted, messages of prevention, behavior change, and condom use were successful elements of Thailand's fight against HIV.

Regulatory frameworks are another key to providing an enabling climate. The Chinese central government recently committed to a response to HIV/AIDS at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). They spoke of improving laws and regulations, launching public awareness campaigns, protecting the rights of people living with HIV/AIDS, increasing international cooperation on HIV/AIDS, and providing free anti-retroviral medicines to low-income HIV/AIDS patients. As this shows, the Chinese government has made great strides in its fight against HIV/AIDS, but more is needed if the epidemic is to be brought under control.

## **Institutional Innovation**

Much is made internationally of the importance of a multisectoral approach to HIV/AIDS. Both Thailand and Cambodia demonstrate the primacy (in an epidemic fueled by commercial sex) of involving a few key sectors—the ministry of health, brothel owners, the police (ministry of interior), and provincial administrations. The lesson is that promoting condoms in commercial sex is extremely difficult if the police are arresting the sex workers who participate in public health interventions. Both Thailand and Cambodia show that many multisectoral implementation efforts arise at the decentralized, provincial level.

Multisectorality, however, can not be well implemented if institutions are not able to agree internally. Responsibility for HIV/AIDS in Indonesia in the mid-1990s was spread throughout the Ministry of Health, with limited coordination across units, limiting the effectiveness of HIV programming. There was also inadequate capacity in the NGO sector. NGOs were generally too small and without the necessary experience to carry out complex interventions. Although institutional innovation in Indonesia is now increasing, these challenges had a negative impact on early responses to the epidemic. It is hoped that renewed commitment will promote an adequate response to what could be an emerging epidemic.

As in Indonesia, determining how to collaborate with civil society will also require innovation within government systems throughout the region. Nongovernmental organizations formed a large role in the prevention campaigns in Thailand. In countries like China with a large population scattered across a huge geographic area, learning how to better promote and utilize these partnerships could be key.

Innovation and capacity must also be encouraged within health systems. HIV/AIDS is straining these systems in several countries in the region. As health systems in many of these countries already lack capacity and are overburdened, this will soon become a major concern.

The same is true for health financing in the face of a major epidemic. In an under-resourced area, there is a need for new paradigms to increase access to health care. Thailand is reforming the way that health care is delivered and financed, and the outcome will have major implications for the effectiveness of HIV/AIDS control. By introducing the “30 Baht Scheme” to expand the availability of free health care, the government has recently committed to increasing substantially the share of health expenditures in the national budget and the share of the public sector in the provision of that care. The focus of reforms: making resource allocation between provinces more equitable, decentralizing health budgets and decisionmaking processes to provinces and subdistricts, introducing performance-based budgeting, and involving civil society in health-related decisions.

## **Learning and Experimentation**

Around the world the international AIDS community is "scaling up" interventions that have been tried in other countries or in a randomized controlled trial—but never piloted in-country. But both Thailand and Cambodia have excelled in this area, systematically launching local pilot projects

before applying them nationally and, in Thailand, embracing the contribution of the international and local research community.

In Thailand the 100 percent condom program was piloted in one province before it was adopted nationally. The mother-to-child transmission intervention was also piloted locally before it was implemented nationally. And the treatment program that started with 10,000 people in 2001 is planned to be rolled out slowly with a recent decision to add around 50,000 more people living with AIDS per year. In addition, Thailand has encouraged large international research projects that measured HIV incidence, and it participated in the first large-scale trial of an HIV/AIDS vaccine.

Cambodia piloted its own version of the 100 percent condom program in the local context (without Thailand's extensive STD clinic system) and home-based care. Both are in the process of being expanded nationally.

In both countries the pilot projects demonstrated political and technical feasibility, although evaluation of their costs and effects could have been stronger before they were extended nationally. But the political feasibility was critical to mobilize commitment for otherwise controversial interventions.

### **External Catalysts**

Regional integration can facilitate the spread of HIV/AIDS. Though linkages between HIV and migration and mobility are complex, they are evident in many parts of the world. The most obvious factor is labor migration, with vast numbers of people traveling between and within countries. Of the Filipinos reported to be living with HIV, 28 percent are workers that have returned home after working abroad.<sup>13</sup> There are also regional networks trafficking in women and illicit drugs. These regional factors create the preconditions of high-risk behavior—behavior that can ignite an HIV/AIDS epidemic. Programs to mitigate the risks of external catalysts, such as mobility, must address all stages of migration with a regional approach extending beyond country borders.

International assistance has also played and will continue to play a major role in local responses in countries throughout the region. The CDC's epidemiological training for the Thai surveillance team was a key factor in the response. In addition, the World Bank's Disease Control and Health Development Project created capacity in the National Center for HIV/AIDS, Dermatology, and STDs for the government to lead the response and financed surveillance. The project also financed the creation of local NGO capacity for HIV/AIDS interventions where it previously did not exist. Finally, it financed numerous interactions between Cambodian policymakers (including provincial authorities) and programs in Thailand, South Africa, and Kenya.

Globally, the movement for wider access to treatment—including antiretroviral therapy and care—is gaining momentum rapidly. It will provide a strong external incentive for action on

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<sup>13</sup> UNAIDS. 2002. *Report on the Global HIV/AIDS Epidemic*. Geneva.

treatment. It is stimulated by demands for equity in access to therapy, reduction of antiretrovirals prices—and by demands from the community and HIV/AIDS activists for the full spectrum of responses to the epidemic, from primary prevention to active treatment to care of the dying.

## Lessons Learned

A major reminder from each of the countries experiencing the epidemic is that inaction can be more costly than action. According to the new report *The Long-Run Economic Costs of AIDS: Theory and an Application to South Africa*<sup>14</sup>, most studies of the macroeconomic costs of AIDS, as measured by GDP, do not pay enough attention to the way human knowledge can be lost. This reports points to several factors that, together, create a particularly devastating combination.

First, AIDS destroys human capital. Adults become infected and then sick, unable to work. Eventually, the disease kills them in their prime, destroying human capital created over years of education and on-the-job training. Second, AIDS weakens and can destroy mechanisms that generate human capital formation. In family homes, the quality of child-rearing depends on the parents. If either or both parents die while young children are still living in the household, the transmission of knowledge and potential productive capacity across both generations are weakened. And the loss of income reduces resources, which may well result in the children spending less time in school or opting out of school. And the chance that the children may contract HIV at a later time makes investment in their education less attractive, even when both parents remain uninfected. Through this long-term process, the disease could lead to economic collapse.

In Papua New Guinea, a recent study illustrates this economic impact.<sup>15</sup> A rising fiscal deficit exceeded 5 percent of GDP in 2002. The ratio of public debt to GDP has grown rapidly in the last five years, reaching 74 percent of GDP in 2002. There has been a serious deterioration in the integrity of the budget institutions and in the transparency of mechanisms for ensuring accountability for public expenditure. This, together with a worsening fiscal situation, has meant reduced public expenditure, a deteriorating infrastructure, and a marked deterioration in public service delivery. While the economic situation has a detrimental impact on the HIV/AIDS epidemic, the epidemic will also affect the economy. A report commissioned by AusAID in the economic impacts of the epidemic in Papua New Guinea concluded that HIV can increase poverty, reduce the labor force, and push up the budget deficit.

HIV has far-reaching implications on poverty beyond Papua New Guinea. In this context, the Millennium Development Goals, to reduce HIV prevalence in persons aged 15-24 by 25 percent by 2010, becomes of utmost importance. If countries are not successful in achieving this goal, the UNDP reports that all other goals could be in jeopardy. As the examples above

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<sup>14</sup> Bell, Clive, Shantayanan Devarajan, and Hans Gersbach. 2003. *The Long-Run Economic Costs of AIDS: Theory and an Application to South Africa*. Washington, DC.

<sup>15</sup> Centre for International Economics. 2002. Potential economic impacts of an HIV/AIDS epidemic in Papua New Guinea. Prepared for AusAID.

illustrate, HIV claims the lives of breadwinners, mothers and fathers, and leaves families with debt. For example, farm output and income in Thailand fell between 52 and 67 percent in households affected by AIDS.<sup>16</sup> This critical theme underlies every element of the fight against HIV.

In order to lessen the economic and social costs of HIV – and continue the fight against poverty – we must learn from the lessons of countries already deeply involved in the struggle.

- First, political commitment is imperative to tackle and mobilize resources around difficult social issues, such as sexual behavior and commercial sex work. This includes comprehensive surveillance systems that can find the major sources of the disease and monitor whether public health interventions are changing the epidemic's course. It also includes strong communications campaigns, focusing on prevention messages.
- Second, institutional innovation within governments, the health system, social services and other sectors must be encouraged. Multisectoral HIV/AIDS programs at the local level, in tandem with dialogue and consensus building at the national level, are necessary and appropriate, especially for prevention efforts targeted at people on the margins of society.
- Third, systematic learning and experimentation, based on strong pilot tests and evaluation, can enhance national programming. This includes building a strong base of prevention programs for the population, especially those practicing high risk behaviors, such as sex workers and harm reduction for injecting drug users.
- Fourth, interactions with external catalysts, including international donor assistance, must be managed well. Governments, donors, the private sector, civil society, and other partners must all join together to strengthen systems, human resources, and overall capacity to build and maintain effective interventions.

The way these and other lessons are adopted and adapted within the East Asian region will determine the future of the epidemic and the social and economic landscape of Asian society. As Jemal ud-din Kassum, the Regional Vice President for the East Asia and Pacific Region at the World Bank, says: “Political leaders and the public have to acknowledge that HIV/AIDS affects the entire society, not just people infected with the virus. Countries must move swiftly to prevent growth of the virus in all high-risk groups, build capacity and awareness, and ensure that their health systems are properly organized and equipped. The focus must be ultimately on containing the spread of HIV/AIDS and on treating people effectively.”

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<sup>16</sup> UNDP. 2002. HIV/AIDS and Poverty Reduction Strategies Policy Note.

**Annex Table 1. Overview of HIV/AIDS epidemic in East Asia and Pacific, 2001**  
(unless otherwise indicated)<sup>17</sup>

Country	Adult (15-49) prevalence rate (percent)	Adult population (million)	Estimated number of adults living with HIV/AIDS	HIV prevalence, selected populations, major urban areas (percent)					GNI per capita 2000 (US\$)
				Female commercial sex workers	Injecting drug users	Male patients with sexually transmitted infections	Women in antenatal care clinics <sup>a</sup>	Women in antenatal care clinics outside major urban areas	
<b>Generalized</b>									
Cambodia	2.7	13.4 (6.3)	170,000 (160,000)	26.3-31 (2000/2001)	...	8.5 (1994)	2.7 (2000)	0.6-5.7 (2000)	270
Myanmar	<sup>b</sup> ...	48.3 (25.8)	180,000-400,000	26.0-50.0 (2000)	37.1-63 (2000)	12.1-13.0 (2000)	2.0-3.5 (2000)	0.0-5.3 (2000)	390
Thailand	1.8	63.6 (36.6)	670,000 (650,000)	6.7-10.5 (2000)	39.6-50 (2000)	2.5 (2000)	1.6-1.6 (2000)	0.4-5.3 (2000)	2,020
<b>Concentrated</b>									
China	0.1	1,284.9 (726)	850,000 (850,000)	0.0-10.3 (2000)	0.0-80 (2000)	0.0-1.3 (2000)	0.0 (2000)	0.5 (2000)	840
Indonesia	0.1	214.8 (118)	120,000 (120,000)	Up to 2.0-27 (2002)	19-48 (2001/2002)	...	0.0 (1999)	0.0 (1996)	580
Malaysia	0.4	22.6 (11.8)	42,000 (41,000)	2.05-6.3 (1996)	16.8 (1996)	4.2 (1996)	...	0.0-0.7 (1996)	3,250
Papua New Guinea	0.7	4.9 (2.4)	17,000 (16,000)	16.0 (2002)	...	7.0 (1998)	0.2 (1995)	0.0 (1992)	670
Vietnam	0.3	79 (43.3)	130,000 (130,000)	4.2-6.0 (2002/2003)	26.8-30.4 (2003)	2.0-3.2 (2002/2003)	0.4 (2003)	0.0-0.3 (1999)	390
<b>Low level</b>									
Lao PDR	<0.1	5.4 (2.5)	1,400 (1,300)	1.0 (2000)	2.0	...	0.0 (1998)	...	290
Mongolia	<0.1	2.5 (1.4)	<100 (<100)	...	No reported cases	0.0 (1989)	...	...	390
Philippines	<0.1	77 (39.6)	9,400 (9,400)	0.3 (1994)	1.0	0.0 (1994)	...	...	1,020

Note: There are numerous discrepancies in HIV data. To ensure a minimal level of standardization, numbers were first taken from UNAIDS when possible. Not all countries in East Asia and Pacific are listed.

<sup>17</sup> There are numerous discrepancies in data on HIV. Therefore, to ensure a minimal level of standardization, numbers were first taken from UNAIDS when possible.

## CASE STUDIES IN SCALING UP POVERTY REDUCTION

These are the primary countries that will be targeted for World Bank HIV programming or countries of concern because prevalence rates are either high or expected to be high in the near future.

a. Antenatal care is not always indicative of prevalence in the general population (as in Indonesia, where it is not a part of regular sentinel surveillance).

b. In Myanmar, UNAIDS does not report prevalence, but it does report the estimated number of HIV cases. This gives an estimate of prevalence ranging for 0.7 to 1.54.

Source: UNAIDS: Epidemiological Fact Sheets by Country – 2002 Updates (UNAIDS & WHO); UNAIDS report on the global HIV/AIDS epidemic 2002; WHO: HIV/AIDS in Asia and Pacific Region; (WHO, 2001); World Bank: World Development Indicators; Dave Burrows, personal communication; Khorloo, 2003; Reid and Costigan, 2002; Feng, undated; NASB/MOH, 2003; NASB, 2002; World Bank, 2003b; Pisani, Prihutomo, and others, 2003.