

**ASEAN WORKSHOP ON POPULATION
MOVEMENT AND HIV VULNERABILITY**

Chiang Rai, Thailand 10-12 November 1999

Co-organized by:

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FOREWORD

The impetus for population movement in the South-East Asia region has been influenced over time by numerous factors including family ties, cultural affinities, socio-political stimuli, natural disasters, wars and, more recently, through large infrastructure construction projects as well as widening gaps in economic development. Furthermore, the mobility of people in South-East Asia took place for centuries before the existence of today's form of national boundaries. This mobility is most often characterized by people either fluctuating between source and host communities, or becoming uprooted for permanent resettlement elsewhere.

The purpose of the ASEAN Workshop on population movement and HIV vulnerability is to present an alternative systems approach in assessing the interrelationship between population mobility and HIV vulnerability which moves beyond the traditional perspective of migrants and HIV/AIDS by examining both internal and international mobility. Those two types of mobility can be interlinked, and jointly, can contribute to the HIV vulnerability for those mobile groups, the source communities they come from, and the host communities with which they come in contact.

The United Nations Development Programme South-East Asia HIV and Development Project (UNDP-SEAHIV) focuses on the linkages between development, population movement and HIV/AIDS. UNDP-SEAHIV, in support of the Association of Southeast Asian Nations (ASEAN) Task Force on AIDS, and the Royal Thai Government, as the acting focal point within the ASEAN Task Force for Population Movement and HIV/AIDS, organized a workshop from 10th to 12th November 1999 in Chiang Rai, Thailand, entitled *ASEAN Workshop on Population Movement and HIV Vulnerability*. Collaborators included the Family Health International (FHI), SEAMEO-GTZ-CHASSPAR and World Health Organization (WHO) South-East Asia Regional Office.

The workshop objective was to formulate joint action plans among clusters of countries in South-East Asia with the purpose of countering the HIV vulnerability associated with population movement. This Report summarizes the workshop proceedings, including the proposed action plans and recommendations that were developed and subsequently fully endorsed by the ASEAN Task Force on AIDS at its 7th meeting, 16th-18th November 1999.

UNDP-SEAHIV gratefully acknowledges the contribution of Dr. Martha Ainsworth, a senior economist of the World Bank Washington DC; Mr. Jacques du Guerny, Focal Point on HIV and on ageing, Chief, Population Services, a population and HIV/AIDS specialist for the Food and Agricultural Organization (FAO), Rome; Mr. Maurice Apted and Mr. Tony Lisle, as facilitators from the UNAIDS Asia-Pacific Intercountry Team (APICT); Mr. Guy Scandlen, as UNDP-SEAHIV's lead facilitator; Mr. Robert Anthony Oliver and Mr. John Richardson, the workshop proceedings editors. Their contributions as well as the active inputs from each and every one of the workshop participants made these proceedings a rich document of collective wisdom on population movement, development and HIV vulnerability in South-East Asia.

LEE-NAH HSU

Manager

UNDP/UNOPS South-East Asia HIV and Development Project

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WELCOMING STATEMENTS

His Excellency Mr. Samrerng Poonyopakorn, Provincial Governor of Chiang Rai Province, Thailand, welcomed the workshop delegates to Chiang Rai and hoped that they would be comfortable. The full cooperation of provincial and district officials would be given during the workshop and the field visit. His Excellency noted the busy agenda and wished everyone success in arriving at a satisfactory outcome with strong recommendations for regional cooperation in addressing the issue of population mobility as it relates to the spread of HIV/AIDS.

Dr. Lee-Nah Hsu welcomed delegates on behalf of UNDP South-East Asia HIV and Development Project. With the rapid pace of economic development in the ASEAN region and recovery from the recent economic crisis, the mobility of people in the region, whether internal or external, was increasing. There were five main points for workshop delegates to consider:

- Mobility and its related vulnerability is not new to Asia but needed to be re-examined from a new angle.
- To be effective in dealing with HIV in the ASEAN region, mobility concerns needed to be included in national HIV policies and strategies.
- To deal effectively with mobility and HIV vulnerability, the focus needed to be on people and their behaviour while taking into account socio-economic and cultural environment and trends.
- Finding cost-effective strategies requires innovative approaches on the basis of collective experience, problem-solving abilities and the principles of good governance.
- Based on three criteria – the quality of the ideas, their feasibility and intercountry cooperation – the UNDP South-East Asia HIV and Development Project would provide technical support and co-financing for the implementation of some of the most promising outcomes from this workshop.

His Excellency Mr. Kamron Na Lamphun, Deputy Minister of Health of the Royal Thai Government, welcomed all delegates from ASEAN countries and the observer from China to this ASEAN Workshop on Population Mobility and HIV Vulnerability. He also expressed sincere thanks to the UNDP South-East Asia HIV and Development Project, the WHO South-East Asia Regional Office, Family Health International and SEAMEO-GTZ CHASSPAR for their assistance and support in making this workshop possible.

His Excellency said that today we could look forward to a new millennium, ready to take on the challenges that come and to utilize all opportunities to enhance cooperation among the ASEAN countries on all fronts. Globalization, trade liberalization and transportation links had contributed to large population flows in the ASEAN region, so much so that cross-border movements have resulted in declining health and well-being. It was important to address comprehensively the impacts of population movements on HIV and AIDS problems, identifying measures and strategies to deal with them.

HIV/AIDS among mobile people was not only a health problem but also an increasingly important economic, social and political concern. His Excellency was confident that, over the next three days, the workshop would provide a useful opportunity for participants to exchange information, views and experience in dealing with the problem. He believed that, with cooperation from all sides, a productive workshop could be conducted that would yield positive results in terms of alleviating the problem.

Formally declaring the workshop open, His Excellency reiterated the pleasure of the Royal Thai Government in hosting the workshop and hoped that everyone had a pleasant stay in Chiang Rai.

PRESENTATIONS

(a) Introduction by Moderator

Mr. Jacques du Guerny, FAO, Rome

The main objective of the presentations was to have a flexible way of viewing the issues in order to ensure more effective progress and intervention. It did not mean that efforts already undertaken would be ignored but that a new perspective on the epidemic would be developed and adopted by broadening the approach. The discussion would be started by looking at how to provide the ideal method of developing national strategies and alternative ways of addressing the issues identified during the workshop. At first, they may not appear to have a common link yet each presentation would reinforce the others and contribute towards the development of the new perspective.

(b) Population Mobility in South-East Asia and HIV

Prof. Ronald Skeldon, UNDP-SEAHIV Consultant

The Egyptian goddess Isis was the starting point for this presentation. Why Isis? Apart from the fact that in Egyptian mythology she was the protector of the people, her name provides an acronym for the four themes developed on the human immuno-deficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and population movement:

- I = Intuition
- S = Subjectivity
- I = Illusion
- S = Substance

These themes evolved from a perusal and consideration of the existing literature on the relationship between population movement and HIV/AIDS.

First, **intuition**. There was an intuitive relationship between HIV/AIDS and population movement. If one took, for example, an AIDS-free area and an area in which HIV/AIDS was prevalent. The only way HIV/AIDS could move from one area to the other (in addition to the possibility of transmission via contaminated blood products) was by population movement. In other words, the intuitive relationship was movement from the area where the infection was found into the AIDS-free area.

A great deal of detective work had been carried out on how HIV/AIDS first appeared in various countries. Three critical issues had emerged:

- It was not so much migration that was important but more the behaviour of the migrants. Obviously, there could have been massive migration between the two areas and no transfer of the infection. It depended on the behaviour of the people who were moving.
- Much of the movement that could result in the transfer of HIV/AIDS would not normally be considered “migration” in the normal definition of the word. “Migration” tended to imply a long term international movement. One of the aspects that needed to be considered was the importance of the other forms of mobility within countries. It was not that movements between countries were unimportant – obviously, they were – but there were other very important forms of mobility. Some of the movement that was generally termed as “migration” was, in fact, low-risk, whereas other types of movement not considered “migration” were actually high-risk.
- Through their mobility, migrants created environments that were high-risk. In other words, communities of migrants were high-risk environments for the dissemination of HIV/AIDS.

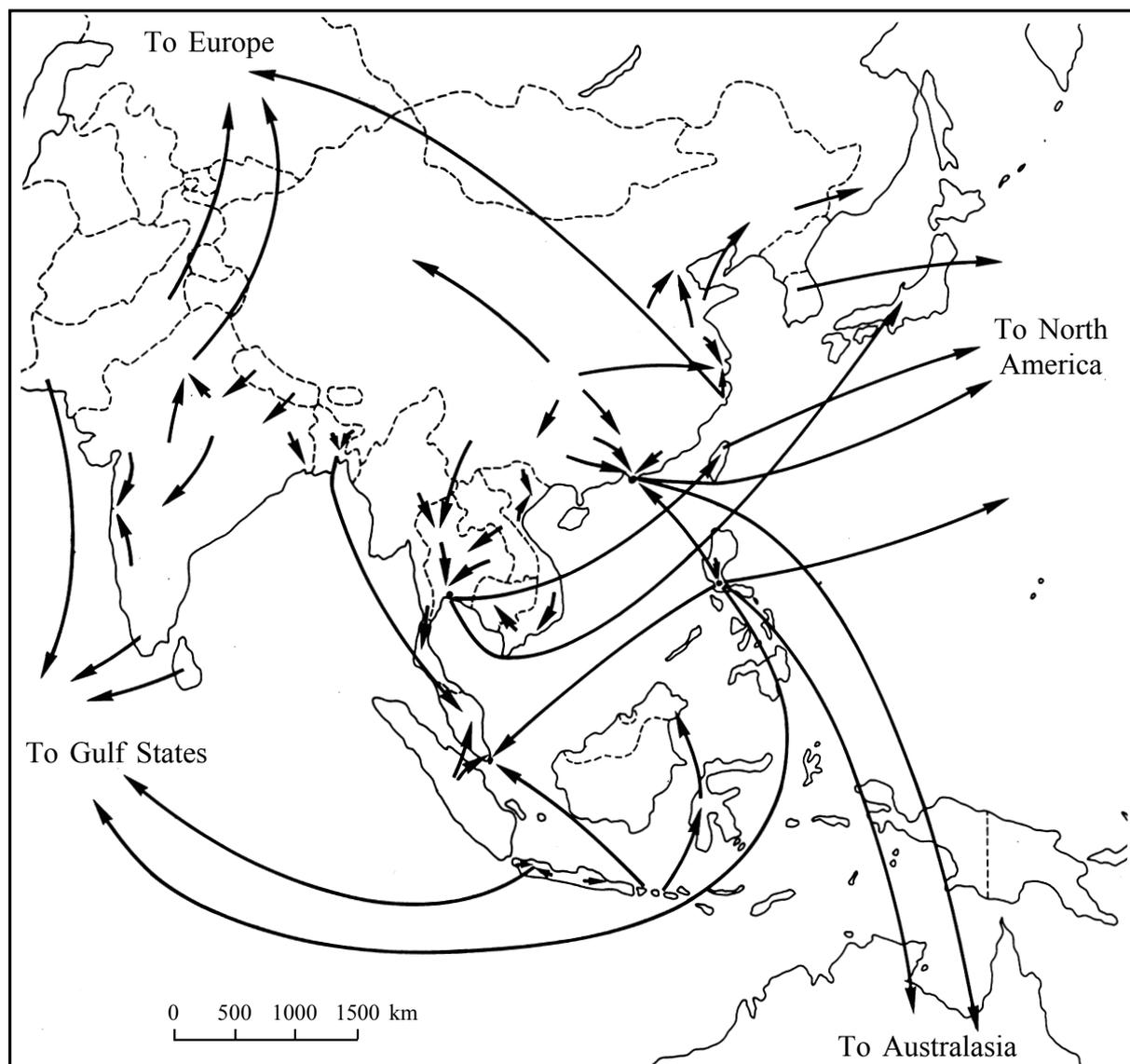
Next, **subjectivity**. Of the three demographic variables of fertility, mortality and migration, by far the most complex was migration. Births and deaths were unique events. Migration was a continuous process and its definition was critical to the volume of movement captured. Most migration or mobility was not captured by the standard instruments of population censuses or large-scale surveys. That had been shown very clearly in the National Migration Survey of Thailand when it specifically set out to capture the different types of mobility. Different definitions made it possible to generate different estimates of the volume of migration.

In discussing migration and HIV/AIDS, international migration had taken centre stage. However, other very important types of mobility were occurring. The tendency was towards two schools of thought in the area of migration – international and internal – and they rarely talked to each other. Part of the problem was that the linkages between international movement and internal movement were, as yet, poorly understood.

There were also major problems with subjectivity when looking at international flows. For example, total estimates of foreign workers in countries of the East and South-East Asian regions up to mid-1997, before the economic crisis began, were: Malaysia, 2.5 million; Japan, 1.3 million; Thailand, 1.26 million; and Singapore, 0.45 million. Data for China and Hong Kong, China were unavailable. Although the crisis might have shifted the balance between legal and illegal migrant workers in the region, it was unlikely to have had a significant effect on the total volume of movement. However, any analysis of international flow in the countries of the Association of Southeast Asian Nations (ASEAN) had to be subjective because a high proportion of the mobility was undocumented.

The direction of major population flows within and from Asian countries was represented in Figure 1. Much research was still required to improve the figure beyond a schematic representation.

Figure 1. Schematic indication of the directions of major population flows in and from Asia in the 1990s



The internal flows tended to be centred around the larger cities in each country. With regard to international movement, the Philippines was one of the main centres for migration within and from Asia. Southern China also exhibited major complex migration patterns.

In considering some of the flows to the United States of America, it had been found that HIV prevalence was almost negligible. However, it was necessary to take account of the composition of those flows. One of the generalizations that could be made

about migration in the Asia-Pacific region was that the proportion of women in the flows was increasing which had given rise to concern among those involved in examining HIV/AIDS incidence. However, not all flows were dominated by women. In considering female Filipina domestic helpers, of whom there were approximately 150,000 in Hong Kong, China, 30,000 in Malaysia and 100,000 in Singapore, no high rates of HIV incidence had been found. In fact, HIV prevalence among migrant groups was not especially significant. With regard to long-distance movement of labour, as well as of migrants as settlers, HIV/AIDS was also not a major issue. There was no evidence to suggest that HIV/AIDS prevalence among those groups was higher than in the local populations themselves.

The issue of borders was clearly a critical one. Short-distance movement across borders had generated an enormous amount of interest in the work on HIV/AIDS and population movement. Cross-border migration between Cambodia, the Lao People's Democratic Republic, Myanmar and Thailand created some high-risk environments. The issue raised here was, how were these movements linked to the national heartlands on each side of the border? This was still very much an unknown factor. The composition of each of the flows was very different. Thailand had emerged as a major epicentre. Within Thailand, pregnant women in the upper north had a very high prevalence of HIV.

When talking about the feminization of the movement of people, particularly in terms of the analysis of HIV/AIDS, emphasis tended to be placed on the importance of sex workers. However, it had to be emphasized that in the overall flow of the movement of people, such women represented a very small part of the total movement. The number of women within these countries, including Thailand, who took up factory employment was much greater. Likewise, the number of women from the Philippines who become domestic helpers was much higher. As stated above, women in those categories constituted a low-risk group.

These groups had to be placed in the context of total mobility. There was a great difference between the movement of unskilled and semi-skilled labour and that of highly skilled labour. Although the number of highly skilled people who moved was a small proportion of the total, they had a profound effect economically.

The issue of subjectivity also related to the statistics of HIV/AIDS and there were interesting contrasts between the reported and estimated number of cases. There seemed to be an element of subjectivity here because the sample surveys under the usual sentinel surveillance system were not evenly distributed among the populations. Data that related migration to the number of HIV/AIDS cases were uncertain.

The epidemic was, however, concentrated within certain areas of Asia and Thailand had emerged as a country with very high prevalence. The country epidemiological fact sheets of June 1998 showed that the epicentre of the disease was a complex area comprising northern Thailand, Myanmar, the Lao People's Democratic Republic and southern China. In the Asian context, it was a relatively sparsely populated area between

two densely populated areas. The question of what happened when the people in that area moved should be kept in mind.

The issue of **illusion** related to attempts to link migration and HIV/AIDS. The relevant literature contained many suppositions and the evidence upon which conclusions were based was questionable. One conclusion, that the movement of female labour around the region possibly contributed to the spread of the disease, did not appear to be supported by the case of females moving from the Philippines, among whom the number infected was very small.

The last issue – **substance** – covered the important issues that were seen in the literature. One of key findings of the last few years was that the 100 per cent condom programme had reduced the incidence of HIV/AIDS. This seemed to be supported by all the available evidence. It did not mean that the epidemic was over but that at least there were optimistic signs of how it might be controlled. However, there was no room for complacency because what seemed to be happening was that it was becoming less visible. The spread of HIV/AIDS was being pushed out of the visible commercial sex network in the brothels of the major cities into more informal networks. In that context, some interesting relationships could be expected between mobility at the local level and the spread of HIV/AIDS.

In the rural environment in particular, people operated in the context of a known world among friends and regular clients. When they moved to the city, they entered a relatively hostile environment with which they were not familiar. This could be a fertile environment for the introduction of a programme to limit the spread of HIV very quickly, as in the Thai programme where behavioural changes had been made. Such changes worked if they were being made among friends and acquaintances in a familiar environment, among people engaged in high-risk behaviour.

It was interesting to consider a traditional but nevertheless still useful example, the system of markets in southern China. They were periodic – some open seven days a week, some three days a week, some only one day a week. These different periods generated different sequences of local mobility that could be systematized. Local mobility was linked by truck drivers, taxi drivers and traders to a wider mobility. The important issues were behavioural patterns within limited local mobility systems that were high-risk and how they linked with the hierarchies of wider movement.

The focus was therefore on linkages – how local mobility was linked with regional and global mobility. Separating and focusing on one sector of that integrated mobility system ignored the important aspect of those linkages. In the case of Thailand, the epidemic seemed to be moving into local areas of mobility where it was much more difficult to control.

The first conclusion was that it was difficult to separate international movers as

a high-risk category – most of them were, in fact, of relatively low risk. Many of the highest-risk categories were the locally mobile. The attention of the next phase of work should be directed at mobility, not migration and the two should not be confused. Mobile populations were not just those who crossed international borders – they were part of a very complex system of mobility. The fear of outsiders that had stimulated so much migration and HIV/AIDS research was unfounded because there did not appear to be any evidence that they were necessarily high-risk or a threat to indigenous communities.

The United Nations High Commissioner for Refugees (UNHCR) had argued trenchantly that no prejudice should be directed toward long distance migrants on the basis of their HIV/AIDS status because the real issues of HIV were evolving within countries themselves. The cost of screening international movers who were likely to be low risk must be balanced against the cost of screening the higher-risk internal movers.

A refocus away from the international movers towards the local mover was therefore recommended. In some areas, there may be little difference between an international migrant and a local migrant because international boundaries bisected local circuits of mobility. In these cases, it was critical to see how border towns were linked back into their hinterlands of national mobility systems and not just examine cross-border movements in isolation.

The final themes to emerge were those associated with overall patterns of development. National patterns of human deprivation were closely associated with the intensity of disease prevalence. The issue of migration and HIV/AIDS needed to be integrated into a broader framework of mobility systems, which itself must be an integrated component of national and regional development planning.

(c) HIV/AIDS Epidemiology and Mobility in Asia

Dr. Gilles Pומרol, WHO

Figure 2 showed the spread of HIV in Asia since 1982. It could be seen that, towards the end of the 1980s, there was almost no HIV infection identified in the Asia-Pacific region. Ten years later, towards the end of the 1990s, every country was affected and some of them highly affected.

This showed that the HIV came from somewhere outside the Asia-Pacific region, whether it was the United States, Europe, Africa or elsewhere. Either people from infected areas had brought it to the region, or people from the region had visited affected areas and had returned with infections. In either case, mobility had been the factor that brought HIV to the Asia-Pacific region and was now contributing to its spread, whether that mobility was internal, external or of the cross-border type.

The most recently available HIV prevalence rates – from late 1998 – were shown in

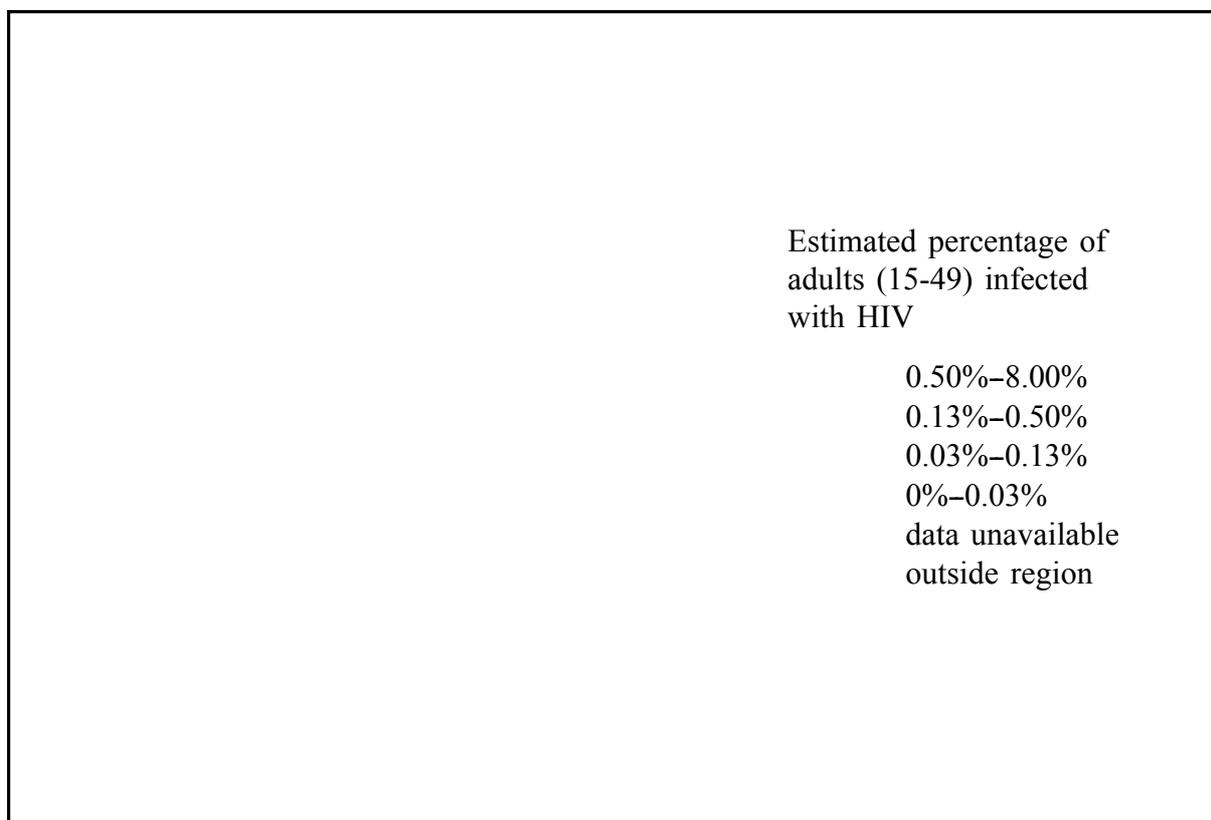
Figure 2. Spread of HIV over time in Asia, 1982-1997

Figure 3. The three countries in which HIV infection had reached relatively serious levels are: Cambodia, where more than 3 per cent of the population was infected; Thailand, just over 2 per cent; and Myanmar, approaching 2 per cent.

Various countries were experiencing different HIV transmission rates. Some

Figure 3. Estimated HIV prevalence and prevalence rates in South-East Asia – 1998

<i>Country/Area</i>	<i>1998</i>	
	<i>HIV prevalence adults (15-49)</i>	<i>HIV prevalence rate adults (15-49)</i>
Cambodia	180 000	3.70%
Thailand	740 000	2.14%
Myanmar	447 000	1.87%
Malaysia	45 000	0.35%
Viet Nam	80 000	0.20%
Singapore	3 800	0.18%
Hong Kong, China	3 400	0.09%
China	400 000	0.09%
Philippines	29 000	0.08%
Indonesia	60 000	0.05%
Lao PDR	1 200	0.05%

countries such as Malaysia, Papua New Guinea and Viet Nam had an increasing and epidemic level of transmission. Some countries were more effective than others at controlling the disease – for example, Australia and New Zealand have declining rates of transmission. Overall country figures were a good indication of the situation but it was necessary to look at local figures to see areas of real epidemic. For example, the national figures for Viet Nam showed that an estimated 80,000 people, or 0.2 per cent of the total population, were infected. This did not look very serious but the infection rate among sex workers of the Ho Chi Minh City area had been found to be over 14 per cent and, in northern Viet Nam, very high rates of infection had been found among drug users. The global situation for a country did not always give the true picture of an epidemic when transmission was occurring at different rates in local areas.

In Asia, there was a large variation in rates of infection as well as ways of transmission. The data showed that there were two principal ways of transmission:

- Injection-drug use, where four countries – China, Malaysia, Myanmar and Viet Nam – had the highest rates.
- Sexual transmission, which was common in the majority of countries.

It was of serious concern that sexual transmission of HIV was increasing everywhere, reaching a level of about 33 per cent of all new cases in 1998 and was probably now equivalent to the proportion of cases acquired through injection drug use.

The history of HIV/AIDS in the world indicated that one of the main determinants of the disease was poverty. To survive and sometimes to support their families, poorly educated women in poverty often had little choice but to enter sex work, which made them vulnerable to the disease.

Mobility in itself did not lead to a high risk of HIV/AIDS infection – it was other behaviour often associated with mobility that led to risk. Mobility especially among men could lead to their use of sex workers and expose them to the risk of infection. Poverty led to mobility and vulnerability, with people having no income tending to look for income somewhere else. All these structures were very much integrated.

Urbanization sometimes went with mobility, poverty and sex work. Women tended to move to cities where they might be able to find work. If they could not find work, they would go into sex work.

Thus it was not really mobility itself which exposes a person to risk but more that person's behaviour and discrimination of the HIV-infected. The epidemiology of HIV/AIDS in Asia nowadays was showing that sex workers, especially female sex workers, who were in this situation of poverty and vulnerability, were often mobile and moved from site to site frequently. This was often linked also to urbanization. Sex workers in Asia who demonstrated most of these factors could be found in many countries. They

were the core group among which transmission occurs and it related to mobility because these women were mobile. Also the ones who were using these women's services tended to be mobile men.

The infection rates among sex workers could be many times higher than the average observed in the general population. For example, WHO figures for Cambodia in 1998 showed that 64 per cent of sex workers were infected, over 20 times higher than the 3 per cent of the general population of 3.5 million that were infected. In Malaysia in 1996, the rate was four times higher than that in the general population. Thus sex workers formed a core group in which HIV transmission occurred at a very high rate. It was also a very highly mobile group with movement from one place to another within a country and also between countries.

A study in Australia in 1993 showed that only 21 per cent of foreign sex workers in Sydney used condoms compared with 92 per cent of local sex workers. The result was high rates of sexually transmitted diseases (STDs) such as gonorrhoea and syphilis and it was known that STDs were closely linked to HIV. Female sex workers of foreign origin were much more vulnerable and this was true everywhere. They did not speak the local language and were very often illegal immigrants without access to health care. They had no access to education and were much more exposed to HIV infection by not using condoms and by not getting treatment for STDs.

The mobility of sex workers between countries and their vulnerability to infection was also true within their home countries. Sometimes women moved from one district or province and lost their access to health care that was dependent upon a registration card in their original domicile.

Clients of female sex workers could not be forgotten because they were very often mobile people. For example, in China, an estimated 100 million migrant workers, mostly young males, moved from one area to another for seasonal work every year. This very large population was often vulnerable to the use of sex workers. Resulting from mobility, seamen, fishermen, drivers, military personnel, police and businessmen also frequently used sex workers because they were far from their families, wives, girl friends and their usual environment and there were no social constraints on their behaviour.

The focus was often on border areas where there was a high risk of transmission in some countries but mobility occurred everywhere, both between countries and within borders. Vulnerability to HIV/AIDS did not occur just in border areas.

The major migration routes in South-East Asia appeared as a kind of web, illustrating that work on migration vulnerability to HIV/AIDS had to be done at a regional level with a common strategy. Sex workers who moved from one place to another must use condoms. If the mobile clients of sex workers found pressure everywhere to use condoms, the strategy would be effective. If they went to one country

and did not use condoms, the strategy would be ineffective. *A regional programme must be designed in which every country adopted a strategy that supported each of the other countries in the region.*

It was necessary to be aware of the barriers to such programmes. Mobile people were difficult to intercept and, apart perhaps for businessmen, often have low levels of education. Their status could sometimes be illegal and they would avoid contact with officialdom. There could also be cultural and linguistic barriers.

Programmes should be targeted at the mobile population. One possibility was to establish health clinics that were open to everybody and to make sure that these clinics could serve the needs of the mobile population from elsewhere. It might be possible to have staff who could speak languages of the migrating population.

Another programme might focus on education of mobile people at the sites of their migration. In China, for example, education posts had been set up at railway stations because most of the annual 100 million migrant people moved by train. The same could be done at harbours and ports for fishermen and people travelling by boat.

A further possibility was setting up pre-departure education, essential for people who moved regularly and within a legal framework. Efforts should be made to intercept this mobile population and educate them on the need to use condoms for protection if they used the services of sex workers. Condom availability and promotion should be pushed very strongly and, as Thailand had done very intensively, condom promotion programmes should be institutionalized throughout Asia. All means should be pursued to make sure that every man who used the services of a sex worker used a condom because this was the only way that the spread of HIV/AIDS could be controlled.

The requirement for this programme was strong political support. This was important because many countries asked why they should serve foreigners when they should be serving their own people first. Politicians must be convinced that it was important to be able to prevent a larger epidemic. Identification of mobile populations, where they were moving to and where they were coming from, was very important in trying to map the movements and target services where they were most needed.

In conclusion, although mobility was not systematic, there was evidence that HIV/AIDS and STDs in general were linked in certain populations and certain sites, not everywhere but certainly in some areas. It was a difficult problem with many barriers and required very strong commitment and flexibility. Programmes had to be adapted to different needs, different populations and specific approaches. Everybody who was mobile had to be educated based on identification of where they were and who they were.

(d) AIDS, Population Mobility and Development – government priorities in resource-scarce settings

Dr. Martha Ainsworth, the World Bank

The two previous presentations showed that population mobility and AIDS were related. However, not all mobility contributes to the epidemic and the key was really behaviour of the people not mobility *per se*. Some people were mobile, some of them were not and AIDS has spread among non-mobile populations as well.

There were some public policy issues raised by these presentations. For example, population mobility contributes to economic growth. Many migrant and mobile populations move in order to improve their standards of living.

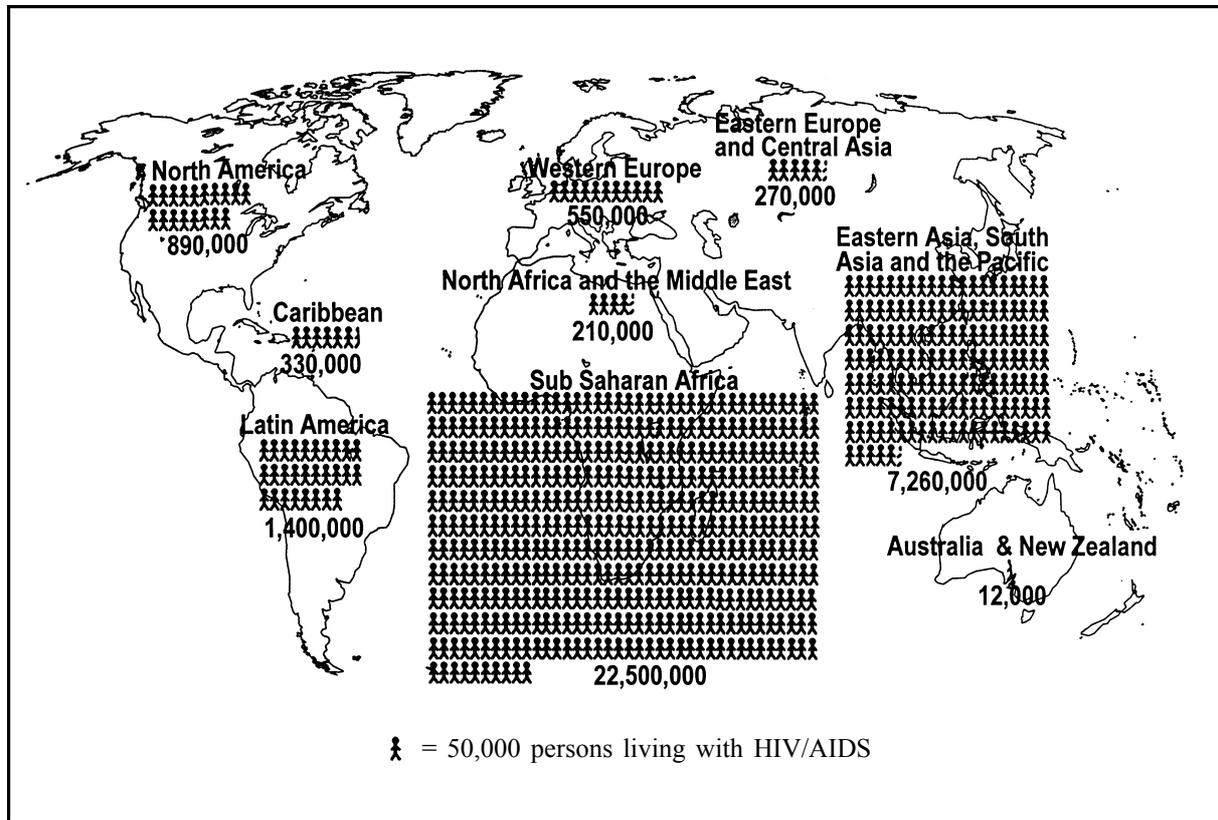
AIDS is one of many important problems on the agenda of public policy makers; it must be remembered that there are other key development issues like illiteracy, poverty, malnutrition and unemployment, and that resources are very scarce. Given all of these considerations – the severity of the AIDS epidemic and the other pressing developmental problems – what should be the priorities for governments? This presentation used the principles of public economics, which relate to the allocation of scarce government resources across different activities, and focused on AIDS, population mobility and economic development. It relied heavily on the conclusions of the book *Confronting AIDS: Public Priorities in a Global Epidemic*, a World Bank publication.

There were three main issues. The first was the relationship between AIDS and economic development and population mobility, where the lines of causation run in multiple directions. The second issue was that AIDS is a development problem, not merely a health problem – although a serious health problem – which actually has greater implications for economic development than other diseases and in that sense is a core development issue. The third issue was the implication for public policy given all the demands on government resources. What should governments do first and what are the most important things that can prevent the HIV/AIDS epidemic and protect the benefits of economic development? How does population mobility fit into that agenda?

First, the relationship between AIDS and economic development, which really runs in both directions. Much has been said about the negative impact of AIDS on economic development. The global picture of HIV was presented in Figure 4 and showed that there were about 33 million infected people worldwide in 1998.

More than 95 per cent of all infections are in developing countries and most infected people are prime age adults, the most economically productive part of the population. Only about 1-2 million of those infected are children. The disease is fatal, there is no treatment, no cure and no preventive vaccine. Those people are the bread-

Figure 4. Number of adults and children living with HIV/AIDS, 1998



winner of families and their infection and deaths have consequences, not just in terms of the demands on health care and the suffering they endure, but also on what happens to their families after they are gone.

There are other diseases that infect people in developing countries but AIDS is particular because it is fatal and affecting prime-aged adults. It is reversing decades of progress in improving the quality of life. Between 1950 and 1990, life expectancy in developing countries increased from 43 to 63 years, an incredible achievement that resulted from huge investment of public and private resources to improve peoples' quality of life. Unfortunately in Cambodia, Myanmar and Thailand, estimates by the U.S. Bureau of the Census indicated that 2-3 years of life expectancy had already been lost due to AIDS.

The relationship between economic development and AIDS was examined in reverse in 72 countries and it was found that, as per capita gross national product (GNP) increases, the urban adult prevalence of HIV declines. In other words, as the country's economic situation improved, HIV prevalence decreases. Similarly, as the inequality of income distribution declines, so does HIV prevalence.

To the extent that incomes increase and governments invest in policies to reduce

income inequality, the AIDS epidemic should be lessened. It was also true from these results that the greater the equality between men and women, the lower is HIV infection. Female education and the status of women were also associated with lower HIV/AIDS infection levels.

On the other hand, there are certain factors associated with development that raise the risk of HIV infection. For example, in urban areas high proportions of men relative to women were associated with higher HIV infection levels. Presumably this reflects low employment opportunities for women and when there were fewer women, men resorted more to commercial sex.

Rapid changes in social norms are important. Most people are familiar with specific development projects that attracted large numbers of single male workers, for example where small camps of followers developed, including bars and restaurants where unsafe behaviour could occur and spread HIV/AIDS. A rapid change in social norms was particularly important after the break up of the former Soviet Union in 1991. The incidence of syphilis, which was spread by the same behaviour that spread HIV, had basically skyrocketed as the constraints on people moving around were reduced.

It is safe to say that, although further economic development would help to reduce the HIV/AIDS epidemic, that alone could not be relied upon to solve the problem of AIDS. It is going to require the involvement of the public and private sectors so that, as countries develop, the extent of HIV/AIDS is not worsened.

The next point was the issue of setting government priorities. There are many things that governments could do to help stop the spread of HIV/AIDS but resources are very scarce so the people must help themselves. Given the different needs of different groups of people in reducing their risk, *what are the most important that governments could do?* Since the resources are scarce, what was the first thing that governments would want to do? In a nut shell, governments should get done what others cannot do to stop the epidemic and protect the poor. There are some things that are essential to stop the epidemic that the private sector and individuals will not do spontaneously.

Governments must ensure that what needs to be done to stop the epidemic would be done. In that sense, government involvement is essential but it does not mean that governments should do everything. They should ensure that certain things got done by involving non-governmental organizations (NGOs), private sector and civil society. Governments have a crucial role in protecting the poor. There are three things in particular that are unlikely to get done if governments do not become involved and those are the priorities.

The first priority is *providing critical information* – on the spread of HIV in the population and on pockets of risky behaviour. For example, it is known that there are many mobile populations but not necessarily much is known about their behaviour. Information must be given to people on how to protect themselves from HIV infection and how to protect others. That information is important for migrant people from rural

areas and also for those who come from other countries who might not understand. It is very important for governments to provide information that everyone can understand, including the cost and effectiveness of different interventions. The private sector is unlikely to be able to provide that information and, if the public sector does not step in, it would not be available when it is critical to stop the epidemic. Economists call this a public good – regardless of who consumes it, everyone benefits from the information.

The second government priority is *reducing risky behaviour*, particularly the highest-risk behaviour. People at high risk are those who have many sexual partners and do not use condoms and those who inject drugs and share needles without sterilizing them. Those people are the most likely to become infected with HIV/AIDS and to spread it to others without their knowing. It is a fundamental responsibility of governments to help people reduce the risk to themselves and the risk of spreading the disease to others.

Why should governments be involved in that? With the AIDS epidemic, the cost of risky behaviour increased. Before engaging in risky behaviour, an individual may think long and hard about the risks of infection if he or she has many partners. However, he or she probably does not think of the risk of already being infected and spreading it to somebody else. When an individual makes a decision to engage in risky behaviour, he or she needs an incentive that reflected not just the personal risk but the risk of passing on the infection to others. In other words, an incentive that reduces the risk is in everybody's interest, beyond a merely personal decision. The possibility of spreading the disease to other people generates negative externalities, referred to by economists as the possibility of spreading it outward in the population. It is therefore a fundamental government responsibility to reduce high-risk behaviour, which is also an effective way of preventing the spread of HIV in the general population.

HIV/AIDS tends to be spread from people with many partners outward to their partners and eventually to people who are monogamous and to their children. An example is in Nairobi, Kenya, where an intervention had succeeded in raising condom use among 500 sex workers to 80 per cent and provided STD treatment. Among the sex workers, 80 per cent had been infected with HIV and they had had four partners *per day*. According to the report, the intervention had averted an estimated 10,200 infections per year. Those averted infections were among the clients of sex workers and the clients' spouses and other sexual partners. They did not include the risk of infection in the children of spouses.

The same study had actually measured the behaviour of everyone in the community including the clients of commercial sex workers, the objective having been to see what might have happened if condom use had been raised to 80 per cent among 500 low-income men. HIV infection had already been present in 10 per cent of the men and they had had an average of four partners *per year*. According to the study, only about 88 new

infections per year would have been averted among the men's partners had their condom use risen to 80 per cent. The point was that helping people with the riskiest behaviour patterns to protect themselves and others protects the largest number of people in the general population.

That example singled out sex workers simply because they had been the focus of the study. It was relevant in general, however, to anyone who has many partners and engages in risky behaviour, as well as the clients of sex workers who on average had more partners than the general population. For example, it is relevant to long distance truck drivers and injection drug users.

The third priority of governments is *protecting the poor*. This is not a public economics argument *per se* but rather a general responsibility of most governments to ensure access by poor people to treatment and prevention. What strategies can governments pursue to reduce risky behaviour?

Three different strategies were considered and the first two were recommended. First, *providing information on protection, access to condoms and access to safe injection equipment* is very important. Studies to date have shown, however, that is not enough – people need more than just information to reduce the risk of spreading HIV/AIDS. The second strategy is therefore to *lower the cost of safe behaviour*. Costs mean not just the monetary cost of buying condoms, clean injecting equipment and disinfectant but also the psychological and social cost. Going out to buy a condom is sometimes socially disapproved and there is inconvenience and travel time. There are many different costs associated with adopting safe behaviour. To the extent that these costs can be reduced, people would adopt safe behaviour to protect themselves and others.

Probably the best documented example in developing countries is in Thailand. As a result of a massive information campaign and a programme to raise condom use in commercial sex to 100 per cent, condom use had risen from about 14-15 per cent in the late 1980s to well over 90 per cent by 1998 and the number of sexually transmitted diseases among men declined dramatically. Male STD clients remained low and condom use remained high through the economic crisis. The rate of infection among military conscripts was reduced by half. These programmes show that when people are given the information and the means to protect themselves and others, they act to do so.

A third strategy is not recommended – *raising the cost of risky behaviour*. Many governments have reacted to the AIDS epidemic by trying to arrest the people who engage in risky behaviour. This discriminates against people and drives them underground where they cannot get access to condoms or information to improve their behaviour. People who are discriminated against and stigmatized do not have the ability to help themselves. That strategy is not conducive to adopting safer behaviour and is not recommended for controlling the HIV/AIDS epidemic, since it is counter-productive. The focus needs to be on the priority role of governments to provide information that

help them to change their behaviour. Some to whom access is easier involve less cost, others who are much more difficult to reach involve more cost. It is fair to presume that interventions that change the behaviour of people with the highest-risk behaviour who are relative easy to reach are highly cost effective and a high priority for governments. In the lower left quadrant, it is very expensive to reach people, the benefits were perhaps not so great and those people would be low priority if resources were scarce. In the upper left quadrant are people for whom intervention would result in very high benefits because many secondary cases could be prevented. It is, however, more costly to reach them and the cost-benefit ratio might be questionable. In the lower right quadrant are people with low risk behaviour but reaching them might be inexpensive. For example, many people raised the issue of secondary school students. They might be very easy to reach but, on average, they might not have many partners. If the costs of reaching them are low enough, these interventions might be cost-effective, but probably less so than interventions for those in the upper right quadrant, (figure 5).

It is possible that mobile people fall into all four quadrants (figure 5). Some people have many partners who were mobile, others do not. In the upper right quadrant, for example, are sex workers in brothels, recipients of the 100 per cent condom programme in Thailand. Injection drug users (IDU) in treatment programmes might be easy to reach, together with prisoners, the military, police, sailors and STD patients. Those IDU not in treatment programmes are very difficult to reach. The specific patterns of behaviour need to be considered in each country, as well as ease of access because different countries have different institutions to reach people. These were examples of people for whom it might be very cost effective for governments to make an investment. Some individuals would be from their home countries, particularly in the case of sex workers in Asia. Some would be from rural areas, some from urban areas and there are issues of mobility. Truck drivers are clearly one example of mobile people.

People who might be more expensive to reach even though the benefits would be great, include street walkers: floating sex workers on the streets who are not organized in brothels, and injection drug users who are not in treatment. Sometimes it is very difficult to reach the homosexual communities particularly if they are discriminated against socially. Street children are also very difficult to reach sometimes although there have been successful programmes in some countries. Sub-groups in the lower right quadrant might or might not be very cost effective, depending on the kind of behaviour those people have and the ease of access to them. The aim throughout is that the priority for use of public funds should be those who are most likely to contract and spread HIV, thus applying available funds in the most cost effective way.

In the context of public policy, preventing HIV/AIDS is a fundamental responsibility of governments and is a very serious developmental problem. Without government intervention, the epidemic really cannot be stopped. The highest priority for governments is to help people protect themselves and others and to protect high-risk people from

discrimination. Providing information is also a high priority, including ensuring that the information is accessible to mobile groups. This is something that the private sector cannot be counted upon to provide.

Policies to reduce the cost of adopting safer behaviour do work. For example, there is evidence in many countries that injection drug users are very responsive to improved availability of safe injecting equipment. Repressive measures do not work and actually run the risk of making the epidemic worse because they deny people the access to means of safer behaviour.

This presentation emphasized the role of government but it should be remembered that governments cannot be successful alone. There has to be collaboration to ensure good results. Governments have the public mandate, technical expertise, finance, sectoral coordination and the responsibility to ensure that all of these are applied. The collaboration of many different parties is then required, including NGOs that often have much better access than governments to the highest-risk people particularly the marginalized population. This is definitely true of mobile populations. NGOs also have potential cost effectiveness in terms of interventions and credibility with marginalized groups. In the case of mobile populations, private companies might be very important as well because they have access to the work force and often recruit workers for their mobility.

The epidemic is at different stages in various countries of Asia. Several countries have nascent epidemics where infection levels, even among people who do not use condoms and have multiple partners, are still fairly low – less than 5 per cent. In Asia as a whole, including China and India, about 85 per cent of the population live in areas where the epidemic is still in a very early stage.

There is an enormous opportunity here to learn from the experience of other Asian countries on the need to prevent HIV before it gets out of hand. The government of every country with a severe AIDS epidemic said, at some point, that it was not its problem because it could not happen here – this country did not have those behaviours. In every case, it has been wrong. HIV does not respect international boundaries, ethnicity, religion or gender. It just spreads when the opportunity presents itself through risky behaviour. There are cases of HIV in all countries now so there is an opportunity to act early, precisely and effectively to prevent the spread of HIV in the population. Some countries and areas have concentrated epidemics – Thailand is an example, also Cambodia, Myanmar, Viet Nam, Yunnan Province in China and many States in India. In those countries and areas, infection levels are very high among people with the riskiest behaviour. Among injection drug users it is 60-80 per cent and among commercial sex workers more than 5 per cent and often up to 40-50 per cent. Even in countries that have not acted early enough, there is an opportunity to stop the spread of HIV/AIDS by helping people with the riskiest behaviour to protect themselves. The example of Thailand is critical – the 100 per cent condom programme provided

very good evidence that the spread of HIV/AIDS can be slowed. It is too late to prevent an epidemic in those countries but the damage and spread can be reduced.

The last implication for public policy, particularly in those countries that do not yet have an epidemic, is that early action to prevent AIDS by helping people to protect themselves and others and prevent them from discrimination, could save millions of lives and protect Asia's future development.

(e) Discussion on Presentations

Question 1. On decreasing the cost of safe behaviour versus increasing the cost of risky behaviour, a simple demand and supply relationship would surely drive people to select the cheaper cost alternative. Why, therefore, was it counter-productive to raise the cost of risky behaviour?

Dr. Ainsworth replied that the fact that HIV/AIDS was spreading and was 100 per cent fatal, raised the cost. The knowledge that there was a risk of getting a fatal disease spontaneously reduced some people's risky behaviour but others still took risks. Attempts to clamp down would not reach everybody and those who continued to practise risky behaviour would then not have access to condoms. Historically, policies to eliminate commercial sex had been unsuccessful and attempts to eliminate injection of drugs had failed universally. People had gotten around attempts to restrict their mobility. Raising the cost of risky behaviour had not changed the nature of the problems but had discriminated against people who continued risky behaviour by denying them access to the means of safer behaviour. That was the rationale for governments not to raise the cost of risky behaviour.

Chapter 3 of *Confronting AIDS: Public Priorities in a Global Epidemic* contained a section on the experiences of different countries in, for example: legislating against sex work; drug enforcement strategies for preventing HIV/AIDS; the impact on people injecting drugs; and, smoking behaviour. There were examples of policies that had induced people to change from smoking to injection, which was clearly not beneficial to eliminate the spread of the AIDS epidemic and other diseases such as hepatitis. The laws of economics were correct – people had not succeeded in eliminating all these risky behaviours and the people who persisted in them were not able to adopt safer behaviour.

Question 2. Concerning long distance mobility, Professor Skeldon's presentation mentioned that it was not necessarily the distance that a person travelled because the quicker the movement, the less the distance and the higher the risk. This did not make any sense and it seemed that distance was a spurious issue.

Professor Skeldon replied that the case in Thailand was that much of the local mobility involved high-risk behaviour, for example in circulation to local markets and temple fairs. Long distance mobility seemed to involve much lower-risk behaviour. For example, the majority of Thai sex workers who invested in going to Japan used condoms because to be discovered as HIV-positive meant instant expulsion. Similarly, there was a negligible incidence of HIV among Thai labourers who moved to Taiwan Province of China, because they were screened before they went and at six-monthly intervals. If found to be HIV-positive, they were sent back. People did not sacrifice the considerable investment in long distance movements and adapted their behaviour very quickly.

Question 3. In terms of talking to governments, could the priority be concluded wrongly as the high-risk groups rather than community mobilization? Targeting high-risk behaviour was very important but it had to be backed by major community mobilization. For example, the 100 per cent condom policy had been very effective in Thailand but could have been overrated as a programme in itself, considering what had been happening in many parts of Thailand, particularly in the north. The 100 per cent condom policy had never been fully implemented in all provinces and its impact had been very uneven in most provinces. What had been most effective in Thailand were media campaigns and community mobilization and that was where focus was required.

Dr. Ainsworth agreed. The first striking piece of public information provided was that 44 per cent of sex workers in the north were infected with HIV. Prior to that being known, most people had regarded HIV as a problem brought into the country by foreigners using sex workers. It had suddenly become evident that there was a more general issue and there might have been considerable changes in behaviour in reaction to that information. It was very important for governments to pursue these public goods of monitoring the epidemic, monitoring behaviour and providing public information.

Community mobilization was important but which communities? NGOs were very critical to reaching the high-risk communities but many governments had difficulty in dealing with NGOs, not all of which were trustworthy. Collaboration and trust were needed to meet the common objective of reducing HIV by reducing the riskiest behaviour, using methods that did not stigmatize people. The scarce resources available to governments would help more people by starting with the goal of changing the riskiest behaviour among people with the most partners. That did change over time. For example, the high-risk behaviour of sex workers in Thailand was probably decreasing because of past interventions and other groups were probably now at higher risk.

Without the attention and continued support for people with the highest risk, the epidemic could not be stopped. Many people in the middle of the spectrum could change their behaviour but as long as the highest-risk people persisted, more infection would be generated. Even after success in changing high-risk behaviour, reinforcement was needed over time so that these groups were not left without the means of continuing to practise safer behaviour.

Question 4. In Asia, the HIV infection rate was quite high in some countries but nascent in others. Stress should be placed on cost-effectiveness, including a proper diagnosis of who were the current carriers of HIV and where the dangers came from, followed by interventions that targeted those groups. Migration was a two-way matter. For female domestic workers from the Philippines who go to all parts of the world, what was the rate at which migrant workers set out as HIV-negative and returned as HIV-positive? That was very important to their country of origin.

Professor Skeldon replied that, although data were currently insufficient, there did seem to be a general misconception about migrant workers from the Philippines being driven by poverty. The vast majority of Filipinos in Malaysia, Singapore and Hong Kong, China had received higher secondary or tertiary education and were receptive to HIV/AIDS information campaigns. One case study of the Filipino community in Hong Kong, China, although not focused on HIV/AIDS, had not identified HIV as a problem.

Question 5. Traffickers were a group whose mobility and vulnerability often went together. Was there any data on the magnitude of trafficking in ASEAN countries and what special policy challenges were there to intercountry cooperation?

Professor Skeldon replied that this was a complex question without an easy answer. Trafficking was a major and complex issue in the ASEAN region because of the large number of people involved who were undocumented. Trafficking existed on many scales, not just women being trafficked as sex workers. Many people were trying to access the labour market and joined the trafficking networks. Some networks were controlled by drug syndicates and triad societies but there were also local level trafficking networks. People were trafficked both willingly and unwillingly and on many levels. For example, the cost of being trafficked from China to the United States of America was reported to be around US\$38,000 per person, so it was not always the poorest people who were being trafficked.

Question 6. In this region, sexual transmission of HIV was the major factor, much of which possibly passed through commercial sex workers. Male society rather than poverty among women, had caused the demand but who decided whether condoms should be used? Most men who use sex workers are married and there should be a broad-based community approach focusing on condom use by the general population. Such an approach should embrace the whole community and include brothel owners, the managers of sex workers, the police and local authorities up to the level of governor. It needed to be implemented with a high coverage of commercial sex establishments and condoms should be available at them all, since many clients went from place to place. The approach should go beyond the logistical supply of condoms to include educational activities.

Professor Skeldon answered that the categories of migrants and sex workers were not always clearly differentiable. Thailand had been successfully focusing on the hard core of commercial sex workers but there were also enormous numbers of women who

moved in and out of sex work on a casual basis. Similarly with migrants; for example, farmers could also be fishermen on a seasonal basis. There was tremendous fluidity depending upon life cycle stages and particular economic circumstances. The less formal, less visible, marginal areas created a high-risk environment.

Question 7. Could data be provided on illegal migration and mobility? This was very important to a country such as Cambodia, where there was known to be a large illegal population movement along the borders with Thailand and Viet Nam.

Professor Skeldon replied that this was a big issue because of the number of undocumented migrants in the region. Most countries were beginning to realize that illegal migration was not going away and control – meaning limitation – had failed. Some controls had succeeded in the short term, as seen in China, but all the international and internal programmes to limit mobility had failed in the medium to long term. Countries needed to adopt proper management, channelling and documentation of movement – until there were channels of legal mobility, illegal migration would remain.

WORKING GROUP SESSION

Workshop participants then divided into three groups to discuss thematic country-specific issues. The composition of the three groups was based on country representation as follows:

Jackfruit Group: Brunei Darussalam, Indonesia, Malaysia, Philippines, Singapore (BIMPS).

Mango Group: Southern China, Lao People's Democratic Republic, Viet Nam.

Sapodilla Group: Cambodia, Thailand.

Guidelines were given to workshop groups on the following country-specific considerations:

- Identify mobility patterns and areas of risky behaviour regarding HIV and translate into a geographic framework.
- Identify which people in the networks were most at risk.
- Decide which groups and which behaviours would be the most efficacious to address.
- Identify interventions that would be most effective in changing risky behaviour.
- Identify specific national interventions that require intercountry cooperation and the actions needed to put those interventions into practice.

The three groups then reported back to a plenary session with a summary of their discussions and findings.

(a) Jackfruit Group Report (BIMPS)

The five countries could be put into two groups: first, the archipelagos of Indonesia and the Philippines; second, Brunei Darussalam, Malaysia and Singapore.

In Indonesia and the Philippines, two main types of internal mobility were identified:

- Seasonal mobility of people looking for work. Movement was mainly from rural to urban areas but, in certain economic zones outside urban areas, it could be from urban to rural areas.
- Students moving from their homes to get education.

Both countries also experienced regular movement of people from island to island, both urban to rural and rural to urban.

Economically, both countries also had significant international movement of people. Regional demand for labour came mainly from three countries – Brunei Darussalam, Malaysia and Singapore. Regardless of whether those who moved were professional, skilled, semi-skilled, or factory workers, health problems tended to shift to the destination countries. It was worth emphasizing that the Philippines did not share land borders with any country.

Brunei Darussalam, Malaysia and Singapore also experienced movement of their people, mainly for emigration, business or education. However, these countries were mainly recipients of mobile people with Indonesia and the Philippines mainly on the supply side.

Concerning HIV/AIDS interventions, the three receiving countries were vulnerable to mobile, high-risk people so the intervention should usually occur before workers departed from their home countries. The Philippines had pre-departure orientation seminars for its departing workers but they needed to be reinforced each time the workers arrived in or departed from the country. An arrival orientation course needed to be established for these workers, similar to that already implemented in Malaysia. Beyond that, access to quality health care services was difficult for these workers in the host countries. The re-integration of workers when they returned to their home countries should be monitored.

The policy and mechanisms of recruitment should permit documentation of workers for formal and legal immigration procedures, which should be simple to access and encourage workers to comply with the requirements. If these groups had difficulty to comply and moved illegally, they would be beyond access and subject to higher risk.

Concerning HIV prevalence in these countries and what needed to be done in the medium and long term, proposed priority activities were as follows:

- Implementing information and education campaigns directed towards adolescents.
- Establishing a safety net for mobile populations, extending from one country to another.
- Providing specific information on HIV/AIDS to mobile people.

These activities would relieve the hard reality of hostility when these people moved to other countries. If support systems were not in place, they would probably be more vulnerable to HIV/AIDS.

(b) Mango Group Report (Southern China, Lao People's Democratic Republic, Viet Nam)

Mobility patterns identified in the Lao People's Democratic Republic and Viet Nam were summarized as follows:

- Two-way movement occurred between the two countries owing to unofficial encouragement by both governments to suit economic development plans.
- In Viet Nam, mobile groups moved from poorer rural areas to more prosperous urban areas.
- In the border areas between Viet Nam and Cambodia and between Viet Nam and China, there was movement of construction workers, businessmen and people employed in business.
- Construction workers came officially from China to Viet Nam and some from Viet Nam moved to Thailand.
- Formal mobility in the Lao People's Democratic Republic comprised repatriation of country nationals from Thailand and other countries at greater distances, such as the United States and France.
- Informal mobility in the Lao People's Democratic Republic comprised mainly local construction workers.

High-risk behaviour included injection drug use and unsafe sex. Examples of those more likely to engage in high risk behaviour were:

- Young people, particularly women, who moved from rural to urban areas to become bar workers, selling sex and moving frequently.
- Business people who crossed the border between China and the Lao People's Democratic Republic.
- Truck drivers who travelled between the Lao People's Democratic Republic and Viet Nam.
- Highland people in Viet Nam with drug habits who moved to the lowlands, bringing their risky drug use behaviour with them.
- Drug users who moved from rural to urban areas to look for work to support their drug habit.
- Sex workers from Viet Nam who went to work in Cambodia, particularly in Phnom Penh.
- Ethnic minority groups, construction worker and fishermen who moved to Thailand.

- Tourists and businessmen who moved between the Lao People's Democratic Republic and neighbouring countries.

High-risk groups that were easy to access comprised:

- Young women working in factories in the Lao People's Democratic Republic, some of them selling sex.
- Bar workers.
- Construction workers, they could be difficult to access if they moved frequently.

High risk groups that were generally more difficult to access were:

- Mobile seasonal workers in Southern China, Lao People's Democratic Republic and Viet Nam.
- Truck and boat drivers in Southern China, Lao People's Democratic Republic and Viet Nam.
- In Viet Nam, fishermen and trafficked women.

Other groups at risk were: male construction workers in the Lao People's Democratic Republic; private male individuals; businessmen travelling across country and between two countries; and rural people who moved to urban areas to seek work.

Geographic areas of high-risk behaviour were: the border areas between Viet Nam and Cambodia and between Viet Nam and China, where there were many truck drivers; and the area around the Mekong River, which was a drug trafficking area.

High-risk geographic areas in the Lao People's Democratic Republic were Savannakhet and Pakse and the highways connecting to Viet Nam.

Proposed intervention activities were as follows:

- Provision of information.
- Education and pre-education campaigns.
- Communication programmes.
- Condom promotion programme.
- Strengthening the diagnostic and treatment capacity for STIs in both the Lao People's Democratic Republic and Viet Nam.

Intercountry collaboration was proposed on education programmes for people who moved between the Lao People's Democratic Republic and Viet Nam. It was very difficult for Viet Nam alone to carry out intervention targeting Vietnamese commercial

sex workers and traffickers in the Lao People's Democratic Republic. A suggestion was made that demands be placed on behaviour of those who travelled across the border between Viet Nam and the Lao People's Democratic Republic.

It was suggested that Viet Nam, the Lao People's Democratic Republic, China and Cambodia should collaborate on target intervention among sex workers at the border areas with Thailand. In the last two years, a request had been made to the Government of Viet Nam to allocate budget for this collaboration. In 1998, several meetings had been held at provincial and district levels and in some provinces near the borders. A larger budget was expected for continuing that approach in 2000.

(c) Sapodilla Group Report (Cambodia, Thailand)

In Cambodia, there were two different types of migration – short distance and long distance. Short distance migration was the internal movement of populations and there were three groups:

- People moving from rural to urban centres, including factory workers, construction workers, sex workers and taxi drivers.
- People coming from areas of urban and rural poverty to work in natural resource jobs, such as fishermen and workers in the gold mines.
- People moving back and forth between rural and urban areas on a constant basis, including truck drivers, the military, police, traders and miners.

Long distance mobility involved two groups – formal and informal workers. Examples of the former included domestic helpers from Cambodia who moved to work in Malaysia. Informal mobile workers from Cambodia made up a much larger number, some 20,000-30,000 people who moved mainly to Thailand, Viet Nam and Malaysia. They included sex workers and fishermen.

Movement into Cambodia was mainly in the form of tourists, about 200,000 to 300,000 a year. Their behaviour was not known for certain but some were sex tourists. There were also sex workers, construction workers and others who used Cambodia as a stopover point before further movement to, for example, China and Viet Nam.

The zones of high risk centred around the border towns and checkpoints between Cambodia and Thailand, Viet Nam and the Lao People's Democratic Republic. In the border area between Cambodia and Thailand, over 50 per cent of commercial sex workers and over 10 per cent of police were found to be HIV positive in 1998.

Bilateral agreements for intervention between Cambodia and its neighbours should target high-risk groups, specifically: commercial sex workers; fishermen; truck drivers;

agricultural workers; and construction workers. Medium-risk groups such as factory workers would probably be more difficult to access, depending on the compliance of factory owners with intervention strategies.

Proposed intervention activities were as follows:

- Education on HIV awareness and prevention for domestic helpers going to Malaysia, both pre-departure and upon arrival.
- Continuation of cross-border promotion of condom use and behaviour change.
- Production of multi-language information and education campaign material.
- Establishment of STI clinics along the proposed highway construction routes through Cambodia.

In Thailand, the focus of movement was on three regions: the western border with Myanmar, including Mae Sai, Mae Sot and Ranong; the border with Cambodia; and the border with the Lao People's Democratic Republic, including Nongkhai.

There were up to one million migrants in Thailand, of which 106,000 were documented. Of the total, approximately 85 per cent were from Myanmar, 10 per cent from Cambodia and the rest from other countries including the Lao People's Democratic Republic.

In terms of spreading HIV infection, the following five high-risk groups existed:

1. Fishermen, who moved from north-eastern areas of the country to the southern and eastern international ports. They were mostly from Myanmar although there were some from Cambodia based mainly in Rayong.
2. Thai commercial sex workers, who generally came from the north-east and north and migrated to the transit spots and major cities within the country, as well as to foreign destinations such as Japan and Singapore.
3. Foreign sex workers, who were mainly from: Yunnan Province, China; Shan State, Myanmar; Cambodia; and Viet Nam.
4. Industrial workers who, in most cases, comprised young migrants that moved from rural to urban areas. With increased industrialization in Thailand, there had been an increase in numbers. Also, factories in border areas tended to attract industrial workers from outside the country in large numbers.
5. Agricultural workers, whose pattern of movement was the same as that of industrial workers and who included young mobile people from outside the country. The pattern of work was seasonal.

Actions that needed to be taken were as follows:

- Strengthen bilateral cooperation with neighbouring countries, especially at the provincial and local levels.

- Strengthen NGOs to implement interventions with migrants on the western borders.
- Improve participatory research in border areas.
- Implement information and education programmes in prevention of HIV and care of AIDS cases, using appropriate languages for migrant labourers.
- Market and promote condom use.

(d) Working Group Discussions

A participant noted that the mechanisms for Thai-Cambodian cooperation included a national committee working at the provincial level and that there were bilateral discussions. However, was there a plan of action?

The response was that a working group had been developed and the Cambodian side was currently working with the Ministry of Health in Thailand and would meet in year 2000. As far as budget was concerned, Thailand had allocated about 20 million baht and there were also contributions from other donors.

The meeting facilitator noted that specific national interventions needed to be formulated at this stage. Generalizing on what had just been presented, it was probably fair to say that nothing was being done in the area. Themes, issues and priorities needed to be established with focus on those that would make a significant impact on the epidemic. Focus would bring it down to one major issue for each country to which that country could respond. For example, Thailand might focus on fishermen and if there were, in two years, an effective programme to target the fishermen population, an impact would have been made. The selected issue would have to be one that incorporated interventions translating into practical effort at the grass-roots level while maintaining the appropriate national-scale action.

The facilitator added that the workshop should be regarded as an ongoing learning process – there was no such thing as being wrong, only being wrong on the path to being right. Participants needed to keep thinking about what were the most and least risky behaviours and which were the easiest and hardest to address.

Ms. Sharuna Verghis, Coordinator of Action Research on AIDS and Mobility, Asia Tenaganita, Malaysia said that it was not appropriate to isolate risky behaviours because of constraints imposed, for example, by the environment and availability of resources. It was equally important to look at what built a supportive environment and that was useful because it shifted the onus of managing HIV away from the migrants who may have been victims of circumstance. Thought needed to be given to incorporating access to health care for all populations as a fundamental human right.

Professor A. A. Kielmann, Consultant to CHASPPAR pointed out that school children of today would become the migrants of tomorrow and pre-emptive measures were needed to educate them on HIV.

Professor Ronald Skeldon responded that this issue was important. However, everyone was mobile to some degree so it was difficult to identify in advance which groups of children should be targeted.

Another participant said that there should be a plan of action and youth was already part and parcel of target group intervention. Promotion of awareness among students at school should include the subject of mobility. However, he thought that the workshop focus should be on current migrant populations.

Another point was made that target groups were not static and comprehensive programmes needed to be balanced with specific targeting.

Mr. Bernard Gardiner from the Australian Red Cross said that it was important to remember that resources for these kinds of interventions tended to flow to people who were already in the system and had access to the system. For example, children who were most vulnerable to HIV were probably not attending school but were already working. Therefore, the choice of partners became important because official partners might miss vulnerable groups entirely.

Professor A. A. Kielmann added that this problem had occurred in Africa because these groups had not been approached at the time when they were approachable.

Mr. Jacques du Guerny thought that ideas were being fielded that were between two extremes. On the one hand, migrant workers were defined as an identifiable group, moving through easily marked areas such as borders, bus stops and brothels. As a result, these were clearly the places where intervention could and should take place. On the other hand, there was the systematic approach that saw migration as a phenomenon rather than a group of people. For example, seasonal migration created vulnerable populations only during the slack season when the workers were idle. This led to a different approach to intervention, focusing on villages, communities and cities that received the migrant workers. Each of these approaches had strengths and weaknesses. The task might be to identify at what point on the spectrum between these two extremes did each country want to locate its strategy.

The facilitator said that another issue was how to prioritize actions to have the greatest impact. What actions at the country level would have the greatest impact? Who would be the participants in these actions and where would the actions occur?

It could be seen that countries were already defining their priorities. For the Philippines and Malaysia, it might be more suitable to address migrants in Malaysia while, in the Lao People's Democratic Republic, periphery-to-centre migration was a more country-specific problem. Consideration was needed to classify actions into short-, medium- and long-term responses and it had to be remembered that no single programme would be completely effective.

FORMULATION OF A FRAMEWORK FOR JOINT ACTION PLAN

(a) ASEAN Task Force on AIDS Medium Term Plan

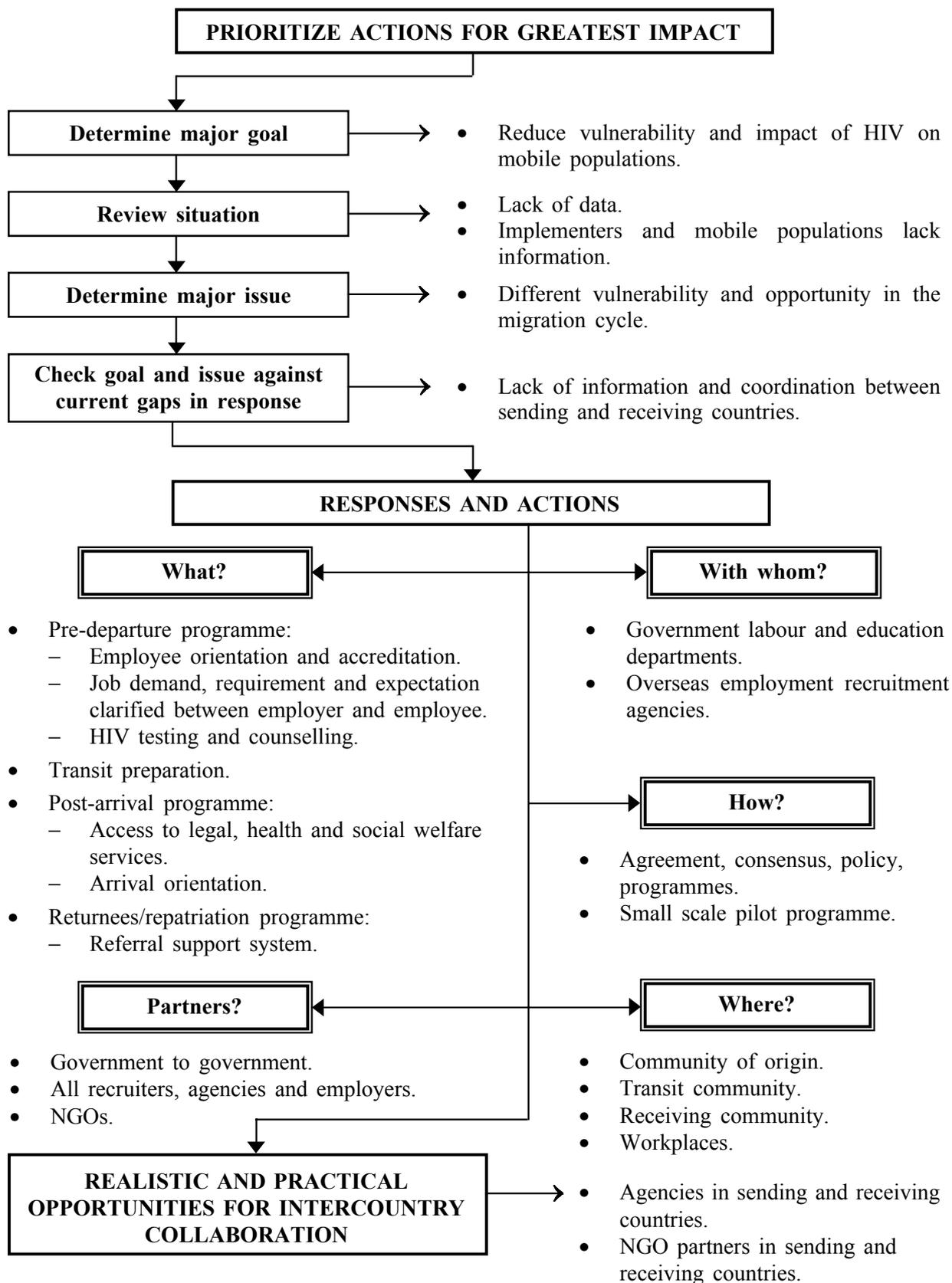
Mr. Yong Chanthalangsy of the ASEAN Secretariat, reported that ASEAN leaders, recognizing the seriousness of the HIV/AIDS situation in the region, had decided at their fourth ASEAN summit in Singapore in 1992 to strengthen cooperation and quality response of ASEAN to the problem. This was reinforced in 1998 during the sixth ASEAN summit in Hanoi, when leaders adopted the Hanoi Plan of Action, in which they pledged strong collaboration among member countries on coping with HIV/AIDS.

In 1998, the ASEAN Task Force on HIV/AIDS completed and adopted the Medium Term Plan to facilitate the ASEAN regional programme. This significant effort by member countries pledged commitment in pulling together resources to address the issues and problems as a regional group and not as individual countries.

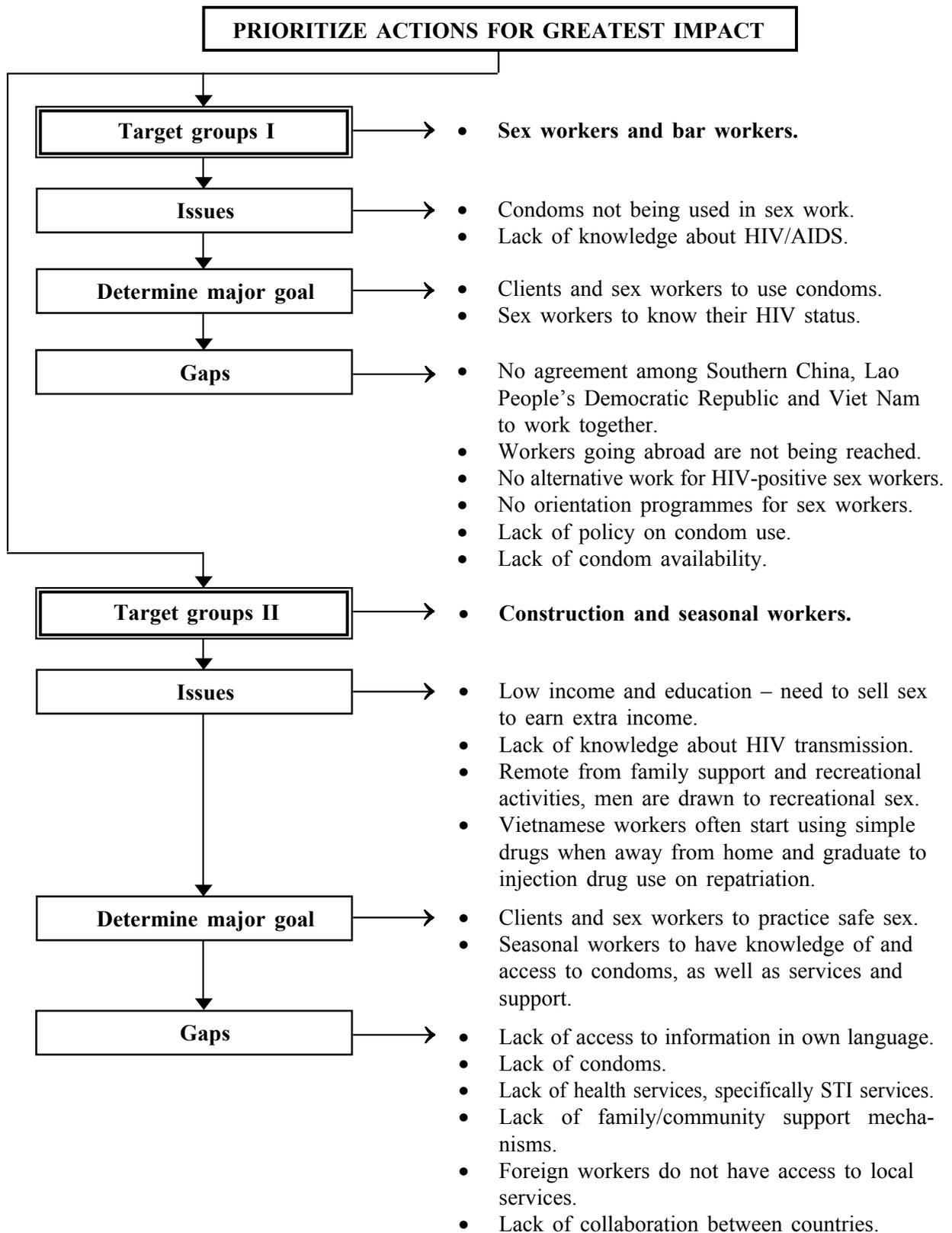
The priority activities identified in the Medium Term Plan were as follows:

- Establishing ASEAN AIDS Information and Research Network.
- Strengthening the capacity of non-health agencies, by working with and consolidating the cooperation in the non-health sector, including NGOs and other agencies.
- Studying the problems raised by population movement and identifying effective interventions.
- Working with youth groups, which may play an important role in conducting prevention while at the same time being possible victims of the epidemic and a target group for intervention.
- Encouraging cooperation among the government sector, NGOs, the private sector and community organizations.
- Publishing activities on HIV/AIDS prevention and control in the regular publication of ASEAN called Update.
- Identifying and carrying out multidisciplinary studies to explore and research the problem.
- Promoting awareness of the HIV/AIDS problem through a family support system that includes peer support and counselling.
- Actively promoting discussion among village leaders, an important group of opinion makers, and Islamic religious leaders, who devised the Jakarta Declaration and advise all Islamic leaders in their respective community and country to respond to the Declaration.
- Through Viet Nam as the coordinating country for ASEAN, studying means of HIV surveillance, which was a complex matter on which ASEAN needed collaboration and assistance from other countries.

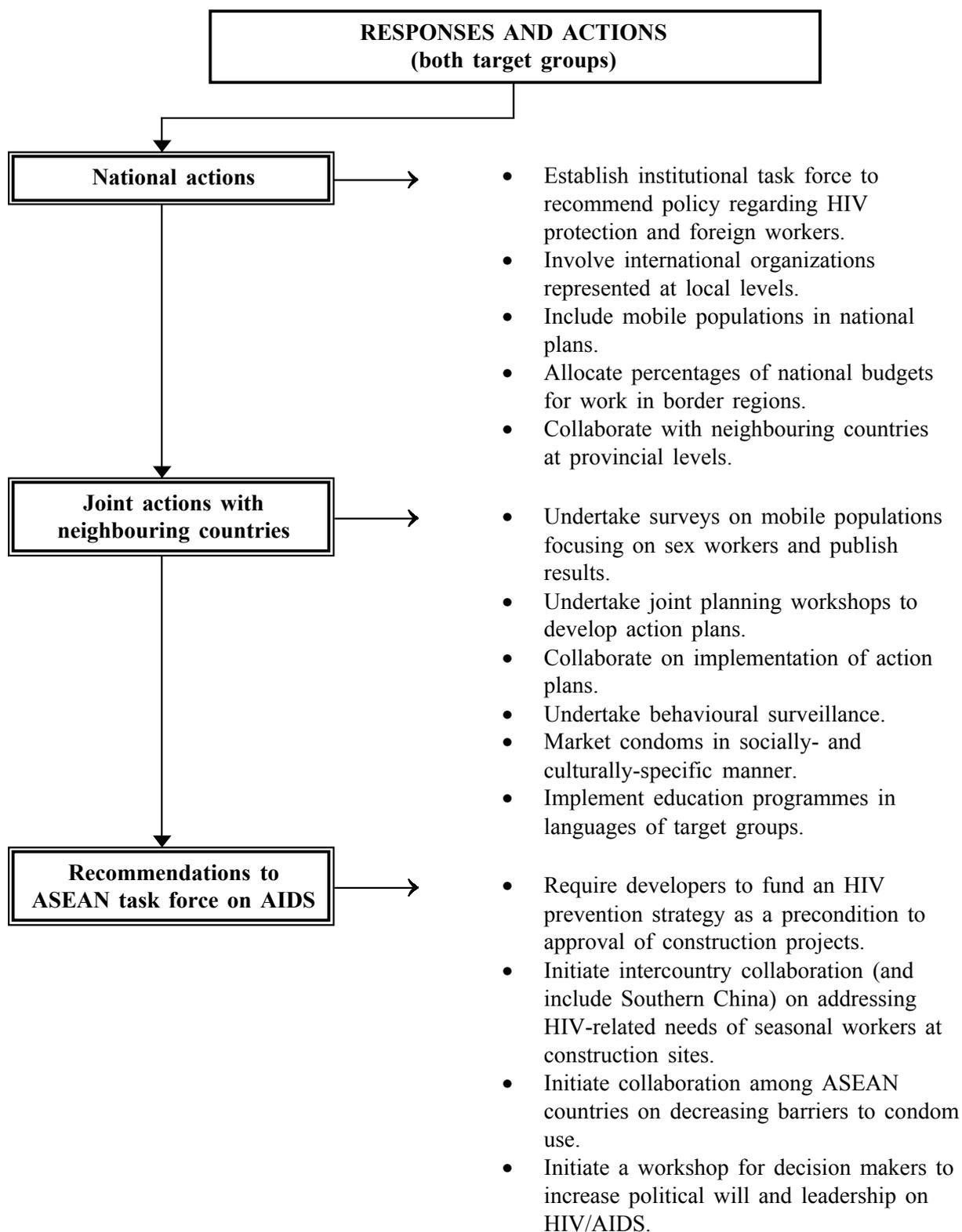
(b) Jackfruit Group Action Plan (BIMPS)



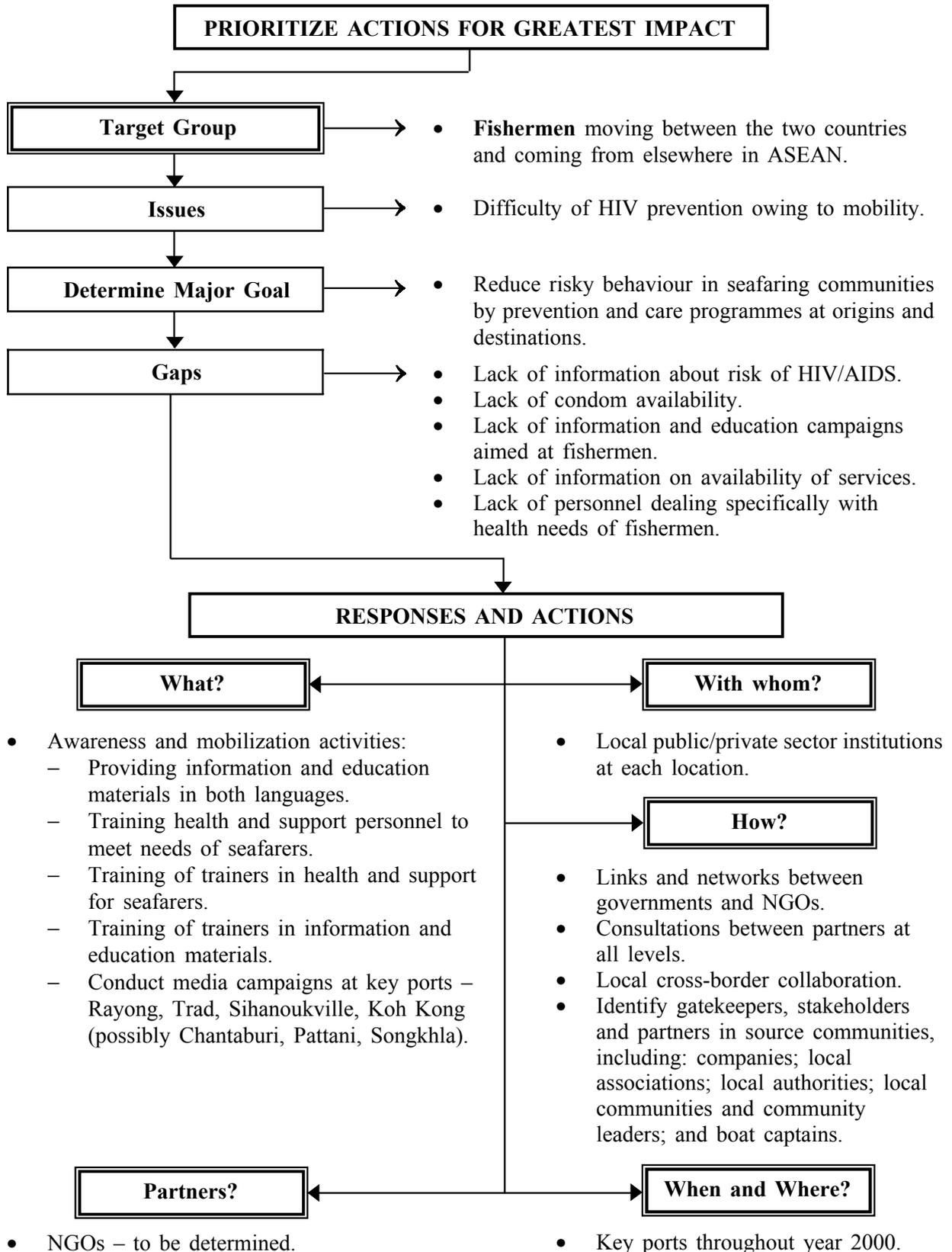
(c) Mango Group Action Plan (Southern China, Lao People’s Democratic Republic, Viet Nam)



(c) Mango Group Action Plan (continued)



(d) Sapodilla Group Action Plan (Cambodia, Thailand)



(e) Proposed Timetable for Completion and Implementation of Action Plans

10-12 November 1999	→	Draft Action Plan Framework prepared at the Chiang Rai workshop
16-18 November 1999	→	ASEAN Task Force on AIDS to endorse draft Action Plan Framework
30 April 2000	→	Countries to complete specific project proposals with technical support as required
May-June 2000	→	Technical review of project proposals by UNDP/UNAIDS Regional Task Force on Mobile Population and HIV Vulnerability
July 2000	→	Joint action programme fund-raising to commence
October-November 2000	→	Joint action programme implementation to commence
2001	→	Joint action programme progress review

FIELD VISIT OBSERVATIONS AND DISCUSSION

Mae Sai Hospital, Mae Sai District, Chiang Rai Province, was the field visit site. Medical staff briefed participants and a meeting was held with a local NGO.

(a) Jackfruit Group Observations (BIMPS)

- Mae Sai hospital was providing assistance on prevention of HIV infection as well as care for AIDS sufferers.
- Many patients from Myanmar were unable to pay for treatment but were still given the same services by the hospital. Care and support went beyond economic and political considerations.
- Cooperation between the hospital and NGOs was strongly evident and the NGOs themselves appeared to be highly motivated. The most active NGO volunteers themselves had family members that were infected with HIV.
- There was little resistance from the community to HIV/AIDS patients in their midst, probably because they were now well aware of the problems.
- Patients came from Myanmar to Mae Sai because there were few services available on the Myanmar side. Activities were needed that focused on that particular side of the border. Mae Sai hospital was able to cope with the influx but the question was, for how long?
- Community motivation was encouraged by having recently received a certificate for having the best HIV/AIDS volunteers. Government support needed to include giving recognition and credit to volunteers.
- There did not appear to be a programme to provide sex workers who had come from across the border with education and information on HIV/AIDS.
- HIV testing at Mae Sai hospital was given anonymously, which was now the policy at Government testing clinics throughout Thailand.

(b) Mango Group Observations (Southern China, Lao People's Democratic Republic, Viet Nam)

- The Mae Sai programme was recognized by the Thai Ministry of Health and supported by donors. In the Lao People's Democratic Republic, there were only community self-help schemes, although government recognition would commence soon with a dialogue with some village communities.

- The support of the village headman in donating the land for the hospital and of NGOs in practising traditional medicine were both impressive.
- Mobility was present in Mae Sai and there were risks of transferring HIV both ways across the border with Myanmar. The programme in Mae Sai seemed well able to respond to these two-way risks.
- Communities themselves participated in HIV/AIDS help programmes, not merely the health authorities. Good publicity of the programmes was used to gain the support of other organizations including international donors.

(c) Sapodilla Group Observations (Cambodia, Thailand)

- Many people came from Myanmar to Mae Sai Hospital. Increased cooperation between the two countries was needed, with joint working groups to respond to the HIV/AIDS problems along the border.
- Some volunteers in NGO programmes had stayed for many years. Further study of the motivation of volunteers would help other regional programmes.
- Communication was not a big problem because the northern Thai dialect spoken was understood by the border people from Myanmar.

(d) Comments by Moderator

- Although there was no formal cooperation between Myanmar and Thailand, informal cooperation was taking place between the border groups.
- Strong Asian cultural values were present in the Mae Sai programme, with many local volunteers taking part. Programmes needed to be designed to incorporate the social, culture and environment of target areas.
- While the field trip focused on the movement of people from Myanmar, there was two-way mobility in the border areas. Little was known about the movement of Thai people to Myanmar.
- The language problem had been addressed in the Mae Sai programme, as exhibited by information posters written in several languages.

WORKSHOP AGENDA

Wednesday 10th November 1999

- 9:00-10:00 Opening
- Welcoming Statement by His Excellency Mr. Samreng Poonyopakorn, Provincial Governor of Chiang Rai Province
 - Welcoming Statement by Dr. Lee-Nah Hsu, Manager of UNDP South-East Asia HIV and Development Project on behalf of UNDP
 - Welcoming Statement by His Excellency Mr. Kamron Na Lamphun, Deputy Minister of Health of the Royal Thai Government
- 10:30-12:00 Plenary session – presentations
Moderator: Mr. Jacques du Guerny
Focal point on HIV and on Ageing, Chief, Population Programme Service, Department of Sustainable Development
Food and Agriculture Organization of the United Nations (FAO), Rome
- Presentation I:* Population Mobility in South-East Asia and HIV
Prof. Ronald Skeldon
Consultant to UNDP South-East Asia HIV and Development Project
- Presentation II:* HIV/AIDS Epidemiology and Mobility in Asia
Dr. Gilles Pומרol
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- Presentation III:* AIDS, Population Mobility and Development –
government priorities in resource-scarce settings
Dr. Martha Ainsworth
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The World Bank, Washington DC
- 12:00-12:30 Briefing for working group Session 1
Mr. Guy Scandlen, Lead facilitator for the workshop
- 13:30-16:30 Working group Session 1

Thursday 11th November 1999

- 8:30-9:30 Presentation by working groups on findings from Session 1
- 9:30-10:00 Briefing by facilitators on formulation of Joint Action Plan
- 10:30-12:30 Working group Session 2 – formulation of Joint Action Plan
- 13:30-17:30 Field visit arranged by SEAMEO-GTZ-CHASSPAR

Friday 12th November 1999

- | | |
|-------------|--|
| 8:30-9:00 | Discussion on field visit |
| 9:00-12:30 | Working group session 2 (continued) – formulation of Joint Action Plan |
| 13:30-14.30 | Presentation of Joint Action Plan and proposed follow-up |
| 14:30-15:00 | Closing ceremony |

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