

SOUTH EAST ASIAN SUBREGION RESPONSE TO AIDS

**A Strategy for HIV/AIDS Prevention
And Care in the Mekong Subregion
1998-2000**

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ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
AIDSCAP	AIDS Control and Prevention Project
AIDSNET	AIDSNET Foundation
APCASO	Asia Pacific Council for AIDS Service Organisations
ARCSAN	Australian Red Cross Subregion AIDS Network
ARO	Asia Regional Office, AIDSCAP
ASEAN	Association of South East Asian Nations
ATFOA	ASEAN Task Force on AIDS
AusAID	Australian Agency for International Development
BDCC	Behaviour Development and Change Communications
CBO	Community Based Organisation
CSW	Commercial Sex Worker
FHI	Family Health International
GPA	Global Program on AIDS (of the WHO)
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
IBRD	International Bank for Reconstruction and Development (The World Bank)
IDU	Injecting Drug Use/ers
INGOs	International Non-Government Organisations
Lao PDR	Lao Peoples Democratic Republic
MCH	Maternal and Child Health
NAPAC	Northern AIDS Prevention and Control Program
NAP	National AIDS Program (of Subregion countries)
NGO	Non Government Organisation
PHC	Primary Health Care
PLWHA	People Living With HIV/AIDS
PSI	Population Services International
RH	Reproductive Health Care
STD	Sexually Transmitted Disease
TOT	Training of Trainers
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation
WVI	World Vision International

EXECUTIVE SUMMARY

The latest data for the Mekong Subregion confirms that the HIV epidemic requires a subregional strategy and response. The fast moving epidemics in Cambodia and Myanmar are intensifying the spread of the epidemic across the subregion. At the micro-level, this leads to increasing social and economic costs for individuals, families and local communities. At the macro-level, it accentuates the need for an increase in resources required for effective national responses for all the countries of the subregion. In all countries, governments have to focus on major and competing social and economic priorities.

The subregion has a rapidly expanding epidemic associated with intravenous drug use and heterosexual transmission: other factors that transcend national borders are migration and the use and availability of commercial sex. The relatively untouched, large populations of Vietnam and Southern China are increasingly vulnerable to the epidemic. High rates of other sexually transmitted diseases are key factors that contribute to rapid HIV transmission in the subregion and increasing rates of mother-to-child transmission. Transborder migration is fuelling changing dynamics and increasing the number of epicentres of the epidemic within the subregion.

- The rapidly increasing trend of HIV prevalence indicates that current efforts aimed at combating the spread of the epidemic are not matching its progress. UNAIDS estimates that six million adults and children in South and South East Asia are living with HIV/AIDS, the majority of those infected between the ages of 15-35 years old.

Except for Thailand, responses to the epidemic have generally been insufficient to impact on its spread. In most countries, only relatively small-scale programs are being implemented as NGO and community organisations build-up their capacity. The strategy notes that while the level of political commitment is increasing, there is a general lack of multi-sectoral or multi-country responses, and are which are the most effective. Few mechanisms exist to foster or allow such collaboration. Donors have differing priorities and constraints in providing assistance: regional collaboration will improve the effectiveness of their responses.

The **rationale for a Subregional approach** is straightforward. The fundamentals of the pandemic are shared by all countries in the region since its nature defies the restriction of borders. As such, a regional approach will have clear economies of scale and will allow for strategic and tactical allocation of scarce financial and technical resources. Countries will benefit from sharing data and resources. An effective regional strategy will add value to national responses and link in-country programs; some issues, such as migration, can be dealt with more effectively at a regional level while successful programs in individual countries can be replicated region-wide. Such an approach will lead to improved co-ordination and collaboration between donors and national organisations.

The **Strategic Goal** of the program is clear. *To increase the effectiveness of multi-country responses to the HIV/AIDS epidemic across the Mekong subregion.* Within this, priority will be given to those elements of the population that are most vulnerable: this will include mobile populations, intravenous drug users as well as sex workers and their

clients: a special emphasis will also be placed on vulnerable groupings of women and youth. Fostering enhanced commitment and advocacy by political leaders will be a key aim.

The Subregional Strategy is based on several **objectives** and proposes an approach for collaborative and urgent action in four key result areas. These will specifically focus on:

- increased supply, distribution, access and use of quality condoms: program efficiency will require standardised quality assessment capabilities and distribution techniques tailored for groups most vulnerable to HIV/STD;
- increased access to appropriate STD management, prevention and care: improved service delivery will include increasing women's access to STD treatment, especially through reproductive and primary health services, increased access by youth to STD services, and the provision of services tailored for other vulnerable population groups;
- increased access to a minimum package of care and support for affected individuals and communities: improving care and support in low resource environments through enhancing existing capacity for community care approaches and at the same time, enhancing the existing capacity of community health services, undertaking activities to foster participation in program and service planning and delivery; and
- expanded access to effective education programs for behaviour development and change (BDCC): this will involve replicating and scaling-up effective behaviour change communication activities, concentrating on and targeting programs on 13-24 year olds, injecting drug users, sex services and mobile populations.

These four areas respond to needs identified from lessons learned concerning effective responses to the epidemic. They require political commitment and timely response; mechanisms for scaling-up effective, practical activities and programs; the development of strategic planning capacity at all levels of national and provincial government; and adequate monitoring, evaluation and accountability.

Achieving **results** through the strategy will depend upon sustained commitment by all parties as well as on the development and adoption of a plan of action with effective mechanisms for collaborative action. Such mechanisms, for example, could include using country clusters/agency coalitions allowing for better allocation of donor resources - using them where they are best needed: different issues provide different opportunities for donors in terms of comparative advantage and involvement.

To achieve the strategy's objectives, attention will focus on the **enabling conditions** necessary for effective action. These will include increased political commitment, an appropriate policy environment, and the building up of planning and implementing capacity. This strategy therefore identifies the need for regional efforts to co-operatively support the development of broad-based political commitment, the participation and capacity development of NGOs/CBOs, the decentralisation and targeting of resources to sub-provincial levels, and the replication or 'scaling up' of effective activities across the subregion.

In order to implement the strategy, a detailed **plan for action** must be developed and priorities established for funding. Implementation of the plan will require establishing a range of key policy and practical outputs as well as verifiable indicators. The plan of action will include specific measures and outputs in relation to the key result areas noted above: improving the supply of condoms and integration of condom strategies with primary health care and reproductive health programs will be required; improving access to and quality of STD services. The plan will aim to establish needs assessment across the subregion for access to a minimum package of care and support, and the development of programs aimed at BDCC to educate senior officials as to the effects of HIV/AIDS on their economies.

Regional initiatives must take into account what is occurring in the region and build on experiences of effective responses. Scarce financial and technical resources need to be focussed upon country priorities and realities. Donors, including the European Union, the Netherlands, USAID, and the International Development Banks are planning major programs of assistance. These all contribute to the opportunity to develop a subregional strategy that augments national programs and provides a framework that donors can adopt and use.

- It is imperative that collaborating countries, organisations and donors have an effective means of co-operation so as to achieve key priorities. This subregional approach, incorporating the use of country clusters, aims to facilitate co-operation, overcome existing constraints and widen access to existing expertise and achievements. *Action in the region is necessary on a transborder basis.*

In conclusion, the strategy provides a clear analysis and justification, as well as proposing the means, for improving the effectiveness of multi-country responses to the HIV/AIDS pandemic in the subregion. Concrete results will only be achieved where there is a shared commitment to co-operative action between countries, donors, organisations and communities. ***This strategy has as its aim improved co-operative planning and project implementation throughout the subregion for an effective response to the pandemic.***

1. Introduction

The *Mekong Subregion* is comprised of Myanmar, Thailand, Vietnam, Cambodia, the Lao PDR and the province of Yunnan in the People's Republic of China. This reports sets out a draft strategy for responding to the HIV/AIDS epidemic in the subregion. It is presented in four main chapters. Chapter 2 addresses HIV epidemiology; Chapter 3 the subregion response to date; Chapter 4 the rationale for a regional strategy; and Chapter 5 the goal, objectives and proposed elements of the plan of action for the strategy.

2. Mekong Subregion and HIV/AIDS Situation

The subregion is faced with a rapidly growing epidemic of HIV/AIDS caused through a variety of factors that transcend national borders such as migration, drug abuse and the use and provision of commercial sex. The relatively untouched, but large, populations of Vietnam and Southern China are increasingly vulnerable to the epidemic.

2.1 HIV Epidemiology and the Mekong Subregion

The World Health Organisation and UNAIDS estimate that over 40 million people are now living with HIV infection. Worldwide, this means that the overall rate of infection is that one in every hundred adults is likely to be HIV positive, but this is concentrated in the sexually active ages of 15 to 49. Every day 16,000 new infections occur: eight thousand of these are in the 15-24 year old age group. In 1997, two and a half million people died of AIDS. The estimate of the rate of overall infection disguises the fact that there are very high concentrations of infection in specific regions.

- UNAIDS has estimated that six million adults and children in South and South East Asia are living with HIV/AIDS with the majority of those infected between the ages of 15-35 years old.

The epidemiological picture within the Mekong subregion presents a diverse set of characteristics of HIV prevalence with various modes of HIV transmission and differing factors contributing to new infections. The subregion has a rapidly expanding epidemic associated with intravenous drug use and heterosexual transmission. In some countries (Thailand, Cambodia and Myanmar), the epidemic is having flow-on effects on their neighbours. Statistics suggest an increasing vulnerability of countries with relatively newer epidemics and large populations (Vietnam and China). Table 1 summarises information regarding the potential for the spread of HIV across the subregion.

- The use and availability of commercial sex, high rates of other sexually transmitted diseases, the mobility of populations, and substance misuse are key factors that contribute to rapid HIV transmission in the Mekong subregion.

- Epidemics associated with injecting drug users (IDU) across the subregion have led to explosive outbreaks of HIV/AIDS. In some localities in Thailand, Northern Myanmar, parts of Vietnam and the southern provinces of China the prevalence of HIV infection in IDUs has reached levels ranging up to 90 percent in a matter of months.

Table 1: HIV Projections across the Mekong Subregion

Country and Population (million)	Estimated HIV Infection	Current Pattern of Infection	STD Prevalence	Volume of Sex Work	Projections of HIV burden by 2000
Thailand 61.4	850,000	Heterosexual IDU	Moderate - decreasing N/A migrants	High	Very high (1.2 million)
Myanmar 48.3	380,000-480,000	Heterosexual IDU	Limited data	N/A	Very high (estimates unknown)
Cambodia 10.3	120,000	Heterosexual	High	High	Very high (160,000)
Vietnam 76.7	60,000	IDU Heterosexual	Low	Medium	Medium (estimates unknown)
Lao PDR 4.9	N/A	Heterosexual	N/A (unofficial High)	N/A (unofficial low)	Unknown
China 1,228.4 Yunnan southern provinces	200,000	IDU Heterosexual	High and increasing	Estimates unknown	High (2003 - 1 million) (2010 - 10 million)

(Main Sources: UNAIDS/WHO (1997), Report on the Global HIV/AIDS Epidemic; MAP: Monitoring the AIDS Pandemic (Oct., 1997); The Status and Trends of the HIV/AIDS/STD Epidemics in Asia and the Pacific, Satellite Symposium, 4th International Conference on AIDS in Asia and Pacific).

In Thailand, Cambodia (see Box 1) and Myanmar (see Box 2) **heterosexual transmission** accounts for the largest proportion of HIV exposure. It is now documented that the biological presence of a sexually transmitted disease (STD) substantially increases the likelihood of acquisition of HIV. High STD prevalence in parts of the subregion has contributed to the spread of HIV.

In addition, it is considered that there are two key behavioural factors contributing to the rapid spread of HIV in sex workers and their clients in the Mekong subregion. These are:

- the high number of customers a sex worker has in a typical week, and the high percentage of men who regularly use them, results in a rapid increase of HIV infection in them and their clients and thus from men to their wives; and
- increasing rates of mother-to-child transmission within the region: this mode of transmission has the potential to have far-reaching effects on the population of the subregion with a particular impact on sexually-active young adults and their families

Box 1: Cambodia

The results of sero-surveillance conducted in 1997 in Cambodia were sobering: the HIV national prevalence reached 2% in less than half the time it took to reach the same rate in Thailand. Around 40% of sex workers, 6% of police/military and 3% of pregnant women tested HIV-positive.

Factors contributing to the rapid increase include high rates of STDs: up to 31% of sex workers and 6% of pregnant women tested positive for gonorrhoea in 1996 surveys, and up to 12% of military/police tested were found to have syphilis.

Poverty, civil war, other priorities for limited government finance, and lack of co-ordination among donors all militate against an effective response. Men frequent sex workers in high proportions in Cambodia (about 75% of military/police and 37% of students reported visiting a sex worker in 1996). Condom use between sex workers and clients is increasing, but not on a regular and consistent basis

Box 2: Myanmar

In 1996, 1,789 cases of people with AIDS were reported in Myanmar. The main modes of transmission were heterosexual (two-thirds) and intravenous drug abuse (one third). WHO has estimated that by end 1996, 450,000 people were already infected with HIV representing the second largest burden of HIV infection in the region after Thailand.

A sentinel sero-survey conducted in 1996 indicated a very high rate of HIV infection among IDUs, over 80% in Myitkyina, Muse and Lashio in the North of the country. The HIV prevalence among male STD patients ranged up to 30%, with a national average of 7%. The rate for sex workers was approximately 20%.

Many factors were identified fostering the HIV epidemic in Myanmar including mobility of population (truck drivers, fishermen, gold and jade miners), high prevalence of intravenous drug use and cross border migration with Thailand, China and India.

Mobility and migration also contribute to the risk of infection and spread of HIV across the subregion. Several behavioural and seroprevalence studies have shown that populations who move through borders areas are at greater risk of infection than in other parts of the country. Migratory populations are primarily sexually active working-age adults and often have, or are faced with:

- a lack of access to appropriate services especially in remote border areas;
- disrupted social norms;
- high levels of disposable income;
- increased rates of crime and lawlessness associated with remote areas; and
- policies that discriminate against migrant workers.

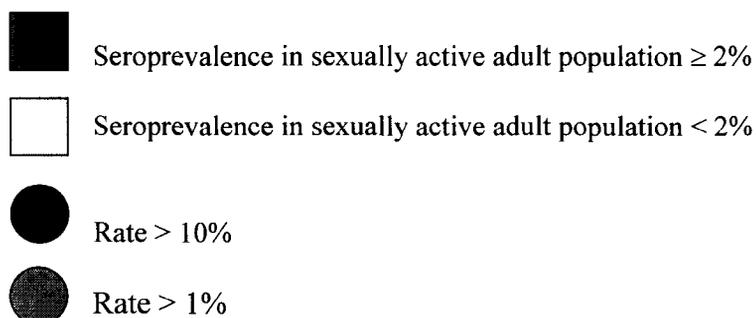
These factors in conjunction with easy access to commercial sex or free-lance commercial sex (people who define themselves as casual sex workers) and access to injectable drugs in borders areas, increases the vulnerability of migratory populations to HIV infections.

Significant migration in the subregion is the result of a number of factors including trade, employment, tourism, civil conflict, and the trafficking of women and children. The total volume of migratory populations is unknown, however the main routes have been generally identified as the following:

- Myanmar to Thailand (Chiang Rai, Tak and Kanchanaburi Provinces);
- Chinese to Thailand (Yunnan Province into Myanmar and then to Chiang Rai);
- Lao to Thailand: Thais to Laos (Savannakhet, Champassak, Bokeo and Vientiane Provinces);
- Vietnamese to Cambodia and back again (Ho Chi Minh to Phnom Penh);
- Vietnamese to Thailand (to Phnom Penh then through Poipet and Arranyaprathet);
- Cambodians to Thailand: Thais to Cambodia (Arranyaprathet and Trat Provinces), and
- Malaysians to Thailand: Thais to Malaysia (Songkhla, Narathiwat and Yala Provinces).

HIV/AIDS PREVALENCE IN THE MEKONG SUBREGION

This map portrays the high HIV prevalence that spans Thailand, Myanmar and Cambodia where national HIV prevalence is equal to or greater than 2% in sexually active adults. Focal epicentres of the epidemic exist at main border crossings as is portrayed by the higher rates in sentinel population data (circles).



Sentinel populations: Myanmar male STD populations; Thailand 21-year-old males
Cambodia policemen; Vietnam female sex workers
China injecting drug users

Finally, of increasing concern in the subregion is the issue of **blood safety** and HIV transmission. In 1995, WHO estimated that less than 50 percent of blood transfusions in Asia were being routinely screened for HIV. In Myanmar and China, screening of blood remains far from complete and in Cambodia declining funding threatens the capacity of screening for any pathogen including HIV.

Variations in the severity of the HIV epidemic in the subregion indicate that there are differences in the degree of risk between countries. This may be due to different social environments and behavioural patterns (see Box 3). For example, in Laos it may be that the low numbers of men who use sex workers on a regular basis may be the reason for the relatively low numbers of people infected in the country. However, to date, there are still limited socio-behavioural data to determine the specific variables and direct appropriate interventions in Laos. Increasing behavioural surveillance is necessary.

Box 3: Youth vulnerability

The majority of new HIV infections in most parts of the world are in young people aged 15-24 years with females being particularly vulnerable. Women aged 15-24 made up 20% of AIDS cases detected in Myanmar up to March 1997 - more than double the proportion of men in the same age group. Believed to be less sexually experienced and 'AIDS-free', younger women are increasingly sought as sexual partners both within and outside commercial sex networks. In fact, their physical immaturity makes them highly vulnerable to being infected with HIV through unprotected sex.

There are groups of young people in all countries who engage in risky behaviour. In a 1994 survey, 25% of Thai men and 3% of women reported having had sex before the age of 15. Rising youth unemployment has stimulated cross-border migration for work, and may also predispose young people to selling sex and using drugs with all the associated risks of HIV infection.

In conclusion, the region is composed of countries whose epidemics are developing rapidly primarily due to heterosexual transmission: additional and rapid IDU transmission is also occurring in several countries. Transborder migration is fuelling changing dynamics and increasing the number of epicentres within the subregion. Trends indicate an increased vulnerability of countries with large populations: Vietnam and China. The rapidly increasing trend of HIV prevalence indicates that the efforts currently being made by individuals, communities, organisations and governments in the subregion are not matching the progress of the epidemic.

- *Due to the multiple factors contributing to the spread of the epidemic, countries are unable to solve this situation alone. Regional efforts and programs will offer economies of scale and facilitate the sharing of effective experience.*

3. Mekong Subregion Response to AIDS

While there has been substantial program implementation in Thailand, elsewhere in the region program development has been insufficient to have an impact on the spread of the epidemic. There are significant gaps in the nature of national and donor responses. Special attention is needed for those countries with limited resources. A substantial increase in the level of political commitment to addressing the epidemic will also be necessary.

3.1 Current responses to the epidemic

In Thailand, the epidemic is having a severe impact on morbidity and mortality and on all aspects of everyday life: nevertheless, the implementation of programs in response to the epidemic is having an impact on the spread of STDs (see Box 4). However, in other countries in the region only relatively small-scale programs are being implemented. While some have had localised and beneficial effects, collectively they are not sufficient to impact on the spread of the epidemic.

- Condom availability and use in some countries has increased substantially. But consistent, widespread availability and use has not occurred across the region as a whole: STD management is unsatisfactory across the region outside of Thailand.

Non-governmental and community-based organisations have begun to build capacity in response to the epidemic, however co-ordination has to be improved. As yet they do not have the resources to meet the range of needs across the region. Within countries there is no effective multi-sectoral response across ministries and linked non-government organisations: this is particularly so in China, Vietnam and Lao PDR while there needs to be greater recognition of the status of the epidemic in Myanmar and Cambodia.

Box 4: STDs & Condom Use in Thailand.

Since beginning a 100% condom use promotion campaign nationwide in 1991, STD incidence has dropped from 7.69% in 1987 to 0.49% in 1996. This campaign has been assisted by government financial and technical support for STD services that are anonymous, affordable, effective and accessible.

3.2 Gaps in responses/potential scope for regional initiatives to fill gaps

Insufficient national and donor resources are committed to core components of an effective response to STD/HIV/AIDS. Main concerns include insufficient supply, distribution and use of quality condoms; inadequate access to anonymous, rapid, affordable and effective STD services; and care and support for those that are infected - across the subregion there is a lack of understanding that care and support can be

integrally linked to prevention and community response. Conditions of stigma, fear and discrimination mean that few with HIV/AIDS participate in advocacy, policy development or program implementation, (the exception is Thailand). With increasing transborder migration, major gaps in national prevention and care are becoming evident.

Donor organisations continue to respond to STD/HIV/AIDS across the subregion but mostly on a country-specific rather than a regional basis. Existing programs implemented on a regional basis are summarised in the attached working paper on regional programs and projects. The development of mechanisms to facilitate collaboration to enable small-scale, single country, effective prevention and care activities to be shared, and taken to scale across the subregion are not priorities. Few mechanisms exist to foster or allow such collaboration between countries in the subregion, particularly at the level of specific programs or of basic technical expertise.

3.3 Political commitment to address the epidemic

Political commitment and the ability to cope with HIV/AIDS vary widely across the region due to the different stages, impact and visibility of the epidemic as well as levels of donor assistance.

- To increase political commitment, successful practical policies are needed: these in turn will stimulate the development and, most importantly, the implementation of action on a wider scale.

Thailand apart, political commitment is primarily limited to health ministries. Effective responses to the epidemic in Thailand and countries outside the region have been through co-ordinated efforts by several ministries in supporting *multisectoral* efforts. In most countries in the subregion, governments must also focus on major, competing priorities including economic and security concerns. Broad-based awareness, acceptance and understanding of how to respond to the HIV pandemic require immediate attention.

- Recent information, including STD/HIV surveys and socio-economic impact analysis, has influenced some key officials, ministries and political organisations in Cambodia, Myanmar, China and Vietnam to develop an awareness of the problem. However, greater levels of awareness, political commitment and action are still required to establish and maintain an effective response to the epidemic across the subregion.

Some countries in the subregion have yet to see the need to work with populations at risk of infection. Efforts to change behaviours, reduce the level of injecting drug use and of commercial sex activity often drive vulnerable people away from services that can reduce the incidence of HIV transmission. Political awareness of this needs to be raised. Additionally, collaboration to establish prevention and care services in border regions requires especial political and community effort.

3.4 Limited resource countries

To support the development of sustained national responses, countries with limited resources and which face major development challenges require specific strategies in order to be able to use international financial and technical assistance effectively. This is especially the case in Lao PDR, Myanmar and Cambodia, which start from a lower base than their regional counterparts. Financial assistance must be carefully phased and

supported by appropriate technical assistance. The acute shortage of trained government and private sector counterparts, and the severe resource limitations and population reach of government organisations and services must be taken into account in any subregional strategy.

3.5 Donor priorities and constraints

Donors have differing priorities and constraints in providing assistance: some do not provide assistance to Myanmar and there are continuing constraints on assistance to other countries because of human rights concerns. However, such constraints should not preclude assistance being given to countries with an epidemic that has major regional implications. The provision of aid to large mobile and migrant labour populations, which live in high-risk situations and contribute to the rapid transmission of HIV in the region, can and should be addressed on a regional basis.

- A regional solution requires co-ordination between governments, donors and international agencies. The development of a “*country cluster*” approach that co-ordinates multiple country strategies and donors with common concerns (e.g. condom availability) will be more effective against the epidemic across the region than any one strategy alone.

4. The Need for a Mekong Subregional Strategy

Despite their diverse backgrounds, all countries of this subregion are increasingly affected by the consequences of the aids epidemic, not least economically. The fundamentals of the epidemic are shared and as such a regional approach will have obvious economies of scale and thus benefits to the countries involved.

4.1 Rationale for a Subregional Approach

The countries of this subregion have a diverse range of cultural, political, demographic, economic and epidemiological links. However the characteristics of the epidemic defy the restriction of country boundaries. The dynamics of the spread of the disease include multiple transmission patterns with increased risk along transportation routes and border zones.

- The rationale for a regional approach is therefore straightforward. It will allow for strategic and tactical allocation of limited resources so as to slow the spread of the epidemic. Countries will benefit from sharing data, resources and action relating to HIV/AIDS prevention and care.
- An effective regional strategy will add value to national responses and link multiple in-country strategies to respond to the epidemic.

4.2 Areas to be addressed through a regional approach.

A number of issues can be dealt with more effectively at a regional level. Some examples are detailed below.

- Planning. Gaining experience from other countries at various stages of the epidemic and benefiting from those with advanced responses developed from years of dealing with the epidemic.
- Using multi-country action to address difficult and sensitive issues. Such actions would include condom promotion, the provision of STD services to persons in risk situations, and harm reduction programs for injecting drug users. The regional approach offers opportunities to facilitate consensus building on critical issues.
- Improving Border/Crossing Point services. These locations have poor services and conditions that combined with high-risk situations promoting STD and HIV prevalence, contribute to the rapid transmission and spread of the epidemic.
- Population movement. The nature of internal and cross-border migration and of population movement in the region is a factor in the growth of the epidemic. Movement of labour (e.g. fishermen, sex workers, and construction workers) as well as of trafficked women and children contributes to vulnerability and risk. Prevention and care activities are required at points of origin, destination and along migration routes.

- Ethnic minorities. These communities span border areas, are often impoverished and beyond the reach of government health and education services, and are particularly vulnerable.
- Scarce technical assistance resources. There is a limited resource base of skilled personnel as well as established education, research and training programs directed at the epidemic. Measures have to be taken to increase technical assistance resources. For example, this could include improving the capacity of health services to meet the needs of affected communities.
- Economies of Scale. Successful programs in individual countries can be utilised region-wide. For example: workplace training manuals and processes designed and field-tested in Thailand are now being adapted for use across the subregion.
- Improved Co-ordination and Collaboration. Many bilateral and international donors are active in STD/HIV/AIDS prevention and care in the region. Key agencies providing substantial financial and technical resources include UNAIDS and others of the UN system; bilateral donors; the European Union; and INGOs including the Ford Foundation, Save the Children, World Vision, CARE, Red Crescent, as well as AIDS Taskforce and Family Health International.

The need for a subregional strategy is straightforward. It is based on the fact that co-ordination and collaboration between all donor and in-country organisations involved in efforts to combat the disease is essential. Regional initiatives must take into account the lessons of experience, the scarcity of financial and technical resources, and the need to focus upon country priorities and realities. It is therefore imperative that collaborating countries, organisations and donors have an effective means of co-operation so as to achieve key priorities. Responses must be undertaken on a transborder basis if effective action is to be achieved.

5. The Subregional Strategy

The strategy has a straightforward goal: increasing the effectiveness of responses to the epidemic.

It is based on several key objectives; it details some of the outputs that will be achieved and which will be further developed as the strategy is implemented. In developing the strategy it will be essential to establish and monitor indicators of performance to ensure efficient and effective use of the limited financial resources available, including those from Australia's aid program.

The plan of action, which is proposed to implement the strategy, includes a series of outputs aimed at contributing to and ultimately achieving the overall goal; some constraining factors are also identified.

5.1 Goal

- ***To increase the effectiveness of multi-country responses to the HIV/AIDS epidemic across the Mekong subregion.***

Priority will be given to those elements of the population that are most vulnerable: this will include mobile populations, intravenous drug users as well as sex workers and their clients: a special emphasis will also be placed on vulnerable groupings of women and youth. Fostering enhanced commitment and advocacy by political leaders will also be a key objective of the strategy.

5.2 Objectives

The strategy for action provides an approach for collaborative and urgent action on key result areas. Action must be on a transborder basis if this approach is to be realised. The four key result areas specifically focus on:

- A Increased access to and use of quality condoms.
- B Increased access to appropriate STD management, prevention and care.
- C Increased access to a minimum package of care and support for affected individuals and communities.
- D Expanded access to effective education programs for behaviour development and change.

These four areas respond to areas of needs identified from lessons learned in developing an effective response to the epidemic. The objectives require political commitment and timely response; mechanisms for scaling-up effective, practical activities and programs; the development of strategic planning capacity at all levels of national and provincial government; appropriate devolution and decentralisation policies; and adequate monitoring, evaluation and accountability.

- The challenge is to create the necessary enabling environment and multi-country collaboration to achieve action in the result areas.

5.3 Making the subregional strategy work: Mechanisms for action

Achieving concrete results through the subregional strategy will depend upon on the development and adoption of a plan of action with efficient and effective mechanisms for co-ordination and collaboration. The following table illustrates mechanisms that could be developed under the plan of action:

ACTION/ISSUES	MECHANISMS
COLLABORATING DONORS AND COUNTRIES	⇒ Major donors and participating countries agree to co-ordinate key results area programming and budgeting around the subregional strategy ⇒ Major donors annually synchronise planning and budgeting around the subregional strategy ⇒ Countries and donors jointly develop and agree on key results area implementation workplan
COUNTRY-LEVEL – Mechanisms for Joint Planning and Programming	⇒ Country-level technical working groups developed by UNAIDS Theme Groups on HIV/AIDS – inclusive of Government, INGOs, NGOs, Mass Organisations, CBOs, UN other multilateral and bilateral donors ⇒ Mechanism(s) identified for channelling funds under the Strategy (e.g. UNAIDS Theme Group on HIV/AIDS initiated Trust Fund; NAPAC/ AIDSNET umbrella type structure for community-based responses) ⇒ Major donors agree on mechanism for channelling funds to subregional level activity for key results priority areas
CRITERIA FOR RESOURCING DECISIONS	⇒ Collaborating donors agree on core and common criteria for appraisal by individual donors of proposals for funds
ACCOUNTABILITY	⇒ Countries and donors jointly review, on an annual basis, progress against the key results area implementation workplan and agree on further priorities for collaborative action
STRATEGY MANAGEMENT OPTIONS	⇒ Subregional strategy co-ordinator to facilitate annual meeting of participating countries and donors.

Using country clusters and agency coalitions. Individual donors are often constrained by policy considerations in their ability to work in countries and sectors. This is a further argument for a subregional strategy since such a strategy allows for better allocation of donor resources, using them where they are best needed. A 'cluster' approach to country/regional programming can thus allow a better focus on inputs and on outputs.

- Within the region, different issues and priorities provide different opportunities in terms of selection of the countries involved in particular country clusters, and thus the selection of donor and implementing agencies involved in particular activities.

As an example of the benefits of this approach, an effective response to migrant labour HIV vulnerability requires action across the subregion and requires implementing agency collaboration. Recently, UNICEF co-ordinated a multi-agency collaboration in preparation of guidelines for rapid applied research on mobile populations. An example of a cluster type approach to mapping population movement is therefore provided below.

Country Clusters: Mapping Migrant Labour and Mobile Population Movement.

CLUSTER	COUNTRIES	CONTRIBUTING FACTORS TO STD/HIV TRANSMISSION
Cluster 1	Myanmar, Thailand & Southern China	Migrant labour & trader movement, including illegal construction workers & sex workers from Myanmar to Thailand; sex, factory and service industry workers from Yunnan to Thailand; & fishermen between Myanmar & Thailand.
Cluster 2	Thailand & Cambodia	Labour & trader movement between the two.
Cluster 3	Thailand & Lao PDR	Labour & trader movement between the two.
Cluster 4	Vietnam & Cambodia	Labour & trader movement including young Vietnamese women working in commercial sex work, and Vietnamese men working in construction.
Cluster 5	Vietnam & Southern China	Migrant labour, traders, ethnic minorities & movement of ethnic Chinese from Vietnam resettled in Yunnan province following 1979 China/Vietnam conflict.
Cluster 6	Vietnam & Lao PDR	Migrant labour, traders & ethnic minorities, including young Vietnamese women in commercial sex work, and Vietnamese men working in construction.

5.4 The Key Result Areas: Detailed Elements of the Strategy

A. CONDOMS

The objective is to increase supply distribution, access and use of quality condoms across all countries in the subregion: this can be achieved through user friendly, non-discriminatory reproductive health service delivery, especially to youth and will utilise condom social marketing approaches which promote use of condoms throughout the general population. Efficiency in regard to this objective will require standardised quality assessment capabilities; sufficient supplies of quality condoms; distribution techniques tailored to reach population groups most vulnerable to HIV/STD which may have difficulty in obtaining condoms, in particular Commercial Sex Workers and their clients, IDUs, unmarried youth, mobile and border populations; and the adaptation of successful projects in the subregion, linking experience across countries of communities, self-help groups, institutions and provinces.

B. STD MANAGEMENT AND PREVENTION

Increased access to and use of quality STD management, treatment and prevention in limited resource settings in the subregion to improve service delivery through the private sector; and increasing women's access to STD management, treatment and prevention, especially through reproductive and primary health services.

Other objectives will include increasing access by unmarried youth to STD management, treatment and prevention through a range of non-discriminatory and user-friendly services and the provision of services tailored to reach vulnerable population groups which have difficulty in accessing STD services.

C. CARE AND SUPPORT

Building and improving care and support in low resource environments in all countries of the subregion through:

- enhancing existing capacity for community care, using a continuum of care approach;
- disseminating relevant low cost nutrition, clinical and palliative care and counselling information, techniques and research across the region.
- undertaking activities to foster compassion and increase support to people affected by HIV/AIDS, and their participation in program and service planning and delivery; and
- undertaking health care worker training and capacity building for public health services utilised by PLWA;
- adapting successful low-resource experiences in the subregion, using a "cluster approach" linking the experience and learning across countries of all communities.

D. BEHAVIOUR DEVELOPMENT AND CHANGE COMMUNICATIONS

Develop and replicate behaviour norm and change activities against the key result areas in all countries of the subregion. This will involve replicating and taking to scale, effective behaviour change communication activities, concentrating and targeting programs on 13-24 year olds, injecting drug users, sex services and mobile populations.

The objective will be to utilise life-skill building approaches (school education, peer education, mass education and community development approaches). It will also aim to adapt successful low-resource experiences in the subregion.

5.5 *Enabling conditions for effective actions in key result areas.*

Action against the four key result areas is already a priority for each country's national response. Yet the enormity and complexity of the task is challenging the capability and resources of individual countries. If the objectives are to be achieved, then certain enabling conditions are essential across the region for effective action to ensure that collaboration on the key result areas will lead to gains which have a significant impact on the epidemic in the subregion. These areas are detailed below.

i. Political commitment and appropriate policy environment: targeting political and "civil society" leaders through subregional fora and inter-country exchange so as to build a common understanding among high-level policy makers, of the determinants, consequences and impact of the epidemic including:

- establishing peer education and advocacy amongst senior policy makers for the development of collaborative workplans to deal with priority issues that require multi-country collaboration; and
- promoting the use of existing fora for subregional advocacy, political commitment building, workplanning and program implementation (e.g. ASEAN Task Force on AIDS,)

ii. Planning capability: there is a need to build a critical mass of strategic planning capacity across key sectors and levels in all countries of the subregion. This requires multi-country involvement in the development, monitoring and review of strategic plans at all levels and across key sectors.

- Initiate and support subregional efforts to adapt and share practical and effective strategic planning tools and experience using a cluster approach linking experience and learning across countries.

iii. Implementing capacity: building a critical mass of implementing capacity across key sectors and levels in all countries of the subregion and adopting a strategic approach across the region to the development and sharing of knowledge, skills and experience critical to the effective implementation of key result area activities.

- Multi-country and donor agreements on capacity development priorities common to the countries in the subregion, and on resource targeting and scheduling.

- Improving the implementing capacity of NGOs, IOs and mass organisations across the subregion.
- Improving the implementing capacity of health care services and health care workers across the subregion.
- Initiating and supporting subregional efforts to adapt and share critical knowledge as to capacity, skills and experience using a cluster approach where appropriate.

iv. Decentralisation: targeting resources and action at the sub-provincial level; improving capacity building, planning and implementation resources at sub-provincial levels, including at the community level and devolution of planning, decision making and accountability: allocating resources conditional on active involvement of and commitment by relevant sectors.

v. Scaling-up: collaborative and complementary activities will be necessary at the sub-provincial level so as to scale-up actions in key response areas and provide opportunities across countries for understanding and applying effective processes and lessons learned. This will involve:

- replicating and sharing successful experiences across countries in key result areas;
- identifying and taking well-demonstrated and effective key result area activities to scale, across a wider range of countries and population groups;
- integrating STD/MCH/RH/PHC programs to reach mobile and other population groups who are most vulnerable to HIV/STD; and
- integrating principles and approaches for reducing harm associated with HIV risk behaviour in programs targeting injecting drug users, mobile populations and other population groups who are most vulnerable to HIV/STD.

5.6 *The Plan for Urgent Action.*

In order to implement the strategy, a detailed plan for action must be developed and priorities established for funding. Implementation of the plan will therefore require establishing a range of key policy and practical outputs as well as verifiable indicators. The main outputs required against the key result areas and enabling factors described above will include:

KEY RESULT AREA 1: Increased supply, distribution, access and use of quality condoms.

Factors required to achieve this output are:

- ***Political Commitment.*** Increased advocacy and consensus-building is required by senior government members in Myanmar, Lao PDR, southern China and Vietnam to provide condoms to young unmarried people; and broaden government policy on condom distribution to make maximum use of private sector distribution channels.

Strategies must be developed to ensure an efficient supply of condoms with governments ensuring that quality assurance standards are met.

- **Planning and Implementation Capacity.** Condom quality must be improved. Local systems of cost-efficient condom production must be developed. Thailand can assist other countries in improving systems for assessing standards of condom quality. Projects employing participatory social communication strategies will be piloted for condom promotion across the subregion. Capacity to integrate condom promotion with HIV/AIDS information and education skills should be assessed and developed in Primary Health Care and life-skills projects targeting young people. Condom marketing requires the development of capacity in marketing, training, logistics and BDCC: current capacities in this regard are not adequate and must be improved. Increased attention to distribution networks is also required, particularly in border areas and migrant populations.
- **Scaling up.** This will need the implementation of widespread social marketing approaches to the distribution and promotion of condoms including increasing the number of distribution points in border areas as well as improved donor co-ordination of projects. Increased condom supply will be essential to vulnerable populations, and in association with IDU programs and migrant communities.
- **Integration** of condom strategies with primary health care and reproductive health programs will be required.

KEY RESULT AREA 2: Increase access to and use of quality STD prevention and management in low resource settings across the subregion.

It is essential that the plan of action aim to achieve improvements in the quality of STD services, thus increasing the availability and accessibility of services for vulnerable populations; as well as basic logistics; and promote and STD prevention practice. Factors required to achieve this output include:

- **Political Commitment.** Promote political commitment to STD services including improvement of human resources, drug supply and training through subregional exchange. Needs assessments of STD drugs and capacity for regional drug production will be required, as will a regional plan for local STD drug production and an update of Essential Drug Lists to include STD drugs.
- **Planning Capacity.** The plan will aim to establish needs assessment across the subregion in STD clinical and syndromic management training capacity; help ensure that national level training capacity in syndromic management exists in each country; analyse opportunities to trial a revolving drug fund for drug utilisation, especially STD drugs; explores private sector/donor/government initiatives to address improved STD drug access for vulnerable populations.

- **Implementing Capacity.** Implement a subregional plan for local STD drug production

ROLE OF COMMUNITIES IN A SUCCESSFUL THAI-MYANMAR CROSS-BORDER INTERVENTION. Successful community-based HIV/AIDS prevention and care activities have been undertaken by local community groups since 1993, through a broad-based partnership of local authorities; local community-based organisations, and World Vision International. The unique nature of this community is their ability and eagerness to be involved in voluntary HIV/AIDS prevention and care activities with the organisations mentioned above. This indicates a level of community awareness which can be attributed to: (a) the visibility of the epidemic in this cross-border setting; and (b) several years of successful national/international, community-based cross-border interventions.

and syndromic management training where national level capacity does not exist. Implement integrated STD services into existing bilateral Primary Health and Reproductive Health programs drawing upon regional expertise (e.g. MSI, RAAC Clinic in Cambodia; Population Council, Ford Foundation, SCF Australia in Lao PDR; and Australian bilateral health sector projects in Cambodia and Laos). Implement innovative projects in the delivery of STD services through private sector and pharmacies (such as the social marketing of STD drug kits or syndromic management through pharmacies). Implement analysis of drug resistance and aetiology of pathogens across the subregion (mapping STDs and drug resistance especially with vulnerable populations).

- **Scaling Up.** Fund on-site training in STD syndromic management in association with high-risk situations across the Subregion (e.g., cross-border areas).

KEY RESULT AREA 3: Increased access to a minimum package of care and support for affected individuals and communities.

In order to attain this objective it will be necessary to build political commitment through identifying and involving key government officials and business leaders, and prepare an advocacy strategy using local epidemiological data and identifying socio-economic consequences of lack of care and support.¹ Increased attention to media involvement will be required. A strategy for securing political support could include acknowledging and assisting the existing health service structures provided by government, especially health services at the village, district or provincial level.

Specific requirements will include: identifying people with planning and implementing skills in government and other political and mass organisations in China, Lao PDR and Vietnam; and providing comprehensive training programs in care and support. Programs should be targeted separately for low and medium-resource settings to increase the capacity among people with HIV/AIDS to participate in program implementation. Program objectives will include the identification of required national and donor resources for implementation; as well as of identifying authorities for scaling up and

¹ The ADB Greater Mekong Subregion project proposal *Targeted Advocacy for High Level Policy Makers* addresses this.

establishing networks so as to assist proponents to use effective planning and budgeting mechanisms as used internationally.

KEY RESULT AREA 4: Behaviour Development and Change Communication (BDCC).

In order to promote BDCC, it is essential that senior officials are better educated to the effects of HIV/AIDS on their economies and people. To build knowledge will require the provision of study tours and workshops to demonstrate the effects of the disease to officials. An example would be law enforcement officials visiting harm-reduction projects for injecting drug users. To further develop BDCC, representation of local, sub-provincial officials on project management committees will be encouraged as will the involvement of local political leaders at the beginning of training and projects in order to increase their commitment to follow-up action.

- Small-scale, cross-border exchange visits to plan programs will be encouraged such as the WVI-assisted project in Kawthaung/Myanmar and Ranong/Thailand. Activities to be developed under the plan that will promote the building of implementation capacity and will include the promotion of technical exchange visits from international donors as well as within the subregion. Workplans will be developed for planning and phasing of technical exchanges and similar criteria are applied to all donor-funded projects. Subregional technical workshops will be held on new and emerging issues and linked to existing UNAIDS programs.

Where appropriate, a task force approach will be adopted including establishing a critical mass of master trainers in the region. This would take the form of an on-going program of capacity building with donor support of national training teams, avoiding one-off training of trainers.

Scale-up activities would include the documentation and marketing of evaluated “best practice” education activities with demonstrated outcomes. These would identify effective programs in BDCC in areas such as life skills, youth, schools and the workplace. Examples of such ‘best practice’ include the UNAIDS AICT BDCC Taskforce AIDSCAP BCC handbooks, and the Thai Red Cross “Friends Tell Friends” manual for workplace prevention. The key to scaling up is the identification of the needs or steps for expanding programs. A regional workshop should be held to identify practical, successful examples that could strengthen this approach. Exchange of multilingual resources and good educational materials in cross-border and migrant worker settings. Activities should support strategic alliances among NGOs/CBOs, multilateral organisations, INGOs, and the private sector in order to establish collaborative programs.

6. Conclusion

Concrete results will only be achieved where there is a shared commitment to co-operative action between the countries, donors, organisations and communities. Co-operative planning and implementation across the subregion will more effectively respond to the challenges posed by the epidemic in the Mekong subregion.