SEXUALLY TRANSMITTED INFECTIONS, HIV INFECTION AND AIDS

In resolution WPR/RC50.R4, the Regional Committee requested the Regional Director to continue to report annually on the situation of sexually transmitted infections (STI), HIV and AIDS in the Region, and on collaboration with the Joint United Nations Programme on AIDS (UNAIDS).

At the global level, in May 2000 the Fifty-third World Health Assembly adopted a resolution calling upon Member States to maintain HIV prevention as a priority; to monitor the HIV epidemic; to improve AIDS care; to continue research on the prevention of transmission of HIV from mother to child; and to increase collaboration with UNAIDS.1

Increased efforts are now needed by Member States to strengthen the primary prevention of HIV by focusing on condom promotion; to improve surveillance systems and the use of data for programme planning and monitoring; and to plan for the health care needs of the increasing numbers of AIDS patients in the Region.

Supporting action by WHO will include identifying international best practices in HIV prevention and AIDS care, and working with Member States to develop national policies and strategies; supporting Member States to coordinate plans and to mobilize additional resources, including collaboration with UNAIDS and other UNAIDS cosponsors; strengthening epidemiological surveillance; and reporting to the Regional Committee on the situation of STI, HIV and AIDS in the Region.

This annual report is presented for the information of the Regional Committee and for discussion at its fifty-first session.

1 Resolution WHA53.14.
1. CURRENT SITUATION

At its fiftieth session in September 1999, the Regional Committee asked the Regional Director to continue to report annually on the situation of sexually transmitted infections, HIV infections and AIDS and on collaboration with the Joint United Nations Programme on AIDS (UNAIDS) in the Region.\(^2\) A detailed analysis of the STI, HIV, and AIDS situation in the Region is included in *The Work of WHO in the Western Pacific Region: 1 July 1999–30 June 2000* (pp. 37–44).

At the global level, STI, HIV and AIDS issues were discussed at the Fifty-third World Health Assembly in May 2000. Member States approved an extensive resolution on these issues, which is attached as Annex 1.\(^3\)

Important recent developments in the STI, HIV, and AIDS situation in the Region include:

- indications of increased HIV prevalence among vulnerable groups (e.g. sex workers and their clients) in China and Viet Nam, and among the general adult population in some areas of Viet Nam;

- a rapid increase in the number of AIDS patients in Cambodia, China, Papua New Guinea and Viet Nam, leading to a danger in some areas that the number of AIDS patients may overwhelm local health services and resources; and

- the stated intention of five major pharmaceutical companies to reduce the price of antiretroviral drugs, which has the potential to improve AIDS care and reduce the transmission of HIV from mother to child (although antiretroviral therapy remains expensive and there are serious operational constraints to its use).

WHO’s collaboration with UNAIDS is described in Annex 2. Selected strategies that have been used at country level for STI, HIV and AIDS prevention and control are summarized in Annex 3. Policy and legal issues related to STI, HIV and AIDS are covered in Annex 4.

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\(^3\) Resolution WHA53.14.
2. ISSUES

1. The proportion of HIV transmission due to sexual contact continues to increase and primary prevention of the sexual transmission of HIV needs to remain the focus of HIV programmes throughout the Region. More efforts need to be made to target vulnerable groups (e.g. sex workers and their clients) with interventions of proven effectiveness. Condom promotion, including the “100% condom use” programme for sex work situations, should be the main intervention in this area.

There is encouraging evidence from Cambodia that intensive condom promotion (through the “100% condom use” programme) and improved STI treatment among sex workers have been major reasons for a drop in HIV prevalence among young sex workers. Behavioural surveillance is confirming increasing condom use among sex workers and their clients.

2. More efforts should be made to improve blood safety and the use of proper disinfection and sterilization measures, especially in the context of increasing HIV prevalence in some areas. World Health Day 2000 focused on blood safety issues, with the slogan “Safe blood starts with me”. Priority safe blood activities include: the expansion of voluntary, non-remunerated blood donation; the appropriate use of blood and blood products; and the effective management of blood transfusion programmes.

3. Given the link between STI and HIV transmission, there is a continuing need to improve STI diagnosis and treatment services. As many STI patients consult the private medical sector or self-treat their symptoms, STI prevention and care programmes cannot be limited to the public sector. There is a need to ensure that STI training, policy-making, development of guidelines, programme implementation and monitoring cover both public and private health systems.

4. More attention needs to be given to preventing HIV infection among injecting drug users (IDU). Some local IDU populations already have extremely high HIV prevalence, but in other populations it is still possible to prevent large-scale HIV epidemics. Health protection interventions, including harm reduction and drug substitution programmes, have proved to be effective in numerous locations around the world. There is a need for Member States and WHO to support efforts by UNAIDS and the United Nations Drug Control Programme (UNDCP) to expand these programmes.
5. There is a need to improve the collection and use of surveillance and epidemiological data. Effective surveillance systems, including behavioural surveillance, remain essential for identifying people at high risk of HIV transmission, targeting prevention programmes and monitoring their impact. HIV and other STI surveillance systems have improved over the past five years in most countries, but there is still room for improvement in a few countries.

6. The number of AIDS patients requiring health care is increasing rapidly, especially in Cambodia, China, Papua New Guinea and Viet Nam. In some areas current levels of health services will be unable to cope with this increasing demand; for example, there will be an annual total of 30 000 new AIDS cases in Cambodia by 2005. Increasing numbers of tuberculosis cases in some countries, including Cambodia, Malaysia and Papua New Guinea, pose an additional problem. The directly observed treatment, short-course (DOTS) programme for tuberculosis care is appropriate for people who have HIV and tuberculosis co-infections. Countries will need to plan for this increasing demand for AIDS care, including developing policies for AIDS care within health systems. Families and communities must be supported to provide appropriate care for AIDS patients. Programmes to reduce discrimination and stigma for people living with AIDS must become a priority.

7. There is a need for governments to develop policies on the provision of drugs for HIV and AIDS treatment. These include antiretroviral (ARV) therapy drugs, and drugs for the treatment of opportunistic infections. Following negotiations between UNAIDS and drug companies, and the use of international trade treaty provisions on parallel importing and compulsory licensing, ARV drug prices may be reduced significantly for developing countries. However, even with these reductions, these drugs are still expensive. ARV treatment regimes are also complex and need specialized medical supervision, further limiting the application of these therapies. Nevertheless, in many countries there is increasing political pressure to make ARV drugs more available, and countries need to develop policies for access to ARV and drugs for opportunistic infections.

8. There are now effective interventions to prevent the transmission of HIV from mother to child. ARV drugs given to HIV-positive pregnant women can reduce HIV transmission to infants by 50%–90%. However, intervention costs are still high, because of the need for large-scale HIV testing of pregnant women. Cost-effectiveness will be low where HIV prevalence is low and antenatal systems are underutilized. Efforts are also underway to support HIV-positive mothers in making the best decision on how to feed their babies, including whether or not to breast-feed.
There is a need for countries to undertake operational research on these programmes before national policies and strategies can be properly developed.

3. ACTIONS PROPOSED

The following actions are proposed for consideration by the Member States.

1. Recognize that primary prevention of HIV continues to be the priority need. To have the greatest impact in limiting HIV epidemics, interventions should target those at greatest risk of HIV infection with effective condom promotion programmes. Efforts should also be made to maintain, and where necessary strengthen and improve, systems for blood safety and the use of proper disinfection and sterilization measures.

2. Strengthen HIV, AIDS and STI surveillance and epidemiological systems, including behavioural surveillance. High quality surveillance is needed in order to identify people at highest risk of HIV infection, target prevention programmes, and monitor the impact of prevention programmes.

3. Plan for the increasing numbers of AIDS patients. Countries need to reduce stigmatization and discrimination against AIDS patients and to prepare health systems to meet the large increase in demands for care, with an emphasis on home-based AIDS care.

4. Develop national policies on access to drugs for HIV and AIDS treatment.

5. Develop policies for the prevention for mother-to-child transmission of HIV. Such policies should be based on the results of operational research.

6. Increase resource allocations for HIV/AIDS programmes and collaborate with UNAIDS, WHO, other UNAIDS cosponsors, and other partners on programme coordination and resource mobilization.

WHO will support Member States to:

1. Identify international best practices for HIV prevention and AIDS care. WHO will support Member States to develop national policies and strategies to:
undertake primary prevention through condom promotion to protect those at greatest risk of HIV infection through sexual transmission;

• ensure blood safety and the use of proper disinfection and sterilization measures;

• plan and develop policies for the increasing numbers of AIDS patients;

• improve access to AIDS drugs and treatments, including drugs for opportunistic diseases; and

• assess the appropriateness and feasibility of efforts to prevent mother-to-child transmission of HIV.

2. Coordinate plans and mobilize additional resources. This should include improving collaboration with UNAIDS, other UNAIDS cosponsors and other partners.

3. Support improvements to epidemiological surveillance.

4. Report annually to the Regional Committee on the status and development of the HIV epidemic in the Region.
The Fifty-third World Health Assembly,

Having considered the report by the Director-General on HIV/AIDS;

Noting with deep concern that nearly 34 million people worldwide are currently living with HIV/AIDS, and 95% are in developing countries; and that the development gains of the past 50 years, including the increase in child survival and in life expectancy, are being reversed by the HIV/AIDS epidemic;

Further noting that in sub-Saharan Africa, where over 23 million people are infected, HIV/AIDS is the leading cause of death, and where more women are now infected than men; and that HIV infection is increasing rapidly in Asia, particularly in south and south-east Asia, where 6 million people are infected;

Recalling resolution WHA52.19 which inter alia requests the Director-General:

*to cooperate with Member States, at their request, and with international organizations in monitoring and analysing the pharmaceutical and public health implications of relevant international agreements, including trade agreements, so that Member States can effectively assess and subsequently develop pharmaceutical and health policies and regulatory measures that address their concerns and priorities, and are able to maximize the positive and mitigate the negative impact of those agreements;*

Recognizing that poverty and inequality between men and women are driving the epidemic; and that denial, discrimination and stigma continue to be major obstacles to an effective response to the epidemic;

Underlining the need to advocate respect for human rights in the implementation of all measures to respond to the epidemic;

Acknowledging that political commitment is essential to deal with a problem of this magnitude;
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Recognizing that resources devoted to combating the epidemic both at national and international levels are not commensurate with the magnitude of the problem;

Recalling United Nations Economic and Social Council resolution 1999/36 on human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), which stresses, inter alia, governments’ responsibility to intensify all efforts in combating AIDS through multisectoral action;

Recalling the recent session of the United Nations Security Council devoted to the HIV/AIDS crisis in Africa, in which the Security Council recognized that HIV/AIDS is a unique modern-day plague that threatens the political, economic and social stability of sub-Saharan Africa and Asia,

1. URGES Member States:

   (1) to match their political commitment, as demonstrated in several recent initiatives of political leaders of Member States, to the magnitude of the problem by allocating an appropriate national and donor budget for HIV/AIDS prevention as well as for care and support of the infected and affected;

   (2) to establish programmes to combat poverty with the support of donors, implement them in a rigorous and transparent manner, and advocate:

   – cancellation of debt in order to free resources for, inter alia, HIV/AIDS prevention and care, as proposed by the G8 Summit at Cologne,

   – improvement of the living conditions of populations,

   – reduction of unemployment,

   – improvement of the standard of public health;

   (3) to provide increased support for UNAIDS, and WHO as one of its cosponsors, in their efforts against AIDS, including efforts in the context of the International Partnership against AIDS in Africa;

   (4) to strengthen public education on HIV/AIDS and to pay particular attention to national strategic plans directed at reducing the vulnerability of women, children and adolescents, bearing in mind that public education and national campaigns should place emphasis on prevention, on reducing discrimination and stigmatization, and on promoting healthy environments to prevent and alleviate AIDS problems;

   (5) to take all necessary measures to protect children infected and/or affected by HIV/AIDS from all forms of discrimination, stigma, abuse and neglect, in particular protecting their access to health, education and social services;
(6) to apply experiences and lessons learned and the growing body of scientific knowledge regarding proven effective interventions for prevention and care in order to reduce the spread of HIV/AIDS and to increase the quality and length of life of those infected;

(7) to ensure that blood transfusion services do not constitute an HIV risk factor by ensuring that all individuals have access to safe blood and blood products that are accessible and adequate to meet their needs, are obtained from voluntary, nonremunerated blood donors, are transfused only when necessary, and are provided as part of a sustainable blood transfusion programme within the existing health care system;

(8) to build and strengthen partnerships between health providers and the community, including nongovernmental organizations, in order to direct community resources towards proven effective interventions;

(9) to implement key strategies for HIV/AIDS prevention, in particular management of sexually transmitted infections and promotion of safer sex, including by ensuring availability of male and female condoms;

(10) to strengthen health systems that ensure adequate and skilled human resources, supply systems and financing schemes in order to address the needs for HIV/AIDS care and prevention;

(11) to take steps to reduce use of illicit substances and to protect injecting drug users and their sexual partners against HIV infection;

(12) to increase access to, and quality of, care in order to improve quality of life, assure the dignity of the individual, and meet the medical and psychosocial needs of people living with HIV/AIDS, including treatment and prevention of HIV-related illnesses and provision of a continuum of care, with efficient referral mechanisms between home, clinic, hospital and institution;

(13) to reaffirm their commitment to previous resolutions on the revised drug strategy and to ensure the necessary actions within their national drug policies to guarantee public health interests and equitable access to care, including medicines;

(14) to make use of indicators developed by WHO to monitor progress;

(15) to collaborate with the WHO Secretariat and other international agencies to regularly update existing databases in order to provide Member States with information on prices of essential drugs including HIV-related drugs;

(16) to increase access to treatment and prophylaxis of HIV-related illnesses through measures such as ensuring the provision and affordability of drugs, including a reliable distribution and delivery system; implementation of a strong generic drug policy; bulk purchasing; negotiation with pharmaceutical companies; appropriate financing systems; and encouragement of local manufacturing and import practices consistent with national laws and international agreements acceded to;
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(17) to define and affirm their role and, where appropriate, engage in partnerships and solidarity initiatives to make prophylactic and therapeutic drugs accessible, affordable and safely and effectively used, whether intended for prevention of mother-to-child transmission, prevention and treatment of opportunistic diseases, or antiretroviral treatment for patients;

(18) to establish or to expand counselling services and voluntary confidential HIV-testing in order to encourage health-seeking behaviour and to act as an entry point for prevention and care;

(19) to continue research on the prevention of mother-to-child transmission of HIV and to integrate interventions for it into primary health care, including reproductive health services, as part of comprehensive care for HIV-infected pregnant women and postnatal follow-up for them and for their families, ensuring that such research is free from interests that might bias the results and that commercial involvement should be clearly disclosed;

(20) to promote research on behaviour change and cultural factors that influence sexual behaviour;

(21) to establish and strengthen monitoring and evaluation systems, including epidemiological and behavioural surveillance and assessment of the response of health systems to the epidemics of HIV/AIDS and sexually transmitted infections, with the promotion of intercountry subregional collaboration;

2. REQUESTS the Director-General:

(1) to continue strengthening the involvement of WHO, as a cosponsor of UNAIDS, in the United Nations system-wide response to HIV/AIDS, including at country level;

(2) to develop a global health-sector strategy for responding to the epidemics of HIV/AIDS and sexually transmitted infections as part of the United Nations system’s strategic plan for HIV/AIDS for 2001-2005, and to report on progress in development of the strategy to the Executive Board at its 107th session;

(3) to give priority in WHO’s regular budget to the prevention and control of HIV/AIDS, and to engage the Organization as an active partner in the implementation of a transparent and joint resource mobilization strategy in support of the unified budget and work plan of the UNAIDS Secretariat and its cosponsors, and to actively encourage the donor community to increase support for regional and country-level interventions;

(4) to further mobilize funds in support of national HIV/AIDS prevention and control programmes and for care and support given through the home and community-level programmes;

(5) to further support the implementation of drug price monitoring systems in Member States, at their request, with a view to the promotion of equitable access to care, including essential drugs;
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(6) to strengthen Member States’ capacity for the implementation of drug monitoring systems in order to better identify adverse reactions and misuse of drugs within health systems, thus promoting a rational use of drugs;

(7) to continue the development of methods and support for monitoring the pharmaceutical and public health implications of trade agreements;

(8) to involve WHO fully in the International Partnership against AIDS in Africa, as well as other programmes against HIV/AIDS in other Member States, particularly at country level, within the context of national strategic plans;

(9) to cooperate with Member States in organizing nationally coordinated blood-transfusion services;

(10) to collaborate with Member States in strengthening the capacity of health systems both to respond to the epidemics through integrated prevention of HIV/AIDS and sexually transmitted infections and care for infected people and to promote health systems research to frame policy on health systems’ response to HIV/AIDS and sexually transmitted infections;

(11) to advocate respect for human rights in the implementation of all measures responding to the epidemic;

(12) to intensify the support of national efforts against HIV/AIDS, aimed at providing assistance to children infected or affected by the epidemic, focusing particularly in the worst-hit regions of the world and where the epidemic is severely setting back national development gains;

(13) to appeal to the international community, relevant United Nations agencies, donor agencies and programmes, and intergovernmental and nongovernmental organizations to also give importance to the treatment and rehabilitation of children infected with HIV/AIDS, to invite them to consider further involving the private sector;

(14) to ensure that WHO, together with the UNAIDS Secretariat and other interested UNAIDS cosponsors, pursue proactively and effectively its dialogue with the pharmaceutical industry, in conjunction with Member States and associations of persons living with HIV/AIDS, to make HIV/AIDS-related drugs increasingly accessible to developing countries through drug development, cost reduction, and strengthening of reliable distribution systems;

(15) to reinforce, promote, and explore partnerships both to make HIV/AIDS-related drugs accessible through affordable prices, appropriate financing systems, and effective health care systems and to ensure that drugs are safely and effectively used;

(16) to cooperate with governments, at their request, and other international organizations on possible options under relevant international agreements, including trade agreements, to improve access to HIV/AIDS-related drugs;
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(17) to promote, encourage and support research and development on: vaccines appropriate for strains of HIV found in both developed and developing countries; diagnostic tools and antimicrobial drugs for other sexually transmitted infections; and treatment for HIV/AIDS, including traditional medicine;

(18) to intensify efforts to prevent HIV and sexually transmitted infections in women, including promotion of research on and development of microbicides and affordable female condoms to provide women and girls with female-initiated protection methods;

(19) to continue, in the context of efforts under way with UNICEF, UNFPA and the UNAIDS Secretariat, to provide technical support to Member States for implementation of strategies and programmes to prevent mother-to-child transmission of HIV, and to improve capacity for intersectoral collaboration;

(20) to provide support to Member States for collecting and analysing information on the epidemics of HIV/AIDS and sexually transmitted infections, developing methodologies for behavioural surveillance, and producing periodic updates;

(21) to provide increased support to Member States for the prevention of HIV transmission in injecting drug users in order to avoid an explosive spread of HIV/AIDS in that vulnerable population;

(22) to advocate for research on nutrition in relation to HIV/AIDS;

(23) to advise Member States on the appropriate treatment regimen for HIV/AIDS and to advise in collaboration with other relevant international organizations on the management, legal and regulatory issues to improve affordability and accessibility;

(24) to appeal to bilateral and multilateral partners to simplify the procedures for the allocation of resources.
COLLABORATION BETWEEN WHO AND UNAIDS IN
THE WESTERN PACIFIC REGION

As a co-sponsor of the Joint United Nations Programme on AIDS (UNAIDS), WHO has collaborated with UNAIDS since its establishment in 1996. This collaboration has included WHO participation in UNAIDS theme group meetings and activities at country level, and technical collaboration between the Regional Office and UNAIDS headquarters on HIV surveillance and blood safety, among others.

However, collaboration between UNAIDS and WHO has intensified in the past year:

- Meetings between UNAIDS, WHO and other co-sponsors at the regional level are held twice a year. These meetings monitor the trends of the epidemic in the Region, and seek agreement between the co-sponsors and UNAIDS on priorities and division of work. WHO has been an active partner with UNAIDS in planning and following-up these meetings. WHO takes primary responsibility for health-related HIV and STI work, including blood safety issues, STI treatment and diagnosis, and AIDS care and health system issues. WHO also works in close collaboration with UNFPA on reproductive health and condom promotion, and with UNICEF on youth and STI issues. The expansion of lifeskills education for young people and condom promotion to vulnerable groups have been identified as key priorities for HIV prevention activities for the next two years.

- There has been a division of responsibilities in the Pacific, with WHO working with Member States to improve STI services, and UNAIDS undertaking media and other advocacy activities. WHO has provided important technical support to UNAIDS and other co-sponsors by chairing the UNAIDS technical working group for the Pacific for the past four years.

- A *Strategic plan for condom promotion for HIV and other STI prevention in Asia: 2000–2003* has been prepared by the Regional Office and will be implemented by WHO and UNFPA with the support of UNAIDS and other partner agencies.
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- WHO regional and headquarters staff have provided technical support on action planning to the UNAIDS/United Nations Children’s Fund (UNICEF) regional task force on young people and HIV prevention. WHO is also a key member of the advocacy and health reform sub-group of the task force.

These examples illustrate the growing collaboration between UNAIDS and WHO in the Western Pacific Region. The aim of this collaboration is to coordinate the response of the co-sponsors and UNAIDS to the HIV epidemic in the Region. In Member States with growing epidemics, such as China, Papua New Guinea and Viet Nam, WHO seeks to work together with other partners to reduce HIV transmission through effective interventions such as condom promotion and risk reduction among injecting drug users. Some Member States such as Cambodia, China and Viet Nam are experiencing increasing growth in the numbers of AIDS patients. Collaboration with other partners is needed to develop programmes to reduce discrimination, and to provide appropriate care for people living with AIDS through health systems and at the community level.

In the face of growing HIV epidemics in a number of countries, the issue of resource mobilization remains a key concern. In the last biennium, support from UNAIDS was reduced in most Member States. Some additional funds have been made available by bilateral donors in some countries in the past two years, but most Member States have had to support HIV prevention and care efforts from their own resources. The need for an increase in resources is becoming especially acute in countries facing an increasing burden of AIDS care, such as Cambodia, China, Papua New Guinea and Viet Nam. There is an important role for WHO and other UNAIDS cosponsors in supporting Member States to mobilize financial and other resources to respond to these increasing needs.
EXAMPLES OF COUNTRY STRATEGIES FOR SEXUALLY TRANSMITTED
INFECTIONS, HIV AND AIDS PREVENTION AND CONTROL

Experience in preventing and controlling HIV has grown over the past decade, as countries of the Region have identified strategies that are appropriate for their national and local situations.

The following strategies have been successful in preventing and reducing the scale of the HIV pandemic.

1. “100% condom use” programmes to prevent HIV infections among sex workers

In an effort to reduce the spread of HIV, many countries have tried to increase condom use in commercial sex. Most interventions have focused on educating sex workers about HIV prevention, and providing condom supplies. These efforts often include community education campaigns and treatment for sexually transmitted infections (STI).

These programmes have had some success in raising sex workers’ awareness of the seriousness of HIV and AIDS and in teaching techniques for negotiating condom use with their clients. However, many clients continue to have sex with sex workers without using a condom. This is resulting in an increasing number of sex workers and male clients becoming HIV infected, and the expansion of the epidemic into the general population.

In order to reverse this trend, Thailand successfully established a “100% condom use” programme for entertainment establishments which is credited with making a major contribution to reducing HIV transmission. The programme requires that the owners of entertainment establishments enforce condom use as a condition of commercial sex. In line with Thai police regulations, if establishments are found repeatedly to allow sex to be sold without condom use, then the establishment is closed. The two key elements of this programme are: (1) the active cooperation of the police, public health officials, the owners of entertainment establishments, and sex workers; and (2) the fact that, when condom use is a requirement of commercial sex, sex workers, clients, owners and the general public benefit.
Over the past three years, the “100% condom use” programme for sex work has been successfully established in Cambodia. Initially piloted in two areas, the programme is now ready for national expansion. The Prime Minister has approved a national policy requiring implementation of the programme in all entertainment establishments. There is evidence that the programme is leading to increases in condom use among sex workers (Figure A1), and that this is being reflected in reductions in HIV prevalence among young brothel-based sex workers (Figure A2).

Pilot projects on the “100% condom use” programme are being developed in China, Papua New Guinea and Viet Nam. A Strategic plan for condom promotion for HIV and other STI prevention in Asia: 2000–2003 has been developed by the Regional Office, and will be implemented in collaboration with the Joint United Nations Programme on AIDS (UNAIDS), the United Nations Population Fund (UNFPA), and other UNAIDS cosponsors.

Figure A1. Cambodian female sex workers always using a condom with clients, 1996–1999
2. **Harm reduction programmes to prevent HIV transmission through injecting drug use**

Countries with significant HIV transmission through injecting drug use (IDU) in the Region include China, Malaysia and Viet Nam. HIV prevalence among injecting drug users can increase rapidly in a very short time. For example, increases from 20% to 80% prevalence among some groups of drug users can happen in only a few months, depending on the mobility of the drug users and the extent to which they share injecting equipment.

Some countries with significant numbers of injecting drug users have succeeded in avoiding large-scale HIV epidemics among drug users through the use of harm reduction programmes. For example, Australia (Figure A3), Hong Kong (China) and New Zealand have avoided large-scale HIV epidemics among injecting drug users, through the use of harm reduction interventions, including needle and syringe accessibility and substitution programmes such as methadone maintenance for opiate-dependent users.
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Figure A3. Reported HIV infections among injecting drug users in Australia, 1989–1999

Source: Ministry of Health, Australia, 1999

There is increasing interest in these programmes by other countries in the Region. For example, China is piloting a “clean needle” programme in one area, and is now expanding this programme to the provincial level.
What is harm reduction for injecting drug use?

Harm reduction does not imply legalization of drugs and/or condoning injecting drug use. Rather, it means providing assistance and taking practical measures so that the harm resulting from drug use (e.g. HIV infection) can be minimized.

Harm reduction emphasizes a pragmatic response to the health consequences of injecting drug use. Activities undertaken to reduce harm resulting from drug use vary in depth and scope. For example, abstinence from drug use may be the best means of preventing transmission of HIV among injecting drug use. However, there are alternatives, such as stopping drug injection, not sharing injection equipment, and decontaminating injection equipment if sharing occurs. A variety of methods need to be implemented simultaneously, some of which may have more achievable goals than others. An appropriate HIV intervention for injecting drug use must be based on knowledge about HIV prevention, and the skills and the means to change behaviour. One without the others would not be useful; there must be an appropriate mix of knowledge, means and skills.

**Drug treatment**

Detoxification, treatment and rehabilitation services provide opportunities for information, education and counselling on drug use and HIV prevention. However, because of the high rates of relapse among drug users and the costs of setting up adequate drug treatment services, other intervention activities should be implemented alongside drug treatment.
Syringe exchange

This programme aims to reduce the spread of HIV and other infections among injecting drug users by allowing injecting drug users to exchange used syringes for clean ones, by promoting non-sharing of injection equipment and cleaning of injection equipment if sharing occurs, and by acting as a bridge to other health-related services.

Disinfectant distribution

This programme aims to reduce the spread of HIV and other infections among injecting drug users by: providing them with bleach (or another local disinfectant); teaching them to clean with disinfectant; promoting non-sharing of injection equipment; and providing information, education and counselling on harm reduction.

3. Planning for AIDS care

The number of AIDS patients is increasing rapidly in some parts of the Region. For example, in Cambodia, it is estimated that by 2005 there will be 30 000 new AIDS patients every year. China, Papua New Guinea and Viet Nam are also experiencing significant increases in the numbers of AIDS patients. In several countries, there is an urgent need to develop AIDS care policies, strategies, plans of action and technical guidelines (e.g. AIDS care protocols and community-based AIDS care).

4. Improving STI services

Most countries and areas of the Region have succeeded in improving STI services significantly in the past few years, including:

- making services more available and accessible by integrating STI services into primary health care;
- improving the diagnosis and treatment of STI through improved protocols and the use of the syndromic approach for the management of STI;
improving STI surveillance and data, including undertaking STI prevalence studies;

- establishing STI policies; and

- improving the counselling and education of STI patients.

In Cambodia, for example, a large-scale training programme on STI diagnosis and treatment has been undertaken for the medical staff of the military health system. STI services have also been integrated into the maternal and child health system. Technical guidelines such as WHO protocols on the syndromic approach to the management of STI have been translated, adapted and distributed. The Ministry of Health has developed a “National Policy and Priority Strategies for Prevention and Control of Sexually Transmitted Infections”. Training activities to improve STI counselling have also begun.

There have been significant efforts to improve STI services in other countries. Mongolia is seeking to update STI protocols, and the diagnosis and treatment skills of medical staff. The Ministry of Health in China has begun to use the WHO syndromic approach system for STI diagnosis and treatment, and is also establishing criteria for the training of all medical staff in STI.

5. **Improving blood safety**

All countries and areas of the Region have taken action to prevent the transmission of HIV through blood. Key strategies have included:

- establishing national blood services;

- screening all blood and blood products prior to use;

- reducing the use of blood and blood products; and

- implementing programmes to promote voluntary, non-remunerated blood donations.

Major efforts still need to be made by some countries. For example, most blood donation in China, Cambodia, the Philippines and Viet Nam is by paid or replacement donors. All of these countries have started programmes to promote voluntary, non-remunerated blood donation, but much remains to be done.
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6. Epidemiological surveillance

All Member States in the Region have case reporting systems for HIV infection and AIDS cases.

However, where HIV and AIDS diagnosis and case reporting is limited, HIV sentinel surveillance is necessary to obtain a more accurate picture of the level and nature of HIV transmission, and to develop HIV and AIDS estimates.

In order to improve intervention design and monitoring, there is increasing emphasis on the need for behavioural surveillance of sexual behaviour. Behavioural surveillance programmes are already in place in Cambodia and the Philippines and they are being initiated in China, the Lao People’s Democratic Republic and Viet Nam.

Good information on STI prevalence is also important to: understand the scale and nature of STI; plan prevention and control programmes; develop treatment protocols; and monitor the impact of interventions. In order to improve data on STI prevalence, high-quality (“gold standard”) STI prevalence surveys have been undertaken recently in China (Nanjing and Yunnan), Malaysia, the Philippines, Samoa, and Vanuatu. The monitoring of gonococcal antimicrobial susceptibility is now in place in the Region and has proved useful in determining whether to adapt treatment regimens for gonococcal infections.

HIV, AIDS and STI data are brought together and reviewed by national and international experts in surveillance consensus workshops. These workshops are held on a regular basis, and have enabled agreement to be reached about the status and trends of these epidemics. Recent consensus workshops have been held in Cambodia, Malaysia, Papua New Guinea, the Philippines, and Viet Nam.
POLICY AND LEGISLATION ON STI, HIV AND AIDS ISSUES

With the expansion of the HIV epidemic in a number of Member States, policy and legal issues related to STI, HIV and AIDS are becoming more important. Member States are developing a range of laws, regulations and technical guidelines to prevent, treat and control STI, including HIV and AIDS. WHO provides technical and other support to Member States in their efforts to develop and implement appropriate policies to prevent and control STI, including HIV. As well as technical visits and training activities, the Regional Office recently published: The role of public policy in prevention and control of sexually transmitted infections: a guide to laws, regulations and technical guidelines.

1. “100% condom use” programmes for sex work industries

A pilot project has been established in Cambodia, and there are now plans to expand the programme nationwide. The Prime Minister has approved a policy requiring implementation of the programme in all entertainment establishments. Pilot projects are also being developed in China, Papua New Guinea and Viet Nam.

2. STI screening for sex workers

The Philippines was one of the first countries in the Region to require regular screening of women working in registered entertainment establishments such as karaoke bars, sauna and massage parlours. Similar policies are also implemented at national or local levels in a number of other countries and areas, including China, Hong Kong (China) and Singapore. STI screening for sex workers is an important component of the “100% condom use” programme. In Viet Nam, some local health authorities have issued guidelines to monitor STI in women at high risk of infection.

3. Guidelines for HIV and other STI prevention among vulnerable populations

The need to improve STI education among vulnerable groups such as migrant workers has been recognized in many countries. For example, as many Filipinos work abroad, a Philippine
government programme provides HIV and other STI education materials to departing overseas contract workers. In Kiribati, special educational programmes have been designed for seafarers. In China, the National HIV and AIDS Centre (Chinese Academy of Preventive Medicine) has taken the lead in developing national guidelines for HIV and STI prevention among vulnerable groups, including sex workers. These guidelines are being issued to provincial health services, and include condom promotion, outreach education, and improving STI services.

4. Preventing discrimination against people living with HIV and AIDS

There is still discrimination against people living with HIV and AIDS in many countries of the Region. In the Philippines, an act strengthening legal protection for people living with HIV and AIDS has been passed.

5. Making condoms more available and accessible

There can be a number of policy barriers which limit people’s access to condoms for STI prevention. These may include: restrictions on the advertising of condoms and on where condoms can be sold; duties on imported condoms; and sales taxes on condoms. Condom social marketing programmes in Cambodia, the Lao People’s Democratic Republic, the Philippines and Viet Nam have succeeded in expanding access to condoms. China has recently established a new national condom standard, which aims to improve the quality of condoms. Efforts are also underway to improve accessibility to condoms for young people in some Pacific countries.

6. Improving blood safety

Recent initiatives by Member States to improve blood safety include the closing of private blood banks in the Philippines, and improved regulation of blood collection activities in China. Development of policies and strategies to prevent HIV transmission through effective blood safety programmes should be a priority in all countries.

7. Improving the quality of government STI services

As STI increase the likelihood of HIV transmission, many national STI/HIV programmes have
developed policies and guidelines aimed at improving the effectiveness and quality of STI services. For example, China has recently adopted a plan and guidelines for HIV prevention. This includes a requirement that 85% of medical doctors be trained in STI diagnosis and treatment by 2002. Cambodia has developed a “National policy and priority strategies for prevention and control of sexually transmitted infections”.

8. **Regulating user fees for STI treatment**

A number of countries are undergoing major changes in health services financing, and government and private health facilities may be required to generate income to cover most of their operational costs. In a few countries, this appears to be resulting in excessively high fees for STI treatment. This may have serious public health consequences for vulnerable groups such as lower paid sex workers, migrant populations, and young people, who may not be able to pay for STI diagnosis and treatment.

9. **STI screening of pregnant women**

Screening of pregnant women for syphilis and/or gonorrhoea is a long-established public health policy in many countries of the Region, such as Fiji. In other countries where STI, and particularly syphilis, have been increasing recently, there is a need to consider the introduction of syphilis screening for all pregnant women. In Malaysia, this policy has been expanded to include voluntary screening for HIV. Any pregnant women found to be HIV-positive are offered antiretroviral therapy to prevent HIV transmission to their infants.

10. **Mandatory screening of specific groups for HIV**

WHO is against mandatory screening for HIV, as such practices have no public health rationale and often violate basic human rights. The recent Philippines AIDS law explicitly disallows such practices. However, other countries in the Region sometimes require screening of, for example, foreigners applying for long-term residence permits. Others require information on HIV status on entry into the country.