Strategies to Control AIDS/HIV in Asian Region

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It was estimated that 4.8 million people in Asia were already infected with HIV. Many countries including India, Myanmar, Thailand, Cambodia, some part of Vietnam and China is experienced a severe HIV epidemic. All categories of HIV risk behaviors and factors are known to exist in most countries of the region but with different degree. Experiences and lessons from some countries such as Thailand suggested that to effectively prevent HIV, it is necessary to have a national AIDS program, adequate budget from the country, and with partnerships from all government and non-government sectors. There are five important strategies which should be implemented with wide coverage: STDs service, condom promotion in all sex establishments, HIV screening for blood supply, HIV surveillance and information dissemination through mass media. With this prevention strategies, there is evidence of decrease of STDs and declining of HIV infection among young Thai male. Because HIV is the effect from poverty, inequality of socioeconomic development, National AIDS program should not neglect the opportunity to reform the unfavorable social or economic situation. Asian countries can and must strengthen their collaboration for joint HIV control program with full commitment and contribution.

HIV, STD, condom, key strategies, Asia

Asia is the prime concern for the world regarding the HIV/AIDS epidemic in this decade and the next century. Because it contains 55% of the whole global population and is the last continent to be hit by HIV pandemic. Appropriate strategy and program before or at the beginning of epidemic should save millions of life. Priority questions for HIV prevention should include A. What is the extent of current and potential HIV infection? B. What are the local determinants of the epidemic? C. What are the role of governments, communities and individuals in responding to the epidemic? D. What is known about successful behavior change at the individual level? E. What is known about the organization and implementation of successful responses? F. What are the most important strategies to implement? This paper is a brief summary of the threat of the HIV epidemic in the region and key strategies which is possible to implement.

THREAT OF HIV IN THE REGION

HIV and AIDS were reported in different countries of the region since the mid of 1980. Before the Vancouver meeting, a group of experts from around the world has estimated that in mid 1996 there are 4.8 millions HIV infected people in Asia. Countries that are severely hit by the epidemic are located in the south or south-east Asian region including Thailand, Myanmar, Cambodia, Southern and Western part of India. The epidemics in these countries are predominantly spreading through heterosexual contact by the frequent practice of men visiting sex workers. Sharing of needles among injecting drug users also played a significant role early in the epidemics of some countries especially in the golden triangle region including Thailand, Myanmar, southern China, northern Malaysia and some cities in Vietnam.

Extensive spread has not been documented in others countries such as Japan, Korea, the Philippines, Singapore, Hong...
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In Bangladesh, Indonesia, Nepal, and Sri Lanka the situation is not clearly established because of limited testing.

However, most of the Asian countries do have problem of commercial sex workers (CSWs), injecting drug user (IDUs), gender inequity, men having sex with men. The potential of HIV epidemic is already existed and ready to start once the HIV had spread and reach it threshold in each area.

KEY STRATEGIES IN HIV PREVENTION

Among the severely affected by HIV epidemic, there are some positive evidences from Thailand that showed a satisfactory outcomes from the National HIV control program. This paper would like to highlight five major strategies which is believed to help curb the HIV epidemic in Thailand.

1. Deliver of STDs Services
   It was clearly demonstrated in a community-based randomized trial in rural Tanzania that establishment of an STD reference clinic, staff training, regular supply of drugs, regular supervisory visits to health facilities, and health education about STDs could reduced HIV incidence by about 40% (1.9% in comparison communities and 1.2% in intervention study) with no change in reported sexual behavior was observed in either group. In Thailand, people are easily access to STD treatment by buying effective antibiotics over the counters or go to either government or private clinics. Most government clinics in big cities also provide special services including condom distribution and outreach educational activities for CSWs in responsible area. It is believed that the synergistic effect of STD services, condom promotion in all sex establishments and awareness of HIV epidemic has played a crucial role to reduce all STDs incidence. For example, gonococcal urethritis decreased from 4.5/1000 population in 1985 to 0.5 per 1000 population in 1995 (Figure 1).

2. Condom Promotion
   The Thai Ministry of Public Health had launched the policy of condom promotion in all sex establishments particularly among the low-price places where sex workers has to serve by average 3-5 clients per night. At present, the condom used rate by clients has increased to a high level of 80-90% in most area. The key factors that contributed to the high usage of condom is the active role of STD staff who frequently visited and convinced the owner of the sex establishments to collaborate and enforce this practice to all CSWs and clients. Support from the local police departments and governors are also very crucial to the success. Each year the ministry has disseminated 50 million pieces of free condom to overall country. It should be emphasized that access to CSWs and the owners of the sex-establishment is the most important step to deliver the intervention. In Cambodia, the promotion of condom by PSI (Population Service International) , a non-government organization, using social marketing approach is also very promising. Condom were sale at low price through wholesalers and retailers everywhere instead of limiting clinics or pharmacies.

3. HIV Screening of Donated Blood
   This may be the intervention which depend solely on the responsible of Ministry of Health or medical institute. In Thailand, the policy of HIV screening for all donated blood was adopted very early in the beginning of the epidemic. Each year approximately 700,000 units of blood were screened. Because the prevalent of HIV detected from donated blood were 0.6% - 0.9 %, it is estimated that with the currently

![Figure 1. Incidence of STDs, Thailand All government clinics. Fiscal year 1982-1995.](source)
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Screening program 4000 - 5000 people can be prevented from getting HIV infection. The blood bank also avoid receiving blood from paid donors or donors in special setting such as prisoners because of high HIV prevalent detected in this group. Most Asian countries has adopted this strategies.

4. HIV Information and Education

Since the Thai government has adopted the policy to publicize HIV/AIDS situation in 1989, more and more HIV/AIDS information and knowledge were disseminated by mass media to people from all walks of life. HIV/AIDS were shared and discussed openly in villages, schools, workplaces, closed friends, entertainment places, parliament and politics forum, etc. The awareness of HIV is increasing and young generation were refrain from some risk behavior which are commonly practice by their older generation. For example, 24% of the 1995 cohort of 21-year-old conscript in the Royal Thai Army from northern region visit CSWs in the past twelve months when compared to 57% among 1991 cohort.6

5. HIV Surveillance

In order to detect the magnitude and trend of HIV spreading it is necessary to have behavior and serosurveillance which is far more timely and valuable than number of reported AIDS cases. The Ministry of Health coordinate the serosurveillance bi-annually among CSWs, STDs attendee, pregnant and IDUs in all township of 76 provinces. The Royal Thai Army also conduct serosurveillance among new conscripts. Both serosurveillance information were used to alert the public and authorities at the beginning of the epidemic and help in assess the impact of the national program. The serosurveillance among conscripts and STDs attendee informed us that, with all the mentioned strategies among conscripts before the epidemic was level-off in this group. The prevalent is peak with 4% in mid 1993 and decreased to 2.5 in 1995 (Figure 2). By roughly estimation, between 10,000 -20,000 young men at the age of 15-21 years old were prevented each year. However, the sero-prevalent trend in women group such as CSWs and pregnant women is still worrisome. Since many Asian countries are in the beginning of epidemic, HIV serosurveillance and behavior surveillance should be a priority area. Based on the Thai experiences, serosurveillance system can be start with simplicity and then modify to fit for the evolving phase of the epidemic.10

TO ORGANIZE AND GENERATE THE RESPONSES

Because HIV/AIDS is not merely a health problem but it is originated from improper socioeconomic development both at the national and international level. The Ministry of Health can certainly not accomplish the whole spectrum of preventive interventions which must involve the authorities from other government or business sector. It is then necessary to establish a National AIDS program, build up a partnership inside the country, and push for a socioeconomic reform in the long run.

National AIDS Program

There are four main patterns of organizational response by Asia governments. The first pattern of response shows the Ministry of Health as the principal agent, hence a focus on surveillance, blood supply issues and limited health education. The second pattern is where the Ministry of Health is responsible to mobilize and maintain coordination with other ministries and agencies. In the third pattern, a quasi independent authority is established to manage and orchestrate the response. Finally, the HIV/AIDS program responsibility is placed within the highest political office of the country. The world bank study has described an effective national AIDS program with the following characteristics a) the chairperson of the National AIDS Committee needs to have the rank of minister or higher b) multi sector from various ministries such as ministry of interior who control the police, ministry of education, office of mass communication authorities, etc., c) involvement of NGO d)
full time national AIDS manager and secretariat offices e) budget allocation must be decided by the National AIDS committee.

Build up Partnerships Inside the Country

Partnership for HIV/AIDS prevention and control program should include: government organization, philanthropic group, people with HIV/AIDS, communities, academic and researchers. The National AIDS program manager play a crucial role to build and keep a true partnership spirit. The key of partnership is to invite, to provide budget and technical support, to compromise for the different point of views in some issues.

Socioeconomic Reform

Most of the study has identified that low socioeconomic and educational group experienced more risk than group with higher status. For example, among the conscripts in Thailand with less than 6 years educational background had 2.5 times incidence infection higher than those with 9 year or higher background [12]. From this point of view, HIV/AIDS epidemic should be a good reason for government to invest more in education and reduce the socioeconomic gap. With this believe, the next 5 year plan for HIV/AIDS control program in Thailand was included in the 8th National Economic and Social Development Plan of the country which will give priority to human as the center of all development program.

THE NEXT CHALLENGE: REGIONAL COLLABORATION

One important characteristics of the globalization is the free movement of people, culture and information from one country to another country without border and less limitation. People mobility occurred overall the region either in the form of working purposed, sex business, tourist, and refugees etc. For example, thousands of illegal workers from Myanmar and Cambodia were employed in Thailand. These people were likely to get HIV infection easily than local people because of inaccessible to education and health services. There are many collaboration between Asian and western countries in term of research, academic and support for HIV prevention program. Asian countries should also build up more and more collaboration among themselves in HIV prevention program by sharing resources and closely working together. Currently, many Asian countries can achieve a high economic growth rate and could certainly contribute to the joint HIV program on a mutual benefit and respect with other countries.

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