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HIV/AIDS HEALTH PROFILE

Southeast Asia Region

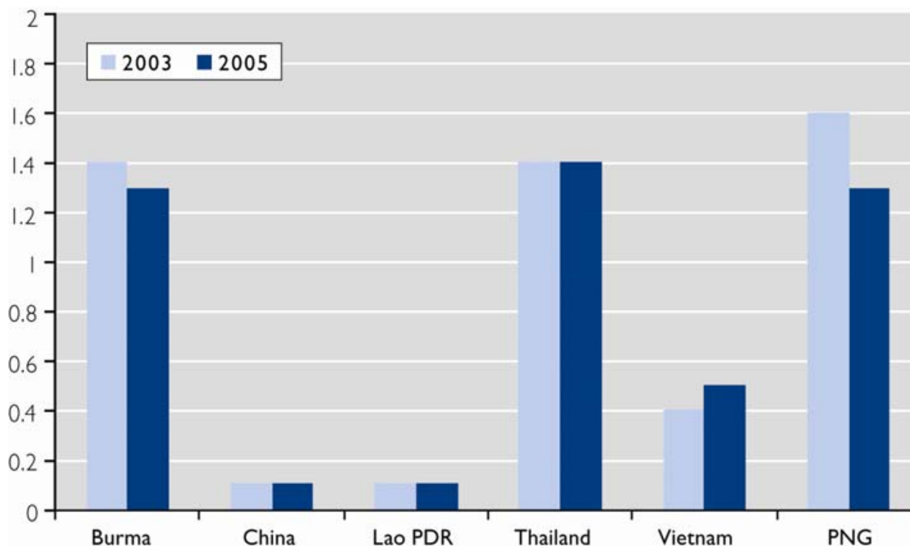
Overall HIV Trends

The Southeast Asia region is of increasing concern in the global HIV/AIDS pandemic. The combination of injecting drug use, mobility within and between countries, the sex industry, stigma, discrimination and poverty makes the region a fertile ground for the spread of HIV/AIDS. The South and Southeast Asia region are home to nearly 4 million HIV-infected individuals and some of Asia's highest national HIV prevalence rates.

HIV-tuberculosis (TB) co-infections, which pose a challenge to providing treatment and care for both diseases, are of increasing concern in the Southeast Asia region. TB prevalence varies across the region, ranging from 170 cases per 100,000 people in Burma to 475 cases per 100,000 people in Papua New Guinea, according to the World Health Organization. In Thailand, which has 204 TB cases per 100,000 people, approximately 7.6 percent of adult TB patients are HIV-positive. In Burma, 7.1 percent of adult TB patients have HIV. Although HIV prevalence in adult incidence of TB cases is low in China, the country has 208 TB cases per 100,000 people.

Thailand has a generalized HIV/AIDS epidemic and the highest adult HIV prevalence rate in the region. After Thailand's first case of HIV/AIDS was reported in 1984, the incidence of infection increased steadily. In 1991, the government adopted a strategy to combat the disease, and in recent years, the number of new infections has declined. HIV prevalence has remained constant from 2003 to 2005, at 1.4 percent. Thailand's early cases of HIV/AIDS occurred primarily among men who have sex with men (MSM); in 2005, 28.3 percent of MSM in Bangkok were HIV positive, according to UNAIDS. After MSM, the virus spread rapidly to injecting drug users (IDUs), where prevalence has ranged from between 30 and 50 percent in 2007.

HIV Prevalence Rate Among Adults Aged 15-49 for 2003 and 2005



The next group to be affected by the epidemic was sex workers and their clients. However, HIV prevalence has been on the decline among this group since the mid-1990s. There have been recent changes in the nature of the epidemic in Thailand. In 2005, more than four in 10 new infections were among women, the majority of whom were infected through intercourse with long-term partners.

Burma is also faced with a generalized epidemic, with an adult HIV prevalence of 1.3 percent. According to UNAIDS, the country has one of the most serious HIV epidemics in Southeast Asia. The Government of Burma's limited response to HIV/AIDS in the early years of the epidemic allowed HIV to spread relatively freely for more than a decade, but a recent scaling up of HIV/AIDS activities may have slowed the epidemic. HIV prevalence among pregnant women declined from 2.2 percent to 1.5 percent from 2000 to 2006, according to UNAIDS. From 2000 to 2004, HIV prevalence among adults seeking treatment for other sexually transmitted infections (STIs) dropped from 7 percent to 3 percent for men and from 12 percent to 6 percent for women. However, prevalence among IDUs and sex workers, at 43 percent and 32 percent, respectively, remains high. HIV prevalence of 2.2 percent among 15- to 24-year-olds is also a cause for concern. Antiretroviral treatment (ART) services are improving but still do not reach more than 7 percent of those in need, according to UNAIDS.

In contrast to Burma, Vietnam's epidemic continues to grow. Adult prevalence is 0.5 percent; HIV has been detected in all 64 provinces; and the number of people living with HIV doubled from 2000 to 2005. The use of nonsterile injecting drug equipment is common. In 2005, infection levels among IDUs in Hanoi and Hai Phong were 63 percent and 67 percent, respectively, according to UNAIDS. Often overlapping with IDUs, sex workers are also a high-risk group, with HIV prevalence of about 16 percent in 2005. A 2004 study found HIV prevalence of 30 percent among sex workers in Hai Phong. The data on MSM are limited, but a 2003 survey found that 8 percent of MSM in Ho Chi Minh City were HIV-positive. As of 2006, 17 percent of HIV-positive women and men were receiving ART.

HIV Estimates in the Mekong Region	
Burma	
Total Population	47.4 million (mid-2007)
Estimated Number of Adults and Children Living with HIV/AIDS	360,000 (2005)
Adult HIV Prevalence	1.3% (2005)
HIV in Most-at-Risk Populations	
Commercial Sex Workers	32% (2005)
IDUs	43% (2005)
MSM	-
China	
Total Population	1,321.8 million (mid-2007)
Estimated Number of Adults and Children Living with HIV/AIDS	650,000 (2005)
Adult HIV Prevalence	0.1% (2005)
HIV in Most-at-Risk Populations	
Commercial Sex Workers in Yunnan province	20% (2006)
IDUs in parts of Xinjiang, Yunnan, and Sichuan provinces	>50% (2006, 2005)
MSM in Beijing	3.1-4.6% (2003, 2006)
Laos PDR	
Total Population	6.5 million (mid-2007)
Estimated Number of Adults and Children Living with HIV/AIDS	3,700 (2005)
Adult HIV Prevalence	0.1% (2005)
HIV in Most-at-Risk Populations	
Commercial Sex Workers	0-1.1% (2001)
IDUs	<5% (2005)
MSM	-
Thailand	
Total Population	65 million (mid-2007)
Estimated Number of Adults and Children Living with HIV/AIDS	580,000 (2005)
Adult HIV Prevalence	1.4% (2005)
HIV in Most-at-Risk Populations	
Brothel-Based Sex Workers	7.7% (2005)
IDUs	30-50% (2007)
MSM in Bangkok	28.3% (2005)
Papua New Guinea	
Total Population	5.8 million (mid-2007)
Estimated Number of Adults and Children Living with HIV/AIDS	46,275 (2006)
Adult HIV Prevalence	1.3% (2006)
Vietnam	
Total Population	85.2 million (mid-2007)
Estimated Number of Adults and Children Living with HIV/AIDS	260,000 (2005)
Adult HIV Prevalence	0.5% (2005)
HIV in Most-at-Risk Populations	
Commercial Sex Workers	16% (2005)
IDUs in Hanoi	63% (2005)
MSM in Ho Chi Minh City	8% (2003)

As in Vietnam, high rates of interaction between at-risk groups, particularly IDUs and sex workers, have led to a confluence of multiple concentrated epidemics in China, where 0.1 percent of adults are HIV-positive. HIV infections have been reported in

all of China's provinces, with the majority of cases occurring in the provinces of Guangdong, Guangxi, Henan, Xinjian, and Yunnan, which border Burma, the Lao People's Democratic Republic (PDR), and Vietnam. HIV prevalence is greater than 50 percent among IDUs in parts of Xinjian, Yunnan, and Sichuan; as high as 20 percent among sex workers in Yunnan; and 4.5 percent for MSM in Beijing, according to data from 2005 and 2006 cited by UNAIDS. Rural populations, the poor, and those living along transport routes are also vulnerable. The Government of China has adopted a program to provide free ART, covering 27 percent of HIV-infected women and men in 2006.

Lao PDR also has a low adult HIV prevalence rate of 0.1 percent, but this does not necessarily indicate low risk. Its geographical location, injecting drug use, and unsafe sexual practices put Lao PDR in danger of an expanded epidemic. Nearly 5 percent of IDUs were found to be HIV-positive in 2005. Although only 0 to 1.1 percent of sex workers were HIV-infected in 2000, a 2004 survey of STIs among female sex workers found that chlamydia and gonorrhea prevalence was 45 percent in Vientiane; 43.6 percent in the border province of Bokeo; and 27.9 percent in the southern province of Champasak, indicating their vulnerability to HIV. As of 2005, 49 percent of HIV-infected women and men were receiving ART, according to UNAIDS.

Papua New Guinea has one of the highest adult HIV prevalence rates in the region. Approximately, 1.28 percent of adults are HIV-positive. In contrast to other countries in the Southeast Asia region, HIV transmission primarily occurs through unsafe heterosexual intercourse, and the majority of reported HIV infections are in rural areas.

Economic and Social Impact of HIV/AIDS in the Southeast Asia Region

Illness, disability, and death associated with the HIV/AIDS epidemic have harmful economic and social 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 supporting dependent populations such as children and the elderly.

The economic and social effects of HIV/AIDS are felt from the family level, where people experience the death and incapacity of loved ones and providers and must cope with the burden of caring for the sick and dying, to businesses, schools, hospitals, and other institutions that suffer the loss of valuable personnel and declines in productivity. Food security is threatened by reduced agricultural production. School enrollments decline, and the payoffs of investments in education are undercut by high death rates among young adults.

Addressing HIV/AIDS and its effects diverts resources from other important needs and from investments critical to economic development. Moreover, in many cases where health services are limited, people seek care outside of the formal health care sector, turning instead to black-market drug sellers who sell medicines that are overpriced, ineffective, or both.

Poor women in the Southeast Asia region are particularly vulnerable to HIV/AIDS. Poor economic circumstances can limit a woman's mobility and force her to stay in situations where her 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 STIs.

Many children orphaned by HIV/AIDS are forced by circumstances to leave school and become producers of income and food, or caregivers for sick family members. Lack of education and limited occupational opportunities impede the children's ability to prepare for the future, increasing their vulnerability for malnutrition, exploitation, and illness. Orphans not only experience emotional distress over the loss of one or both parents but also face stigma, isolation, and discrimination from other community members.

National/Regional Response

The urgency of the issue and the ease with which HIV/AIDS crosses borders prompted the countries in the Southeast Asia region to coordinate their approaches. In 2002, the Asian Development Bank launched Regional Technical Assistance for Information Communication Technology and HIV/AIDS Preventative Education in Cross-Border Areas of the Greater Mekong Subregion. The project included radio soap operas on HIV/AIDS, a clearinghouse facility on HIV prevention education, and vulnerability mapping. In 2004, it was followed by the HIV/AIDS Vulnerability and Risk Reduction Among Ethnic Minority Groups through Communication Strategies project, designed to enable minorities to reduce vulnerabilities and mitigate risks, support regional cooperation in prevention, and monitor and evaluate the effectiveness of communication strategies.

In 2006, the Global Coalition on Women and AIDS, Cambodia's Ministry of Women's Affairs, the Rockefeller Foundation, and the Asia-Pacific Leadership Forum hosted "The Women's Face of AIDS in the Greater Mekong Region" symposium. The symposium, attended by a total of 75 participants from all six Mekong-region countries, brought together policymakers,

networks of women living with HIV/AIDS, and women's organizations to share approaches to addressing increasing rates of HIV infection among women.

All six Southeast Asia-region countries have approved national programs to address HIV/AIDS:

- 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 the test results.
- Burma's National Strategic Plan for HIV/AIDS, 2006–2010, aims to reduce transmission and vulnerability, particularly among at-risk populations; improve treatment, care, and support; and mitigate the epidemic's social, cultural and economic effects. Target populations include sex workers and their clients, MSM, IDUs, partners and families of HIV-infected individuals, prisoners, mobile populations, uniformed services personnel and youth.
- 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.
- China's long-term plan for 1998–2010 focuses on reducing transmission among at-risk populations and preventing the spread of HIV among the general public. Between 2001 and 2005, the government established centers for disease control and prevention; secured increased funding for HIV/AIDS education, prevention and treatment, as well as for surveillance and pilot programs for high-risk populations; and issued updated regulations and recommendations on STI diagnosis and treatment. Stigma reduction and distribution of information, education, and communication materials is also part of the country's range of activities.
- Lao PDR's National Action Plan on HIV/AIDS/STIs, 2006–2010, focuses on achieving universal access to treatment, care and support. The National Socioeconomic Development Plan, 2006–2010, also addresses HIV/AIDS, indicating Lao PDR's commitment to expanding the national response. Since implementing the plan, national authorities have worked to reach those most likely to be exposed to HIV; scaled up prevention, treatment, care and support; and improved strategic information.
- The National Strategic Plan for 2004–2008 in Papua New Guinea focuses on seven priority areas of intervention: treatment, counseling, care and support; education and prevention; epidemiology and surveillance; social and behavioral change research; leadership, partnership and coordination; family and community; and monitoring and evaluation.

Several nongovernmental organizations (NGOs) contribute to the Southeast Asia region's HIV/AIDS response, including the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund has disbursed more than $250 million to the region. The U.S. Government provides one-third of the Global Fund's contributions.

USAID Regional Support

The strategic approach to HIV/AIDS of the Regional Development Mission for Asia (RDMA) of the United States Agency for International Development (USAID) is to act as a regional catalyst for technical leadership, ultimately increasing the impact of investments in HIV/AIDS and other infectious diseases within the region.

The goals of RDMA's HIV/AIDS strategy in the region are to reduce the incidence and prevalence of HIV/AIDS and to mitigate its impact on people living with HIV/AIDS (PLWHA) and their families. This entails reducing HIV transmission among most-at-risk populations (MARPs). The primary target MARPs are IDUs, MSM, sex workers and their clients, and PLWHA.

RDMA works in partnership with the U.S. President's Emergency Fund for AIDS Relief (Emergency Plan/PEPFAR) in Vietnam. The program also provides bilateral HIV/AIDS support to Burma, China, Lao PDR, Papua New Guinea and Thailand. The overall objective is to increase the use of effective responses to HIV/AIDS, focusing primarily on prevention, but also including care, support and treatment. To achieve the goals and objectives of the program, the strategy focuses on four major components: 1) make strategic information more available and useful; 2) increasing access to comprehensive prevention interventions for MARPs; 3) increasing access to care, support and treatment for PLWHA and their families; and 4) strengthening the enabling environment, focusing on increasing participation of civil society, including regional networks, and developing and implementing supportive policies and regulations. Capacity development and scale-up of successful, innovative models are themes that cut across all four components.

USAID/RDMA Implementing Partners

RDMA provides assistance primarily through international NGO implementing agencies (IAs), which then provide grants and technical assistance to local government and local NGO partners. The IAs for HIV/AIDS presently are Family Health International (FHI); Population Services International (PSI); International HIV/AIDS Alliance (Alliance); Pact, Inc. (Pact); Health Policy Initiative (HPI)/Research Triangle Institute (RTI); and JSI/MEASURE Evaluation (MEASURE).

- FHI is implementing a combination of primary HIV prevention and clinical care activities.
- The focus of PSI's efforts within the USAID program is condom social marketing targeting MARPs, as well as modeling effective prevention with IDUs.

- Alliance's main contribution to the USAID program is to support the involvement in HIV prevention, care, and treatment of MARPs, as well as PLWHA, through small grants to local NGOs and networks.
- Pact's focus is to act as an umbrella for subgrants to local NGOs and networks for implementation and to provide organizational capacity building to the NGOs.
- The focus of HPI/RTI's efforts within the USAID program is to facilitate an enabling environment for better HIV/AIDS policy and programs and to build the capacity of local groups' HIV/AIDS advocacy skills.
- MEASURE's main contribution to the USAID program is to support the development and implementation of national and provincial HIV monitoring and evaluation strategies.
- Additionally, from fiscal years 2005 through 2007, RDMA provided $1 million annually through HPI to support the Association of Southeast Asian Nations Secretariat for HIV/AIDS.

Results to Date

- Rapid expansion of prevention services targeting MARPs
  - The number of individuals reached by USAID community outreach programs increased from 21,249 in 2003, to more than 200,000 in 2006.
  - The number of NGO programs supported by USAID and implementing behavior change interventions increased from 37 in 2004, to 105 in 2006.
  - The number of drop-in centers supported by USAID and targeting MARPs increased from 14 in 2004, to 45 in 2006.

- Rapid expansion of HIV counseling and testing targeting MARPs
  - By 2006, USAID was supporting 28 counseling and testing clinics that previously did not exist.
  - In 2006, USAID IAs built local capacity by training 481 people in provision of quality counseling and testing services.
  - The number of MARPs targeted by USAID accessing counseling and testing increased from 1,085 in 2004 to 18,246 in 2006.

- RDMA successfully leveraged $4.26 million of non-U.S. Government resources for HIV/AIDS targeting MARPs.

Important Links and Contacts

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USAID HIV/AIDS Web site, Southeast Asia:
http://www.usaid.gov/our_work/global_health/aids/Countries/ane/aneregion.html

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