HIV/AIDS in South-East Asia Region: Lessons Learnt
1. INTRODUCTION

Since it was first reported in the United States of America in 1981, the AIDS epidemic has quickly become one of the most serious health and development problems facing the world today. Over 33 million people are currently infected with HIV, the virus that causes AIDS. Sixteen million people have already died; more than 80% of AIDS deaths have occurred in Africa. In 1999 alone, AIDS was responsible for over two million deaths globally.

High-level political commitment supplemented by a supportive policy environment is crucial to combat AIDS. Experience shows that these elements are essential for the implementation of successful AIDS programmes that prevent the spread of HIV, provide care and support to those infected, and reduce the impact of the epidemic.

In the South-East Asia Region, all Member Countries have developed national policies, strategies and plans to guide the implementation of HIV prevention and care initiatives. At the same time, it is vital to mobilize financial and other resources to build national capacity for a sustained response to the epidemic. During the 1990s, all countries in the South-East Asia Region developed and implemented comprehensive national AIDS control policies with varying degrees of success. This paper describes the experiences in the Region in responding to HIV/AIDS and identifies the challenges that lie ahead.

2. HIV/AIDS: THE REGIONAL SITUATION

The World Health Organization (WHO) and UNAIDS have estimated that by the end of 1999, 33.6 million people were living with HIV/AIDS worldwide. A total of 16.3 million adults and children have died, and 50 million people have been infected with HIV, since the beginning of the pandemic (Figure 1). During 1999 alone, 5.6 million people (including 570 000 children aged <15 years) became infected; this is equivalent to almost 15 000 new infections per day. While the epidemic continues to spread in all regions of the world but at very different rates, the situation is most alarming in sub-Saharan Africa; the South-East Asia Region is the next worst affected region.

![Fig. 1 Adults and children estimated to be living with HIV/AIDS as of end 1999](image-url)

Total: 33.6 million
The current situation

In the South-East Asia Region, the first patient with HIV/AIDS was reported in 1984 from Thailand. In most other countries, HIV was not diagnosed until 1986 or later. Since then, HIV infection has spread very rapidly and WHO estimates that currently there are more than 5.5 million HIV-infected people in the Region, which is 18% of the global total. Besides persons with high-risk behaviour, HIV infection rates have now begun to increase in the general population as well.

As of 1 January 2000, a total of 135 311 cases of AIDS have been reported in the Region – an increase of over 48% from 65 091 cases reported up to 1 July 1997 (in March 1994, the reported number was only 5 700). Thailand, India and Myanmar continue to report the largest number of cases – 123 355; 8 491 and 2 854 respectively – accounting for more than 95% of the cases reported from the Region. Allowing for under-diagnosis, incomplete reporting and delays in reporting, it can be estimated that not more than 25% of the total AIDS cases are currently being reported. While 91% of the cases range from 15-49 years, children with a male to female ratio of 4:1 form 4.6%. Heterosexual intercourse is the most predominant mode of spread (85%), followed by injecting drug use (7%) and from mother to child (5%).

HIV Trends and Future Projections

HIV prevalence studies confirm the alarming increase in HIV infection rates in selected high-risk populations. In Thailand, HIV rates of 0 to less than 1% among injecting drug-users (IDU) in Bangkok were found in various ad hoc surveys from 1985 to 1987. However, HIV rates increased sharply to 40% by September 1988. The June 1999 sentinel surveillance results show the average prevalence rates in Thailand of 51.1% among IDUs, 16.6% in female sex workers, and 1.7% among pregnant women. Northern provinces are more severely affected.

In Manipur, North-East India, the epidemic which was mainly confined to injecting drug users, is now spreading into the general population as well. In Bombay, the HIV seropositivity rates among sex workers and STD patients are now 51% and 35% respectively. The rate among sex workers in Tamil Nadu in 1996 was 30%. There is evidence of an increase in HIV among women attending antenatal clinics; the seroprevalence rates in 1999 in Bombay, Tamil Nadu, Manipur, Karnataka and Andhra Pradesh during 1999 were in excess of 1%.

Similar increases in HIV seropositivity, particularly among populations with high-risk behaviour such as IDUs have been documented in Myanmar too. The latest sentinel surveillance data show median rates among IDUs of 47%, in male STD patients (5%), CSWs (26%) and pregnant women (2%).

HIV prevalence rates in many other countries in the Region are lower than in these three countries. However, given the country experiences described above, there is every possibility of a similar scenario being repeated in other countries of the Region. Risk behaviours which promote the spread of HIV, such as injection of drugs, male patronage of prostitutes, high rates of STD and low condom usage, are present in all countries. In Nepal, the prevalence of HIV in IDUs has recently been reported to have increased to 40%. In Indonesia, HIV has remained generally low but the potential for spread can be indicated by outbreaks seen in Merauke and Maluku islands recently where relatively high HIV infection rates were noted among blood donors and sex workers.
In general, the HIV/AIDS epidemic in the Region continues to remain dynamic and ever-evolving with areas of explosive, new epidemics co-existing with areas where HIV is still low. This disparity is attributable to the extent and intensity of risk behaviours prevalent in various areas coupled with the vulnerability or marginalization of populations on the basis of economic, social or educational status and on the basis of gender and access to information and education. It is clear that the risk behaviours which play a major role in the spread of HIV in Asia include unprotected sexual activities and sharing of injection equipment. Considering that heterosexual contact is the predominant mode of HIV transmission and the prevalent risk behaviour, continued transmission of HIV in the general population appears inevitable, unless effective measures are taken urgently in all countries.

3. COUNTRY RESPONSES TO THE HIV/AIDS EPIDEMIC

While in many countries the first AIDS cases were reported in the mid- to late-1980s, the development of comprehensive policy and medium-term plans did not begin until early 1990s. In the beginning, AIDS was treated more as a medical problem and was addressed by strengthening laboratory diagnosis facilities, training of health care workers in safe medical practices and on surveillance. Some early responses also included enactment of specific regulations and laws, many of which subsequently had to be repealed. As the epidemic advanced in many countries, the medium-term plans focused more on prevention through condom promotion, screening of donated blood and mass media campaigns. During this phase, the response to AIDS broadened considerably to include initiatives such as social marketing of condoms and the study of behavioural and social interventions.

During the 1990s, when the number of AIDS cases began to increase and its broad social and economic impact was felt, the need for multisectoral responses was recognized. WHO urged all sectors of the government to get involved in AIDS control activities. Moreover, the role of NGOs, the private sector and communities took on greater importance. Not only were different sectors asked to participate in the planning, implementation and evaluation of national AIDS programmes as members of AIDS committees, national responses expanded to AIDS education in school, provision of care and social support and also discussion of ethical and human right issues. The latest phase now includes a focus on issues relating to accessibility to new treatment and prevention options such as antiretroviral drugs for the prevention of mother-to-child transmission.

Most countries now recognize AIDS as a national crisis. Multisectoral National AIDS Committees headed by a high-ranking government official such as the health minister have been established. The operational focus is within the Ministry of Health. The role of the national AIDS programme is to coordinate, mobilize and facilitate the response from various sectors and to provide technical and operational support to all stakeholders. With financial inputs from WHO during the initial part of the epidemic and now with support from bilateral agencies and UNAIDS and co-sponsors, the participation of nongovernmental organizations (NGOs) including the community-based organizations (CBOs) as well as of the people with HIV has been very encouraging.

4. LESSONS LEARNT SO FAR

As the epidemic continues unabated in the Region, many lessons have been learnt and useful insights gained. While the degree of activity and political mobilization vary considerably across the Region, it is clear to say that the countries which responded quickly
to the epidemic are now seeing the results of these early interventions. Numerous prevention and care initiatives provide models for wider application elsewhere. These show that prevention interventions can delay the spread of HIV. Many of these examples exist in the SEA Region. However, in order to have an epidemiological impact, these successful models need to be implemented on a large scale with appropriate modifications to suit local situations. Some of the lessons learnt include the following:

(a) Prevention Does Work

The 100% condom use programme in Thailand has received worldwide attention and is one of the most widely written and talked about programmes. The effectiveness of this programme can be assessed by the declining HIV incidence among military transcripts from 3.6% in 1993 to 2.1% in 1995. STDs have declined to unprecedented low levels (Figure 2).

The Sonagachi project in Calcutta, India, is another success story of how the target population could be involved in all phases of the programme aimed at HIV prevention. The project, besides peer education, includes many other initiatives, such as provision of health care; a literacy programme for peer educators, and schooling for children of sex workers. The project serves as a model of a successful peer education programme for sex workers. The latest data show that HIV prevalence continues to be low - around 11%, and that STDs have declined over the years (Figure 3).

In Myanmar, the information, education and communication (IEC) and community-based treatment approach (designed and implemented to encourage early seeking of treatment

Source: S.Jana, Sonagatchi Sex Worker Intervention Project, Calcutta, 1998
and greater family involvement in the treatment process) has been effective. As a result, behavioural change is occurring among injecting drug users (IDUs) and HIV infection rates have decreased to less than 50% from 66-73% reported prior to 1994. In order to prevent the heavy burden of sexually transmitted infections, all countries have adopted the syndromic approach for STD case management. The integration of STD care into the general health services is now considered a major priority in the Region. In this regard, the training of the primary health care workers and private practitioners is considered extremely important.

Based on the above experiences, it can be seen that the approaches adopted by the countries have been appropriate, relevant and effective. However, these approaches must be upscaled in terms of coverage as part of national programmes and sustained in order to effectively deal with the HIV/AIDS pandemic.

(b) Political Mobilization is the key

One of the biggest lessons learned, globally, as well as in the Region, is that national responses should not wait for the numbers of HIV and AIDS cases to soar. Lack of suitable policies should not be allowed to hinder crucial prevention, care and information services. In some instances, at least initially, prompt practical responses to the epidemic can actually mobilize policy decisions. Thailand presents a good example of how government commitment, a strong public health infrastructure, openness about AIDS and the involvement of the mass media for public information under the 100% condom programme helped prevention activities leading to a decline in HIV prevalence in various population groups.

Thailand drafted its first national plan in 1987 and a three-year medium-term plan (the first in Asia) in 1988. The Ministry of Public Health coordinated the implementation of the plan through the existing health care system. The programme, though, was limited compared to the scale of the rapidly-growing epidemic. Strong political mobilization came in 1991 when the Prime Minister took over the chairmanship of the National Committee on AIDS and all ministries became actively involved. Funds allocated by the government increased 17-fold between 1990 and 1993, and a national AIDS prevention plan (1992-1996) was integrated into the seventh national five-year development plan.

(c) Involvement of target population is essential

Involvement of populations with high-risk behaviour is essential for effective interventions. The “successful” examples of HIV/AIDS programmes clearly show that the target populations must be involved right from the stage of programme planning and implementation to evaluation. The starting point could be recognition by the national programmes of this need and the provision of some resources to catalyze populations at risk. The role to be played by NGOs, particularly those based at the community level, is not only essential but critical. In many cases, an individual or a small group of individuals have mobilized communities for action. The Sonagachi project in Calcutta is an example of affected populations taking up the responsibility of educating their own community through peer education.

AIDS prevention is an individual responsibility. Each individual must adopt a lifestyle without risk of HIV and recognize his/her own vulnerability, and also take appropriate preventive action. While public events and the media have provided a common starting point
for promoting HIV/AIDS prevention and care in communities in the Region, individual and personal interaction has been increasingly recognized as an important means to mobilize community-level responses. Sex workers, injecting drug users, migrant populations, truck and taxi drivers, rickshaw pullers and seafarers are among a diverse range of networks that have been effectively utilized to mobilize responses to HIV/AIDS. Personalizing communication as well as making it practical and simple has been shown to be an important factor in influencing behaviour change.

(d) Public Health Infrastructure is important for AIDS prevention and care

While much effort has been made in countries to foster partnerships and to encourage a multisectoral response, a substantial component of AIDS prevention and care efforts falls within the public health domain. Experience shows that countries with a strong public health infrastructure have been generally successful in mounting a more effective health sector response to AIDS. These include early diagnosis and treatment of sexually transmitted infectious using syndromic approach; blood transfusion safety; epidemiological surveillance and research, and a continuum of HIV/AIDS care linking health institutions, community and home.

Moreover, all countries in the Region have accepted the policy of integrating the management of sexually transmitted diseases as well as HIV-associated opportunistic infectious into the general health services or primary health care. This further necessitates the need to strengthen the public health infrastructure through the provision of financial and other resources, build capacities and strengthen technical and operational support to various stakeholders involved in the programme.

(e) Situation getting increasingly complex

The epidemic is rapidly changing, requiring prevention and care strategies to be modified according to the changing epidemiology. Moreover, the changes in technologies such as new drugs require that national expertise is available to deal with increased complexities, to evaluate their advantages and the feasibility of implementation, as well as to address the emerging issues such as drug resistance. Moreover, since new therapies are available in the western countries, the persons living with AIDS (PLWA) in the Region increasingly start demanding enhanced availability and access to these new drugs.

5. ISSUES FOR CONSIDERATION: Opportunities and Challenges in the new millennium

(a) Continuing Advocacy and Social Mobilization

Adequate political, societal and administrative commitment and support from all sectors is crucial for HIV/AIDS prevention and control programmes. In order to mobilize and sustain partnerships at every stage among the government, the private sector, NGOs, community groups and donor agencies, considerable social mobilization and advocacy are needed so that HIV/AIDS programmes continue to receive priority attention.
Although all countries have been responding positively to the HIV/AIDS epidemic, not all programmes enjoy priority status and political support, including funds. Several countries still depend on funds from donors, bilateral and international organizations such as WHO, other UN agencies, the World Bank and NGOs. However, to make the most effective use of limited resources, programmes should (1) focus on a few priority areas which will have maximum impact; (2) integrate HIV/AIDS into the ongoing programme; (3) develop better coordination and information-sharing to avoid duplication of programme and activities, and finally (4) develop collaboration with NGOs.

(b) Forging and Sustaining Partnerships

Since the first AIDS case was reported, there has been a tremendous response from all communities and sections of societies including NGOs and various other institutions. At the country level, however, collaboration with various stakeholders and partners in fighting the epidemic is often not easy. Considerable efforts are needed by the AIDS programme managers, to carry out advocacy among top policy-makers, other ministries, political leaders, professional organizations, donor agencies, as well as among private and business community leaders. While each partner may develop its own programmes to support national HIV/AIDS programmes, they all must work within the framework of the national policy and strategy, and according to national priorities.

(c) Expanding the programme in scale

Experience shows that, in many countries, the prevention interventions are still restricted to a few project areas. The major challenge therefore is to expand the coverage of the intervention programmes to benefit as many of those at risk as possible. Only then can the impact of these interventions, in terms of a decline in sexually transmitted infectious including HIV, be seen. Moreover, although information and education are the backbone of all HIV prevention and care programmes, this alone is not enough. Education programmes must be supported with improved availability and accessibility to condoms, provision of STI and other related health services and, most importantly, the creation of a positive social environment without discrimination and stigma to encourage appropriate behaviour change. The role of NGOs, particularly those at the community level with full involvement of the targeted population for intervention is most crucial. The emphasis will have to shift from “creating awareness” to “behaviour change”.

(d) Integrating Prevention and Care services

Since 85-90% of HIV transmission is related to sexual intercourse, education aimed at adoption of safer sexual behaviour by people at risk remains crucial to stemming the HIV/AIDS pandemic. Safer sexual behaviour includes abstinence, fidelity, and use of condoms. Such behaviour can be encouraged through information and education programmes, by ensuring that condoms are easily accessible and affordable, and by empowering, providing support for, and educating women and other vulnerable groups about the risks of unsafe sex. These prevention interventions targeting young people are likely to be most effective when implemented in collaboration with NGOs or by using a peer education approach integrated into existing health and development programmes.
Mobilization of local resources is vital for the success of HIV/AIDS prevention programmes. These programmes should be a part of appropriate development plans and fully integrated into HIV/AIDS care programmes.

In order to provide comprehensive care for HIV/AIDS-infected persons and their families, the continuum of care model is being promoted. This extends across various levels of the health care system, linking facilities such as hospitals at state/provincial and district levels, health centres and village health posts, as well as families in their homes through supportive community networks. Therefore, HIV/AIDS care integrated into all levels of the health care system helps in the management of important HIV-associated opportunistic infections such as TB, fungal infections and diarrhoea, and in fulfilling the needs of people with HIV/AIDS in terms of their medical, psychological and social needs.

(e) Improving access to new drugs

Major technological breakthroughs have been reported recently in the development and use of antiretroviral (ARV) drugs in promoting and prolonging life of those infected with HIV/AIDS and, more importantly, in preventing transmission of HIV from an infected mother to her children. Wider application of such an intervention however, requires that the identity of pregnant women who are HIV-positive is known. This is possible only through voluntary counselling and testing programmes. Such voluntary, confidential testing and counselling services, however, are presently very limited in the Region and need to be promoted through the necessary infrastructure so that individuals who want to know their HIV status can get this service. Pregnant women can be offered this service voluntarily at the antenatal clinics or at other public health facilities, with proper pre- and post-test counselling, informed consent and confidentiality. Women who are HIV-positive could then have the option of antiretroviral therapy to prevent mother-to-child transmission and get counselling regarding the merits or demerits of medical termination of pregnancy as well as on infant feeding choices.

While ARV therapy is considered a major breakthrough, it is beyond the reach of most developing countries. It is therefore necessary to continue developing new drugs and to urgently take action to ensure that these drugs are accessible to those in the developing world, where most of the HIV infections are.

6. WHO SUPPORT TO NATIONAL PROGRAMMES

The WHO Special Programme on AIDS, and later the Global Programme on AIDS (GPA), was officially established on 1 February 1987 with the “responsibility for the urgent mobilization of national and international efforts and resources for global AIDS prevention and control”. The AIDS epidemic was defined as a “world health problem of extraordinary scale and extreme urgency” representing an unprecedented challenge to the public health services in the world. The global AIDS strategy was endorsed unanimously by the World Health Assembly in May 1987 and presented to the World Summit of Ministers of Health in London.

Thereafter, a significant amount of funding and technical support were provided by WHO not only for the implementation of national AIDS control programmes but also to community-based organizations. As an international leader in coordinating international/
global response to HIV, WHO also actively encouraged the involvement of the community, respect for human rights and compassion for people living with HIV/AIDS. Involvement of people with AIDS and community organizations was a part of WHO policy. The Organization provided guidelines for the development of national AIDS programmes in different countries and helped in mobilizing resources or by providing funds directly. These guidelines articulated the role of injecting drug use and homosexuality and promoted the use of condoms.

In 1996, GPA was replaced by the UN co-sponsored programme, UNAIDS, with WHO as one of the five co-sponsors. As a result, WHO’s role now is focused more on the public health aspects of the epidemic. WHO’s area of work involves the prevention and management of sexually transmitted diseases, blood transfusion safety, HIV/AIDS continuum of care, epidemiological surveillance and research. In these areas, WHO will take a leadership role as a part of the health sector response to AIDS. In doing so, it will continue to promote the health, social and political dimensions and develop networks of creative partnerships throughout the world.

7. CONCLUSIONS

HIV continues to spread in the South-East Asia Region, although unevenly in different countries. While three countries, namely India (in parts), Myanmar and Thailand, are in an advanced stage of the epidemic, HIV prevalence remains low in many other countries of the Region.

Experiences in responding to the global pandemic show that HIV can be prevented, provided sound, rational and effective strategies are used. These include prevention interventions which promote safer behaviour, primarily with regard to sex and drug use; early diagnosis and management of sexually transmitted infections, and ensuring accessibility to good quality condoms. While NGOs and community-based organizations have a critical role to play in implementing these interventions among various population groups, the government has the overall responsibility to plan, coordinate, mobilize and facilitate various HIV/AIDS prevention and care activities. Government responsibility also includes ensuring safe blood for transfusion as well as in providing care and support for those living with HIV/AIDS.

Continued advocacy for enhanced political commitment and support; mobilization of partnerships across various sectors; intercountry collaboration and sharing of country experiences, and ensuring access to new drugs and other interventions, are the major future challenges.