



HIV/AIDS AND DEVELOPMENT IN ASIA AND THE PACIFIC
A LENGTHENING SHADOW

**AIDS IN ASIA
AND THE PACIFIC**

**World Health Organization
Regional Offices for South East Asia
and the Western Pacific Region**

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The Australian Government's Overseas Aid Program

AIDS in Asia and the Pacific

Status and trends

Strategies for prevention and control

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Introduction

AIDS was first recognized as a distinct clinical entity over 20 years ago. Since then it has been estimated that, globally, close to 22 million individuals have died of AIDS, 13 million children have been orphaned and 36 million people are living with the human immunodeficiency virus (HIV) - the cause of AIDS - while, every day, another 15,000 people acquire the virus.

Figure 1

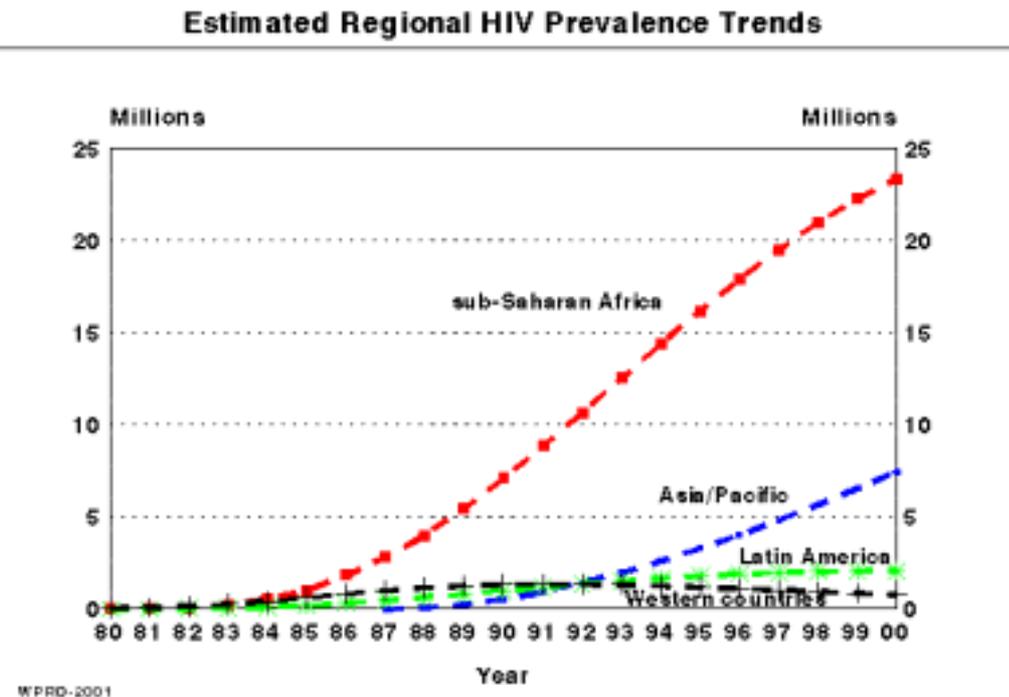


Figure 1 shows the estimated temporal distribution of HIV prevalence in four major country groupings. North American countries, countries in Western Europe and Australia and New Zealand are combined into a grouping of Western countries.

Although HIV transmission has been declining for the past few years in Western countries, it continues to expand in Africa and in Asia. The negative socioeconomic impact of the AIDS epidemic has already been heavily felt in many African countries

HIV/AIDS situation in Asia and the Pacific

HIV was introduced into Asian countries during the early to mid-1980s. The first AIDS cases were detected among men who have sex with men (MSM) in several countries and areas such as Hong Kong (China), Japan, Malaysia and Singapore during the early 1980s. Subsequent indigenous HIV transmission probably peaked during the mid-to-late 1980s.

By the mid-to-late 1980s, increasing HIV transmission was documented among female sex workers (FSW) in Thailand and in parts of India, notably Mumbai (Bombay). Increasing transmission among injecting drug users (IDU) was reported from Thailand, parts of north-east India, and the "golden triangle" area (where the borders of China, Myanmar and Thailand meet).

By the early 1990s, the increasing spread of HIV was evident. In several Asian countries (Thailand, parts of India, Myanmar, and Cambodia), significant heterosexual transmission of HIV was reported, primarily from FSW to their male clients, and then from these infected males to their regular sex partners. Explosive spread of HIV within IDU populations, which can reach very high level of infection within a year or two, continued to occur in Thailand, north-east India, several provinces of China, Malaysia, Pakistan, Myanmar, Vietnam, and most recently, in the late 1990s, in Nepal and Indonesia.

By the beginning of the new millennium, it is estimated that more than 6 million individuals are HIV infected in Asia, about 20% of the worldwide estimated HIV infections among adults. The estimated adult HIV prevalence rates in Asia varied from under 1 per 10 000 in some counties to 2%-3% in Cambodia, Myanmar, Thailand, and in several major states in India.

In Papua New Guinea, an estimated 10,000-15,000 people are currently estimated to be infected with HIV. These numbers are increasing annually by between 15 and 30%.

In the Pacific islands and areas, the first cases of HIV infection were reported in the mid 1980s. As of 2000, over 600 HIV infections (including more than 200 AIDS cases) have been reported. Three areas (French Polynesia, Guam and New Caledonia) have accounted for 80% of reported HIV infections and over 80% of AIDS cases. The next highest reported prevalence rates of HIV are in Kiribati, the Marshall Islands, the Northern Mariana Islands and Tuvalu. Some countries/territories have not as yet reported any HIV infections. The majority of reported cases have occurred among men, with sexual contact with other men being the most frequently reported mode of transmission. However, the proportion of heterosexual cases has been increasing over the last few years. It appears that most of the HIV infections are imported and that there are, as of 2001, no data to suggest that any significant or sustained HIV transmission is occurring in these island countries and territories. However, recent surveys conducted show that curable STI are common (e.g. one in three women was found to have an STI in Apia, Samoa), suggesting a relatively high level of high-risk sexual behaviour.

Encouraging results and Regional cooperation in Asia

Thailand and the Philippines initiated epidemic surveillance systems during the late 1980s and early 1990s, respectively. The experience and data acquired from these surveillance systems were widely shared at the regional level through regional meetings and regular diffusion of results and methodology. As a result, most countries in the region now have better data for estimating their HIV/AIDS status.

Since it was recognized from the beginning of the HIV epidemics in Thailand that most HIV transmission was occurring through commercial sex, major efforts were focused on reducing the number of males visiting FSW and on promoting condom use in all commercial sex interactions (100% condom use program). These efforts substantially reduced the levels of sexual risk behaviour in Thailand with a reduction in the percentage of young adult men visiting FSW (from 60% in 1991 to 10% in 1997) and rapidly increasing condom use in commercial sex encounters, reaching 90%. It is estimated that these behaviour changes have prevented millions of HIV infections in Thailand during the past decade.

Learning from Thailand's success, Cambodia adopted a pragmatic and comprehensive HIV/AIDS prevention program. This encompassed education and communication through a variety of channels and vigorous promotion of condom use during high-risk sexual encounters, in particular through the national "100% Condom Use", which has been implemented since 1998 in entertainment establishments. A steady decline in the number of persons infected with HIV has since been noted in Cambodia.

Although it is not the end of the HIV epidemic in these countries, the success of these programs shows that a sound epidemiologically-based prevention strategy can work. It also shows that national political commitment and leadership to implement sound strategies in a coordinated manner can reverse epidemic spread of HIV when it occurs.

Experts from China, Indonesia, Myanmar, and Viet Nam have recently visited Thailand and Cambodia and are adapting similar approaches for their countries.

Projected Impact of HIV/AIDS in Asia Pacific

In Asian and Pacific island countries and areas that currently have a low HIV prevalence, annual AIDS deaths are projected to be less than 1% of all adult deaths throughout the first half of the coming decade. In Asian countries with moderate HIV prevalence, annual adult deaths will increase by about 5% during this coming decade, with most AIDS deaths among young male IDU. For countries with high HIV prevalence (Cambodia, Thailand, Myanmar, and a few states in India), annual AIDS deaths will increase the total number of annual deaths in the 15-49 year population by up to 40%.

With the possible exception of the few countries in South and Southeast Asia with high HIV prevalence, current and projected numbers of paediatric AIDS cases and maternal AIDS orphans are relatively low and are expected to remain stable in most Asian Pacific countries .

Cambodia can expect to have an increase in HIV-related tuberculosis (TB) cases that is expected to increase the total annual TB case load by about 30% by the end of this decade. Most Asian countries with current low or moderate HIV prevalence can expect only modest increases in HIV-related TB — 5%-10% or less.

Current and Future Challenges to HIV/AIDS Prevention in Asia and the Pacific

The common thread that runs through all extensive or epidemic transmission of HIV in Asia is that the primary HIV risk behaviour groups affected are all socially marginalized and they engage in socially unaccepted and often illegal behaviour(s). Injecting drug use and sexual behaviours are difficult subjects for government or official agencies to deal with. Urgent and universal support for primary prevention and behaviour change programs must be developed on a large scale in most countries in Asia Pacific.

Public Health Interventions

The available interventions for prevention of HIV transmission should be separated into short-term and longer-term interventions.

Examples of short-term interventions are those often referred to as “risk reduction” and “harm reduction” interventions— e.g. routine and consistent condom use with commercial or casual sex partners and provision of safe drug injecting equipment. These interventions remain controversial because their opponents believe that acceptance of these interventions may be interpreted as implicitly condoning these HIV risk behaviours and/or will tend to promote such behaviours. In the Pacific, programs will also need to continue to focus on prevention and control of treatable STI.

The best example of a longer-term intervention is the reduction, modification or elimination of HIV-risk behaviours—having multiple sex partners, especially on a concurrent basis, and/or the recreational use of legal or illegal drugs. These latter interventions are universally accepted, but their impact and application are limited because it takes decades or generations to effect meaningful change and because we still have a lot to learn on the most effective interventions to change human behaviours. Ideally, both types of interventions (short- and longer-term) should be fully implemented.

Some countries have tried to provide routine anti-HIV treatment to HIV-infected persons. However, with the present cost of multi-drug treatment regimes, it is unlikely that most countries will be able to provide optimal HIV treatment to a significant percentage of HIV-infected adults during this decade until significant external funding for treatment programs becomes a reality, as supported by the last United Nations General Assembly meeting focusing on HIV/AIDS global prevention and care.

The short- and long-term interventions needed to be underpinned by one or more of the following strategies -

- Improved testing for HIV and STIs in order to enable monitoring of the epidemic and evaluation of the Government's national program.

- A supportive legal and ethical environment (including laws governing discrimination, workplace policies, child welfare and censorship) in order to protect the rights of people affected by HIV/AIDS.
- Education and training.

Competition for Limited HIV/AIDS Program Support

There is competition for resources between prevention/control programs and treatment/care programs. In the Asia Pacific region, only a few countries or/and areas (e.g. Japan, Republic of Korea, Australia, New Zealand, Hong Kong (China), Singapore, New Caledonia, French Polynesia, Guam) have adequate resources to support both types of programs. In most other countries, there are insufficient resources to adequately support prevention programs and therefore the funding of routine anti-HIV drug treatment is completely out of reach. Also, risk reduction and harm reduction programs that are required for effective prevention of HIV in the Asia-Pacific region continue to be severely under-funded.

With only a few exceptions, most national HIV/AIDS programs in the Asia Pacific are still under-funded, despite the fact that in virtually all of the poorer countries, many foreign donors have provided support for specific projects such as outreach programs for FSW or IDU populations in a few selected districts. HIV/AIDS prevention/control programs in most less-developed Asia Pacific countries and areas require that external donors increase their current HIV/AIDS support very significantly. The challenge is to strengthen institutions to improve the response to HIV/AIDS in countries which do not yet have sufficient capacity to work effectively across a range of areas with donors.

HIV/AIDS in Asia and the Pacific Region in the New Millennium

Asia and the Pacific is a vast and diverse region with a population of nearly 3.5 billion in the most sexually active age (15-49 years) group - representing nearly 60% of the world's population. This region has the potential, because of its sheer size, to have a significant influence on the course and overall impact of the HIV/AIDS pandemic.

In addition to countries with diverse epidemiological patterns of HIV/AIDS - high versus low HIV prevalence countries and different predominant HIV risk behaviour(s) - countries in this region also have extremely diverse capabilities to develop and support public health prevention and control programs.

As of 2001, HIV prevalence in most Asian countries remains low, but there are major public health concerns regarding the future growth potential of HIV/AIDS.

The future of HIV in Asia will be largely dependent on the success of HIV prevention and control programs in countries:

- (1) where extensive heterosexual HIV transmission is occurring, especially those countries with the highest HIV prevalence (Cambodia, Thailand, Myanmar and several large states in India); and
- (2) which have large population sizes such as China, India and Indonesia

In the Asian countries where extensive HIV transmission has occurred during the past decade (Cambodia, Myanmar, Thailand, and parts of India), although HIV transmission may have peaked during the mid-to-late 1990s, HIV prevalence is not expected to decrease rapidly.

In countries where extensive HIV spread has occurred primarily in IDU populations (China, parts of India, Indonesia, Malaysia, Nepal, Viet Nam), this pattern is projected to continue during this decade. Of concern is the overlap between IDU and sex work in some countries which has the potential to lead to general population epidemics. Public health interventions, directed at minimizing HIV transmission among IDU groups, can only be effective if these interventions are fully supported by national governments. In the absence of extensive heterosexual transmission, HIV prevalence rates in the total 15-49 year old populations of these countries are not expected to increase to much more than about 0.5%.

Where pockets of high-risk heterosexual behaviours exist, some extensive HIV transmission may occur, when and if, a sufficient number of HIV infections are permitted to accumulate.

In addition, in countries with rapid economic development, increasing mobility and changing social norms can be observed, leading to higher sexual risk behaviours and a potential for extensive heterosexual HIV transmission.

While there are relatively few recorded cases of HIV infection in most Pacific island countries and areas, there is the potential for HIV to become a more serious problem, since many facilitating factors for the potential spread of HIV/AIDS co-exist.

Therefore, HIV/AIDS will continue to pose an immense challenge to public health workers throughout the region because all of the major HIV risk behaviours are present in virtually all Asian countries, albeit in significantly varying patterns and degrees.

To ensure that extensive HIV transmission will not occur or will not continue to occur in Asia and the Pacific, public health programs must fully implement the "100% condom use" program for all commercial sex encounters. Such programs are urgently needed not only in high HIV prevalence countries but also in low HIV prevalence countries before HIV prevalence rises to detectable levels. Similarly, where HIV prevalence is high or still low among IDU populations, public health programs should aggressively implement or at least fully support harm reduction programs for IDU groups to prevent HIV transmission in this very vulnerable risk group.

To what extent HIV levels may increase in the new millennium will depend on how effective national AIDS programs will be in implementing risk and harm reduction interventions in FSW and IDU populations in Asia and in young adults in the Pacific.

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