

Health Consequences of Trafficking of Women and Girls in Southeast Asia

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THROUGHOUT ASIA, THE TRAFFICKING OF women and girls for the sex industry has generated a complex and politically sensitive range of health threats and prevention challenges for the women involved, local and national health authorities, and the international community.¹ The crime of sexual trafficking and slavery is widespread. Source countries from which significant numbers of women were trafficked in 2002 include Burma, Thailand, Vietnam, Russia, Uzbekistan, Nepal, Laos, China, and the Philippines. Destination countries for these women include Thailand, China, Cambodia, India, Russia, Sweden, the United States, and the EU. Countries in which trafficking of women occurs within state borders for the domestic sex industry include China, Russia, India, Thailand, Cambodia, and Burma. All of the countries listed above (save the U.S.) are signatories to the UN Convention on the Rights of the Child, which explicitly bars both trafficking and child sex work. Yet, in 2003, the trafficking industry and its harmful effects appear, if anything, to be increasing. This industry, a major source of HIV and other sexually transmitted disease (STD) potential, is a problem that will require regional and international cooperation to be mitigated or resolved.

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While this analysis focuses on the health impacts in the Southeast Asian women trafficking industry, several broad categories of health consequences are likely applicable to trafficking of women and girls globally.

- Most obvious are the *direct health consequences of commercial sex*, including increased risk of exposure to STDs, such as HIV infection and sexual trauma. The long-term complications of these threats include infertility, ectopic pregnancy, and malignancies associated with STDs (e.g. cervical cancer and AIDS).

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- The second category of health threats encompasses *threats to mental health*, such as depression, substance abuse, post-traumatic stress disorder (PTSD) and the complex psychological burdens of rape, slavery, and sexual exploitation.
- The third group includes difficulties relating to *health care access*, (e.g. prevention services), relevant to all the categories of health threats for which trafficked persons may have less access than non-trafficked sex workers.

Access to health care is particularly vital for trafficked women, in large part because women often face the gravest health threats as a result of their trafficked status. In Thailand, for example, contraception and sexual health services for women—including

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sex workers—are markedly better than in Burma, which was ranked second to last among all UN member states in health care services by the World Health Organization in 2000. Trafficked Burmese women working illegally and

in debt-bondage in the Thai sex industry have little or no access to these services. Consequences of these structural barriers to health services include lack of care, late treatment, septic abortions (instead of contraception), and chronic untreated infections like gonorrhea and syphilis which can lead to life-long disability, chronic pelvic pain (PID), infertility, and a host of other chronic complications. HIV rates are approximately two to three times higher among trafficked Burmese sex workers in Thailand, than among Thai women voluntarily working in the industry.²

Finally, there are broader health threats to the communities in which trafficked women are forced to work. Lack of access to health care for these women can often mean chronic infectiousness for male partners, their wives, and a much wider circle of risk for the community than the physical brothels, truck stops, and bars in which these women toil. This domain has been the most politically problematic and controversial, since highly vulnerable sex workers can and have been seen as disease vectors, carrying and spreading infections to men in destination countries and undermining local education and prevention efforts. Many states, including the United States, have long histories of identifying foreigners and illegal aliens as disease vectors. HIV status, for example, can be a cause for expulsion from many states, while knowingly spreading HIV has been criminalized, adding to the burden of women with little or no control over their sex lives.

Legal debates aside, it is clear that legalized sex work has shown to be highly safe and minimally involved in the transmission of HIV or other epidemics.³ Nevada, for

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example, the only U.S. state with legally protected sex workers, has had the lowest HIV rate among sex workers of any U.S. state for more than a decade. In contrast, the locked brothels and debt-bonded sex workers of Thailand and Cambodia have had consistently high rates of HIV infection, as have their patrons. This kind of illicit sex work *is a real threat* to the health of wider communities. Despite the obvious threat posed by sex workers, placing the legal and punitive burden on the least empowered persons in the industry (i.e. the trafficked women) is both morally wrong and a bad public health policy.

While HIV infection is clearly not the only health consequence facing women in the sex industry, it is the one for which the best data are available and for which there exists the most active programmatic responses across Asia. Hence, it makes sense from both an analytic perspective and a response perspective to focus on HIV in assessing the health consequences of trafficking. It should be remembered, however, that where sexual transmission of HIV occurs, other STDs generally are also present, and most are much more easily transmitted and acquired in unprotected sex than HIV. Few, however, are as fatal. And none have global resources available for responses on the scale of the HIV/AIDS pandemic in 2003. The same holds true for the mental health burdens of trafficked women who can be seen as an intrinsic part of the burden of sexual trafficking, but limitations on available data make it difficult to analyze the scale and scope of these threats. Severely limited mental health services in the region generally mean that program responses are likely to be rhetorical in nature.

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SOUTHEAST ASIA, HIV, TRAFFICKING, AND SEX

Southeast Asia is the second most HIV-affected region globally after Sub-Saharan Africa, with over 7.5 million people estimated to be infected with HIV in 2002.⁴ The Southeast Asian epidemics have been characterized by two distinct routes of transmission: 1) large scale, explosive epidemics among sexually active heterosexuals, as in Thailand and Cambodia and 2) epidemics spread by predominant injection drug use (IDU), as in Vietnam, Malaysia, and, recently, in Indonesia.⁵ Several countries, notably Burma, Thailand, and India, give evidence of both IDU and heterosexual epidemics. African epidemics, conversely, appear to result primarily from commercial sex and young male patronage of sex services. And, since these regional sex industries have relied, and increasingly rely, on the trafficking of women and girls for sexual laborers, Southeast Asia is perhaps the best country with which to examine the health consequences of trafficking.

Trafficking occurs throughout Southeast Asia in varying degrees and diverse forms. This article will address those heavily affected states for which at least some data are available, such as Burma, Thailand, China, Cambodia, and Vietnam (because China's

southern and southwestern border zones with Burma, Laos, and Vietnam are culturally and geographically linked to Southeast Asia, it is included in this analysis).

THAILAND-LIMITATIONS TO SUCCESS: UNDOCUMENTED SEX WORKERS

The Thai response to HIV/AIDS is generally regarded as one of the rare examples of a developing country successfully promoting HIV prevention and control. After an explosive outbreak from 1988-1994, Thailand's rates of infection among its reproductive-age adults have fallen steadily, from a high of over four percent of all adults, to under two percent in 2001. This overall record of success, measured in actual declines in new infections, masks some significant gaps. In 2000, the World Bank Thailand Office commissioned a review of Thailand's success in suppressing HIV/AIDS and an assessment of where the nation's response to the HIV crisis could be improved. An area that emerged of primary concern was the lack of access to Thai health care and services among trafficked and undocumented sex workers. This was contrasted with the effectiveness of such services to women in more licit zones of the large Thai sex trade. Most prominent among these services was the Thai "100 percent Condom Campaign" which distributed 60 million free condoms a year to sex workers and their clients throughout the 1990s. While a considerable success, the campaign appeared not to be reaching the trafficked and lowest end brothel-based sex workers in the country. The great majority of trafficked women in the Thai sex industry are from Burma, and most of these women are from Burma's ethnic minority peoples, including Shans, Akha, Lisu, Lahu and others. The remainder is a heterogeneous group, including Thai hill tribe minorities, women from Laos, Yunnan Province of China, Cambodians, and women from Russia, Uzbekistan, and other Central Asian Republics.

The World Bank report on Thailand found that:

Undocumented women in the Thai sex industry have clear risks and vulnerabilities for HIV infection, including illiteracy, vulnerability to trafficking, low levels of HIV and STD awareness, limited access to health care, very limited ability to negotiate with clients, and a reluctance to seek services even when they are available because of fear of arrest and deportation. Since these women are breaking two sets of laws (prostitution laws and illegal entry and work in Thailand) they are highly vulnerable to arrest and detention and to abuse from male guards.

As a result, HIV rates and risks are considerably higher among Burmese sex workers than among Thai women. No information is available about the number of partners or condom use rate of these women. However, given the nature of their job and the large number of sexual partners, in the absence of condom use they are at very high risk of acquiring HIV and in turn transmitting it to clients, whether Thai or foreign, thus spreading the epidemic more widely.

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The number of undocumented sex workers is difficult to quantify because of the illicit nature of the industry and their need to avoid detection. In a study done in three northern provinces in 1995 (Chiang Mai, Lamphun, and Phayao), more than 40 percent of brothel-based sex workers were Burmese, mostly ethnic Shans. A recent study along the Burmese coast in the fishing areas of Ranong Province, found that more than 80 percent of women in the sex trade were Burmese. NGOs active in Thailand put the number at perhaps 10,000 to 20,000. In addition to Burmese sex workers, significant numbers of women from Cambodia, Laos, China's Yunnan Province, and Russia work in the Thai sex industry.

The presence of a large number of sex workers who are not reached by current efforts may hinder Thailand's sustained success in the "100 percent condom campaign." A further prevention challenge for migrant women and girls involved in the sex industry is in regard to detention centers and prisons. The International Detention Center in Bangkok, as an example, has significant numbers of detained women from the sex industry, almost exclusively male guards, and no condom distribution program.⁶

Since the release of this report, Thai authorities have begun addressing some of these challenges. However, the ever-increasing number of non-Thai women in the Thai sex industry has continued to raise barriers to health care. Some Thai investigators see this as an unintended by-product of the success of the Thai national awareness campaigns. As Thai women and their families have become increasingly aware of the dangers of sex work, the number of Thai women willing to work in the sex industry has sharply declined. This has driven traffickers further afield—into tribal areas, and to Burma and Laos, to find women and girls (and parents) ignorant of the dangers of sex work. This is true for male sex workers in Thailand as well—an increasing share of gay bar and brothel workers are Burmese and tribal youths, though precise numbers are difficult to obtain (Ministry of Public Health, Chiang Mai Province).

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BURMA

Burma has a growing domestic sex industry, and is a major source of trafficking women and girls for the sex trade in Thailand and China. The U.S. State Department's Annual report on the status of human rights in the country reports that:

Child prostitution and trafficking in girls for the purpose of forced prostitution—especially Shan girls who were sent or lured to Thailand, continued to be a major problem. Reports from Thailand indicated that the rising incidence of HIV infection there has increased the demand for supposedly "safer" younger prostitutes. . . Burma is a source country for thousands of women and young girls who are trafficked into the commercial sex industries of neighboring countries.⁷

Burma contrasts markedly with Thailand in that health services for all Burmese citizens are severely limited, largely private, and available almost exclusively to those who can afford them. In the World Health Organization's 2000 ranking, Burma ranked second worst in the world in health care delivery—only Sierra Leone, at war at the time, performed worse. According to the United Nations Family Planning Association (UNFPA), access to modern contraceptive methods was available to only 18 percent of

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Burma's women nationwide in 2000, one of the lowest rates in the world. In addition, prostitution and the use of sex services are illegal and highly stigmatized. Men using sex services can be charged under British era rape laws, which carry long prison terms and extreme social stigma. Hence, Burma's sex industry has long been one of Asia's most dif-

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ficult to access. Burmese levels of HIV/AIDS awareness are strikingly low and mass media efforts have been hampered by the total control of the media exercised by the junta and its military censors. In combination, these factors make Burmese women and girls highly vulnerable to STDs, HIV, and sexual exploitation. The chronic state of civil war in minority areas, and the collapse of the national economy under the current junta, have also made ordinary Burmese desperate to leave their homeland, and hence, particularly vulnerable to traffickers.

In the last two to three years the Burmese sex industry has undergone some significant changes. While officials deny that prostitution exists, in fact, Burma's sex industry has been expanding. Cheap and increasingly available sex, the availability of underage girls, a corrupt police force and judiciary, and isolation from western law enforcement, have made the country increasingly appealing to both international sex tourists and Asian business elites looking for sex. Information on sex tourism to Burma, including venues, prices, and access to women and girls, is now widely available on the Internet. Rangoon's international level hotels have increasingly provided sex services, albeit informally, and cater to a wide, largely Asian, clientele. These venues are far beyond the economy of nearly all Burmese men. The growing demand for sex services appears to have increased the supply of women, and, hence, initiated internal trafficking in Burma. It is striking and instructive to read the characterization of Burmese women on these sex-for-sale sites, some of which have been monitored by the Free Burma Coalition in Japan. They portray Burmese sex workers as passive, compliant,

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“unspoiled,” and willing to provide an array of sexual services. They are often contrasted with Thai sex workers, who are usually described as more demanding, controlling, and non-compliant. This can, and probably should, be read to imply that Thai sex workers are better educated, more empowered, and more insistent on condom use. Hard numbers of the extent of this trade are virtually impossible to access.

Prostitution is highly stigmatized in Burma, with major social sanctions against women working in the industry. As in many societies, these social strictures appear to increase the social harms and psychological burden of the women and girls working in the industry.

A marked example of the health problems facing Burmese women and girls is septic abortions. Lacking both access and knowledge of modern contraception, Burmese women resort to illicit abortion as a form of contraception. Among Burmese women factory workers in the Thai-Burma border industrial zone of Tak Province, Thailand, septic abortions and maternal deaths have become an epidemic problem for the Thais. While no definitive evidence is available, it is likely that septic abortion contributes significantly to illness and death among Burmese sex workers. As reported by the UNFPA, it has been shown that Burma's high maternal mortality rate is largely due to septic abortion and that it is the most common cause of mortality among pregnant women. Emergency contraceptive services (e.g. the morning-after pill) have been introduced in some of the factory settings, but are unavailable in Burma.

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CAMBODIA

Cambodia has the highest HIV infection rate in Asia. By 1997, this generalized heterosexual epidemic had reached one out of every twenty-five Cambodian adults.⁸ The Khmers responded, largely with donor aid, by adapting the Thai “100 percent Condom Campaign” to their commercial sex industry with considerable success. Rates of HIV among pregnant women have fallen each year from 1999-2001 and the overall national prevalence has fallen below three percent of adults. This explosive epidemic fueled by commercial sex rapidly declined as a result of these efforts to increase the safety of sex services. However, Cambodia's sex industry remains heavily dependent on internal trafficking of Khmer women and girls and on the trafficking of Vietnamese women into the country.

Cambodia has also been an infamous target country for child prostitution. This appears to be on the decline, since a number of extradition treaties with other countries have brought Cambodia into the international legal fold, rendering it less attractive as a venue for child sex offenders.

VIETNAM

Vietnam has a large commercial sex industry and provides women for the brothels of Cambodia and southern China, particularly Guangxi Province, which links China and Vietnam by road and rail. HIV rates among sex workers in Vietnam have remained relatively low—less than eight percent—while the spread of the epidemic in the nation has been largely due to IDUs. The trafficking of women and girls to China remains a special concern for Vietnam, as do increasing STD rates among both men and women. The Vietnam-Cambodia border zone in the Mekong Delta has higher rates of HIV in sex workers than does most of the rest of the country, as do several Vietnamese islands in the South China Sea where brothel services are provided to fisherman and crews on trading vessels. These islands are largely closed to outsiders, so there is virtually no information on the women working there. There is some evidence of women being trafficked and traded at sea for sexual services in this area, but information is limited and international cooperation is necessary to investigate these allegations. There is evidence that on some Cambodian island brothels, women from Vietnam have been rescued from sexual slavery, and they had been traded at sea before reaching Khmer soil.

CHINA

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Prostitution is illegal throughout China, but it is intermittently supported by some corrupt officials and shut down by others. It is a huge, rapidly expanding industry about which little is known. Anecdotal evidence suggests that most Chinese sex workers are native Chinese volunteers, not trafficked or enslaved. HIV rates have remained low, though STDs, long absent in China, are on the rise in this and other populations at sexual risk. The one area in which trafficking into China is definitely known to occur is on the China-Vietnam border. This area is a “Special Economic Zone” between the two states and is a major center for smuggling narcotics, trafficking, and a large licit trucking industry. The border zone, about fifteen kilometers south of the special economic zone (SEZ) city of Pingxiang, has a large commercial sex industry. On a site visit to the area, one of the authors (CB), accompanied by provincial officials, enumerated 19 brothels in a four-by-two block of the red light district in 2000. All of the sex workers were young women and girls from rural northern Vietnam. As for Burmese women in Thailand, language is a major barrier to care and prevention for these women—none can speak even rudimentary Chinese. The clients are largely truckers from both countries and the sexual services are inexpensive and widely available. The epidemiologic situation is strikingly like that in African and Indian trading centers and could have disastrous implications for both China and Vietnam. In both the African

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and Indian epidemics, similar trucking and sex venues proved to be essential routes for wide dissemination of HIV. Prevention is urgently needed here to avoid this potential multiplier of both countries' epidemics.

Women trafficked from China have begun to appear in the sex industries in the northern parts of Laos, Burma, and Thailand. Most appear to be rural women from the Yunnan province, particularly from ethnic minority areas where language cognates with Thai and Lao are spoken. The Yunnan district of SipSongPanNa (XiShaungBanNa), home to the T'ai Lue (Dai in Mandarin) ethnic group is the best understood. The T'ai Lue are cousins of the Thai and Lao and speak a language quite similar to northern dialects of Thai. Women from this area have been trafficked into Thailand, and have brought the Thai variant of HIV home with them. Indeed, this district has a distinct Thai subtype E virus found nowhere else in Yunnan, making a clear DNA fingerprint linkage to Thailand.

HOST COUNTRY POLICIES

Trafficking is illegal throughout Asia and, indeed, virtually worldwide. Despite these laws, it is rarely prosecuted, and remains a lucrative industry. Weak border controls along the mountainous and forested borders between Burma and Thailand, Thailand and Cambodia, Burma and China, and China and Vietnam generally allow traffickers to move with considerable freedom. In Thailand, trafficked persons are most likely to encounter the authorities, if at all, during work place or residence raids, rather than at the border. Trafficked persons are more likely to be prosecuted or harassed for bribes for illegal entry or for being in host countries without permission or proper documentation, than they are to be seen as victims.

An exception to harassment is found in girls under the age of eighteen who are treated in Thailand, at the least, as victims of trafficking and have most often been sent to remand homes or boarding facilities run by the state or NGOs. Prostitution is illegal in Thailand, China, and Burma and (under-age children aside) most sex workers, trafficked or not, are routinely harassed by the police and security agencies throughout the region. Burmese sex workers in Thailand are often arrested in raids called by brothel owners or managers when the women have paid off their debt, and should begin to be paid by the managers.⁹ Thai police also generally have free access to sex venues, and do not have to pay for sex. The net result of these policies is that trafficked sex workers are highly vulnerable to both rights violations and health threats. Fear of the police and of the bribes needed to pay them have been cited repeatedly as a deterrent from seeking necessary health care and for delay of treatment.

INTERVENTIONS

The emerging global network of sex work advocates has articulated the position that sex work is legitimate work and, therefore, that sex workers have fundamental rights *as workers*.¹⁰ Sex workers, empowered to protect themselves and their clients and in control of their working conditions can and do protect themselves and their clients from

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HIV and other sexually transmitted infections. This leads to calls for decriminalization of sex work, and recognition of the right of sex workers to organize, unionize, and take control of their working lives. For women and girls who are working by choice in their own

country, this position is clearly optimal from a public health perspective, since the data available do suggest that given options and control, sex workers generally do choose to practice safer sex. As an intervention, this is primarily a legal and policy approach to sex work. How such a structural approach might function for women working illegally outside their home countries is much more problematic. It is here that public-based outreach approaches to sex workers, with provision of clinical and prevention services blind to status or right of residence, are urgently called for. Regarding trafficked sex workers, or those who would leave debt bondage and sex work if given options, a very different set of policies and approaches apply. Firstly, trafficked persons need protection from traffickers and those who control them. They are crime victims, and deserve special consideration and services. This was recognized by the U.S. Congress with the passage of the 2000 Trafficking Victims Protection Act (TVPA), which provides for health care and counseling benefits for the victims of trafficking, albeit at quite moderate levels for adults.

In Asia, repatriation for trafficked persons is a special problem. Women who have worked in the sex industry may face harsh social and family censure for having been prostitutes despite their victimization. For minority women from Burma, fear of the junta, police, and border security forces, who often feel that rape of sex workers is not a crime, can make “going home” a terrifying prospect. For those who have become infected with HIV through their sex work—which, in some settings, may be as many as 30-40 percent of women and girls—repatriation without protection and appropriate medical care may be even worse. In these contexts, advocates and agencies working with trafficked women are obliged to carefully investigate the possible outcomes of

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repatriation before advocating this for trafficked persons. No victim of trafficking should ever be forced to return home. Indeed, such policies, where they have been tried, typically lead to a cycle where women quickly agree to be trafficked again rather than face the hostility and censure of home communities. Traffickers may be their only way “out.” In Thailand, a common practice is to bring Burmese women from detention centers to Thai-Burmese border crossings. Traffickers and brothel agents typically wait at these checkpoints and bring women back into the sex industry within hours of their supposed “return home.” And these women typically have to pay for the expensive travel back through Thai checkpoints, ensuring that they are debt-bonded when they begin work. Unwilling returns are also clear violations of human rights.

REGIONAL POLICY OPTIONS

The Trafficking of Women and Girls

Trafficking in women for the sex industry occurs across the Asian region, and has made HIV prevention a complex and politically sensitive issue. Source countries that must take responsibility to prosecute traffickers include Burma, Thailand, Vietnam, Russia, Uzbekistan, Nepal, Laos, China, and the Philippines. Destination countries, which must consider increased protection for the adult and child victims of trafficking, include Thailand, China, Cambodia, India, and Russia. In Sweden, the United States, and the EU policies to protect trafficking victims exist, but reach only a small number of trafficked persons. The TVPA has provided services for approximately 400 victims of trafficking out of an estimated 20,000 such persons present in the U.S. in 2003. Countries in which trafficking of women occurs for the domestic sex industry include China, Russia, India, Thailand, Cambodia, and Burma. These countries should increase vigilance and protection of trafficked persons.

Trafficking and sexual slavery are both human rights abuses and crimes, and all of the countries listed above (save the United States) are signatories to the UN Convention on the Rights of the Child, which explicitly bars both trafficking and child sex work. Further, China, Russia, India, Thailand, Cambodia, and Burma are all undergoing severe, worsening HIV epidemics, making this issue an urgent public health priority.

Labor and Social Mobility

Beyond the sex trade, Asia has large populations of internal migrants, such as laborers, internally displaced persons, refugees, and workers in industries requiring mobility, including fisheries, shipping, trucking, and trade. As in Africa, social mobility has played important roles in the spread of HIV and is likely to be a growing source of social vulnerability. Crucial populations at risk include the 1-1.2 million Burmese in

Thailand, the more than 3 million Afghans in Pakistan, Burmese refugees and migrants in China, India, Bangladesh and Malaysia, and migrant and/or overseas workers from Thailand, the Philippines, Indonesia, Laos, and other states. Asia's labor and migration laws have lagged strikingly given the mobility of her populations in 2003 and policies for workers and migrants infected with HIV are contradictory, often punitive, and frequently act as barriers to provision of preventive services and care. The sex industry is a small component of the much larger traffic in persons throughout the region.

The social status and educational levels of women and girls

While both trafficked and non-trafficked women in the sex industry are at extraordinarily high risk of HIV, most women at risk and/or currently infected with HIV are young, married, monogamous, and at risk largely due to their husbands' risk behaviors. The traditionally low social status, lack of education, high rates of female illiteracy, and lack of power in sexual negotiations for women in many Asian societies place these women and their future infants and children at increased risk. Gender disparities have played similar roles in the African epidemics of HIV/AIDS and could render countries including India, Nepal, Pakistan and Bangladesh especially vulnerable to widespread heterosexual epidemics.

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Sexual health education and services

Clear and effective sexual health education and programs are woefully inadequate across Asia and have been limited by a wide range of social, cultural, religious, and—in the case of the several communist states—political barriers to practical and evidence based policies. While some states, such as Thailand and South Korea, have long been successful in implementing effective sexual health programs through family planning services, many other states lag sharply. Where political or social barriers are easing, the lack of local expertise will remain a barrier to addressing the health consequences associated with sex trafficking.

CONCLUSIONS

Southeast Asian regions rank second after Sub-Saharan Africa in HIV/AIDS cases in 2003, and HIV is poised to have significant human, development, and economic impacts on this densely populated region. The regional sex industry has played key roles in the spread of HIV in Thailand, Cambodia, and Burma, and could lead to similar dynamics of spread in China, Vietnam, and South Asia. Given the enormous and young populations of the region, such an outcome would be a true public health catastrophe. A catastrophe, it must be pointed out, that does not need to happen. The

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example of Thailand, and of states as diverse as Uganda and Senegal, shows us that HIV epidemics can be contained, and their harsh impacts mitigated, by implementing the prevention measures public health and policy makers already have in hand. Trafficking into the sex industry is driven by demand for sexual services on the part of Asian men. The unsafe nature of this industry, and the conditions which increase HIV vulnerability for both sex workers and clients can be improved. Traffickers can be brought to justice, and partnerships between health, civil society, and security officials can be built, although such coalitions will be novel in many Asian settings. The urgency of HIV demands that peoples, governments, and societies respond with innovative, humane, and progressive public health policies and programs. Absent such efforts, HIV is likely to spread with persistence, devastating individuals, families, and communities across Asia. 

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