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HIV/AIDS in South-East Asia Region

Report of the 14th Meeting of National AIDS Programme Managers

Thimphu, Bhutan 16–19 November 1999

World Health Organization
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1. INTRODUCTION

The HIV/AIDS epidemic started rather late in South-East Asia, the first case being reported in Thailand in 1984. Since then, the spread of the disease is so rapid that it causes grave socio-economic consequences in these countries. The WHO Regional Office for South-East Asia (SEARO) has been providing technical and financial support to Member Countries in controlling this rapidly emerging disease. WHO has been conducting regular meetings of the National AIDS Programme Managers to exchange country experiences and share lessons learnt in combating the disease in their own countries. The 14th meeting of the National AIDS Programme Managers was conducted in Thimphu, Bhutan from 16 to 19 November 1999.

The meeting was organized in collaboration with and support from the Health Division, Royal Government of Bhutan. All Member Countries except DPR Korea and Maldives participated in the meeting (see Annex 1 for list of participants). The meeting was also attended by representatives from WHO headquarters, SEARO and country offices as well as by STD/AIDS programme staff of the Health Division, Royal Government of Bhutan. The programme consisted of plenary presentations, discussions and group work (see Annex 2 for programme).

2. OBJECTIVES

The main objectives of this meeting were:

(1) To review and exchange country experiences on STD/AIDS prevention and control in SEAR, including follow up of the recommendations made at the 13th Meeting of NAP Managers;

(2) To discuss the recent advances in the area of HIV prevention, diagnosis and treatment and their application in and relevance to the South-East Asia Region;

(3) To identify mechanisms for further strengthening of national STD/AIDS programme (NAP) initiatives, including coordination and national responses and intercountry co-operation;

(4) To plan follow up the CCPDM/RC resolution to intensify HIV surveillance at the country level, and

(5) To recommend further steps needed for enhanced country responses to the AIDS epidemic as well as areas for WHO support.

3. OPENING CEREMONY

The meeting was inaugurated by Dasho (Dr) Jigmi Singay, Secretary, Royal Civil Service Commission. Dr Singay expressed his deep gratitude to the officials from WHO/SEARO for conducting such an important meeting in Bhutan, and also to AIDS programme managers from Member Countries for attending it. He further emphasised the momentous threat of HIV/AIDS in the South-East Asia Region, and urged the Member Countries to work collectively in fighting against the problem, while sharing the experiences, concerns and issues in their own countries.

Dr Orapin Singhadej, WHO Representative in Bhutan, read out a message from the Regional Director, Dr Uton Muchtar Rafei. It was emphasized that HIV/AIDS was an area of priority concern for WHO and all member countries were urged to continue in their efforts to halt the spread of HIV infection. She also thanked the Royal Government of Bhutan for kindly hosting the programme managers 'meeting in such beautiful surroundings and for providing all facilities.

4. GLOBAL AND REGIONAL OVERVIEW OF HIV/AIDS

Since it was first reported in the United States in 1981, the AIDS epidemic has quickly become one of the most serious health and developmental problems facing the world today. Over 33 million people are currently living with HIV/AIDS and 16 million have already died.

Although the first patient with AIDS was reported in 1984 from Thailand, in most other countries of the South-East Asia Region, HIV was not diagnosed until 1986 or later. As of December 1999, WHO/UNAIDS estimated that 33.4 million people were living with HIV/AIDS and 16 million had already died. In the South-East Asia Region, 5 million people are infected, of which 3.5 million are in India alone. Therefore, HIV prevention and provision of care for those living with HIV/AIDS are both important priorities for the Region. The experience of responding to HIV/AIDS over the years shows that HIV/AIDS prevention is possible through community-based interventions targeted at various population groups. However, high-level political commitment, allocation of resources and involvement of target populations in programme planning, implementation and evaluation is essential for success.

5. HIV/AIDS/STI SURVEILLANCE IN THE REGION

In most countries of the Region, sentinel surveillance has become a regular annual feature and yields data about the trends and geographic variability of the epidemic. Myanmar made very effective use of surveillance data to fine-tune its national programme. India increased the sentinel sites to 181 from the earlier 55 sites and ensured that one round of annual surveillance is carried out at all sites, including 18 antenatal sites representing the rural population. A rationalization exercise is under way and it is likely that the sites would become even more representative of the population. The national coverage enabled India to carry out a fresh estimation exercise and come up with national and international consensus on the total number of HIV-infected people in the country.

In future, the focus of the national AIDS programmes should be on improving the quality and coverage of HIV sentinel surveillance. The situation regarding AIDS case-reporting continues to be variable with most countries reporting considerable under-diagnosis and under-reporting of cases. Thailand reports the best coverage of nearly 80% in the Region. All Member Countries are aware of the problem and making efforts to increase the reporting of cases.

Surveillance of sexually transmitted infections (STIs) continues to be a problem in many parts of the Region. It was agreed that effective and feasible mechanisms needed to be evolved to get a good idea of the prevalence and trends. Behavioural surveillance and assessment of levels and types of risk behaviour in the community are being carried out in many Member Countries. Thailand made extensive use of this methodology for its programmatic purposes and conclusively demonstrated the relationship between behaviour change and change in new HIV infections. India made a beginning and the data from three waves of surveillance in Tamil Nadu has given important pointers to the programme. Bangladesh also carried out an innovative risk behaviour survey and its methodology might be of interest to many countries.

6. COUNTRY EXPERIENCES: HIV PREVENTION

6.1 Behavioural Change Interventions including Condom Promotion

Thailand set an example in this area with an active awareness and condom promotion programme since the beginning of the epidemic. Since 1990, regular surveys were carried out to assess condom use, which demonstrated that condom use has increased both amongst sex workers and the general population. It was also shown that visits to sex workers by the general population had considerably decreased. This reflected in lower HIV and STI rates amongst young male army recruits. Presently, the HIV prevalence in patients at STI clinics is around eight per cent. Condom promotion has the best chance for success when supported by an effective and efficient health care system and integrated into a coordinated HIV/STI prevention and care programme.

6.2 STI Management: Priorities and Issues

The control, early detection and treatment of STIs proved to be an effective tool to prevent HIV. STIs by themselves also cause considerable morbidity and have a deleterious effect on the quality of life of the individuals and the community. Unfortunately, in most Member Countries, detection and treatment of STIs is given low priority and has neither been integrated into the general public sector health care system, nor is it actively sought by the

community. As a result, a large proportion of those that seek care do so from the private sector and from various categories of qualified and unqualified health care providers.

Integrating the management of STIs into the primary health care system is a desirable goal. Management of STIs based on syndromic diagnoses has been advocated by WHO because of the difficulty in getting etiologic diagnosis. The syndromic management of STIs needs to be promoted and used by the private sector in addition to the public sector. Training of health care professionals in the private sector is also an important priority, since they tended to treat a greater majority of patients with STI.

For optimal efficacy of this approach, it is essential that attention be paid to logistic support to ensure appropriate, adequate and timely supplies of the required therapeutic agents. The primary health care system would also need to be backed up, when required by a referral system of diagnostic laboratory facilities to diagnose and treat those who do not get relief from the syndromic approach.

Some research into the exact nature of etiologic agents prevalent in the community and their pattern of anti-microbial sensitivity could help in fine-tuning the syndromic management guidelines to meet local needs. WHO/SEARO has already established a system of gonococcal antimicrobial susceptibility programme (GASP) in the Region, which needs to be strengthened to be of benefit to the programmes. Another area identified for research relevant to the programme was investigation of treatment-seeking behaviour.

While many countries had targeted interventions programmes, these needed to be expanded to scale and to become an integral part of the national effort. It is important for Member Countries to plan a comprehensive and systematic research agenda to meet the need for information for programme planning and implementation.

6.3 Preventing Mother-to-Child Transmission of HIV: Issues relating to new Technologies

The best way to prevent mother-to-child transmission is to reduce the number of women infected with the virus, and the number of HIV-positive women

who become pregnant. This entails a comprehensive programme targeting women and includes components such as education, HIV/AIDS awareness and social empowerment.

Mother-to-child transmission takes place in-utero, during labour and while breastfeeding. All three periods must be attended to in a comprehensive programme. In all three periods, the crucial factor appears to be the level of viraemia. Anti-retroviral therapy during pregnancy apparently reduces blood HIV levels to a point where transmission becomes less likely. Many regimes have been tried, generally based on AZT. The Bangkok short course regime demonstrated that transmission could be effectively reduced, and that too at a price within the reach of many countries in the Region.

Currently, Nevirapine programme is of great interest. It was demonstrated that just two doses of Nevirapine, one to the mother during labour and the other to the child within 72 hours, cuts HIV transmission to about a third, and that too in the presence of breastfeeding. The cost of the drug for both doses is about three or four US dollars.

The main constraints in the effort to reduce mother-to-child transmission are the problems associated with identifying those infected and finding an alternative to breastfeeding. Children of poor mothers, living in environmentally stressed situations are at great risk of dying of diarrhoeal and respiratory tract infections. Breast-feeding is their only protection. Choosing between the risk of HIV infection and the chances of succumbing to common childhood infections might be their only choice.

Voluntary counselling and testing for HIV infection in antenatal clinics is an expensive procedure, not because of the expense involved in the test kit, but because of the need for trained counsellors. Several Member Countries in the Region are working out practical methods to achieve this goal so as to have an effective programme for minimizing mother-to-child transmission. Without effective VCT programmes, programmes such as the prevention of MTCT cannot be established. VCT services need to be expanded in all countries of the Region.

Thailand has been a pioneer in this area and the results of its studies on the short course regime with AZT influenced thinking on this subject the world over, and was enthusiastically adopted by many developing countries.

India instituted a programme in 11 centres to evaluate its feasibility. Myanmar not yet adopted a national programme, but pilot projects are underway at three different sites. Further developments in this rapidly evolving area are keenly awaited, though the early reports on Nevirapine held much promise, but the feasibility of implementing the programme as a national endeavour remains one of the major challenges.

6.4 HIV and Injecting Drug Use

Though the sexual route of spread is dominant in the Region, injecting drug use is driving the epidemic in some parts of the Region. Predominant amongst such areas are Myanmar, north-east India and some parts of Thailand. Myanmar showed the way by a vigorous and effective campaign against the spread of HIV through injections for drug use. Through its efforts, the prevalence of HIV in drug users is now not increasing any more. Interestingly, this was achieved without a needle-exchange programme. The efforts in Myanmar focused on education in schools, deploying 20 trainers for drug abuse and working in the worst affected areas with the help of 300 volunteers.

Nepal recently conducted a rapid assessment of the prevalence of injecting drug use in all five regions of the country, in 19 population concentrations. 1,109 new drug users were identified and 759 individuals, all male except for 4, agreed to give blood for testing. It was found that 40 per cent of the injecting users and eight per cent of those who derived the use of intravenous drugs tested positive for HIV. It is evident that HIV infection is a major problem amongst drug users in Nepal and harm reduction strategies are urgently required.

The methodology might be of use to other Member Countries who might wish to carry out similar rapid assessments after further referring the procedure. Nepal started a community-based intervention to combat the menace of injecting drug use mediated HIV spread, as had India in the affected states. Education and needle exchange are the main pillars of the programme for the prevention of the spread of HIV through injecting drugs, coupled with de-addiction and rehabilitation. Studies of the pattern of substance abuse need to be initiated to help in programming.

6.5 Safe Blood Transfusions

Most countries in the Region made significant progress in ensuring safe blood. India achieved its objective of ensuring that all blood used in the country for transfusions is screened for HIV (and other conditions) by an innovative approach. The use of judicial mandate (Supreme Court of India) to expedite the implementation of the National AIDS Control Organisation programme to ensure blood safety had not been used earlier in the Region or elsewhere. All blood banks were registered and had to meet the standards laid down for blood safety. Failure to do so was punishable by law and the persons breaking the law were also held to be in contempt of the Supreme Court.

All countries made much progress in ensuring safe blood. Presently, except in Bangladesh, more than 95% of donated blood in all countries in the Region is screened for HIV. In Bangladesh, up to 80% of the blood is still being supplied by professional donors. Much of the blood used, especially outside major metropolitan areas, is unscreened. Though a start had been made in some metropolitan areas, safe blood for all was still an urgent priority in that country.

It was agreed that attempts should be made to ensure safe blood for all by 2001. Moreover, quality assurance programmes for all laboratory-based services need to be put into place in all Member Countries that do not have them yet and existing programmes strengthened.

7. COUNTRY EXPERIENCES IN HIV/AIDS CARE: DEVELOPING MODELS OF CARE ACROSS THE CONTINUUM

In most countries of the Region, antiretroviral drugs are not available as a part of the public sector response to persons with HIV. However the provisions for the early detection of opportunistic infections with appropriate treatment were being instituted in many areas. Even without Highly Active Antiretroviral Therapy (HAART) much relief from avoidable suffering was possible by the management of opportunistic infections and such provisions needed to be built into the health care system in all areas with a significant HIV morbidity.

Thailand had demonstrated an exemplary programme for care of the HIV-infected and persons suffering from AIDS. The options of care extended from the household and community to the hospital for those needing in-patient care. Besides the support mechanisms at the community level, special facilities for the terminally ill have been established in the community. Such programmes for a continuum of care extending from the home and community to the hospital level need to be developed in all Member Countries of the Region. The provision should include self-help and support groups and draw upon the resource present in persons living with HIV/AIDS.

This is an area where community-based organizations (CBOs), NGOs and religious leaders can play an important role and all Member Countries should take active steps to use organs of civil society to extend quality care to persons living with HIV/AIDS across the continuum of care from hospital to the community. Persons living with HIV/AIDS form a vital resource and their involvement in such programmes could be of great benefit.

The interactions and synergistic relationships between HIV and other diseases such as TB need to be explored further. In this context, it was considered desirable that the HIV/AIDS programme managers' meeting and TB programme managers 'annual meeting be held back-to-back with a day of overlap.

The utility of the HIV/AIDS programme managers' meeting was reiterated and it was emphasized that these meetings should be regularly held. Besides the coordination of activities in the Region, another perceived advantage was the opportunity to learn from the country experiences in the Region. It was felt that within the Region, visits/study tours would greatly enhance the programme. For example, in most Member Countries, the programme would benefit from a visit to the continuum of care project in northern Thailand.

8. RECOMMENDATIONS

The meeting discussed and shared country experiences in various programme areas including surveillance, behavioural change interventions, STI, injecting drug use, blood transfusion safety and newer technologies such as

antiretroviral therapy (ARV) and issues relating to prevention of mother-to-child transmission (PMTCT). HIV/AIDS Care approaches and models were also shared. Individual discussions provided an opportunity to discuss country-specific issues and plans for year 2000-2001. The following recommendations were made:

8.1 For Government

(1) HIV/AIDS/STI should continue to be accorded high priority and should be treated as a major developmental issue. The programme should be extended into all sectors, both government and private.

(2) Countries should ensure the achievement of Safe blood for all' by the year 2001.

(3) STI management is the most important priority for STI control and prevention of HIV transmission. Since 50-80% patients are cared for in the private sector, efforts are needed to encourage the concept of syndromic management among private sector clinicians and pharmacists.

(4) Community-based behavioural change interventions should be expanded on a priority basis to cover all populations with high-risk behaviour and in all the areas. Intervention-linked behavioural studies could be useful in planning specific targeted interventions.

(5) Community-based care along the model of Mae Chan hospital in Thailand should be planned and implemented in the Region. Involvement of people living with HIV/AIDS and NGOs as a part of the continuum of care should be encouraged and actively promoted.

(6) In order to obtain reliable data for advocacy and planning, and to follow-up CCPDM/RC resolution, during 2000-2001, all countries should strive to improve the quality of HIV surveillance, establish STI surveillance and to initiate/expand risk behaviour surveillance.

8.2 For WHO

(1) The programme managers' meeting serves a very useful function and must continue as an annual event. The possibility of inviting TB and RCH programme managers for a part of the future meetings to facilitate joint and comprehensive planning should be considered.

(2) Intercountry visits and exchange of programme managers and related staff within the Region would serve a useful function and enable sharing of experiences/best practices.

(3) A systematic approach to HIV/AIDS/STI-related research should be encouraged.

(4) Evidence and information-based planning should be facilitated, and monitoring and evaluation strengthened.

(5) WHO should support countries in resource mobilization.

(6) Transborder issues should be taken up with a focus on mobile population and trafficking: the WRs should be the focal point for initiating such a dialogue.

Annex 1

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Annex 2

PROGRAMME

Tuesday, 16 Nov 1999

0900-1030	Opening Session
1045-1115	Revisiting Recommendations Of The 13th Meeting Of Nap Managers
1115-1200	HIV/AIDS Surveillance In The SEA Region: REPORT OF THE MEETING Dr Indriyono Tantoro, INO
1200-1230	**Country Experiences:** HIV/AIDS prevention • Behavioural change interventions including availability and accessibility of condoms – Dr Anupong Chitwarakorn, THA
1400-1700	**Country Experiences** (*contd.*): – Discussion on behaviour change interventions including availability and accessibility of condoms – STD management: Priorities and Issues Dr I. Abeywickrama, SRL • Preventing mother-to-child transmission: issues relating to new technologies – Dr Ying-Ru Lo, WHO

Wednesday, 17 Nov 1999

0900-1030	**Country Experiences:** HIV/AIDS prevention • HIV and injecting drug use: community-based interventions for prevention and care – Dr Than Myint, MMR – Dr T.N. Jha, NEP

1045-1230	• Safe blood for all by the year 2001: Is it possible? – Dr P.L. Joshi, IND – Dr M. Ahmed, BAN
1400-1530	HIV/AIDS Care: Developing models of care across the continuum – Dr Eric van Praag, WHO Community mobilization and HIV/AIDS care – Ms Laksami Suebsaeng, WHO
1545-1700	**WHO HIV/AIDS Initiative and SEARO POA, 2000-2001** Dr Jai P Narain, WHO UNAIDS initiatives in support of national programmes – Dr S. Sarkar, UNAIDS

Thursday, 18 Nov 1999

0900-1230	Individual country discussions with WHO and UNAIDS staff regarding DPOA, 2000-2001, and WHO/UNAIDS support in these initiatives: – Bangladesh – Bhutan – DPR Korea – India – Indonesia
1400-1700	Individual country discussions (*continued*): – Maldives – Myanmar – Nepal – Sri Lanka – Thailand

Friday, 19 Nov 1999

0900-1230	Technical updates (5th ICAAP, Malaysia Formulation and Presentation of meeting recommendations Closing

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