

Asian Culture and AIDS

ELIZABETH WILLIAMS
Senior Program Officer
HIV/AIDS Asia Society

"The HIV/AIDS pandemic is spreading through Asia/Pacific societies in the same way termites attack a house, invisible at first, catastrophic in the end." - Nafis Sadik, UN Special Envoy to AIDS in Asia

NOWHERE IS THE GLOBAL HIV/AIDS crisis growing faster than the Asia Pacific region, broadly defined as the area from Australia to Iran. One of every five new infections worldwide occurs there; ten years ago it was fewer than one in ten.¹ Statistics from the region suggest that the problem is getting worse. In a well-known report issued in September 2002, the National Intelligence Council (NIC) declared India and China, along with Russia, Nigeria, and Ethiopia, to be sites for the next wave of HIV/AIDS.² In this same report, the NIC projected that even if effective prevention programs could be implemented quickly, China could have 10 to 15 million HIV/AIDS cases and India 20 to 25 million by 2010—the highest estimates for any country.

Despite these dire predictions, recent examples of leadership give reason for hope. Premier Wen Jiabao recently spent the Chinese Lunar New Year's Day visiting villages heavily affected by AIDS. Dr. Peter Piot, Director of the United Nations Joint Program on HIV/AIDS (UNAIDS) called this visit a "spectacular indication" of the political momentum on the issue, and most of those working on AIDS in China agree that the Central Government has moved quickly in the past 18 months.³ In India, Prime Minister Manmohan Singh recently announced that he would personally chair the National Council on AIDS. Marina Mahathir, President of the Malaysian AIDS Council and daughter of the former Prime Minister of Malaysia, recently reported that the Malaysian government is making efforts to bring in cheap generic drugs to provide free treatment to infected individuals.⁴

ELIZABETH H. WILLIAMS, MPH is a Senior Program Officer at the HIV/AIDS, Asia Society. The author would like to acknowledge the contribution of Seema Arora, who is a Program Assistant at the Asia Society, for her help at the end, especially with citations.

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Politicians are not the only ones involved. Outside of government, responses to AIDS reflect the creativity of cultures and communities. Asia, with its diversity of cultures, is witness to an equally diverse range of responses. People in the arts, sports, and microenterprises are part of the regional—and increasingly international—response.

The close relationship between poverty and AIDS, however, continues to threaten and to hinder these efforts. Throughout Asia, poor people migrate long distances to

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urban centers searching for work and create floating populations of poverty within even the most modern and cosmopolitan cities. In nations where some live in palaces, poor women are often forced to sell sex to feed their families. Prevention and treatment programs, where they exist, often fail to meet the needs of these marginalized populations,

in part because governments and municipalities turn a blind eye to impoverished communities, focusing instead on the upwardly mobile middle class. This gap ensures that the next generation will also be infected.

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This paper considers the growing response to AIDS in Asia. In particular, it examines the way culture, governance, geography, and history influence and are influenced by the response to AIDS: the feminization of AIDS, the internationalization of the response to the epidemic, and the roles of drug use and human trafficking in spreading the disease are three important aspects of AIDS in Asia. Finally, the paper concludes with some broad suggestions for moving forward.

AIDS IN ASIA

Until recently, HIV/AIDS has been defined as an African disease in the public imagination and in the minds of policymakers because most HIV/AIDS infections are in Sub-Saharan Africa. Yet nations in Asia and Africa no longer compete just in cricket. Current estimates of HIV infections in India—5.1 million⁵—fall just short of those in South Africa, which leads the world with the highest number of people infected.

So far prevalence rates in most parts of Asia are still low: nowhere in Asia is there a concentration of disease anywhere close to the numbers seen in Africa, where some communities have prevalence rates between 30 and 40 percent.⁶ The current scale of Asia's epidemic has more to do with the size of the continent's population than with an explosive spread of the virus.⁷ Given the tremendous population numbers in Asia, very small increases in prevalence translate into millions of people newly infected. But the

distribution of disease is not uniform. In India, the prevalence of disease in the state of Andhra Pradesh grew to two percent in 2004 with a rate of four percent in the Prakasam district⁸—rates that are comparable to those in Sub-Saharan Africa.

The practices and behaviors that spread the disease are different in Asia. Unlike Africa, where most HIV spreads through heterosexual transmission, HIV in Asia is concentrated in “high-risk” groups. The danger now is that HIV will move into the population at large.

One of the key drivers in Asia is intravenous drug use. One in three new infections is the result of sharing dirty needles.⁹ Afghanistan is the number one producer of heroin in the world. Myanmar and Laos are number two and number three. Local production leads to local use. In rural China, heroin is more affordable and available than cigarettes.¹⁰

It is not just dirty needles that make IV drug use so risky in Asia. A recent conversation between IV drug users in Chengdu, China and colleagues from an international HIV/AIDS organization revealed a shocking fact. When the women in the group were asked if they engaged in transactional sex, all of them said yes.¹¹ These are the same women middle class businessmen turn to on visits to the region. This highlights an important point: many individuals in Asia practice more than one risk behavior.

People with identifiable risky behaviors are not isolated: they are part of communities and families. They bring the infection home to their partners. This has a significant impact in Asia, where the sexual behaviors of men and women differ. Evidence shows that in the high prevalence areas of Africa, both men and women have more than one partner in one year.¹² In Asia, most women are married early in their lives, tend not to have many partners before marriage, and do not engage in extra-marital sex. It is husbands who have sex outside of marriage and bring the disease home. For example, in India nine out of ten infected women have had no sexual partners besides their husbands.¹³

When the infection moves out of high-risk groups, it spreads very quickly through the general population. In response to the talk of a “low and slow” epidemic in Asia, Nafis Sadik, United Nations Special Envoy to AIDS in Asia, replied, “This is a myth, with no foundation...It seems to come from a combination of assumed superiority and wishful thinking.”¹⁴

TABOO ISSUES: INADEQUATE RESPONSES

The link between AIDS and taboo behavior means that responding to AIDS in Asia requires open discussion of many practices governments are most anxious to avoid. Most prevention programs in Asia have kept away from issues relating to drug use, sex

tourism, human trafficking, and homosexual behavior. This is a huge mistake that could prove fatal for the millions of Asians whose HIV infections could have been prevented.

Outside of Hong Kong, there are few comprehensive harm-reduction programs for intravenous drug users. Thailand recently went in the opposite direction and targeted users in a stepped-up war on drugs, forcing many drug addicts into hiding.¹⁵ Although China should be commended for implementing small scale harm-reduction programs in some of its urban centers and infectious disease hospitals, public health officials tend to criminalize drug behavior and often send users to compulsory detention and treatment centers. In India, recent photos of one treatment center show drug users chained to their beds.¹⁶

This discrimination also extends to sex workers. There are significant gaps even in Thailand, which is generally regarded as a developing country that successfully promotes HIV prevention and control. Throughout the 1990s, the Thai "100 percent Condom Campaign" distributed 60 million free condoms per year to sex workers and their clients and reduced rates of infection among reproductive-age adults.¹⁷ The campaign, however, did not reach the lower end, brothel-based sex workers, the great majority of whom were trafficked from Thai hill tribe minorities, Myanmar, Laos, Cambodia, and Central Asia, including Russia and Uzbekistan. Moreover, because these women were breaking two sets of laws (prostitution and illegal entry), they did not take advantage of help even when it was available.¹⁸

Many Asian governments are also wary of supporting prevention campaigns in the gay population, including those launched by international AIDS organizations or programs started by local communities. In Singapore, there were 30 percent more infections in 2004 than in 2003, with approximately one third of the new cases in men who have sex with men.¹⁹ However, the Singapore government has done little to address the spread of the epidemic in this group, and have not even defined them as a high risk group. Activists believe such neglect is designed to further marginalize this already stigmatized population.

THE NEW FACE OF AIDS: THE OLD ISSUE OF POWER AND EQUALITY

Since the Cairo Declaration in 1994 and the United Nations Fourth World Conference for Women in Beijing in 1995, much has been achieved to empower women throughout the world. Unfortunately, places with the least progress are the same places that now face the greatest AIDS epidemics. For example, the rural Salem district of Tamil Nadu, where approximately 60 percent of girls are killed within three days of birth,²⁰ is also categorized as one of India's "high-prevalence states."²¹

This link between women with low economic positions and HIV infection means that life for those with little economic power is more tragic, more desperate, and most vicious. Women are affected by the disease by no risk behavior of their own. The resulting stigma and discrimination affect women of all ages: girls and youth, women who are married and those who are not, women in the prime of life, and those beyond. This link is particularly strong in South Asia. In a country such as India, with a long history of caste and social order, women have traditionally fallen to the bottom ranks in all parts of society.

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Now a new social class has been created in India for HIV-positive women, lower than any existing class.²² No matter that 90 percent of these women are married and monogamous, because for an average Indian woman the greatest risk of acquiring HIV infections is through marriage. Frequently, a woman does not learn of her status until she becomes pregnant and is tested. Because her husband seems healthy, her in-laws blame her for bringing disease into the house. These women are shunned by their own families and left to fend for themselves with few skills and very little training. Many are forced into the streets and prostitution.

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Other traps exist for women. Dr. Suniti Solomon, Director of YRG Care in Chennai, has often spoken of the pressure for women to be mothers, a pressure so great that even a woman who knows her husband is HIV positive will seek motherhood, though she is putting herself and her child-to-be at risk of infection. In the words of an old Indian folksong, "The lives of women without children are like oxen milked out, like a plant leaf discarded after the meal."²³

In several regions of the world today, getting married puts a woman at risk for contracting HIV. The ABC (Abstinence, Be Faithful, Use a Condom) strategy does not take into account the sexual imbalance of power in many Asian societies. As Kathleen Cravero, UNAIDS Deputy Director explains, "Across the globe women, particularly young women, are not in a position to abstain. They are not in a position to demand faithfulness of their partners. In many cases they are in fact faithful, but being infected by unfaithful partners."²⁴ Sadly, this situation is not new. What is new is the presence of HIV.

Throughout Asia, discrimination against women has been socially and politically institutionalized. It is exacerbated for women with HIV/AIDS. A comprehensive AIDS campaign must address both types of discrimination.

RESPONDING TO THE CHALLENGE

While it is true that a large percentage of women in Asia do not have a voice, not all women in Asia, or elsewhere in the world, fit this stereotype. The region is a vibrant, powerful, and complicated place full of strong, accomplished, and powerful women.

Mary Robinson, the former High Commissioner on Human Rights, President of Ireland, and current Executive Director of Realizing Rights, pointed out recently:

“The fact [is] that women are some of the greatest leaders in the response to this pandemic . . . Don’t let us think we’re in the lead on this. Women in Asian countries on the ground are already leading, they carry the burden. What we can do is recognize that and use our leadership to link with that and to make a difference.”²⁵

Several important womens’ leadership initiatives are working to promote change in gender rights and power for women. Most notable is the Global Coalition on Women and AIDS, which was launched by UNAIDS and others to promote solutions with the needs of women and girls at the center. These needs include keeping girls in school, reducing violence against women, promoting economic opportunities, protecting property rights, ensuring access to central health care services, and making microbicides and other female-controlled reproductive options a reality.

At the 2004 World Health Assembly, a new group was formed. The Network of Women Health Ministers helps its members share ideas and experiences as they address the persistent inequalities in women’s access to basic health services. Another strong leadership group is the International Community of Women Living with HIV/AIDS (ICW), which was very visible during the 2004 AIDS Conference in Bangkok.

As Mary Robinson says, these international efforts recognize that the challenge of HIV for women is social, economic, cultural, and unavoidably political.²⁶ While international efforts are important and necessary, it is initiatives at the local level which showcase the community of women and their remarkable partnerships that provide aid, care, and education to those most at risk.

The Saheli project in Mumbai, India is one example of a program that helps prevent HIV transmission among commercial sex workers and their clients. Under the program, brothel managers provide a *saheli* (girlfriend), who is responsible for about 25 sex workers. Her responsibilities include educating the sex workers about HIV/AIDS, providing them with condoms, and taking them to the clinic if they become sick.

In Sonagatchi, India, the Durbar Mahila Samanwaya Committee (Women’s In-

tegration Committee) has organized 30,000 sex workers. In 1995, these workers unionized under the slogan "Sex work is real work. We demand workers rights." In Southeast Asia, the Cambodian Prostitutes Union, founded in 1999, has created a safe space for sex workers to discuss HIV/AIDS and reproductive rights. Support services for women that perform outreach into the brothels begin by talking about HIV/AIDS and move on to discussions of human rights and gender equality. For some women, these forums are the first time they have considered the idea that men and women should have equal human rights.

In these examples and in many other ways Asian women are responding creatively to the AIDS epidemic. Women, however, cannot win this war alone.

BEYOND WOMEN

Asian popular culture is an important ally in the fight against HIV/AIDS. In India, popular arts have long been effective at reaching at-risk women and girls. Visual media, puppetry, television and film, dance, music, and theatrical performance—both at the street level and broadcast through modern media—can reach all community members, including the illiterate. Arts, song, and dance can bring messages of prevention and care to populations where other messages are ignored.

For example, a recent Bollywood film, *Phir Milenge* (*See you Again*), uses well-known actors to tell a positive human story that simultaneously shatters myths relating to HIV, as the Tom Hanks movie *Philadelphia* did in the United States more than a decade ago. Another Bollywood example is the film *My Brother Nikhil*, released earlier this year. Set in Goa in the 1980s, the film tells the story of a popular, championship swimmer who is diagnosed with HIV. Nikhil is ostracized by his community and by his family and must struggle against stigma and discrimination with only his sister and lover by his side. One

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of the top ten most watched TV programs in India is *Jasoos Vijay*, or *Detective Vijay*, a Doordarshan detective show that features a private investigator who is HIV-positive.

In Vietnam, the locally based Hanoi Reproductive Health Theater Troupe uses drama and comedy to address HIV/AIDS. The Troupe has performed in formal halls and theaters, but its origins are at community gathering centers.

From growing cities such as Beijing to devastated rural provinces like Henan, people living with AIDS use visual arts for therapy and for raising public awareness.

One notable example is the Positive Art Workshop in China. Positive Art, an organization of young people living with AIDS in Beijing, uses the skills and creativity of its participants to earn a basic living through the sale of artworks. More importantly, the production of art creates links between those involved with the Positive Art workshop and the larger community of artists and patrons. These links facilitate the integration of those who are infected back into society.

Popular culture is not the only ally in the fight against AIDS. Thailand's early success at AIDS prevention has often been attributed to the work of Meechai Viravaidya, the Condom King. During his tenure as senator in the late 1980s, he began a campaign

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to educate and raise awareness about AIDS while simultaneously encouraging sex workers to refuse sex without a condom. Brothels and massage parlors were given free condoms and threatened with closure if they refused to use them. In just three years, condom use in

Thai brothels jumped to 90 percent.²⁷ Viravaidya's strong leadership may have saved millions of people from becoming infected with HIV.

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Social marketing for public health is an old tool that is finding new uses in the era of AIDS. The new head of India's National AIDS Coordinating Office (NACO), Dr. S.Y. Quraishi, was the first person in the world to be awarded a PhD in social marketing. His innovative ideas for increasing condom use include promoting condoms for enhancing sexual pleasure.²⁸ Creativity and strong leadership, together, may be the right combination to slow the spread in India.

Sports are another ally. Recently, UNICEF, NACO, and the Sports Authority of India teamed up in a highly visible event aimed at breaking down stigma and discrimination. Cricket, India's most popular sport, is leading the way, and the spokespersons are some of its most popular athletes. In a public media event, Sachin Tendulkar, India's star cricketer, reacted publicly to the story of a young woman and the discrimination she and her family faced because her husband is HIV-positive. He said forcefully, "People with HIV are part of us. This discrimination has got to stop."²⁹

This winter, Chinese television viewers saw public service announcements featuring Yao Ming, one of the biggest NBA stars in both the United States and China, playing basketball and eating with Magic Johnson, who publicly disclosed his positive HIV status nearly 10 years ago. The same announcements recently appeared in Hong Kong, where they were equally well received. At the Asia Society last year, Jaspal Rana, a famed Indian archer, discussed how sports figures were uniquely poised to deliver

messages of prevention and acceptance, not just on TV or at splashy media events, but by going to the communities where they are most well known.

These efforts are all commendable and are moving the agenda forward with new energy and effectiveness. In practice, however, the AIDS response is also being set back as old norms and practices come to light.

A recent report from the central Chinese province of Henan accuses the government of preparing a prison facility for AIDS patients who are labeled troublemakers for complaining about their treatment at the hands of local officials.³⁰ Sources said HIV/AIDS efforts would target patients who had been to Beijing to register complaints with higher authorities, but those who frequently visited local authorities were also at risk of incarceration. China deserves tremendous credit for its recent efforts to address its epidemic, but clearly much hard work remains.

GLOBAL IMPACT: GLOBAL RESPONSES

Both India and China are strategically important to the United States. The political and economic stability of India and China are essential to American peace and security. In his new book, *The World Is Flat: A Brief History of the Twenty-First Century*, Thomas Friedman highlights how India and China are benefiting from, and contributing to, the global collapse of traditional “barriers to entry.” Wal-Mart alone imported \$18 billion worth of goods from China in 2004.³¹ A recent *Business Week* report suggested that India’s “booming” economy could “come crashing back to Earth” because of HIV/AIDS, which is costing the country “billions” of dollars in lost productivity and health.³² A study completed by UNAIDS and the Asian Development Bank estimated that economic losses in the Asia-Pacific region resulting from AIDS totaled \$7.3 billion in 2001 and could reach \$17 billion annually by 2010.³³ The study highlights the impact of AIDS on poverty, which is especially fast and direct. In Cambodia, for example, AIDS will slow the annual rate of poverty reduction by 60 percent.

AIDS affects regional and global security. In July 2000, former United States Ambassador to the United Nations Richard Holbrooke asked the UN Security Council to discuss AIDS as a security threat; it was the first time the Security Council had ever considered a health issue. While there were skeptics in the room at that time, five years later AIDS has become a real economic and security threat. As Asia quickly becomes the new front in the global war on HIV/AIDS, the United States is increasingly aware of, and responding to, this threat.

It is therefore not surprising that the United States is significantly increasing its global commitment and financial and strategic resources employed to fight AIDS. Great Britain, Australia, and other developed nations are following suit.

Two years ago, in his State of the Union Address, President Bush promised to direct \$15 billion against HIV/AIDS in low- and middle-income countries. As Dr. Peter Piot explains, "That was a defining moment in terms of resource mobilization. We moved from the 'M' word to the 'B' word—from millions to billions."³⁴ The result of this commitment was the President's Emergency Plan for AIDS Relief (PEPFAR), which is quickly affecting prevention, care, and treatment all over the world.

The administration initially specified that money be directed solely to countries in Africa and the Caribbean. Since then, the United States has added Vietnam, where the overall prevalence of infection is still relatively low at 0.4 percent but where the

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national prevalence of infection for injecting drug users is 30 percent and in some areas more than 60 percent.³⁵

U.S. legislation directed for the Global AIDS epidemic, including PEPFAR

funding, has been called "a high-water mark of cooperation across political, religious, and ideological lines, some of its features [make] both the left and the right uneasy."

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This cooperation between strange bedfellows first came together on the issue of trafficking persons, particularly women and children. Human trafficking involves the recruitment, harboring and movement of people through the use of fraud, coercion or deception for the purpose of enslavement; sex trafficking is thus not "just about prostitution."³⁶ The State Department estimates that India alone has 2.3 million women and underage girls forced into its sex industry.³⁷ In 2003 President Bush signed into law the Trafficking Victims Protection Act (TVPA), which expanded the scope of U.S. legislation on slavery and involuntary servitude and criminalized trafficking. The TVPA places the onus on host governments to act on this issue, rating countries based on their efforts to control and reduce trafficking, and threatening economic sanctions to those who do not control it.

In India, the United States has partnered with the government, NGOs, and the private sector to invest 1.8 million dollars to fund 34 Indian NGOs working on issues related to child sexual abuse and trafficking in women and children. As current ambassador to India David Mulford explained, these projects are spread throughout India and address the full range of prevention, arrest, protection, prosecution, and rehabilitation issues related to trafficking.³⁸ For example, the United States funded one of India's most effective anti-trafficking organizations, STOP, and helped it rescue 450 victims of forced prostitution, leading to the arrest of 155 traffickers and 68 convictions in 2004 alone.

But the situation is too complex for a simple solution. Recently, Representative Chris Smith (R-N.J.), an anti-trafficking leader in the House, offered a provision to the AIDS bill that prohibited funding to any organization that did not oppose trafficking and prostitution. In contrast, Holly Burkhalter, U.S. Advocacy Director of Physicians for Human Rights, advocated a two-part approach:

“Rescue initiatives, shelters, and alternative job opportunities, as well as reform of the police and the judiciary, should be funded to help those who wish to leave brothels. Health care, protection from violence, and freedom to organize should be promoted for those who wish to stay in the trade.”

This debate highlights the overall concern by those in the field that ideology will trump pragmatism and diminish the impact that the United States, the world’s biggest donor on HIV/AIDS, can have.

Drug control, an equally controversial issue, is also drawing out ideological factions. Money spent now to reduce the harm of intravenous drug use, a major driver of AIDS in Asia, will prevent the spread of HIV infection and delay or avoid the opportunistic infections related to AIDS. In Iran, where drug users had been criminalized and their treatment was illegal, a policy shift in the mid-1990s allowed new types of harm reduction programs, including programs for needle and syringe exchanges and programs for methadone maintenance. Dr. Kamiar Alaei and Dr. Arash Alaei, pioneers in the harm reduction movement in Iran, recently stated, “Our approach was to form networks and develop activities in the users’ natural environment, to personalize prevention for each person at risk, to have dignity and respect with sensitivity to cultural, racial, ethical and gender issues, and to do all of this without any propaganda and stigma.”³⁹

But many countries in Asia have been reluctant to take the necessary steps. In Vietnam, a prevailing method of dealing with drug users has been to forcibly isolate them at rehabilitation centers. While the intention may be altruistic, these centers have been shown to cause greater harm than good. Unsafe sex is common, as is informal tattooing with shared needles. Many drug users continue to inject drugs while in rehabilitation, sharing needles with their fellow inhabitants. With some estimates of HIV prevalence in rehabilitation centers reaching 75 percent, these practices are clearly cause for concern.⁴⁰

Change, however, may be on the horizon. The Vietnamese government has recently pledged to recognize the need for a comprehensive harm reduction program. The limitations on PEPFAR funding may affect the way the money is spent, but the

government commitment is a step in the right direction.

The impact of U.S. policy goes far beyond the direct allocation of resources. When the UN Commission on Narcotic Drugs (UNCND) met in March to discuss HIV/AIDS prevention methods, there was stark and sometimes heated disagreement on the use of needle exchanges for HIV/AIDS prevention.

Delegations from the United States threatened not only to cut off American support for international initiatives administering needle-exchange programs, but also to force the UN Office of Drug Control to change its own position on the issues. Aryeh Neier, President of the Open Society Institute, explained that this left the UNCND "caught between the rock of American intransigence on drug policy and hard facts that show needle exchange and other harm-reduction strategies to be effective."⁴¹

More than 300 scientists, policy analysts, human rights and HIV/AIDS advocacy groups, and advocates from 56 countries released an open letter expressing their concern, and drawing on examples from areas throughout much of Europe and Australia where harm reduction interventions have long been used. Many in the field maintain that needle-exchange programs are proven to be safe and effective. In fact, many people credit Australia's success in stemming its epidemic to its use and promotion of such strategies. And in Indonesia, Vietnam, Myanmar, and China, there are small pilot projects including needle exchanges and methadone (or other opiate substitution) treatments. These programs are just now realizing the resources and supports necessary for scaling up to more effective sizes.

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KEY STEPS FORWARD

AIDS is spreading quickly throughout Asia, affecting communities, businesses, and nations. So too are responses to the diseases, guided by local initiatives and government actions. Efforts must continue to support effective local and governmental projects. Limitations on funding for AIDS agencies trickle down to organizations at the grassroots level in nations where the values they promote are simply not viable. The U.S. government must be careful to resist the temptation to promote a domestic ideology abroad at the expense of global health and millions of lives. We need a more practical and realistic plan of action.

Some leaders in Asia have risen to the challenge, and everything must be done to support their efforts. A second group of leaders is on the brink of action, while still others refuse to acknowledge the seriousness of the problem. Collectively, we must work to make them aware of the reality of this disease, and demand a response. We must also work to encourage leaders to take a strong stand against the gender inequality that has gone unchecked for too long in many Asian countries. It is critical for

global health, economic development, and international security that women in developing nations are elevated to equal status under the law. Property rights, access to schooling, and an increased focus on maternal and child health are essential components of empowering women and decreasing the spread of the epidemic.

Adding support to grassroots and government efforts are international organizations, members of the United Nations family, and private foundations including the Bill & Melinda Gates Foundation and the Clinton Foundation. Multinational corporations and national corporate communities are increasingly leading the way using the core competencies of their businesses and workforce. These organizations deserve our praise and encouragement.

Similarly the media, both at home and in Asia, must continue to use their expansive reach to influence behavior at all levels of society. Through the use of film, television, radio, art, and theater, the messages of reducing stigma and discrimination and increasing HIV/AIDS prevention will be heard by the people who need them most. Training for local media is equally important, and efforts to ensure accurate reporting must be supported at all levels.

With each of these important components moving independently, a coordinating body may be crucial to avoid duplicating efforts. In a recent interview on C-SPAN's *Washington Journal*, Dr. Peter Piot stated, "[it is important that we] have one song sheet. We all sing one song, and it's not so easy to do that. As executive director, [I am] the conductor of the orchestra of all AIDS efforts."⁴² In addition to UNAIDS, local and regional governing bodies must take on a greater role in coordinating the response to HIV/AIDS.

With a well-coordinated and comprehensive effort, strong leadership, and creative thinking, Asia has the potential to put a halt to the AIDS epidemic before it spirals out of control. The global community has a duty to band together and ensure that this occurs. Otherwise, the impact of AIDS in Asia will be felt all over the world. 

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