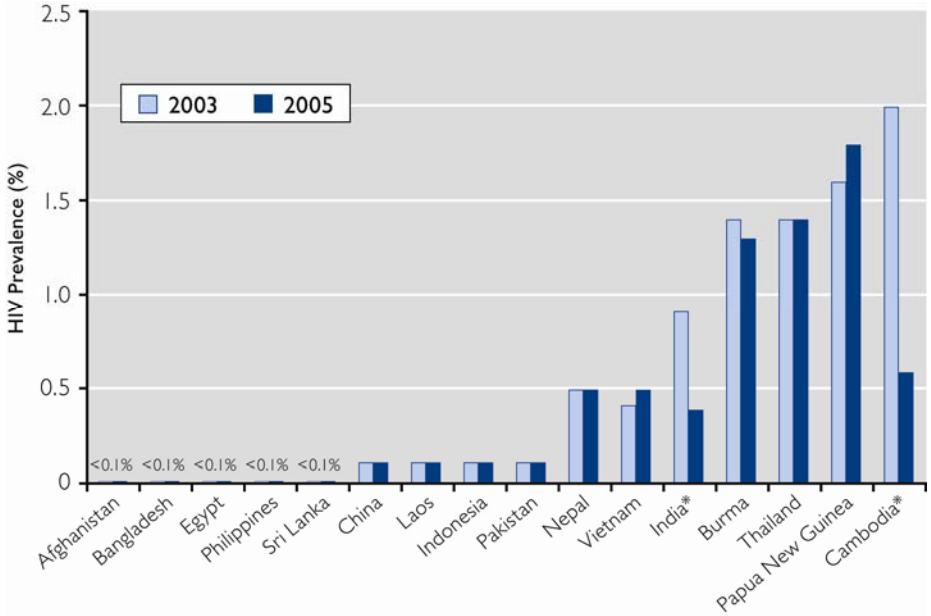
HIV/AIDS HEALTH PROFILE

Asia and the Near East

Overall HIV Trends

National HIV infection levels in Asia and the Near East (ANE) are low compared with those in Africa. HIV prevalence is highest in Southeast Asia, with wide variation in epidemic trends between different countries. Burma, and Cambodia show declines in prevalence, but the epidemic is growing at a particularly high rate in Indonesia (particularly, in the Papua Province) and Vietnam. In East Asia, there were almost 20 percent more new HIV infections in 2007 compared to 2001. In South and Southeast Asia, the number of new HIV infections decreased from 450,000 in 2001 to 340,000 in 2007. In the Middle East and North Africa, the number of new HIV infections in 2007 remained approximately stable. Even though prevalence rates may be low, the large populations of many Asian nations mean that large numbers of people have HIV infection. For the Asia region, the latest estimates show that 4.9 million people were living with HIV in 2007, including 440,000 people who became newly infected in the past year, and that AIDS claimed approximately 300,000 lives in 2007 (UNAIDS, November 2007). In East Asia, approximately 800,000 people were living with HIV, and AIDS claimed 32,000 lives in this subregion in 2007, according to UNAIDS. In the Middle East and North Africa, 380,000 people are living with HIV, and 25,000 people died of AIDS in 2007, according to UNAIDS.

Trends in HIV Prevalence, 2003–2005



Source: UNAIDS 2006 Report on the Global AIDS Epidemic and UNAIDS 2006 Epidemic Update
*Cambodia data are from the 2005 Cambodia Demographic and Health Survey. India data are from the National Family Health Survey 2005-06. The decline in HIV prevalence observed between 2003 and 2005 in both countries is probably due to a change in the methodology used to calculate HIV prevalence.

The figure on the previous page shows recent trends of HIV prevalence in selected ANE countries. Cambodia and Thailand, two countries that successfully curbed their earlier epidemics, are designing and implementing programs to reduce HIV transmission among groups who were not the central focus of previous responses, such as injecting drug users (IDUs), sex workers, and men who have sex with men (MSM). Thailand has made considerable progress providing HIV treatment to 88 percent of those who need it, according to a recent report (WHO/UNAIDS/UNICEF, Towards Universal Access, April 2007). In Cambodia, the national HIV prevalence has fallen to an estimated 0.6 percent among the adult (15–49 years) population in 2006, down from a peak of 2 percent in 1998.

India has a lower prevalence than Cambodia and Thailand but has significantly more people living with HIV infection, an estimated 2.5 million in 2006, according to the 2006 National Family Health Survey. However, HIV prevalence in India varies widely between states and regions. Although the majority of people living with HIV are residing in four southern states (Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu), prevalence tends to be concentrated in certain districts. HIV prevalence in southern states overall is four to five times higher than in northern states. Data from 2006 sentinel surveillance show stable or declining prevalence among pregnant women in the four southern states, but prevalence is high among sex workers and rising among IDUs, and MSM in a few states. Knowledge about HIV/AIDS is limited in India, with only 84 percent of men and 61 percent of women saying they have ever heard of AIDS.

In Vietnam, a focus country in the U.S. President's Emergency Plan for AIDS Relief (Emergency Plan/PEPFAR), the epidemic continues to increase, with HIV having been detected in all 64 provinces and all cities. In 2005, the number of people living with AIDS reached 260,000 (twice the number in 2000), largely because of use of contaminated injecting equipment and unprotected sex with nonregular partners or sex workers. Prevalence increased from 9 percent in 1996 to 34 percent in 2005 among IDUs.

Risky behaviors (often more than one) continue to sustain serious AIDS epidemics in Asia, the Middle East, and North Africa. At the heart of many of ANE's epidemics lies the interaction between injecting drug use and unprotected sex, much of it commercial. The characteristics of transmission, such as the percentage attributed to IDUs or sex workers, vary greatly among countries. Most infections occur around corridors or areas of development and industrialization where mobile populations, migrant workers, and sex workers are key factors in transmission.

The rate of HIV infections in the region attributed to injecting drug use is growing. In China and Indonesia, injecting drug use is the leading cause of HIV infection at 44 percent. Although prevalence is low in China and Indonesia at 0.1 percent, 650,000 and 170,000 people, respectively, are currently living with HIV/AIDS due to the large population size of the two countries. For instance, in Jakarta, more than 40 percent of IDUs tested HIV-positive in 2005. In some South and Southeast Asian countries, such as Pakistan, HIV prevalence is increasing among IDUs. In Karachi, one study found a dramatic increase in HIV prevalence among IDUs, from under 1 percent in 2004 to 26 percent in 2005. The Ministry of Health found that 48 percent of IDUs in Karachi and 82 percent in Lahore had used nonsterile syringes in the week before a 2004 survey. A study among IDUs in Karachi and Rawalpindi found only about half knew HIV could be transmitted through unclean needles. IDUs and sex workers are Burma's most-at-risk populations (MARPs), with 43 percent and 32 percent, respectively, found to be HIV-positive in 2005, according to UNAIDS. However, the epidemic is showing signs of a decline, with HIV prevalence among pregnant women at antenatal clinics dropping from 2.2 percent in 2000 to 1.5 percent in 2006.

In the Middle East and North Africa, inadequate surveillance systems, especially among most-at-risk groups, make it difficult to discern the patterns and trends of the diverse epidemics.

HIV/AIDS is also a highly stigmatized illness in Asia and the Middle East because of its association with sexual and drug use behaviors. Often, it affects those considered to be outside the mainstream of society, including MSM, IDUs, and sex workers. The level and type of discrimination varies from country to country. For example, only 26 percent of women who responded to a survey in Egypt would care for a sick family member who had AIDS, whereas 93 percent of women in Vietnam would do so. However, in Vietnam half of the men would keep their family member's HIV status a secret, whereas only 21 percent of men in the Philippines would do so. Failure to address stigma can deter individuals from getting tested, further perpetuating the epidemic. Addressing stigma and discrimination will require a comprehensive multisectoral response that includes changing social and cultural beliefs and behaviors and modifying policies at the government, employer, and educational levels.

HIV co-infection with tuberculosis (TB) is a major concern for the ANE region. According to the World Health Organization, the ANE region has the highest rates of TB in the world, and 11 out of the world's 22 high-TB-burden countries are ANE countries. HIV suppresses the immune system, which makes a person more susceptible to contracting TB. TB is also one

of the main causes of death among HIV-positive persons. In Asia, more than 2 million people with TB are co-infected with HIV. The HIV prevalence rate among incident TB cases in the ANE region ranges from less than 0.05 percent in Iraq and Afghanistan to 9.7 percent in Papua New Guinea.

Economic and Social Impact of HIV/AIDS in Asia and the Near East

Illness, disability, and death associated with the HIV/AIDS epidemic have harmful social and economic effects. The vast majority of people who have the disease are between the ages of 15 and 49, and often the under-30 age group is the most affected. This changes a population's demographic structure and poses a challenge to the systems for supporting dependent populations such as children and the elderly.

The economic and social effects of HIV/AIDS are felt from the family level, where families experience the death and incapacity of loved ones, to providers who must cope with the burden of caring for the sick and dying. The International Labor Organization found in 2003 that the average monthly expenditures for families of people living with HIV/AIDS (PLWHA) in New Delhi exceeded income, in part because of the costs of medications. Food security is threatened by the effects on food production and the reduced ability of households to afford a nutritious diet. School enrollments decline, and the payoffs of investments in education are undercut by high death rates among young adults.

The economic costs of addressing HIV/AIDS and its effects, both in the health sector and other economic sectors, divert resources from other important needs and from investments critical to economic development. UNAIDS estimated in 2002 that providing antiretroviral therapy (ART) to all those in need in the Mekong subregion alone would cost $250 million in 2007. The costs also divert resources from other public health issues. For instance, a 2003 United Nations Development Program (UNDP) assessment in Vietnam suggested that mounting a comprehensive response to HIV/AIDS could absorb nearly 5 percent of public health spending by 2007. In many cases, the impact of the epidemic on families, communities, and countries has feedback effects that influence the epidemic's future course. For example, poverty and the breakdown of social and economic systems impair community systems that could help stem the spread of infection.

Poor women in the ANE region are particularly vulnerable to HIV/AIDS. Poor economic circumstances can limit a woman's mobility and force her to stay in situations where physical and emotional well-being are at risk. Dispossessing women of land and other means of production at home and the lack of formal skills to participate in economic activities can lead women to travel to urban areas in search of work. If they are unable to find a job, some are forced into commercial sex work or other vulnerable situations that can increase their risk of contracting HIV. Human trafficking is increasing in all the Mekong subregion countries. Women trafficked into sex work are particularly vulnerable to HIV. They tend to work in lower-class, often underground, brothels where they may be forced to service several clients each day. They often have no power to insist on condom use, even if they understand the risk of HIV/AIDS and other sexually transmitted infections (STIs).

Finally, HIV/AIDS has orphaned many children who are now raised by extended family members. In Thailand's Chiang Mai province, for instance, a large proportion of children who have lost one or both parents to AIDS are being cared for by grandparents and other extended family members, according to a 2004 study cited by UNAIDS. As parents die, the effects on children cannot be overstated. Many children orphaned by HIV/AIDS lose their childhood and are forced by circumstances to become income and food producers or caregivers for sick family members. They suffer their own increased health problems related to increased poverty and inadequate nutrition, housing, clothing, and basic care and affection.

National/Regional Response

The urgency of the issue and the ease with which HIV/AIDS crosses borders is prompting the ANE region and subregions to pursue a coordinated response to the epidemic. In 2007, the South Asia region held an intercountry consultation on the prevention of HIV among IDUs. Multisector country teams participated from Afghanistan, Bangladesh, Burma, India, Nepal, Pakistan, and Vietnam. Actions were identified to scale up HIV prevention among IDUs. In the Arab region, UNDP worked with UNAIDS to mobilize religious leaders to speak out about HIV/AIDS. In December 2004, 80 key religious leaders from 18 Arab countries signed the Cairo Declaration, calling for solidarity with PLWHA. Since then, five subregional meetings were held to teach religious leaders about the reality of HIV/AIDS in the region and its impact on communities.

Most countries in the region have HIV/AIDS programs and policies. Although institutional capacity and financial resources are limited, many countries are making progress in responding to the epidemic. However, challenges remain, and stigma and discrimination persist.

The following are examples of the status of United States Agency for International Development (USAID)-assisted countries' HIV/AIDS policies and programs.

- India has taken an aggressive stance toward HIV/AIDS since 2004, implementing the third phase of its National AIDS Control Programme, designed to reverse the spread of HIV/AIDS by 2012. The country is mobilizing its response by using prevention, care, support, and treatment, increasing funding for HIV/AIDS activities, and establishing the National AIDS Council.

- Cambodia's National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS, 2001–2005, concentrates on changing individual behaviors and the socioeconomic, legal and political environment. The National Strategic Plan for 2006–2010 builds upon this approach and calls for expanded HIV sentinel surveillance and behavioral surveillance systems.

- Thailand reinvigorated its HIV/AIDS prevention and control efforts in 2006. Thailand's HIV/AIDS activities include conducting a public education campaign, improving STI treatment, discouraging men from visiting sex workers, promoting condom use, and requiring sex workers to receive monthly STI tests and carry records of their test results.

- Vietnam's National Strategic Plan on HIV/AIDS Prevention, 2004–2010, provides the framework for a national response to the epidemic, calling for mobilization of government-, party-, and community-level organizations across multiple sectors.

- Pakistan's Medium Term Development Framework, 2005–2010, includes among its goals the halving of HIV/AIDS prevalence in MARPs and pregnant women. The new National Strategic Framework, 2007–2011, broadens the scope of HIV/AIDS control efforts established by the Framework for 2002–2006 by including women, children and young adults in prevention efforts.

- Egypt's National Strategic Plan, 2006–2010, builds on the successes of the previous five-year plan and is designed to maintain the low prevalence of HIV/AIDS and improve health care services for those infected or affected by the disease.

- Jordan is implementing its National Strategic Plan on AIDS for 2004–2009, which recommends legal and policy reform, intensification of prevention efforts, and provision of ART.

Businesses have a stake in responding to the epidemic that affects their workforce and can reduce the markets for their goods. As a result, the private sector is becoming more involved in HIV prevention efforts as shown through the following examples from India and China. Reliance Industries Limited, India's largest private sector company, established a medical center to treat TB and AIDS. Company physicians and local nongovernmental organizations (NGOs) reached 300,000 people through prevention, testing, counseling, and ART. In China, UNDP launched an HIV awareness campaign with EPIN Technologies, a leading player in the country's new media industry. The campaign reached millions of passengers on board trains through education clips with basic facts about HIV/AIDS and the need to treat those living with HIV/AIDS with tolerance.

The Global Fund to Fight AIDS, Tuberculosis and Malaria has approved grants to most of the ANE countries to implement HIV/AIDS responses. The U.S. Government provides one-third of the Global Fund's contributions.

USAID Support in Asia and the Near East

USAID programs in ANE are implemented in partnership with the President's Emergency Plan for AIDS Relief. The Emergency Plan is the largest commitment ever by any nation for an international health initiative dedicated to a single disease – a five-year, $15 billion, multifaceted approach to combating the disease in more than 114 countries around the world. To date, the U.S. has committed $18.8 billion to the fight against the global HIV/AIDS pandemic, exceeding its original commitment of $15 billion over five years.

In ANE, USAID work with PEPFAR places special emphasis on the focus country of Vietnam, as well as Cambodia and India. In addition, HIV/AIDS programs are also implemented in a number of other countries, some including Bangladesh, Burma,

China, East Timor, Egypt, Indonesia, Jordan, Laos, Nepal, Pakistan, Papua New Guinea, the Philippines and Thailand. Examples of USAID assistance include the following activities and interventions:

- USAID implemented a program in Bangladesh to assist local NGOs working with vulnerable groups to educate people on HIV-risk reduction, improve knowledge about and treatment for other STIs, minimize contextual and policy-related constraints concerning HIV/AIDS, increase linkages between prevention and care, and improve monitoring and evaluation of HIV prevention programs.
- In Cambodia, USAID assisted with referrals for orphans and vulnerable children and HIV-positive women to receive care and treatment from other agencies.
- In India, 23,000 individuals received ART in 2006.
- In Vietnam, 202,500 pregnant women in 2006 received mother-to-child transmission services.
- USAID transferred state-of-the-art national surveillance capacity to Indonesia's Central Bureau of Statistics and Ministry of Health; provided training for staff and equipment to perform quality diagnostic services and treatment to 91 HIV counseling and testing sites and 66 STI clinics in nine provinces; and initiated HIV/AIDS counseling and testing at TB sites in DKI Jakarta and Central Java.
- In China, USAID-supported programs increased levels of condom use among MARPs in hot-spot locations
- USAID efforts in Egypt focus on conducting surveillance and prevention in MARPs, educating health providers about diagnosis and treatment, and increasing awareness in the general population. The Agency supported HIV counseling and testing centers, behavior change and prevention messages, and blood safety practices.

Important Links and Contacts

USAID HIV/AIDS Web site, ANE: http://www.usaid.gov/our_work/global_health/aids/Countries/ane/hiv_summary_asia.pdf
For more information, see *http://www.usaid.gov/our_work/global_health/aids*

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