

PREVENTION & TREATMENT:

You can't have One without the Other



ASAP is an independent non-governmental body of experts and organisations from Asia and the Pacific committed to reducing the transmission and impact of HIV/AIDS. It aims to promote opportunities for the discussion of HIV/AIDS issues and the exchange of relevant information and technologies; seeks to influence HIV/AIDS policy development in the region and awareness of the gravity of the regional epidemic internationally; and, works with different regional sectors and stakeholders towards collective advocacy

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The past two decades have brought important paradigm shifts in the understanding and response to the global HIV epidemic. The most significant shift has been the conceptualization of HIV/AIDS as a basic issue of human security. Now, a new paradigm shift is upon us, this time centred on the debate between prevention vs. treatment. The combination of the dramatic reduction in prices and the increased production of generic drugs has meant that antiretroviral medicines are no longer off-limits to the developing world. Access to medicines, as constructed by WHO's 3 x 5 initiative, has become a global priority.

With treatment emerging as an option, or at the very least with the removal of significant barriers to treatment, there is the need to evaluate the effectiveness of prevention work and to question the future role of prevention. What place will prevention work have as viable treatment options start rolling out? As resource dollars shift to treatment, will there be enough money to continue prevention work, given the high costs associated with treatment? Will the increased availability of treatment change how prevention work is done? If so, how should we plan for these changes?

This paper argues that prevention, as a method of containing the spread of HIV, has not and will not fail. We have learnt a great deal from and can continue to draw upon the many examples of success from within the Asia-Pacific region (Australia, Cambodia and Thailand) and beyond (Brazil, Uganda, Senegal). While acknowledging that there is a moral imperative to provide treatment wherever possible, it is imperative to show that prevention and treatment are not competing forces, but rather two parts of a larger and more effective, integrated HIV/AIDS strategy for Asia and the Pacific. For this to happen, new opportunities need to be identified so that effective partnerships can be formed with treatment.

Prevention vs. Treatment

The United Nation's International Guidelines on HIV/AIDS and Human Rights states that governments are now required to ensure access to essential medicines as well as prevention programs. Admirable as that objective is, there are inherent reasons for concern regarding the simplistic combination of treatment with prevention. The increased treatment push into resource poor settings has the potential for treatments to overshadow prevention work, leaving successful practices sidelined and other practices, which may be more difficult to measure, seen as unsuccessful. Considerable problems still plague HIV prevention work. Some religious leaders still prohibit the use of condoms and some governments still will not introduce harm reduction measures for drug users beyond small pilot programs. Many of the region's governments, organizations and individuals still overlook the needs

of hard to reach 'invisible' populations and continue a tokenistic approach to the involvement of people living with HIV/AIDS in policy and decision-making. Many people still have no access to prevention. The Global HIV Prevention Working Group¹ estimates that prevention efforts still reach less than 1 in 5 of those at risk. As a consequence, many people remain ignorant of the risks.

The 3 x 5 initiative

On World AIDS Day 2003, WHO and UNAIDS announced a plan to reach the 3 by 5 target of providing antiretroviral treatment to three million people living with HIV/AIDS in developing countries by the end of 2005.

The debate between prevention and treatment draws on a number of well known dichotomies that have tended to construct this issue as an 'either /or' debate. This is illustrated in a recent example of the effectiveness argument based on assumptions of limited resources and debated predominately within an economic and public health framework. A recent article published in the British Medical Journal argued against increased treatment in India because the money devoted to one person on ARV can be better spent on preventing many cases of HIV.²

The either/or debate has been fuelled by fundamental differences between prevention and treatment. Effective prevention work requires the confrontation of cultural taboos and morally difficult issues, such as sex work, drug use, and homosexuality. Societies and governments often choose not to acknowledge these issues, or as Thailand has recently done in its war against drugs, revert to repressive actions with devastating consequences for vulnerable people. In stark contrast to prevention work, treatment sidesteps these difficult social issues, offering more easily measurable hope for the suffering.

Given these differences, there is a common and mutually reinforcing ground between prevention and treatment. Treatment lowers the viral load, and as a consequence, is considered by some to be a form of prevention. Brazil has shown how both universal antiretroviral treatment and treatment for opportunistic infections has significantly reduced the incidence of new cases of HIV. The social mobilisation that accompanies the introduction of universal treatment is also important for more effective prevention efforts. Much of the same infrastructure is needed for prevention and treatment. Treatment helps to preserve a society's human infrastructure, which is vital in carrying out prevention work. Treatment also gives people a reason to be tested and ultimately helps break the silence, stigma and discrimination around HIV and AIDS.

Integrating prevention with treatment in Indonesia

Prevention programs incorporating treatment are rare, but they do exist. The Indonesian HIV/AIDS Prevention and Care Project (IHPCP), now in phase II (2002-2007), builds upon phase I which focused on strengthening the capacity of national and provincial governments and civil society institutions to respond to Indonesia's growing HIV epidemic. Phase II is an example of the integration of prevention with treatment.

Activities that are supported range from:

Mobilisation of local resources to reach people most vulnerable to HIV, such as sex workers and men who buy sex; and their partners; people who inject drugs; and people living with HIV/AIDS and their partners.

Advocacy work with government at national, provincial and district levels; legislators, communities and faith-based organizations; and private sector organizations.

Development of stronger national leadership through partnerships with the National AIDS Commission in the development of appropriate policy and program guidelines and building multi-sectoral partnerships.

Capacity building to improve the quality of evidence-based planning and management.

Technical and financial support across a range of activities, including; social and behavioural research, regular surveys to track the spread of HIV and to measure changes in knowledge and behaviour; promotion and distribution of condoms; harm reduction related to injecting drug use; establishment of voluntary counselling and testing services; and comprehensive care, support and treatment.

The Dangers of using treatments as an impetus for change

Holmes³ points out that the targets set for treatment often exceed the number of people who have been diagnosed as HIV positive. In Indonesia, a target has been set to treat 9,200 people by 2005, however, to date, fewer than 4,000 people have been identified with HIV. Holmes argues this is the result of the urgency of the 3 x 5 program and its narrowly defined objectives. What are the consequences of increased testing without the provision of increased care and support? Most people who are positive in the early stages of epidemics do not

require treatment; however what support will be made available once they have been diagnosed with HIV? With a target set to treat 9,200, will there be increased pressure to identify and test people who are labelled at high risk? Will the emphasis on testing lead to a decline in resources for prevention?

Are we now seeing medicine beginning to drive the prevention agenda? If so, will the option of treatment draw political will, leadership and resources away from prevention efforts? Will a shift in focus towards treatment give leaders an opportunity to claim they are committed to fighting HIV without having to deal with the taboo and socially unacceptable elements of society?

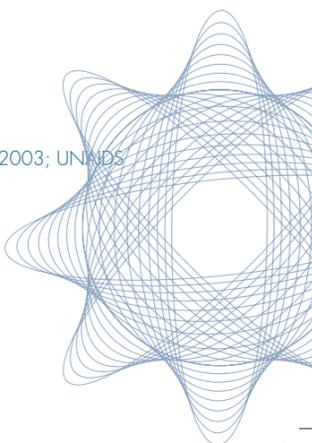
HIV/AIDS in Asia and the Pacific

The epidemic varies significantly throughout the region. Thailand and Australia were among the first countries in the region to report the virus in the early 1980s. Almost a decade later the virus arrived in India and China. HIV epidemics in IDU populations continue to grow throughout the region, with a significant increase in HIV prevalence among injecting populations within India, Burma/Myanmar, Thailand, Malaysia, Pakistan, China, Vietnam and more recently Nepal and Indonesia. In much of Asia and the Pacific the epidemic is relatively young and the prevalence rates remain low, at under one percent, with the overall HIV prevalence at about 7.4 million in 2003.⁴ While the number of people infected in the region continues to grow, evidence now shows that the HIV prevalence in several population groups has begun to decline in both Thailand and Cambodia. WHO estimates that by the end of 2003 there were 60,000 people on treatment in South-East Asia and a further 10,000 within the Western Pacific region, with an estimated 1 million people needing treatment in both regions at the end of 2003.⁵

Table 1: Adult HIV prevalence level for selected Asia-Pacific countries (2002)

Country	Adult HIV prevalence level %
Cambodia	2.6
Thailand	1.8
Burma/Myanmar	1.1- 2.2 (urban)
India	0.7
China	0.2
Papua New Guinea	0.7
Indonesia	0.01

Source: WHO HIV/AIDS in Asia and the Pacific, 2003; UNAIDS



¹ Global HIV Prevention Working Group, Access to HIV prevention: closing the gap, Gates Foundation May 2003

² Potts, M., Walsh, J., Tackling India's HIV epidemic: lessons from Africa British Medical Journal 2003; 326:1389-1392

³ Holmes, W. 3 by 5, but at what cost? The Lancet Vol. 363, March 2004

⁴ WHO, HIV/AIDS in Asia and the Pacific Region 2003, p10

⁵ <http://www.who.int/3by5/coverage/en/>

Low prevalence levels throughout the region conceal large localised epidemics like those experienced in India where approximately 4.58 million people were living with HIV/AIDS at the end of 2002, second only to South Africa. In the most affected state of Maharashtra, HIV has reached 60% of Mumbai's known sex workers, 14-16 % of attendees at sentinel STD clinics and over 2% among women attending antenatal clinics (ANCs). The prevalence in women attending antenatal clinics, a reliable indicator for the prevalence in general population, has reached 6.5% in Namakkal in Tamil Nadu and 5.3% in Churachandpur in Manipur.

China tells a similar story, with an estimated 1 million people living with HIV by 2002. UNAIDS estimates that without an effective response a total of 10 million Chinese could be infected with HIV and as many as 260,000 could be orphaned by the end of the decade. Although the HIV prevalence is low nationally, high-level prevalence exists in specific populations and certain regions. Rates of HIV among intravenous drug users in certain areas of Yunnan and Xinjiang provinces are as high as 80%.⁶

Essential factors for successful prevention

Uganda, Senegal, Brazil, Australia, Cambodia and Thailand have either successfully contained, or made substantial impacts in the slowing of the spread of HIV. Experience in each of these countries tells us that although different responses are required in different settings there are some essential components to prevention work.

The essential package of HIV prevention strategies includes: positive policy environments, widespread public education about HIV, promotion of prevention skills, condom availability and social marketing, sex education, epidemiological and behavioural surveillance, HIV counselling and testing, treatment for Sexually Transmitted Infections, treatment for HIV, harm reduction, treatment for drug and alcohol dependence, and the screening of the blood supply.

In addition to the adequate resources required to carry out prevention programs, other elements are needed. Ownership, participation and a politicised civil society are vital characteristics of a successful prevention program. Interventions that work best take place within the context of societies that have strong social networks and strong internal communication structures. Prevention programs, whether peer support or condom promotion, have succeeded best when they work in partnership with local communities and reflect local cultural norms.

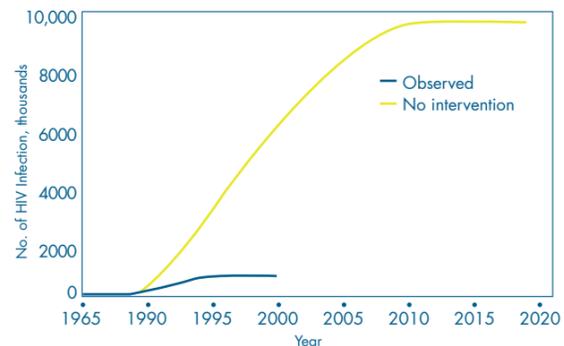
A great deal has changed over the past two decades. We now know that the majority of cases of HIV can be prevented by the correct use of condoms and clean

needles. Epidemiological and behavioural surveillance systems have continued to improve. We have access to more comprehensive data and examples of what has worked at various times and places.

We know that teaching adolescents about sex and sexuality does not encourage young people to become sexually active at an earlier age. In an examination of sex education projects conducted by UNAIDS, it was found that when young people are provided with accurate information on sex and HIV, they are more likely to delay sexual activity and use condoms when they do have sex.

We know that HIV/AIDS is inextricably linked to issues of sex, sexuality, gender inequality, stigma and discrimination, human rights abuses, poverty and marginalisation of behaviours. We have witnessed prevention efforts opening spaces for new identities to evolve and for human rights to be examined and challenged. We have learnt that while appropriate prevention policies do exist, access is much harder to overcome.

Through Thailand's experience we have learnt the importance of community mobilisation, strong and timely political leadership, and how economic, political, social and cultural factors render individuals and communities vulnerable to HIV/AIDS. Mobilisation of communities to establish broad levels of commitment is a core strategy in successful prevention. The mobilisation of communities requires the elimination of stigma, the development of partnerships between social and government actors and the systematic involvement of communities and individuals infected and affected by HIV/AIDS. Thailand's first national HIV/AIDS plan was drafted in 1987, followed by the three-year medium plan the following year. Thailand's prevention program during the 1990s used the mass media and the community to reach the general population and young people. Emphasis was also placed on risk behaviour beyond specific population groups. Condoms played an important role in Thailand's response to HIV. Today, approximately 30,000 new infections occur each year, a significant drop from the almost 143,000 cases in 1991.



⁶ Joint Assessment Report on HIV/AIDS Prevention and Control in China, Ministry of Health, the People's Republic of China and United Nations Theme Group on HIV/AIDS in China, June 2003

It must also be kept in mind that successful prevention programs may be tied to particular contexts and lessons may not be transferable. Thailand and Brazil have succeeded partly because of the size of their health budgets and existing health infrastructure. The implementation of Thailand's first medium term HIV plan was coordinated through the existing health care system. The program built upon a well established and functioning STI surveillance and service delivery infrastructure.

India has yet to give HIV the sustained high priority that has been a key to stemming the rise of the HIV tide in countries like Thailand. For example, India's total health spending is one of the lowest in the world in contrast with its military spending which is one of the largest in the world with only the US and China making a larger outlay on defence in 2003.⁷

Strong political leadership is vital if prevention is to have an impact. Governments need to confront cultural taboos – intimate practices must be discussed openly. Social norms must be challenged; conservative attitudes about sex and drug use must be confronted, and most importantly marginalized communities must not only be acknowledged but involved in creating enabling environments. For prevention work to be successful socially and politically difficult, and at times unpopular, decisions must be made. Thailand has demonstrated strong political leadership with the Prime Minister taking the chair of the National AIDS Committee and the dramatic increase in the AIDS budget from \$2.5m in 1991 to \$48m in 1992 with most of the money coming from local sources. This helps to create positive policy environments.

Quantifying the impact of prevention measures is very difficult, as we cannot predict, in any one setting, what the trajectory of the epidemic will be. If the prevalence rises from 1% to 3% to 5% then on first glance it looks as though prevention efforts have failed. But it is impossible to tell whether or not the rise would have been 1% to 3% to 6% to 10% without the prevention strategies. That is why detailed analyses of behaviour change are so valuable.

Missed Opportunities

The Global HIV Prevention Working Group (2003) estimated that 2002 funding for HIV prevention programs in Asia, from all sources, was less than \$421 million. The estimated need by 2005 for Asia is \$1.9 billion annually, growing to \$2.4 billion by 2007. The recent creation of the Global Fund has increased opportunities to rally international will and resources. The aim is to increase the amount of money now needed for prevention and treatment. The task of the Global Fund has been to mobilise international political will and resources and ultimately increase the size of the pie. Money now needed

⁷ Stockholm International Peace Research Institute (SIPRI)

⁸ Global Fund Progress Report 14 January 2004

for treatment doesn't have to be taken from prevention work. The expected outcomes from Global Fund rounds 1, 2 and 3 (after five years of funding) are that more than 700,000 people will be on antiretroviral treatment, tripling current coverage in developing countries. Thirty-five million people will also have been reached with HIV voluntary counselling and testing services for prevention.⁸

A lack of resources is only one reason why dangerous myths about HIV continue to persist throughout the region. Prevention programs often don't reach people because the people most at risk are invisible and marginalised. Prevention efforts can also stigmatise groups and leave others ignorant of the risks.

Creating and enabling environment in India

The Sonagachi sex worker project in India began in 1992 by mapping sexual behaviour among sex workers, their clients and partners in Sonagachi, Calcutta. Health care services were then provided in a clinic, IEC material disseminated and condom use promoted. An outreach component was also developed. The project soon expanded to include issues of gender, class and sexuality, with the aim of increasing self-esteem, which in turn helped to change deeply entrenched sexual practices.

The project worked closely with the controllers of the sex trade, aiming to create a meaningful dialogue to negotiate and bring about social change. Extensive and on-going advocacy campaigns were also implemented. The project gained considerable public recognition and acceptance, providing an opportunity to question and challenge the structural constraints that kept sex workers excluded from participation in policy decision making.

The project has helped to successfully control STIs and HIV transmission among sex workers and their sexual partners. The VDRL positivity (1:8 and above) has changed from 25.4 in 1992 to 11.5 in 1999. Genital ulcers have reduced from 6.22 in 1992 to 0.99 in 1999. HIV prevalence has remained stable at 5% during 1995 to 1998, which is significantly low for this community. In comparison, rates of infection among Mumbai sex workers as of 1997 were as high as 70 percent. Condom use has increased from 2.7% in 1992 to 80.5 % in 1998.

Today, 430 peer educators spread awareness throughout Bengal, and 36 brothel-based medical clinics regularly treat sex workers. In 1995, the Sonagachi women established the first union of sex workers in Asia, the Durbar Mahila Samanwaya Committee (DMSC), and took control of the local government AIDS project. Among other things, DMSC has established a school for sex workers' children, a money-lending co-op, and a cultural group that spreads AIDS awareness through music, dance, and street theatre.

Condoms

The supply of condoms is far short of what is needed. People are also denied information about condoms. The United States, historically the world's leader in donating condoms, has drastically reduced its condom commitment over the last decade while increasing resources to HIV prevention programs that give greater emphasis to sexual abstinence and marital fidelity. The change in direction is a result of pressure from the religious right. This change in policy is having a significant impact on availability of condoms throughout the region.

In 2003, conservative members of the Philippines parliament blocked legislation that would have authorised the use of national funds for condoms. This restricted the supply of free condoms to those sourced through donations from the private sector and through local government. This lack of access to free condoms was further compounded when the United States announced in 2002 that it would be phasing out its shipments of free condoms to the Philippines.

In 1998 Cambodia adopted the 100% condom program from Thailand and saw the HIV prevalence decline the following year, mirroring the response in Thailand. However, the program does raise some concerns relating to mandatory testing of sex workers. There are also concerns about increased difficulty in disseminating general prevention information because of the stigmatisation of condom use and the association of condoms with sex workers, the rise in the number of indirect sex workers, such as 'beer girls' and the barriers associated with implementing 100% condom use with indirect sex workers.

Men who have sex with men

Prevention efforts have come up against the problem of stigmatising groups through their association with HIV and AIDS. The most obvious groups are sex workers and drug users, leaving others ignorant of the risks. Our knowledge of sexual networks and behaviours of men who have sex with men in Asia and the Pacific are reflected in the neglect of prevention programs addressing male-to-male sexual activity and the associated risks.

The main modes of transmission throughout the region are through heterosexual sex and through the sharing of needles. The existence of sex between men is often denied and when it is acknowledged this group is discriminated against. The inherent difficulties in reaching these men are compounded by this stigma and the fact that male-to-male sex is often illegal.

⁹ Daniel Wolfe *Condemned to Death thanks to the drug war, a global aids epidemic is exploding among injection drug users.* *The Nation*, April 26, 2004

While AIDS in parts of the region is still associated with homosexuality, homosexuality is seldom talked about and often denied. Over the past 5 years, HIV infection rates in Japan have increased significantly among Japanese men. Within this group, transmission through unsafe sex between men accounts for more than twice as many infections as through heterosexual sex. As a marginalised group, men who have sex with men in Japan have inadequate information related to sexual health.

There is no singular 'MSM' population, or defined group. They are not only diverse and dynamic, but also contradictory in nature. For example; many men who have sex with other men also have sex with women. There are also emerging patterns of sex between men resulting from modernisation and urbanisation. These factors, combined with the group's low visibility, make them hard to reach for prevention work and so the message that ends up being conveyed is the fact that male-to-male sex does not involve risk of HIV.

Harm reduction vs. eradication in Thailand

Thailand has been praised for its work in reducing the rate of HIV transmission, predominantly through its 100% condom program. While rates of HIV have fallen among female sex workers, they have steadily increased among injecting drug users. Opportunities to reduce the HIV prevalence among drug users were diminished when the Thai Prime Minister, Thaksin Shinawatra declared a war on drugs on February 1st 2003. This "war" was part of a larger social order campaign. In the two months following his declaration of the war against drugs, more than 2,000 people were killed due to extrajudicial killings.⁹ The government's repressive policy towards drug use has had a significant negative impact on the country's harm reduction work. The 'war on drugs' has driven intravenous drug users beyond the reach of public health workers, making prevention work with people who inject drugs too difficult and too dangerous. This crackdown, in conjunction with the cancellation of the country's only needle-exchange program and the failure to implement countrywide methadone maintenance programs are clear examples of how government action towards eradication of a social disorder have led to a reduction in harm minimisation. The government's social order campaign was also felt throughout gay saunas as repeated raids resulted in the removal of free condoms. Sauna owners have been advised that condoms could be used as evidence against them if they were charged with operating sex establishments.

Greater Involvement of People living with HIV and AIDS

The failure to involve people living with HIV/AIDS in policies and programs continues. Support is still limited to ensure that people living with HIV/AIDS (PLWHA) have the necessary policy skills to participate equally. Few examples exist of meaningful involvement of people with HIV/AIDS whereby participation involves policy dialogue and at the highest levels. Treatments will help to give people a reason to be tested and help reduce stigma and discrimination. Greater visibility to PLWHA must be given in order to overcome the fear, ignorance and prejudice they face and to counter all forms of discrimination against PLWHA.

Conclusion

The 15th International AIDS Conference marks a critical time for Asia and the Pacific. Although the number of infected people remains below 1% for most countries in the region, these figures mask the potential for large epidemics and worrying trends in countries such as India, China and Papua New Guinea. A slight shift in the prevalence rate for India will have a potentially catastrophic effect for both India and the region as a whole. As a result, our aim must be to keep the number of infected people as low as possible.

The technology exists to foster this aim. After two decades of implementing prevention programs across different settings and at different stages of the epidemic's development, we have uncovered what works and perhaps more importantly, what does not. However, significant barriers to effective prevention still exist. Many people at risk still do not have access to information about risky practices, do not have access to condoms and do not have access to clean needles. While the knowledge and will exists, local and international resources have proven inadequate. This is especially troubling in light of the United States reduction of financial support in areas that do not support the current government's agenda on sexual health issues.

Although the recent advances in treatment have been very encouraging, we must not allow a shift in our focus from prevention to treatment, or a construction of the prevention/treatment debate in 'either / or' terms. Without a doubt, the introduction of treatment has changed the global response to HIV and as a result, the future role of prevention. The challenge is to acknowledge that the gains in treatment have provided us with prevention opportunities that can be even more effective if they are closely coordinated with treatment and care programs.

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